Report to Congress on Medicaid and CHIP

MARCH 2024

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

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

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

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

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

Report to Congress on Medicaid and CHIP

MARCH 2024

MACPAC
Medicaid and CHIP Payment and Access Commission

March 15, 2024

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

The Honorable Mike Johnson
Speaker of the House
The Capitol
Washington, DC 20515

Dear Madam Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the March 2024 *Report to Congress on Medicaid and CHIP*. This report includes chapters that address improving the Medicaid beneficiary experience through Medical Care Advisory Committees (MCACs), increasing the transparency of the denials and appeals process in Medicaid managed care, and examining payment policy for the nation's safety net hospitals.

Chapter 1 includes recommendations on how state Medicaid agencies can improve beneficiary engagement on MCACs and actions the federal government can take to aid states. Federal rules require each state Medicaid agency to establish an MCAC that includes beneficiaries or consumer group representatives. However, there is little guidance on state engagement of beneficiaries, and there are challenges with recruitment of beneficiaries and barriers to meaningful beneficiary engagement. The Commission unanimously voted in favor of three recommendations that call on the Centers for Medicare & Medicaid Services to issue guidance focused on specific state concerns related to implementation challenges. The recommendations also call on state Medicaid agencies to develop a plan to recruit beneficiary members from historically marginalized communities as well as to develop and implement policies that reduce beneficiary participation barriers.

Chapter 2 focuses on the monitoring and oversight of denials and appeals in Medicaid managed care and makes recommendations to improve monitoring, oversight, and transparency of denials and appeals as well as the beneficiary experience with the appeals process. Medicaid managed care organizations (MCOs) authorize and pay for covered services as well as deny or limit services to ensure that only appropriate, medically necessary care is provided. Beneficiaries have the right to appeal MCO coverage decisions. Federal rules require that states have monitoring systems in place to provide oversight of MCOs and their appeals systems. The chapter lays out the current federal requirements for the appeals process as well as for monitoring, oversight, and transparency; elaborates on state flexibilities within the current federal framework; and describes key challenges with the current structure. The Commission makes seven recommendations to improve the appeals process and enhance monitoring, oversight, and transparency efforts.

The final chapter of the March report continues the Commission's work on our annual, statutorily mandated report on Medicaid disproportionate

share hospital (DSH) allotments to states. As in prior years, the Commission continues to find little meaningful relationship between state DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations. The policy response through the COVID-19 public health emergency helped lower the uninsured rate, improve hospital finances, and increase DSH allotments. Under current law, $8 billion in federal DSH allotment reductions are scheduled to take effect in fiscal year 2024. However, at the time of the chapter's drafting, Congress had delayed the implementation of these reductions.

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

Sincerely,

Melanie Bella, MBA
Chair

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Executive Summary: March 2024 Report to Congress on Medicaid and CHIP

MACPAC's March 2024 *Report to Congress on Medicaid and CHIP* contains three chapters of interest to Congress: (1) improving the Medicaid beneficiary experience through Medical Care Advisory Committees, (2) increasing the transparency and improving the monitoring of the denials and appeals process in Medicaid managed care, and (3) our statutorily required review of hospital payment policy for the nation's safety-net hospitals.

CHAPTER 1: Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking

Chapter 1 examines how state Medicaid agencies can improve beneficiary engagement on Medical Care Advisory Committees (MCACs) and actions that the federal government can take to aid states. Medicaid beneficiaries can offer state Medicaid programs their insights and feedback on how programs and policies are meeting their needs, challenges in accessing care, and opportunities for improvement. Federal rules require each state Medicaid agency establish an MCAC that includes beneficiaries or consumer group representatives.

Historically, states have reported little information about state implementation or use of MCACs, the effectiveness of MCACs in bringing the beneficiary voice to Medicaid programs, or the experience of states or beneficiaries with MCACs. The Commission voted in favor of three recommendations, one of which calls on the Centers for Medicare & Medicaid Services (CMS) to issue guidance focused on specific state concerns related to implementation challenges. The recommendations also urge state Medicaid agencies to develop a plan to recruit beneficiary members from historically marginalized communities as well as to develop and implement policies that reduce beneficiary participation barriers.

In this chapter, we make the following recommendations:

1.1 In issuing guidance and in providing technical assistance to states on engaging beneficiaries in Medical Care Advisory Committees (MCACs) under Section 42 CFR 431.12, the Centers for Medicare & Medicaid Services should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate meaningful beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.

1.2 In implementing requirements in 42 CFR 431.12(d)(2) that Medicaid Medical Care Advisory Committee (MCAC) membership include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment, and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

1.3 In implementing requirements in 42 CFR 431.12(e) to increase the participation of beneficiary members in Medicaid Medical Care Advisory Committees (MCACs), state Medicaid agencies should develop and implement a plan to facilitate meaningful beneficiary engagement and to reduce the burden on beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, technological, financial, and content barriers.

CHAPTER 2: Denials and Appeals in Medicaid Managed Care

In Chapter 2, we focus on the monitoring and oversight of denials and appeals in Medicaid managed care. Medicaid managed care organizations (MCOs) authorize and pay for covered services as well as deny or limit services to ensure that only appropriate, medically necessary care is provided. Beneficiaries have the right to appeal MCO coverage decisions, and federal rules require that states have monitoring systems in place to provide oversight of MCOs

and their appeals systems. However, beneficiaries appeal few denials, and program operators do not collect comprehensive information about denials in Medicaid managed care.

Currently, federal rules do not require states to collect and monitor data needed to assess access to care, monitor the clinical appropriateness of denials, or require that states publicly report information on plan denials and appeals outcomes. The chapter lays out the current federal requirements for the appeals process as well as for monitoring, oversight, and transparency; elaborates on state flexibilities within the current federal framework; and describes key challenges with the current structure.

In this chapter, we make the following recommendations:

2.1 To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process that can be accessed at the beneficiary's choice, with certain exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing.

2.2 To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services.

2.3 To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in addition to the mailed notice.

2.4 To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service.

2.5 To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. The rules should require that states use these data to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

2.6 To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit.

2.7 To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan.

CHAPTER 3: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Chapter 3 of the March report fulfills MACPAC's statutorily mandated report on Medicaid disproportionate share hospital (DSH) allotments to states for payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. As in prior years, the Commission continues to find little meaningful relationship between state DSH allotments and the number of uninsured individuals; the amounts and sources of hospitals' uncompensated care costs; and the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.

The policy response through the COVID-19 public health emergency (PHE) helped lower the uninsured rate, improve hospital finances, and increase DSH allotments. A total of 25.9 million people, or 7.9 percent of the U.S. population, were uninsured in 2022, a 0.4 percentage point decline from 2021. Some of the decline in the uninsured rate may be attributed to the continuous coverage requirements implemented during the PHE.

Hospitals reported $39.3 billion in hospital charity care and bad debt costs on Medicare cost reports in fiscal year (FY) 2021, which represented a $1.3 billion (0.4 percentage point) decrease in uncompensated care costs from FY 2020. Although uncompensated care as a share of hospital operating expense dropped substantially after coverage provisions of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) went into effect, it has largely remained unchanged since 2015.

In FY 2021, the aggregate operating margin for all hospitals was negative across all hospitals and was lower for deemed DSH hospitals, which may be partially attributed to financial disruptions of the COVID-19 pandemic. MACPAC also calculated total margin, which accounts for all forms of hospital revenue, including federal provider relief funding authorized during the PHE. The aggregate total margin was similar for both deemed DSH and other hospitals (9.3 vs. 10.1 percent, respectively). Aggregate operating and total margins for deemed DSH hospitals would have been 3 to 4 percentage points lower without DSH payments.

Under current law, $8 billion in federal DSH allotment reductions are scheduled to take effect in FY 2024. However, at the time of the chapter's drafting, Congress had delayed the implementation of these reductions. Due to the uncertainty of when the allotment reductions may be implemented, the analyses in this chapter assume the federal DSH allotment reductions will begin in FY 2026. In FY 2026, the $8 billion reduction is projected to be 48.7 percent of unreduced allotments.

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH policy. Congress has partially implemented MACPAC's recommendations on data transparency and the treatment of third-party payments in the definition of Medicaid shortfall. However, the Commission's recommendations on restructuring DSH allotments and adjusting DSH allotments to account for changes in the federal matching assistance percentage have not been implemented. The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety-net providers but has not taken a position on whether Congress should proceed with reductions in current law. However, if Congress proceeds with DSH allotment reductions, it should change the methodology to phase in reductions and gradually improve the relationship between DSH allotments and measures of need for DSH funds.

Chapter 1:

Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking

Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking

Recommendations

1.1 In issuing guidance and in providing technical assistance to states on engaging beneficiaries in Medical Care Advisory committees (MCACs) under Section 42 CFR 431.12, the Centers for Medicare & Medicaid Services should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate meaningful beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.

1.2 In implementing requirements in 42 CFR 431.12(d)(2) that Medicaid Medical Care Advisory Committee (MCAC) membership include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

1.3 In implementing requirements in 42 CFR 431.12(e) to increase the participation of beneficiary members in Medicaid Medical Care Advisory Committees (MCACs), state Medicaid agencies should develop and implement a plan to facilitate meaningful beneficiary engagement and to reduce the burden on beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, technological, financial, and content barriers.

Key Points

- Beneficiaries have much to offer state Medicaid programs in the development and implementation of Medicaid policies and can provide feedback to policymakers on the issues that affect their access and use of Medicaid-covered services.
- Federal rules require each state Medicaid agency to establish a Medical Care Advisory Committee (MCAC) that consists of beneficiaries or consumer group representatives, along with other stakeholders, to advise on the Medicaid program and policies (§ 1902(a)(4) of the Social Security Act, 42 CFR 431.12).
- MACPAC examined federal and state policies on beneficiary participation in MCACs and how states use beneficiary input to inform programs, policies, and operations. This work focused on how states engage groups that are often excluded from the decision making process.
- States have varied MCAC policies and implementation approaches, and the majority of state MCACs have beneficiary vacancies.
- States identified specific areas related to beneficiary inclusion in MCACs for which they need guidance and technical assistance, such as approaches for increasing beneficiary recruitment and diverse beneficiary representation, use of financial arrangements to encourage beneficiary participation, and strategies to support beneficiary engagement in discussions.
- Beneficiaries participating in MCACs generally described their experience as positive. However, they also cited challenges to participating on MCACs, such as the application and appointment process, meeting attendance requirements, and difficulty contributing to certain complex policy discussions.
- In May 2023, the Centers for Medicare & Medicaid Services released a notice of proposed rulemaking that would rename and expand the scope and use of states' MCACs; require states to make MCAC materials publicly available; and establish a beneficiary-only group consisting of Medicaid beneficiaries, their family members, and their caregivers.
- MACPAC's recommendations focus on the need for federal guidance and technical assistance to states to address beneficiary recruitment challenges, state efforts to strengthen the diversity of representation of beneficiary members, and state efforts to reduce burden on beneficiaries while participating in MCACs.

CHAPTER 1: Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking

Medicaid beneficiaries can offer state Medicaid programs their unique insight and feedback on how programs and policies are meeting their needs, challenges in accessing care, and opportunities for improvement. Policymakers can engage with beneficiaries to develop a deeper understanding of the issues that affect their access to care, co-create solutions, and anticipate potential unintended consequences of policies that would negatively affect the people served by the program. Sustained beneficiary engagement can help build trust between the community and the state Medicaid agency and promote accountability to beneficiaries (Skelton-Wilson et al. 2021). In addition, research shows that engaging people with lived experience is one strategy government officials can use to advance health equity (Allen et al. 2021, Zhu et al. 2021). However, beneficiaries are not often included in policymaking decisions that affect their coverage and health outcomes (Coburn et al. 2021).

As a way to include those with lived experience with the Medicaid program in state Medicaid agencies' policymaking process, federal rules require each state Medicaid agency to establish a Medical Care Advisory Committee (MCAC) that includes beneficiaries or consumer group representatives along with other stakeholders (§ 1902(a)(4) of the Social Security Act, 42 CFR 431.12). These rules grant states flexibility in implementing their MCACs to fit the needs of their state. As such, states have adopted varied approaches to structuring and running their MCACs. To establish more explicit expectations for including beneficiary perspectives in MCACs, in May 2023, the Centers for Medicare & Medicaid Services (CMS) proposed a rule on ensuring access to Medicaid services that also revises the MCAC regulations. This proposed rule is the first change to MCAC regulations since CMS established them in 1978. The proposed rule emphasizes beneficiary engagement and increases transparency between the Medicaid agency and beneficiaries (CMS 2023).

Historically, little information has been reported publicly about state implementation or use of MCACs, the effectiveness of MCACs in bringing the beneficiary voice to Medicaid programs, or the experience of states or beneficiaries with MCACs. The Commission signaled that additional research should be done to learn more about current state practices for engaging beneficiaries of color, incorporating beneficiary input into program policies and operations, and promoting greater participation (MACPAC 2022a). To address gaps in knowledge about MCACs, MACPAC contracted with RTI International (RTI) to examine how states use MCACs to engage beneficiaries, particularly those from historically marginalized communities, to inform programs, policies, and operations. RTI conducted a policy scan of state statute and regulations as well as publicly available bylaws, charters, member lists, and websites for all 50 states and the District of Columbia to understand state rules for MCACs.[1] RTI analyzed MCAC membership requirements, including requirements for engaging beneficiaries from historically marginalized populations, current MCAC composition, supports offered for beneficiary participation, frequency of meetings, beneficiary recruitment practices, and policy areas in which states require MCACs' input.

Our analytic approach helped identify how each state's MCAC is established and conducted. MACPAC and RTI interviewed a CMS official from the Center for Medicaid and CHIP Services as well as state Medicaid officials, beneficiaries, and consumer group representatives who participate in the advisory committee meetings in six states.[2] These interviews explored the barriers to beneficiary participation as well as approaches to overcome these barriers. The majority of our research concluded before the release of the proposed rule from CMS.

The findings from the policy scan and stakeholder interviews identified several challenges with recruitment of beneficiaries, particularly those representing historically marginalized communities, and barriers to meaningful beneficiary engagement. Examples of engagement barriers include beneficiary feelings of intimidation, reacting to proposed policy versus informing the policymaking process, or inconvenient meeting times. The findings also identified potential approaches to addressing these challenges, such as

partnering with community-based organizations to recruit individuals or hosting premeeting sessions with beneficiaries to help increase their understanding of and comfort with complex policy topics.

As CMS works to finalize the rule on MCACs, the federal government and states can continue their efforts to improve beneficiary engagement. States have identified specific areas related to engaging beneficiaries in MCACs for which they need guidance and technical assistance. Beneficiaries have also cited challenges to participating on MCACs, such as the application process. Addressing challenges to beneficiary engagement in MCACs is likely to require ongoing state focus. However, our work identified steps CMS and states can now take to address challenges raised by state officials and beneficiaries. The Commission makes three recommendations to improve beneficiary engagement on MCACs:

1.1 In issuing guidance and in providing technical assistance to states on engaging beneficiaries in Medical Care Advisory Committees (MCACs) under Section 42 CFR 431.12, the Centers for Medicare & Medicaid Services should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate meaningful beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.

1.2 In implementing requirements in 42 CFR 431.12(d)(2) that Medicaid Medical Care Advisory Committee (MCAC) membership include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

1.3 In implementing requirements in 42 CFR 431.12(e) to increase the participation of beneficiary members in Medicaid Medical Care Advisory Committees (MCACs), state Medicaid agencies should develop and implement a plan to facilitate meaningful beneficiary engagement and to reduce the burden on beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, technological, financial, and content barriers.

This chapter begins by providing background on the importance of beneficiary engagement, challenges to beneficiary engagement, and state approaches to address these challenges. Next, we review the federal statute and regulations related to MCACs and recent proposed changes to these regulations. Then we discuss key findings about state approaches to MCAC beneficiary recruitment, meeting structure, and beneficiary engagement from the policy scan and the interviews. This section of the chapter highlights the barriers to beneficiary recruitment and engagement and examples of state strategies to address these challenges as well as how CMS plans to address certain challenges in the proposed rule. The chapter then concludes with the Commission's recommendations and its rationales.

The Importance of Beneficiary Engagement

Beneficiary engagement ensures that those being served by the health system have a voice in how policies and programs are both created and implemented, which can support states' efforts to advance health equity. The Centers for Disease Control and Prevention (CDC), which helped develop the principles of community engagement for federal health agencies, stated that the goals of community engagement are to "build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations" and to engage the community in policymaking (NIH 2011, CDC 1997). Community engagement research notes that those most affected by programs and policies often have the solutions on how to improve them, which is why it is important to codevelop strategies (Agonafer et al. 2021).

Efforts to engage meaningfully with beneficiaries should be mindful of historic distrust of health care systems and other institutions and the factors that affect beneficiaries' ability to provide feedback (MACPAC 2022a). This distrust from Medicaid beneficiaries, particularly those from marginalized communities, is the product of decades-long

structural inequities (Agonafer et al. 2021).[3] A 2022 U.S. Department of Health and Human Services report stated that such inequities stem from racism, ableism, and other systems of oppression and require sustained institutional changes to overcome them. This report notes individuals who experience these inequities mistrust institutions with power, such as government agencies. Trust building consists of acknowledging the systemic barriers and validates the experiences of those harmed by such systems (Ramirez et al. 2022). Often beneficiaries are either excluded from discussions of the policies that affect their health and coverage or are asked to react to policies after decisions have been made (Coburn et al. 2021, Zhu et al. 2021). Lack of trust in government systems and programs and uncertainty about whether feedback will be taken into account may also discourage beneficiaries from sharing their views (Musa et al. 2009).

BOX 1-1. Other State Strategies to Engage Beneficiaries

State Medicaid agencies use varying methods for incorporating beneficiary input into policy and program decision making outside of Medical Care Advisory Committees (MCACs). States are required to provide public notice and offer the public the opportunity to submit comments or provide input before proposed program changes are submitted to the federal government. States can also solicit feedback from beneficiary surveys. Additional strategies for obtaining beneficiary feedback include the following:

Member-only advisory councils. Several states convene member-only advisory councils to make the engagement opportunities more accessible. In one study, states reported more robust consumer participation in beneficiary-only subcommittees compared to the committees in which other stakeholders participate (Zhu et al. 2021). For example, Pennsylvania has a beneficiary-only subcommittee that focuses on members' needs. This group is facilitated by a consumer advocacy group and meets separately from the MCAC meeting. The objective of the subcommittee is to initiate consumer-focused policy ideas and provide input on state policy initiatives. This subcommittee holds the agency accountable and elevates issues to gain greater attention (Zhu and Rowland 2020).

Tribal council consultation. State Medicaid agencies are required to consult with American Indian and Alaska Natives (AIAN) tribes and be responsive to their issues and concerns when making changes to the Medicaid program that have tribal implications (CMS 2015). Section 5006 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) requires states to consult with tribes, designees of Indian health programs, and urban Indian organizations on matters related to Medicaid and the State Children's Health Insurance Program (CHIP) that affect the populations. States are required to consult with tribes before submitting Section 1115 waiver requests to CMS (42 CFR 431.408(b)).

Town halls. State Medicaid officials can host town hall meetings to provide beneficiaries the opportunity to share their experiences with the Medicaid program. For example, state officials in Nebraska host town hall listening sessions every six months in various locations around the state. These town halls allow for beneficiaries to directly share areas of concern as well as suggest policy and programmatic changes to improve the program.

Managed care organization (MCO) member advisory committees. Given that managed care is the predominant delivery system in Medicaid, MCOs can play a role in engaging beneficiaries and encouraging them to share their perspectives on the Medicaid program in addition to their views on the MCOs' operations. Some states require MCOs to have member advisory committees (Bailit Health 2023). For example, Oregon's Medicaid beneficiaries are enrolled in coordinated care organizations; each organization must have at least one community advisory council, and more than half of the council's voting members must include representatives of the community (ORS § 414.575). Medicaid officials can attend MCO beneficiary meetings to engage directly with beneficiaries.

Equitable engagement strategies consist of understanding the strengths that exist within communities, including members of communities that are most impacted by systemic injustices; dedicating resources to ensure engagement is done in culturally meaningful ways; providing the adequate orientation, background, or preparatory materials for effective participation; and offering supports that ensure participation for those with varied abilities and access needs (Ramirez et al. 2022).

Community engagement research highlights the importance of establishing continuous and sustained bidirectional feedback loops even if every concern cannot be addressed or recommendation made. Experts in the field of community engagement stress the need to create meaningful opportunities for input, such as engaging people as early as possible in the decision making process and being realistic with beneficiaries about timelines to help set expectations. Research also indicates that regular communication with beneficiaries about how the state uses and applies their input is particularly important to building trust and their continued engagement (Roman et al. 2023, Ramirez et al. 2022). One study of MCACs found that not all states could identify instances in which the advisory committee's recommendations affected policymaking. However, states defined success as building relationships between agency leaders and beneficiaries (Zhu et al. 2021).

Federal Statute and Requirements

Section 1902(a)(4) of the Social Security Act, as implemented in 42 CFR 431.12, requires states to have an MCAC to advise the state Medicaid agency on health and medical care services and participate in policy development and program administration. Federal regulations describe requirements for the appointment and composition of the committee members, the scope of topics for committee discussion, and the support committee members can receive from the Medicaid agency. The state Medicaid director or a higher authority in the state must appoint MCAC members on a rotating and continuous basis (42 CFR 431.12 (c)). MCACs must include (at a minimum) board-certified physicians and other health professionals who are familiar with the medical needs of low-income population groups, Medicaid beneficiaries and members of other consumer organizations, and the director of the public welfare department or the public health department (42 CFR 431.12(d)). In addition, federal rules require states to make financial arrangements, if necessary, to support the participation of beneficiaries in MCACs and provide states flexibility in determining such arrangements (42 CFR 431.12(f)). Federal funding is available at 50 percent to cover committee expenditures (42 CFR 431.12(g)). The main purpose of MCACs is to provide a bidirectional feedback loop between the state Medicaid agency and the individuals who provide, pay for, or use Medicaid services (Davidson et al. 1984).

Proposed rule

CMS released a notice of proposed rulemaking (NPRM) in May 2023 to increase the two-way communication between state Medicaid agencies and stakeholders and to promote transparency and accountability by state Medicaid agencies to committee members.[4] CMS's intent is to make MCAC requirements more robust to ensure all states are using these committees optimally by informing the program with the experiences of beneficiaries, their caretakers, and other stakeholders (CMS 2023).

The NPRM would add specificity to the rules for MCAC structure and operations to create more meaningful engagement opportunities for Medicaid beneficiaries. The proposed rule, if finalized, would rename MCACs to Medicaid Advisory Committees (MACs) and expand the scope of topics to be addressed by MACs.[5] The state has discretion to identify topics the MAC will address, such as services that address health-related social needs, coordination of care, beneficiary communications from the Medicaid agency, grievances, consumer experience survey ratings, or design of a new program.

The proposed rule, if finalized, would also require that state Medicaid agencies establish a Beneficiary Advisory Group (BAG), that would meet separately from the MAC, with crossover membership with the MAC. Specifically, BAG members would constitute at least 25 percent of the MAC membership. The BAG would include Medicaid beneficiaries, their family members, and their caregivers. Other members of the

MAC would include representatives from consumer groups, clinical providers or administrators, Medicaid managed care plans, and other state agencies. The NPRM proposes minimum requirements for making information on the MAC and BAG activities publicly available. Specifically, states must post MAC and BAG membership lists, meeting schedules, meeting minutes, bylaws, recruitment processes, and an annual report on MAC activities and how the state used MAC and BAG feedback on its website. If the rule is finalized, states would have one year to implement these requirements (CMS 2023). CMS has indicated that it will issue a final rule and future guidance on meaningful beneficiary engagement and transparency, but it is unclear when this would occur.

State Implementation of MCACs

Though federal regulations require beneficiary representation on MCACs, little research has explored MCAC implementation, outcomes, and state strategies for beneficiary engagement on MCACs, particularly with those from historically marginalized communities. One study found that MCAC beneficiary engagement varies state by state; states appreciated beneficiary input in regard to identification and overcoming implementation challenges for agency programs and faced barriers when it came to authentic and sustained engagement (Zhu et al. 2021).

Our analysis also found that substantial variation exists in how states have implemented MCACs with respect to beneficiary and consumer group membership requirements and meeting participation requirements. In implementing MCACs, states experience many of the challenges with engaging beneficiaries described in community engagement research. This section highlights state approaches for MCAC beneficiary representation and recruitment, financial arrangements to encourage beneficiary participation, and beneficiary engagement, drawn from our policy scan and stakeholder interviews.

Beneficiary representation and recruitment

State rules for beneficiary representation on MCACs and approaches to recruiting beneficiaries vary. CMS defers to states on how to structure their MCAC composition and recruit beneficiaries onto their MCAC. Given this flexibility, our analysis found that each state's MCAC composition is different.

Beneficiary and consumer group membership. In our review of publicly available information for 44 state MCACs and the District of Columbia, 38 states explicitly describe requirements for beneficiary or consumer group representation in their state policy documents. Publicly available information related to MCAC membership requirements in the remaining states was not found. Of the states that had these requirements publicly available, there was variation in committee composition and specific requirements for representation.[6] Only 14 states explicitly require beneficiary representation (i.e., Medicaid recipients, their family members, or caregivers of Medicaid recipients) in the MCAC, and 13 of these 14 states also require consumer group representation.[7] Twenty-three states and the District of Columbia require representation from either consumer group members or beneficiaries.[8] Some states do not specify the number of beneficiary members, while Utah and Nebraska specify that at least 51 percent of MCAC members should be beneficiaries, beneficiary representatives, or consumer groups.

Interviewees noted that beneficiary members of MCACs may feel uncomfortable participating during meetings if they make up a small proportion of the membership relative to other types of members. In addition to consumer groups and beneficiaries, MCAC membership can include state Medicaid officials, officials from other state government agencies, health care providers, and hospital and plan representatives. State officials from two states noted that they had reconstituted their MCACs so that committee membership is weighted more equally between Medicaid beneficiaries and consumer group members relative to providers and plan representatives.

States are not federally required to have beneficiary representation from historically marginalized communities on their MCACs, but some have adopted fairly narrow, state-specific requirements. For example, Connecticut, Oregon, and Wisconsin require representation of persons with disabilities. Connecticut and Wisconsin also require representation of dually eligible beneficiaries or older adults. Minnesota requires tribal representation on its MCAC. No state requires specific beneficiary representation by race or gender. A few states have requirements for consumer group member representation. For example, Idaho requires representation from legal aid providers and clergy. Kentucky requires consumer group representation of persons reentering society after incarceration, children and youth, women, and minorities.

Diverse representation of beneficiaries can provide state Medicaid agencies with access to a broad range of perspectives on how the Medicaid program is meeting their needs and challenges with the program. As previously mentioned, meaningful engagement can help the state Medicaid agency establish trust with these communities and advance state health equity efforts by providing opportunities for beneficiaries and other MCAC members to codevelop solutions to beneficiaries' challenges. It is also a way for state Medicaid agencies to demonstrate commitment to the individuals being served, and it increases program accountability (Allen et al. 2021).

The NPRM retains current rules about beneficiary representation and does not add requirements around diverse representation. Instead, CMS encourages states to consider diverse representation as part of their member selection of Medicaid beneficiaries. The proposed rule encourages states to consider geographical diversity, tribal communities, people older than age 65, or people with disabilities. These considerations for states are consistent with CMS's strategic plan for advancing health equity for underserved populations (CMS 2023).[9]

Beneficiary member recruitment. State Medicaid agencies use different strategies to recruit beneficiaries. States advertised openings for beneficiary representation on the MCAC through announcements on their state Medicaid websites. The policy scan found that 12 states published information on their MCAC website to actively recruit MCAC members. Our interview findings suggest that publishing information on the MCAC website alone is insufficient to recruit beneficiary members. Beneficiaries confirmed they did not learn about MCAC position openings through such a public posting. States may partner with community-based organizations to identify individuals or recruit beneficiaries directly from town halls and other public meeting forums. Another common approach is to recruit beneficiaries who serve on other state advisory committees or managed care organization beneficiary committees. Alaska, Maryland, and Utah require state Medicaid officials to contact consumer, provider, or community organizations for recommended beneficiary members. In Virginia, the state Medicaid agency works with community-based stakeholders to identify potential committee members and also sends letters to randomly selected Medicaid enrollees with information on how to apply to the committee.

States often recruit consumer group members to represent Medicaid beneficiary perspectives and to speak to issues beneficiaries experience. This strategy can be beneficial because consumer group members may be easier to recruit than beneficiaries, can represent a broader community perspective, may have more familiarity with technical Medicaid topics, and may face fewer barriers to participation. For example, one state Medicaid official stated that they rely heavily on consumer groups to gain beneficiary input. However, one consumer group member shared that although consumer group representation is important, these advocates do not necessarily provide the same perspectives as beneficiaries who have more intimate experience with the program.

The policy scan and interviews revealed little information about how MCACs recruit from historically marginalized communities. Most of the interviewed beneficiaries and consumer group representatives were unaware of MCAC efforts to recruit beneficiaries from historically marginalized communities. In Utah, the MCAC bylaws state that the MCAC should ensure that individuals from underrepresented groups, communities, or identities are aware of opportunities to participate on the MCAC.

Beneficiary recruitment challenges. State Medicaid agencies note difficulties in finding beneficiaries willing to participate in MCACs, which can lead to beneficiary vacancies. The analysis of publicly available membership lists found that the majority of states had beneficiary vacancies. Only 11 states had beneficiaries listed as part of their MCACs. One state official noted that because of challenges related to finding new beneficiary members, the same beneficiary has been a member of the MCAC for nearly two decades.

Our research shows that state educational efforts regarding MCACs is limited. Thus, beneficiaries may be unaware that their state has an advisory group that seeks their participation and input, the purpose of the MCAC, or how to apply. By increasing outreach and education about the MCAC and beneficiary opportunities to participate, states may be able to increase the number of beneficiaries choosing to participate.

State officials noted their intent and efforts to increase the number of beneficiaries on the MCACs but that doing so was difficult. Although our findings suggest that using other Medicaid-related committees to recruit members is a helpful tactic in finding beneficiaries, Medicaid officials also commented that this strategy can create challenges when multiple agencies and committees seek the same beneficiaries' input. Most state officials acknowledge that Medicaid beneficiaries, such as those who work during traditional business hours or those who are parents, have responsibilities that affect their ability to participate in MCAC meetings.

Recruiting individuals from marginalized communities requires additional effort, so some states have focused on community-based approaches to implement this tailored approach. A Nebraska state official reported that MCAC community listening sessions held in different locations around the state have been an effective tool for recruiting diverse beneficiary members. An Oregon Medicaid official described sharing recruitment information in Spanish and has offered to translate these materials into other languages to attract beneficiaries who do not speak English as their first language. Most Medicaid officials described a word-of-mouth approach in collaboration with beneficiary members from diverse communities whose terms were ending soon. Other states noted challenges with recruiting beneficiaries in general and were not yet focused on targeted recruitment of beneficiaries from historically marginalized groups. There has been no federal guidance or technical assistance on how to recruit and retain members from historically marginalized groups.

The NPRM proposes that states develop their recruitment and appointment processes for both MAC and BAG member recruitment and appointment and publish the processes on their state websites. This information would need to be easily accessible to the public. CMS indicates that guidance about recruitment strategies is forthcoming.

State use of financial arrangements for beneficiaries

States have adopted strategies that address logistical barriers that limit beneficiary participation in MCACs. Examples of logistical barriers include the inability to take time off work and the availability and cost of transportation and childcare. Some state Medicaid agencies are beginning to host more virtual MCAC meetings to eliminate transportation barriers (Coburn et al. 2021). Other strategies to increase participation include hosting MCAC meetings outside of traditional work hours, providing food during meetings, or providing transportation to and from meetings (Allen et al. 2021).

Most states offer at least one type of financial arrangement to facilitate beneficiary participation on MCACs, but either most beneficiaries are unaware of these supports or the supports are underused. The financial support can be reimbursements for unspecified incurred expenses, per diems, or can be provided on a case-by-case basis determined by the state Medicaid agency. Among the states with published policies, travel supports was the most common. Twenty-two states offer travel expense reimbursement. All six states interviewed reimburse for beneficiary MCAC members' travel costs (which may include reimbursement of transportation and hotel expenses) to attend in-person meetings. Despite these financial arrangements for travel, some beneficiaries and consumer group members noted that individuals may experience challenges that are not addressed by available supports. For example, some beneficiaries may not be able to attend in-person meetings because they do not have a car or have limited access to alternative transportation options.

Few states offer other types of financial arrangements to support beneficiary MCAC participation. Three states offer childcare or dependent care expense reimbursement. Four states offer reimbursement for personal assistance. Vermont is unique in that it limits its per diem, reimbursement for travel and childcare expenses, and personal assistance services to MCAC members whose income does not exceed 300 percent of the federal poverty level.

Beneficiaries often cite the lack of compensation and lost income from having to take time off work as barriers to participation in MCAC meetings (Zhu and Rowland 2020). Community engagement researchers note that other experts are often compensated for providing their expertise and posit that beneficiaries, who are experts in their lived experience, should be treated similarly. Adequately compensating beneficiaries for their time and expertise demonstrates that the state Medicaid agency values their input (Roman et al. 2023, Allen et al. 2021).

Challenges in using financial arrangements. Of states providing financial arrangements, 19 states offer financial compensation; however, little information is provided on their availability or how to access them. Seven states provide financial arrangements "if needed," and five offer reimbursements for "necessary expenses," but no further information was provided in publicly available documentation. Oregon passed legislation in 2022 that offers certain MCAC members $166 per day for when they are performing MCAC-related duties, such as preparing for and attending meetings (ORS § 292.495).[10]

Some beneficiary interviewees expressed that they do not use financial arrangements because they fear it may affect either their Medicaid eligibility or status with other entitlement programs.[11] During the interviews, state Medicaid officials asked for more clarification from CMS about the appropriate financial support for beneficiaries that does not affect their eligibility. States also sought more information about the appropriate forms of reimbursement, such as gift cards or checks. CMS has not indicated publicly whether it will issue further guidance about how states can offer financial support without affecting beneficiaries' eligibility.

Efforts to support beneficiary engagement in MCAC discussions

Some states provide supports to better engage beneficiaries during MCAC meetings, but most consumer group members and beneficiaries identified this as an area for improvement. Some interviewees identified examples of helpful supports that state officials may provide, such as sharing information with committee members in advance of MCAC meetings, providing background information for agenda items, working with beneficiaries to cocreate the meeting agenda, and hosting premeeting question-and-answer sessions to help increase beneficiaries' understanding of complex policy topics. Maryland provides staff assistance specifically for beneficiaries to review meeting materials. Some states also provide interpretation services to enable participation by beneficiaries with limited English proficiency.

States may also use subcommittees as a strategy to obtain input in specific areas that are important to beneficiaries. Twenty-three states use topic-based MCAC subcommittees or beneficiary-only subcommittees as ways to solicit beneficiary input on specific topics. Common subcommittees include, for example, special health populations, long-term services and supports, consumer-focused groups, or managed care.

State resource challenges limit additional engagement efforts. Meaningful engagement efforts to strengthen the relationship between the Medicaid agency and beneficiaries is time and labor intensive, and states face difficulty balancing this investment with other priorities. State officials agreed on the need to improve beneficiary engagement practices but acknowledged staff capacity as a key limitation to such efforts. State Medicaid officials suggested providing additional federal funding to states for the time and work state Medicaid agencies put in to organize and run MCAC meetings. State officials indicated such funding could help support state efforts to engage beneficiaries in meeting proceedings, such as preparing beneficiaries for each meeting. Under current and proposed federal MCAC rules, federal match for Medicaid administrative activities is available for expenditures related to MCAC and, in the future, MAC and BAG activities.

Beneficiary Experience Participating in MCACs

Beneficiaries participating in MCACs generally described their experience as a positive collaboration between the state Medicaid agency and MCAC members. Beneficiaries agreed that beneficiary voice on MCACs was important because it is an opportunity for policymakers to learn from the beneficiaries' lived experiences to inform current and future policies and improve program administration. At the same time, beneficiaries identified several challenges that hindered their ability to participate in MCACs. These include the application and appointment process, participation requirements, and engagement in discussions.

Application and appointment processes

In some states, the MCAC application and appointment processes, which are designed and implemented by states, can hinder new beneficiary participation. Some beneficiaries described the application to join their state's MCAC as long, complex, overly formal, and similar to a job application. Current federal regulations require appointments to an MCAC be made by either a state Medicaid director or higher state authority but does not prescribe the application process.

Challenges with completing the application. Some state officials noted that overly complicated MCAC applications could deter potential beneficiary members, especially those with lower educational attainment and less experience with formal job applications. For example, in one state, MCAC applicants must create a profile on an online job application platform. The application requires a resume, short personal biography, and background check. Applicants must disclose potentially sensitive information, such as past bankruptcy filings or criminal charges. Although sharing this information does not automatically disqualify applicants, these questions may dissuade potential applicants. In contrast, the Nebraska MCAC application is simpler and asks applicants two open-ended questions: their affiliation with the Nebraska Medicaid program and the reason for wanting to serve on this committee. One strategy used by state Medicaid officials is to assist potential new members with the MCAC application. This help includes previewing the application questions with potential applicants, translating the application into Spanish, and offering assistance in completing and submitting the MCAC application.

Challenges with appointment process. Some states require MCAC members be nominated and appointed by the governor. Interviewees from these states noted that this process is tedious because it requires several rounds of vetting candidates. Others noted that some beneficiaries may assume that they will not receive governor approval due to personal reasons (e.g., having a different political affiliation than the governor or a prior legal record). One consumer group member who tried to recruit more beneficiaries noted that beneficiaries who were previously incarcerated were hesitant to apply, thinking they would be disqualified, which is untrue.

MCAC participation requirements

MCAC requirements for member term length vary by state, with three years as the most common term length. Current federal rules require that after committee members complete their terms, the state will appoint a new member to ensure that membership rotates continuously. State officials indicated that it can be difficult to find beneficiaries willing to participate in a multiyear commitment. Interviewees also noted that one benefit of longer terms is gaining a deeper knowledge of the state's Medicaid program, but they acknowledged that the downside could be a lack of new voices on the MCAC, particularly from potentially diverse populations.

MCAC meeting frequency ranges from monthly to annually, though most MCACs meet quarterly. Our review found that in 44 states and the District of Columbia, MCACs have met at least once in the past two years. In addition to scheduled meetings, 18 states allow the MCAC chair, governor, state Medicaid director, or other members to schedule additional meetings as needed. Interviewees noted that increasing the frequency of meetings can strengthen

the connections between the state Medicaid agency and the MCAC members as well as provide beneficiary members greater opportunity to provide regular feedback. State officials mentioned that the transition to virtual or hybrid meetings, due to the COVID-19 pandemic, had a positive effect. Hybrid meetings had greater attendance than in-person-only meetings because they were more accessible for participants. However, some consumer group members described a lack of closeness with their peers when joining meetings only virtually.

Challenges with attending meetings. The time commitments and inconvenient meeting times can be barriers to beneficiary engagement. Across all interviewee types, most stakeholders agreed that time commitments for traveling and attending MCAC meetings can be a barrier to participation. Beneficiaries may have jobs, childcare responsibilities, or other obligations that may preclude them from joining meetings during the business day. The beneficiary experience stands in contrast to that of consumer group and other members (e.g., state agency officials, health plan representatives) who attend these meetings as part of their jobs. Some states move their MCAC meeting locations around the state, such as hosting some meetings on tribal reservations, in rural parts of the state, or in public locations such as libraries and schools, to make them accessible for diverse populations.

Engagement in MCAC discussion

Beneficiaries and other individuals, such as some consumer group members, who do not have a background in health policy may feel hesitant about participating in MCAC meetings due to the complexity and specialization of the topics. States require MCACs to discuss and provide input on a wide variety of policy topics, including program administration, covered services, quality of care, access to care, managed care, quality assurance strategies, eligibility, and enrollment. Beneficiaries tend to feel more qualified to participate in MCAC discussions on topics that directly apply to their lived experience (e.g., provider networks, covered services, and enrollment) than with other Medicaid technical topics, such as provider payments or managed care contracting. When the latter topics are discussed, interviewees noted that beneficiaries may be less likely to speak up as they have not had experience with these issues. Given the range of topics within the purview of MCACs, it may be unrealistic to expect that beneficiary members will be able to contribute equally to them all.

Most beneficiaries interviewed reported that they received little to no orientation, training, resources, or supports to familiarize them with the MCAC or provide background information on policy topics discussed. To clarify areas in which beneficiary feedback is most needed, three states define specific areas for beneficiaries' input, such as beneficiary use of services and gaps in service, design of outreach programs, and dissemination of accessible information.

Some beneficiaries noted that they did not always receive timely responses to questions or follow-through on requested information on MCAC matters. Beneficiaries stated that they have to be persistent with the Medicaid officials to have these questions addressed and noted that not all beneficiaries feel comfortable doing this.

Uncertainty around the use of beneficiary input. Beneficiaries and consumer group members across all six study states indicated that they had experienced the Medicaid agency staff listening to their input on Medicaid policy and program topics, but some were uncertain whether their feedback led to real change. Beneficiaries indicated that they would like information from their state Medicaid programs about how their feedback leads to program improvements to demonstrate that their participation is not a pro forma activity by the state. For example, one beneficiary noted that they do not always feel like their voice has equal power compared to that of other state officials or participating providers. Another beneficiary noted that it is unclear how much authority the MCAC has to effect change and wondered if the Medicaid agency is obligated to act on their recommendations. The state's MCAC bylaws do not address this. Other beneficiary and consumer group members commented that oftentimes, MCAC meetings are solely updates from the state with little opportunity to provide input and collaboration early in the policymaking process.

Beneficiary-only subcommittees

Some state MCACs convene beneficiary-only subcommittees without the presence of other stakeholders. Beneficiaries and consumer group members described feeling intimidated or discouraged from participating if certain MCAC members, such as government officials, providers, or plan representatives, dominated the discussion. Additionally, consumer group representatives cautioned how overrepresentation of certain MCAC members in meetings compared to beneficiaries can lead to an unbalanced power dynamic and limit beneficiary participation. Beneficiary-only subcommittees can help provide a less intimidating meeting environment that is more conducive to beneficiary participation. One consumer group member stated that their state's beneficiary-only group has more representation from marginalized populations and that there is more robust participation by beneficiaries than in other state advisory groups. The NPRM would mandate each state establish a BAG consisting of beneficiaries, family members of beneficiaries, or caretakers.

Subcommittee challenges. Although beneficiary-only subcommittees may provide a less daunting environment for some members, the subcommittees may experience challenges to beneficiary engagement similar to those of MCACs generally unless steps are taken to address them. For example, beneficiaries may still feel unprepared to discuss certain topics without advanced briefings or preparation support. Depending on how the beneficiary-only subcommittee is structured, there may be an imbalanced ratio of Medicaid staff to beneficiaries, which may hamper conversation. In addition, beneficiary members may experience challenges with the time commitment associated with preparing for and attending meetings, especially if the member is expected to participate in both the subcommittee meetings and the MCAC meetings. One consumer advocate who chairs a beneficiary-only subcommittee noted the importance of ensuring that information and perspectives shared during subcommittee meetings are considered in MCAC and state Medicaid agency policy and program deliberations and acted upon. The consumer advocate noted that this has not always been the case.

Commission Recommendations

MACPAC's recommendations to improve beneficiary engagement on MCACs aim to address key challenges that emerged during our examination of state use of MCACs. The recommendations focus on the need for more federal guidance and technical assistance to states to address beneficiary recruitment challenges, efforts to strengthen the diversity of representation of beneficiary members, and efforts to reduce the burden on beneficiaries while participating in MCACs. In conjunction with ongoing work at the federal and state levels to address these challenges, these recommendations may facilitate improvements in beneficiary recruitment and participation on MCACs.

Recommendation 1.1

In issuing guidance and in providing technical assistance to states on engaging beneficiaries in Medical Care Advisory Committees (MCACs) under Section 42 CFR 431.12, the Centers for Medicare & Medicaid Services should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate meaningful beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.

Rationale

The states in our study described specific topics for which they need guidance and technical assistance from CMS to leverage the expertise and experience of beneficiary MCAC members in their program policies and operations. CMS has indicated plans to issue guidance on beneficiary recruitment and model practices for facilitating beneficiary participation in MACs and BAGs following the issuance of final rules. In issuing such guidance, CMS should ensure that it addresses the topics identified by states.

Our work highlights a number of such areas, including approaches for recruitment and retention of beneficiary members from historically marginalized groups. States experience recruitment and retention challenges for MCAC members in general, and many appear to have relatively little experience conducting outreach and

describing the need and opportunities for beneficiary participants in MCACs to certain historically marginalized communities. CMS is also well positioned to help state-to-state learning on approaches to elicit beneficiary participation during MCAC meetings. Beneficiaries indicated that it can be challenging to fully engage in MCAC discussions on certain topics, and states have noted a need for information on how to assist beneficiaries. For example, some states have adopted strategies, such as providing an orientation for new beneficiary MCAC members, facilitating premeeting briefings, collaborating on the agenda setting, and creating bidirectional feedback loops, to help beneficiaries prepare for MCACs, which may be useful for other states. In addition, there may be other areas in which guidance and technical assistance could be useful to states, such as approaches for demonstrating the ways beneficiary input has affected program policy.

In addition, states seek clarification on the rules for providing financial arrangements to help beneficiaries participating in MCACs, including, specifically, how to offer financial support without affecting beneficiaries' eligibility. State Medicaid officials indicated a need for clarification from CMS on permissible forms and amounts of financial arrangements to facilitate beneficiary participation.

At the time of publication of this report, it is unclear when the rule will be finalized or when CMS guidance on MCACs will be issued. In addition to changing the structure of MCACs, the proposed rule includes many other changes to Medicaid, which we expect will also necessitate federal guidance and technical assistance. Given the importance of beneficiary MCAC participation in lifting up the experience of beneficiaries, the Commission urges CMS to issue guidance as described above as expeditiously as possible. It is the Commission's view that the challenges states and beneficiaries experience with MCAC participation and engagement under current rules are likely to persist under the proposed restructured MACs and BAGs, if finalized. Thus, timely issuance of guidance on the topics described in this chapter is needed.

Implications

Federal spending. The Congressional Budget Office estimates this recommendation would not have a direct effect on federal Medicaid and CHIP spending. CMS would have to dedicate resources to develop the guidance and provide technical assistance to states as it indicated it would. This guidance and technical assistance will provide further clarity to the federal requirements.

States. Federal guidance could assist states with their efforts to engage beneficiaries on MCACs in a way that promotes their voice and contributes to policymaking decisions. States may be able to strengthen beneficiary participation and engagement in MCACs and benefit from the beneficiary feedback about issues related to the Medicaid program and the services it covers. This bidirectional feedback loop ensures that the program operates efficiently and as it was designed to operate.

Enrollees. When states increase meaningful engagement, beneficiaries may have a more positive experience, and they may be able to make greater contributions to the MCAC discussions. This would provide them the opportunity to have an input on policymaking.

Plans and providers. There would be no direct effect on plans and providers.

Recommendation 1.2

In implementing requirements in 42 CFR 431.12(d)(2) that Medicaid Medical Care Advisory Committee (MCAC) membership include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

Rationale

States serve a diverse array of Medicaid beneficiaries, including those who are too often marginalized due to factors such as their race and ethnicity, age, disability, sex, gender identity, sexual orientation, and geography. The current federal regulations require state Medicaid agencies to include Medicaid beneficiaries but do not speak to their diversity. This recommendation directs states to include a diverse range of voices reflective of their Medicaid population as part of operationalizing this existing requirement. Some states will need to revise their bylaws and other policy documents to implement this recommendation. If the BAG is included in the final rule, states should also include diverse representation within this group.

Engaging beneficiaries from historically marginalized backgrounds allows them to share their unique experiences and concerns. It is the Commission's view that there should be diverse representation of Medicaid beneficiaries participating in policymaking decisions, including beneficiaries of color and individuals with disabilities, who can share their experiences with Medicaid (MACPAC 2022b). Intentional and continuous effort is required to engage people who have historically been excluded from the decision making process related to the design, implementation, and operationalization of Medicaid policies and programs.

Implications

Federal spending. The Congressional Budget Office estimates this recommendation would not have a direct effect on federal Medicaid and CHIP spending.

States. States will have to invest resources to develop strategies and policies for recruiting beneficiaries from communities that are marginalized due to factors such as their race and ethnicity, age, disability, sex, gender identity, sexual orientation, and geography. States may face resource constraints given other programmatic needs.

Enrollees. Under this recommendation, beneficiaries from historically marginalized communities may increase participation in MCACs, providing them an avenue to share their perspectives and experiences to help improve program policy and administration.

Plans and providers. There would be no direct effect on plans and providers. State Medicaid agencies may work with plans and providers to recruit beneficiaries from diverse communities to participate in MCACs.

Recommendation 1.3

In implementing requirements in 42 CFR 431.12(e) to increase the participation of beneficiary members in Medicaid Medical Care Advisory Committees (MCACs), state Medicaid agencies should develop and implement a plan to facilitate meaningful beneficiary engagement and to reduce the burden on beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, technological, financial, and content barriers.

Rationale

Beneficiaries have noted challenges that can prevent their participation in MCACs. One such difficulty in some states is a burdensome application process. Application processes involving long applications or applications asking sensitive questions about issues that are unlikely to affect beneficiaries' ability to provide input and their perspective on the Medicaid program may dissuade individuals from participating. Complex applications also can hinder some beneficiaries from applying if they find the application overwhelming. In addition, application processes that require a nomination or referral from high-level state government leaders may in effect disqualify beneficiaries willing to participate. Eliminating such requirements and streamlining the application could make MCACs more accessible to and reduce the burden on the individuals willing to serve on MCACs.

Addressing logistical and other barriers may also make it more feasible for beneficiaries to participate in MCACs. Logistical barriers that hamper beneficiary participation include inconvenient meeting times, particularly for those Medicaid beneficiaries working in jobs from which it can be hard to get time off or in which taking time off results in lost income. Certain

meeting locations may be inconvenient, particularly for beneficiaries residing in rural regions or for those without reliable transportation. Other beneficiaries can face financial barriers, such as the cost of childcare or public transportation, gas, or parking associated with attending meetings. Greater state use of financial arrangements under 42 CFR 431.12(f) could help address some of these financial barriers.

Addressing the content barriers that beneficiaries experience would also assist their engagement during MCAC meetings. Medicaid beneficiaries are experts in their own experience but are not necessarily Medicaid policy or health services experts and can experience difficulty contributing to MCAC discussions. States should take steps to help beneficiaries prepare for MCAC meetings, particularly if topics are technical in nature, to ensure that beneficiary points of view are considered in those areas.

Implications

Federal spending. The Congressional Budget Office estimates this recommendation would not have a direct effect on federal Medicaid and CHIP spending.

States. States would need to dedicate resources to assessing current barriers to beneficiary participation and developing a plan for addressing them. States may face resource constraints given other programmatic needs.

Enrollees. Streamlining the MCAC application process and addressing logistical, financial, and content-related concerns for beneficiaries would reduce key barriers to their participation. By doing so, the willingness of beneficiaries to participate in MCACs could increase.

Plans and providers. There would be no direct effect on plans and providers.

Endnotes

[1] RTI conducted the policy scan in the fall of 2022. RTI was unable to find publicly available MCAC documentation for four states: Arkansas, Missouri, Tennessee, and Wyoming. RTI was unable to confirm an active committee (one that has met within the past two years) for California and New York. In the spring of 2023, California launched a Medicaid member advisory committee (DHCS 2023).

[2] Interviewees included state Medicaid officials, beneficiaries, and consumer group representatives from Kentucky, Maryland, Nebraska, North Carolina, Oregon, and Virginia. The state Medicaid officials identified beneficiary members and consumer group representatives on the MCACs for the interview process.

[3] Marginalized communities consist of groups that are excluded from involvement in decision making processes or policies due to factors such as to race, gender identity, sexual orientation, age, physical ability, language, geography, or socioeconomic status (Pratt and Fowler 2022).

[4] In addition to promoting beneficiary engagement, the proposed rule also includes a number of provisions designed to meet the statutory obligations to ensure that Medicaid provides access to services, such as increasing payment rate transparency and standardizing reporting (CMS 2023).

[5] For this chapter, MACPAC staff will continue to use the term “MCAC” unless discussing the proposed rule.

[6] The total membership requirement ranges from 9 members to 48 members, while most MCACs require between 15 and 20 members.

[7] The 14 states that explicitly require beneficiary member representation are Alabama, Connecticut, Florida, Kentucky, Maine, Maryland, Minnesota, Mississippi, New Hampshire, North Carolina, Oregon, Pennsylvania, Vermont, and Wisconsin. Mississippi is the only state from this list that does not also explicitly require consumer group representation.

[8] The 23 states are Alaska, Arizona, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Montana, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, South Dakota, Texas, Utah, Washington, and Wyoming.

[9] In 2021, CMS announced a strategic plan to apply a health equity lens across all its programs to achieve equitable outcomes through high-quality, affordable, person-centered care (Brooks-LaSure and Tsai 2021).

[10] Any member of a state board or commission, including those on MCACs, who earns less than $50,000 per year qualifies for this per diem (ORS § 292.495). The amount is tied to the legislative per diem.

[11] According to the Internal Revenue Service, for any additional compensation received that is at least $600 during one calendar year, a 1099 tax form must be completed, and the amount must be reported for tax purposes (IRS 2023).

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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 December 15, 2023.

Engaging Beneficiaries through Medical Care Advisory Committees to Inform Medicaid Policymaking

1.1 In issuing guidance and in providing technical assistance to states on engaging beneficiaries in Medical Care Advisory Committees (MCACs) under Section 42 CFR 431.12, the Centers for Medicare & Medicaid Services should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate meaningful beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.

1.2 In implementing requirements in 42 CFR 431.12(d)(2) that Medicaid Medical Care Advisory Committee (MCAC) membership include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

1.3 In implementing requirements in 42 CFR 431.12(e) to increase the participation of beneficiary members in Medicaid Medical Care Advisory Committees (MCACs), state Medicaid agencies should develop and implement a plan to facilitate meaningful beneficiary engagement and to reduce the burden on beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, technological, financial, and content barriers.

1.1-1.3 voting results	#	Commissioner
Yes	17	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Medows, Snyder, Weno

Chapter 2:

Denials and Appeals in Medicaid Managed Care

Denials and Appeals in Medicaid Managed Care

Recommendations

2.1 To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process that can be accessed at the beneficiary's choice, with certain exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing.

2.2 To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services.

2.3 To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in addition to the mailed notice.

2.4 To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service.

2.5 To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. The rules should require that states use these data to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

2.6 To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit.

2.7 To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan.

Denials and Appeals in Medicaid Managed Care

Key Points

- Medicaid managed care organizations (MCOs) manage and provide care to most Medicaid beneficiaries, and MCOs may deny or limit services to ensure that only appropriate and medically necessary care is provided.
- Beneficiaries have a statutory right to appeal MCO denial decisions. Yet few denials are appealed, and little is known about the beneficiary experience.
- Federal rules govern the denials and appeals process and require monitoring and oversight of MCOs.
- Our research indicated key challenges with the appeals process, including a lack of trust in the MCO appeals process, the burdensome nature of the appeals process, late and unclear denial notices, and barriers in accessing continuation of benefits.
- In addition, we identified gaps in federal monitoring, oversight, and transparency requirements, including that there are no federal requirements for states to collect data on denials, beneficiary use of continuation of benefits, and appeal outcomes; to evaluate denials for clinical appropriateness; or to publicly report this information.
- The Commission recommends improvements to the appeals process and federal monitoring, oversight, and transparency requirements:
    1. External medical reviews of denials should be required to bring greater independence to and improve trust in the appeals process.
    2. The Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve denial notices and identify approaches for states and MCOs to assist beneficiaries in appealing denial decisions.
    3. Beneficiaries should have a choice to receive electronic denial notices to get these notices in a timely manner.
    4. Beneficiaries should have a longer timeline to file for continuation of benefits, and CMS guidance is needed to address existing barriers in accessing continuation of benefits.
    5. States should collect and monitor data on denials, beneficiary use of continuation of benefits, and appeals outcomes to better assess beneficiary access.
    6. States should conduct clinical audits of denials to assess clinical appropriateness of managed care denials and improve state oversight of managed care.
    7. CMS and states should make data on denials and appeals publicly available in accessible formats to improve transparency for beneficiaries, stakeholders, and researchers.

CHAPTER 2: Denials and Appeals in Medicaid Managed Care

Medicaid managed care organizations (MCOs) play a large role in providing health care services, with 74 percent of Medicaid beneficiaries enrolled in comprehensive managed care (MACPAC 2023). Under contracts with state Medicaid programs, MCOs manage and provide care to beneficiaries enrolled in their plan. MCOs may deny or limit services to ensure that only appropriate and medically necessary care is provided (42 CFR § 438.210).[1] To ensure access to medically necessary care, beneficiaries have a statutory right to appeal MCO denial decisions (Section 1932(b)(4) of the Social Security Act (the Act)). Federal monitoring and oversight requirements on states aim to ensure MCO compliance with authorization and appeals rules and promote access to appropriate care. However, recent federal reports and news coverage have highlighted instances of beneficiaries being denied medically necessary care, suggesting the need for improved managed care oversight (OIG 2023; Terhune 2019; McSwane and Chavez 2018).

The Commission sought to understand the extent to which federal and state agencies monitor MCOs to ensure that beneficiaries are not denied services inappropriately and can ultimately receive covered, medically necessary care through the appeals process. We also examined beneficiaries' experiences with the appeals process. To investigate these areas, we conducted a federal policy review, a state policy scan, state and stakeholder interviews, and beneficiary focus groups.

The federal policy review focused on current federal requirements for the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies regarding the appeals process and associated monitoring and oversight. For the state scan, we reviewed publicly available data and documents from 40 states and the District of Columbia.[2] We conducted approximately 30 semi-structured interviews across a variety of organizations, including Medicaid officials in five states, providers, MCOs, beneficiary groups, external quality review organizations (EQROs), national experts, and officials at CMS. Our interviews focused on denial and appeals processes as well as monitoring and oversight efforts. Last, we contracted with Mathematica to conduct focus groups with beneficiaries and caregivers who have filed appeals with their MCOs.[3] The focus groups largely centered on the appeals process to better understand barriers throughout this process.

Findings from the state scan and stakeholder interviews identified gaps in the federal oversight requirements. Federal rules do not require that states collect and monitor certain key data, including denials, continuation of benefits, and appeals outcomes. There is also no federal requirement to assess denials for clinical appropriateness. In addition, transparency requirements are incomplete, with no federal requirements to publicly report information on MCO denials and appeals outcomes.

Findings from the stakeholder interviews and beneficiary focus groups identified several challenges with the appeals process. Beneficiaries and advocates indicated a lack of trust in and general frustration with the MCO appeals process, describing it as challenging and burdensome to navigate. MCOs are required to mail denial notices, but beneficiaries do not always receive these denial notices in time to pursue an appeal within regulatory time frames. Furthermore, stakeholders expressed that the content of notices can be unclear and difficult to understand, and MCOs acknowledged the challenges in conveying clinical and legal language to beneficiaries. Last, beneficiaries encounter barriers in accessing continuation of benefits, including a lack of awareness of this right, short timelines to file for receiving the benefit, and the risk of repayment for services delivered.

To address these challenges, improve the appeals process, and enhance monitoring and oversight of MCOs, the Commission makes seven recommendations:

2.1 To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process that can be accessed at the beneficiary's choice, with certain

exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing.

2.2 To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services.

2.3 To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in addition to the mailed notice.

2.4 To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service.

2.5 To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. The rules should require that states use these data to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

2.6 To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit.

2.7 To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan.

This chapter begins with a brief background on denials and appeals in managed care. It then outlines the current federal requirements for both the appeals process as well as for monitoring, oversight, and transparency of MCOs and the state's role in each domain. The chapter goes on to describe challenges with the appeals process and critical gaps in the federal monitoring, oversight, and transparency structure. Next, the chapter presents the Commission's recommendations and associated rationale as well as implications for federal spending, states, enrollees, plans, and providers. The chapter concludes with additional considerations and describes next steps.

Background

Until recently, little was known about the extent to which Medicaid beneficiaries experienced denials in managed care. The U.S. Department of Health and Human Services Office of the Inspector General (OIG) examined Medicaid managed care denials under prior authorization in 2019 and found a higher rate than in Medicare Advantage (MA). Specifically, the Medicaid MCOs included in the study denied 12.5 percent of prior authorization requests compared to 5.7 percent denied by MA plans. Furthermore, approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with prior authorization denial rates greater than 25 percent.[4] The OIG found that 11.2 percent of prior authorization denials were appealed (OIG 2023).

Our findings also suggest that few denials are appealed. In conducting a state scan of publicly available data, we found a few examples demonstrating a low rate of appeals of denied services and items. However, we were unable to estimate an overall appeal rate in Medicaid managed care because few states publicly report these data, and they use a range of measures to monitor and report appeals. In Iowa, less than one-tenth of 1 percent of denials (0.05 percent) were appealed in fiscal year 2021 (IA HHS 2022). New Hampshire and Maryland publish data showing how many appeals are filed for every 1,000 beneficiaries. For plans in those states, there were 0.08 to 1.47 appeals for every 1,000 enrollees, respectively (NH HHS 2022, MD DOH 2021).[5] New research suggests that lower income individuals are less likely to appeal and more likely to assume their denial will be upheld if appealed than those with higher incomes. One study found that every $25,000 increase in annual income is associated with a 4 percent increased likelihood of appeal (Yaver 2024).

Media reports have highlighted instances of Medicaid MCOs inappropriately delaying or denying medically necessary services (Terhune 2019; McSwane and Chavez 2018). In California, one MCO failed to authorize health care services in a timely and adequate manner, including authorization delays for cancer patients, among others. This MCO also did not adhere to federal requirements regarding resolutions of grievances and appeals. As a result, the state fined this MCO $55 million (CA DMHC 2022). In 2018, a series of investigative news reports found that MCOs operating in Texas were inappropriately denying services, particularly for children in foster care, resulting in avoidable harm (McSwane and Chavez 2018). Subsequently, the Texas legislature passed a law to increase reporting requirements for Medicaid MCOs, including publicly reporting aggregated complaint and appeals data (Texas 2019). These news reports exposed weaknesses in managed care oversight processes and accountability mechanisms at the state and federal levels.

Current Federal Requirements

Federal regulations allow Medicaid MCOs to limit services based on medical necessity criteria or utilization management tools (e.g., quantity limits, prior authorization). Such limitations of services can help to ensure that care provided is necessary, cost effective, and aligned with medical standards. While federal regulations allow plans to use these tools, plans must provide services that are no less than the amount, duration, and scope for the same services offered to beneficiaries under fee-for-service (FFS) Medicaid. MCOs are also prohibited from arbitrarily denying or reducing a required service solely based on the diagnosis, type of illness, or condition of the enrollee. (42 CFR § 438.210) Specific rules and protections apply to beneficiaries younger than age 21. Early and periodic screening, diagnostic, and treatment (EPSDT) requires states and MCOs to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan (Section 1905(r)(5) of the Act).[6] Federal regulations also specify the processes and timelines by which MCOs must make these decisions (42 CFR § 438.210). If the beneficiary disagrees with the MCO's decision, they have a statutory right to appeal the decision to the MCO (Section 1932(b)(4) of the Act).

For purposes of this chapter, denials include only an MCO's decision to deny or limit the authorization of a requested service or to reduce, suspend, or terminate a previously authorized service.[7] Receiving a denial triggers a beneficiary's right to appeal.[8] Appeals and

grievances are often discussed together; however, they are distinct actions—an appeal sets in motion a process that requires the health plan to review its denial, whereas a grievance is an expression of dissatisfaction about matters other than a denial (42 CFR § 438.400).[9]

Appeals process requirements

Section 1932(b)(4) of the Act requires MCOs to have an internal system for beneficiaries to challenge denials. Since 2002, federal rules have required that MCO contracts include specific language regarding MCO appeal systems. The 2016 and 2020 updates to managed care regulations added additional beneficiary protections and increased consistency in the appeals process (e.g., updated timelines and requiring only one level of internal MCO appeal) (CMS 2020, 2016).

Federal regulations specify the processes and timelines related to denials and appeals but allow states to modify certain aspects of the process (e.g., shorter time frames, external medical review) (Figure 2-1).

Denial and notice

Any MCO decision to deny or limit the authorization of a service must be made by an individual with the appropriate expertise in addressing the beneficiary's medical, behavioral health, or long-term services and support needs. MCOs must notify the requesting provider of the denial and give beneficiaries timely and adequate notice of a denial in writing (42 CFR § 438.210). This notice must explain the decision, the reason, the beneficiary's right to appeal, and the beneficiary's right to continue receiving services through the appeals process, as well as how to exercise this right.[10] Federal rules require that this notice is written and mailed to beneficiaries; however, states may also require additional modes of communication (42 CFR § 438.404(c)). Federal rules require MCOs to provide this information in alternative formats, without cost and upon request. This may include auxiliary aids and written translation (42 CFR § 438.10).

Currently, standard authorization decisions that deny or limit services must be sent to beneficiaries and the requesting provider as expeditiously as the beneficiary's condition requires and within 14 days of the service request, or within 72 hours for expedited cases. States may impose shorter timelines for standard and expedited authorizations. In January 2024, CMS released a final rule on prior authorization and interoperability that will reduce the timeline for standard cases to seven days. These changes will take effect on January 1, 2026 (CMS 2024).[11] MCOs must provide 10 days' advance notice for decisions that terminate, suspend, or reduce previously authorized services (42 CFR § 438.404, 431.211).

Beneficiary appeals to MCOs

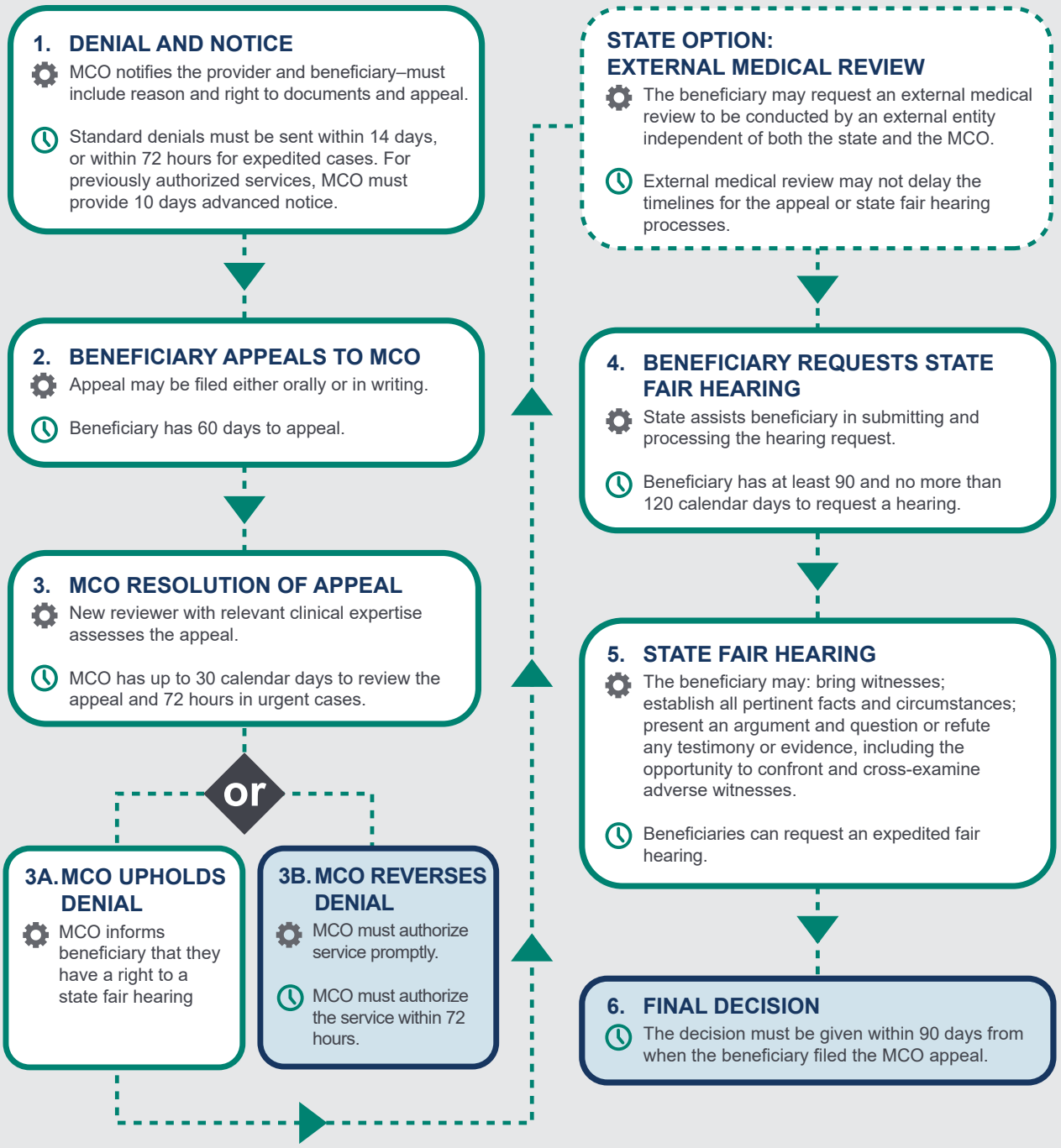
Beneficiaries have a statutory right to appeal denied services to their MCO. Beneficiaries have 60 calendar days to appeal the MCO's decision and may submit the appeal either in writing or orally (42 CFR § 438.402).[12] MCOs must provide beneficiaries with any reasonable assistance in completing the necessary steps to file an appeal (e.g., providing interpreter services). Additionally, when requested, MCOs must provide beneficiaries with case files, including medical records, and any other evidence considered by the MCO in connection with the appeal (42 CFR § 438.406).

Continuation of benefits

In cases in which the MCO terminates, reduces, or suspends a previously authorized service, beneficiaries have the right to continue receiving the services at the previously authorized level while either the appeal or state fair hearing is pending (42 CFR § 438.404, 42 CFR § 438.420(c)). The beneficiary, if eligible for continued benefits, must request them within 10 days of the date of the denial notice or before the denial goes into effect, whichever is longer (42 CFR § 438.420(a)).

If a beneficiary's denial is upheld by the MCO or in the state fair hearing process, federal rules allow the MCO to recover the costs of these services provided during the appeal in specific circumstances. Federal rules allow MCOs to recoup these costs only if the managed care policy is consistent with the state's usual policy on recoveries (42 CFR § 438.420(d)).

FIGURE 2-1. Timeline and Federal Process Requirements for Appeals



Note: MCO is managed care organization.

Source: MACPAC analysis of 42 CFR § 438.210, 402, 404, and 408.

Resolution of beneficiary appeals to MCOs

MCOs must ensure that the individuals reviewing the appeal were not involved in the initial decision and have the appropriate clinical expertise to evaluate the appeal (42 CFR § 438.408). MCOs must give beneficiaries timely and adequate notice of the resolution of appeals in writing. They also must explain the decision, the reason, the beneficiary's rights to a state fair hearing, and how to exercise those rights. MCOs must resolve the appeal as expeditiously as the beneficiary's health condition requires but within no more than 30 calendar days and within 72 hours for urgent cases. Extensions are allowed if requested by the beneficiary or if the MCO demonstrates a need for additional information and if the delay is in the beneficiary's interest (42 CFR § 438.408).

State option: Independent external medical review

External medical reviews are clinical reviews of an MCO's decision to uphold a denial by an independent, third-party entity not affiliated with the MCO or the state. Under federal rules, states may offer beneficiaries an external medical review after the completion of the internal MCO appeal. Specifically, the external medical review must not be a prerequisite for the state fair hearing and may be initiated only by the beneficiary's choice. In addition, the review must be independent of the MCO and the state, must be offered at no cost to the beneficiary, and may not disrupt a beneficiary's receipt of continuation of benefits or any timelines for the appeals process (42 CFR § 438.402(c)(1)(B)).

State fair hearing

If a beneficiary has completed the internal MCO appeals process and disagrees with the MCO's determination, they have a right to request a state fair hearing (Section 1902(a)(3) of the Act). A state fair hearing offers the beneficiary the opportunity to appear before an administrative law judge to request that the MCO's decision be overturned. The state should assist the beneficiary in submitting and processing the hearing request (42 CFR § 431.221). The beneficiary has at least 90 days but no more than 120 calendar days from the date of the MCO's notice of resolution to request a state fair hearing (42 CFR § 438.408). A fair hearing decision must be granted within 90 days from when the beneficiary filed the appeal with the MCO (42 CFR § 431.244).

Monitoring, oversight, and transparency

Federal oversight of managed care denials and appeals includes three components: state monitoring, external quality review, and annual reporting. CMS requires that states establish internal monitoring programs to review health plan–reported data and use EQROs to conduct reviews of managed care programs and plan performance. The results of these activities must be reported to CMS annually.

Monitoring requirements

Federal rules require that states establish a managed care monitoring system and use the data collected to improve the performance of the program (42 CFR § 438.66). These rules require that states collect plan-reported data related to beneficiary appeals. At a minimum, states must collect: the reason for the appeal, relevant dates (e.g., received, reviewed, resolved), resolution at each level, and the name of the beneficiary (42 CFR § 438.416). CMS regulations do not require states to collect and monitor denials data.

External quality review

Section 1932 of the Act requires that states work with an EQRO to conduct an annual independent review to validate the performance of a state's contracted Medicaid MCOs. Among other things, the EQRO is required to conduct a review, at least every three years, of an MCO's compliance with standards in subpart D of 42 CFR § 438, which include the processes related to authorization of services and appeals.[13] Under federal rules, EQROs are not required to collect and monitor trends related to denials and appeals, nor are they required to assess whether denial and appeal decisions are clinically appropriate. Although federal rules require that states use the findings from these reviews to improve the program, they do not obligate states to take specific actions upon these compliance findings from the EQRO (42 CFR § 438.66).

Managed Care Program Annual Report

In 2022, states began submitting data to CMS for the Managed Care Program Annual Report (MCPAR), which the agency introduced in the 2016 managed care rule. In finalizing this requirement, CMS explained that the report will provide valuable and timely information to assess managed care programs in each state, as well as improve transparency for beneficiaries, providers, and stakeholders (CMS 2016).

States must submit key metrics related to their Medicaid managed care program annually to CMS and make this report available to the public on the state website. Such key metrics include plan-level reporting on the number and type of appeals, the service types of appeals, the number of state fair hearings and their outcomes, and the outcomes of any external medical reviews. States are not required to collect or report on the outcome of MCO appeals unless the appeal goes to an external medical review or state fair hearing. This report also does not include data related to denials, as states are not required to collect this information (CMS 2023a).

State Role

The requirements described previously represent the minimum federal standards for the appeals process as well as for monitoring, oversight, and transparency of denials and appeals. States have flexibility in how they implement these requirements and may establish requirements that go beyond these minimums.

Appeals process

States have some flexibility to modify the appeals process. Although federal regulations require that states establish timelines for appeal resolution that are no longer than 30 days for non-urgent cases, some states have shorter time frames associated with the appeals process. For example, Ohio requires that MCOs resolve appeals within 15 calendar days (Ohio Admin. Code § 5160-26-08.4(D)(6)). Some states have elected to insert an additional step in the appeals process and offer independent external medical review to beneficiaries after the internal MCO denial is upheld. Through the California Department of Managed Health Care, Medi-Cal enrollees can request an independent medical review if their MCO upholds a denial (CA DMHC 2023). Last, some states offer ombudsperson services beyond those federally required for individuals with long-term services and supports to assist with appeals. Minnesota offers ombudsperson services to any resident enrolled in MinnesotaCare or Medical Assistance (MN DHS 2023).

Monitoring, oversight, and transparency

States have the responsibility to monitor and oversee state managed care programs and ensure that beneficiaries have access to appropriate care. Through our state scan and interviews with state officials, we found that some states have developed more robust monitoring and external review programs, exceeding the federal minimum requirements discussed previously. These efforts include collecting data on denials and appeals outcomes and conducting clinical audits. For example, our review of state documents and contracts identified 23 states and the District of Columbia that require MCOs to report denial data to the state. Eleven states require that MCOs report denial reasons, and 14 states require that they report information related to the services that were denied.[14]

During our interviews, state Medicaid officials discussed how they use findings from routine monitoring of denials. In one case, monitoring of denials data led to uncovering an unclear state policy, which officials were able to correct. Another state shared how it uses these data in quarterly meetings with MCOs to examine any issues that arise. Last, another state has issued civil monetary penalties upon discovering improper denials by MCOs.

As part of this work, we also sought to understand the extent to which MCOs are complying with federal authorization and appeals regulations. In a review of state external quality review technical reports, we found that compliance issues with authorization of services and the appeals process are widespread. Twenty-two of the 46 states had MCO compliance issues with authorization of services, 25 states had

MCO compliance issues with the appeals process, and 18 had compliance issues with both areas.[15] Again, states vary in how they use these findings. For example, some states issue corrective action plans or civil monetary penalties, and others use EQRO findings to alter auto-assignment algorithms for passive MCO enrollment.[16]

Currently, 14 states publicly report some data on denials or appeals in Medicaid managed care, but what is reported varies greatly. For example, New Hampshire reports the share of prior authorization requests denied across all plans, and Maryland reports the number of prior authorization denials per 1,000 enrollees for each MCO in the state (NH HHS 2022, MD DOH 2021). Among the states we interviewed, three states publicly posted denials or appeals information. Medicaid officials in one state believed the report to be largely unused by the public, though they found the denials and appeals data helpful for monitoring. The other two states viewed the public-facing data to be important for transparency of the program and helpful in holding MCOs accountable.

Current Challenges

Through interviews, focus groups, and the state scan, the Commission identified challenges with the appeals process as well as with monitoring, oversight, and transparency of MCOs. These challenges, detailed in the following sections, underscore accessibility issues with the appeals process and insufficient monitoring, oversight, and transparency of MCOs.

Appeals process

The Commission identified several challenges with the appeals process. Specifically, beneficiaries and caregivers who participated in our focus groups lack trust in the MCO appeals process and find navigating the process to be burdensome. In addition, those beneficiaries who have the right to continue receiving benefits face considerable barriers.

Beneficiaries expressed both a lack of trust and general frustration with the MCO appeals process

The appeals process can be a frustrating experience for beneficiaries, and they expressed a lack of trust in the MCO appeals process. MCOs are responsible for notifying the beneficiary of their right to an appeal, providing the beneficiary support through the appeals process if requested, conducting the appeal, and notifying the beneficiary of the appeal outcome. Many focus group participants reached out to their MCO for information regarding an appeal upon learning of the denied service request, and most reported not having a positive experience. Many participants indicated that the member services representatives lacked knowledge about the appeals process, did not provide needed information to enrollees, or provided incorrect information regarding the appeal. Conversely, one focus group participant shared that they had a helpful experience with their health plan representative, and this representative helped them come up with an alternate treatment plan.

Additionally, several stakeholders provided examples of MCO member service representatives dissuading beneficiaries from filing an appeal. Some focus group participants did not reach out to their MCO for information about appealing a denied service because they did not think the MCO would provide helpful assistance on appeals. Conversely, interviewed MCOs discussed how they conduct regular trainings with member service representatives to assist beneficiaries. In addition, one interviewed MCO detailed internal monitoring efforts, which include routine training and testing for nurses and medical directors who evaluate appeals as well as monthly audits of performance.

The appeals process is challenging and burdensome

The appeals process can be burdensome and challenging for beneficiaries. Many focus group participants found the process to be time consuming and difficult to manage, specifically the effort to gather documentation. Assembling documentation can require working with multiple providers to gather letters and supporting clinical documents to demonstrate medical necessity. Beneficiaries who appeal multiple denials over the course of their coverage can experience substantial burden.

External support often plays a critical role in beneficiary appeals. Medical providers assist beneficiaries by providing supporting clinical documentation, requesting peer-to-peer consults with the MCO, and in some cases filing an appeal on behalf of the beneficiary. Community-based

organizations and ombudsperson offices help beneficiaries understand the process and get connected to legal assistance organizations. Many focus group participants noted the importance of legal representation in advocating for them throughout the process.

Denial notices can be late and content is unclear

Mail delivery of notices that is not timely can be a barrier for beneficiaries in filing an appeal. Denial notices often arrived late, leaving several focus group participants with insufficient time to request an appeal. Some focus group members serving as a caregiver to a beneficiary noted that letters were delivered to the beneficiary's address, which delayed the caregiver's ability to appeal on behalf of the beneficiary. In some cases, beneficiaries never received a denial letter. These concerns were echoed in interviews with state officials and stakeholders. Beneficiaries across all focus groups expressed support for adding more ways for beneficiaries to receive denial notices (e.g., text, e-mail, phone). Although federal rules allow MCOs to provide electronic denial notices, they are not required to do so (42 CFR § 438.10(c)(6)).

Denial notices can also lack clarity. Beneficiary advocates and providers shared that many beneficiaries receive only generic reasons for their denial, which can lead to confusion. For example, one beneficiary advocate shared that their client received a denial notice citing that the requested service was not medically necessary. However, they ultimately learned that the lack of medical necessity was the result of missing documentation from the provider. Most focus group participants shared that they did not understand the MCO's rationale for denying the service or upholding a denial after the appeal.

Denial notices can be lengthy and rely too heavily on clinical and legal jargon that can be challenging to understand.[17] MCOs noted that it can be difficult to draft letters at the appropriate reading level (e.g., sixth-grade level) given the requirements to include the reasons for the denial, which are often clinical. In addition, some states require regulatory citations throughout the notice, which can add complexity.

Beneficiaries encounter multiple barriers in accessing continuation of benefits

Barriers to accessing continuation of benefits include lack of beneficiaries' awareness of their rights, tight timelines, and threat of repayment. Some stakeholders, including legal assistance organizations, described continuation of benefits as an important beneficiary protection but said awareness and use of the benefit are limited.

Awareness. Many focus group participants were not aware that they could continue receiving previously authorized services that are terminated, suspended, or reduced while pursuing an appeal. Additionally, several focus group participants indicated that they became aware of this beneficiary protection only once they had enlisted the help of a legal aid organization. Beneficiary advocates noted that knowledge of continuation of benefits is primarily spread by word of mouth rather than by the denial notice. These stakeholders raised concerns that the notices may lack or not prominently display required information regarding continuation of benefits.

Timelines. To continue receiving services at the previously authorized level throughout the appeals process, beneficiaries must file for this benefit within 10 days of the date of the notice to terminate, suspend, or reduce or before the termination, suspension, or reduction goes into effect, whichever is longer. This timeline is insufficient for many beneficiaries. Providers and beneficiary advocates indicated that beneficiaries often do not receive the notice until several days into the 10-day window. Many focus group participants corroborated these findings, emphasizing that the 10-day window to file for continuation of benefits is too short.

Repayment. The potential of having to repay for services if the appeal is upheld in favor of the MCO dissuades some beneficiaries from requesting a continuation of benefits. However, some interviewed stakeholders, including state officials, indicated that they have never heard of an MCO recouping costs associated with services provided while an appeal is pending.

Monitoring, oversight, and transparency

The Commission sought to better understand the extent to which federal and state agencies ensure that beneficiaries are not inappropriately denied services and can ultimately receive covered, medically necessary care through the authorization and appeals processes. The Commission found gaps in federal monitoring and oversight requirements for data monitoring, clinical audits, and transparency.

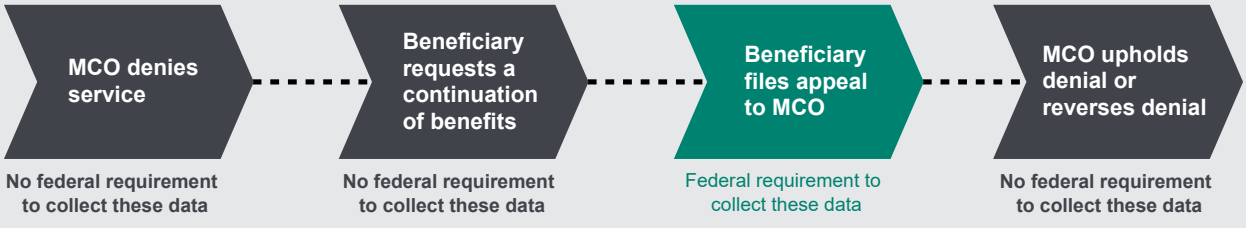
Federal rules do not require states to collect and monitor data needed to assess access to care

Federal data collection requirements provide only limited insight into MCO denials and the outcomes of beneficiary appeals (Figure 2-2). States are not required to monitor MCO denials. Although states are required to collect some beneficiary appeal data, they are not required to collect information on whether a beneficiary is exercising their right to continue benefits. Furthermore, states are not required to monitor the outcome of any appeal to the MCO.

Denials. Collecting and monitoring denial data allows states to assess the extent to which beneficiaries experience denials, and states can use these data to perform trend analysis to identify plan-wide issues with access to care. While not federally required, more than half of states with managed care collect or monitor these denial data from MCOs. Our state scan indicated that 23 states and the District of Columbia require that MCOs report denials data to the state.[18] Similarly, the OIG recently surveyed state Medicaid agencies on their monitoring efforts and found that 22 of the 37 surveyed states reported using prior authorization denials data for oversight (OIG 2023). In our interviews, there was broad consensus that reviewing denials is a critical component to identifying issues with beneficiary access to care. Some states noted that breaking down denial data by service type can help identify trends specific to certain services or populations. In addition, one interviewed MCO indicated that it routinely monitors denial data.

Continuation of benefits. Federal rules do not require states to collect data on the extent to which beneficiaries are continuing their benefits through the appeals process, and little is known about the beneficiary use of this benefit. The extent to which states monitor access to and use of continuation of benefits is unclear. Some state officials indicated that they have not heard from beneficiaries or advocates that accessing continuation of benefits is a problem. However, in our interviews with state Medicaid officials and MCOs, interviewees were not able to identify or describe any monitoring of this beneficiary protection (e.g., number of beneficiaries who exercise this option after a denial). Legal advocates have called for careful monitoring of this right (Perkins 2016). To ensure that beneficiaries have access to this protection, states would need to monitor beneficiary use of the benefit.

FIGURE 2-2. Federal Data Monitoring Requirements



Note: MCO is managed care organization.

Source: MACPAC analysis of 42 CFR § 438.66.

Appeals outcomes. Federal rules require that states collect only certain data on appeals (e.g., the reason for the appeal, relevant dates, resolution). However, it is unclear whether resolution includes the outcomes of the internal appeal to the MCO.[19] Reviewing the outcomes of MCO appeals can provide a more complete picture of the appeals process and the extent to which denials are being upheld or overturned. In addition, examining appeals outcomes can help states understand underlying reasons for the denial (e.g., issues with documentation standards, clinical criteria, or any other part of the service authorization request that requires a change) and whether overturned denials are an indication of access issues resulting from denied or delayed care. Using these data allow state officials to identify and address underlying policies or practices that may be resulting in inappropriate denials. During interviews, one state official indicated that overturned appeals cause concern because often many other beneficiaries receive similar denials and yet do not appeal. Even fewer beneficiaries pursue a state fair hearing. Interviewed MCOs indicated that they also internally monitor the outcomes of appeals routinely.

Federal rules do not require states to assess clinical appropriateness of denials

Federal rules do not require that states audit or examine whether MCOs are making clinically appropriate denial decisions. Instead, regulations require an assessment of MCO compliance with the process requirements for service authorization and appeals through the external quality review process. These compliance checks are mandatory activities for EQROs and must be conducted at least every three years, but they do not assess whether MCOs are making appropriate clinical decisions.[20]

Unlike compliance audits, clinical appropriateness audits can be used to determine whether an MCO has inappropriately denied services. In our interviews, one state official described how they perform spot checks and clinical reviews for the EPSDT benefit because of a history of improper denials for these services. This official pointed to these spot checks as a helpful oversight tool, allowing state officials to better understand the clinical rationale for denials and address access issues with the managed care plans.

The OIG found that 13 of 37 surveyed states reported regularly reviewing the clinical appropriateness of MCO prior authorization denials. These states found that some denials were inappropriate. Examples of inappropriately denied services include medically necessary heath screening services for children, drug therapy, and inpatient hospital services. Among the states already conducting these audits, some use Medicaid agency staff, and others rely on their EQRO (OIG 2023).

CMS conducts audits of denials in the MA program and has found persistent problems, including inappropriate denials in more than half of the audited plans in 2015 (OIG 2018). Given that denial rates are higher in Medicaid managed care than in MA, audits of this nature would help identify whether those higher rates are appropriate. The OIG has recommended that CMS require states to review the appropriateness of a sample of MCO prior authorization denials regularly (OIG 2023).[21]

Federal requirements do not ensure that states publicly report information on plan denials and appeals outcomes

Federal rules currently do not require plans or states to publicly report information on denials. As a result, little is known about the extent to which beneficiaries are denied health care services by their MCOs. Similarly, limited information is available about the extent to which beneficiaries appeal service denials and whether these appeals are later reversed by the health plan or through the state fair hearing process. We found that 14 states publicly report data on denials or appeals in Medicaid managed care; however, what is reported varies widely.

States are required to report some appeals data to CMS through the MCPAR. Specifically, states' MCPARs must include plan-level reporting on the number and type of appeals, the service types of appeals, the number of state fair hearings and their outcomes, and the outcomes of any external medical reviews (CMS 2023a). Although states are required to make this annual program report available to the public on state websites, current regulations do not specify a timeline for posting, and this information has yet to be made widely available. At the time of this

writing, MACPAC was able to find reports for six states on public websites.[22] In the 2023 proposed managed care rule, CMS would require that states post these reports within 30 days of submitting them to CMS (CMS 2023b). Separately, CMS indicated that it would post the MCPARs on its website but had not done so at the time of this writing (CMS 2022a).[23]

Additionally, the 2023 proposed rule on managed care included implementation requirements for the Medicaid managed care quality ratings system (QRS). The goal of the QRS is to increase accountability, empower beneficiaries with information about their MCO choices, and provide states with another tool to manage plan performance improvement (42 CFR § 438.334). Under the proposed rule, states will be required to set up websites, described as a "one-stop shop" for beneficiaries to access information about their health plan choices. The websites will include the quality ratings of MCOs and other key information, such as drug formularies, provider networks, and other CMS-identified metrics. CMS notes that since states are already required to report some information related to appeals, including such data would not impose substantial burden on states. In addition, individuals who participated in user testing indicated an interest in seeing appeals data on the QRS websites (CMS 2023b). The proposed rule did not address denials data, as states are not currently required to collect these data.

Through its final rule on prior authorization, CMS, beginning January 1, 2027, will require MCOs to publicly report aggregated prior authorization data, including the number of requests received, approved, and denied, on their websites. This transparency requirement is intended to encourage plans to measure their own performance on these metrics, allow beneficiaries to use this information when selecting a plan, and help inform provider decisions in selecting payer networks. Metrics would be available only at the aggregate level across all services and items (CMS 2024).[24] Although this requirement will improve transparency, it relies on MCOs to publicly post on their websites and does not incorporate the data in existing federally required Medicaid monitoring and oversight mechanisms (e.g., MCPARs and QRSs).

Recommendations

In the following sections, we present seven recommendations to improve the beneficiary experience with the appeals process as well as bolster monitoring, oversight, and transparency of managed care denials and appeals.

Recommendation 2.1

To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process that can be accessed at the beneficiary's choice, with certain exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing.

Rationale

Findings from our stakeholder interviews and beneficiary focus groups suggest that many beneficiaries lack trust in the managed care appeals process. Beneficiary advocates and providers also expressed concern regarding potential conflicts of interest with MCOs adjudicating appeals of their own denial decisions. The current process does not require that an appeal be reviewed by a medical professional who is independent of the state or MCO. According to focus group participants and interviewed beneficiary advocates, requiring an external medical review conducted by an independent clinician could improve trust in the appeals process, reduce potential conflicts of interest, and ensure appropriate access to medically necessary care.

Under federal law, beneficiaries can request reconsideration of denial decisions through MCO appeals and state fair hearings, but those processes do not include an external medical review. An external medical review would ensure a review that is both independent (i.e., not conducted by a provider associated with the MCO) and clinical (i.e., done by a clinician rather than an administrative law judge). This type of review is not currently required in either the internal MCO appeal or the state fair hearing. Moreover, although beneficiaries have a right to a

state fair hearing, most beneficiaries do not ultimately request one.[25]

In 2019, 14 of the 37 states that the OIG surveyed offered external medical review as an option for Medicaid managed care beneficiaries. The OIG found that appeals submitted to an external medical reviewer were fully or partially overturned 46 percent of the time in favor of the beneficiary (OIG 2023). Providing this intermediary step could help ensure greater access to medically necessary care and would better align with beneficiary protections in MA, which requires an automatic external medical review.[26] In promulgating rules and subregulatory guidance to codify this requirement, CMS can look to existing models to identify approaches that center this process around beneficiaries and reduce potential complexity. Commissioners discussed allowing states to incorporate external medical review into the state fair hearing process; however, this was not pursued, as it was outside the scope of this chapter.

This process should be oriented around the needs of beneficiaries to promote the use of external medical review. This process should be initiated by beneficiaries, but the Commission acknowledges there may be instances in which an automated process would be in the best interest of beneficiaries. For example, a state may choose to automate the external review for upheld denials of certain types of critical services, for particularly vulnerable populations, or for services for which access issues are documented. An independent, external medical review can also be a tool for oversight and performance improvement. For example, a high overturn rate on a specific service may indicate that improvements to the authorization process should be made to ensure appropriate access. Under current federal rules, if a state allows for external medical reviews, then it must collect and monitor the outcomes of these reviews and submit the data to CMS (CMS 2023a). It is the view of the Commission that this information should be used to improve the performance of the program.

Implications

Federal spending. The Congressional Budget Office (CBO) estimates that requiring external medical review would increase federal direct spending by less than $500 million over a 10-year period.

States. States that currently do not have external medical review would have to implement this requirement, increasing their administrative burden. Conversely, states that already allow for an external medical review would likely see a reduced burden depending on the extent to which their program aligns with CMS rulemaking. Additionally, if states choose to make the external medical review process automatic, the burden would likely increase.

Enrollees. Implementing external medical review may bring increased accountability and improve beneficiary trust in the appeals process. As a result, more beneficiaries may choose to appeal denied services. Additionally, a clinical review, whether automatic or initiated by the beneficiary, may result in fewer MCO denials of medically necessary services, thus increasing access to care among beneficiaries. This option would be made available at no cost to the beneficiary.

Plans. The presence of a clinical review may encourage MCOs to revisit authorization protocols and deny fewer authorization requests for medically necessary services. Additionally, some states may require that MCOs pay for the cost of any requested external review.[27]

Providers. Providers may see an increased administrative burden, as their documentation and expertise may be needed to support beneficiaries who choose to pursue external medical reviews. However, the clinical review may increase access to medically necessary services, meaning providers would be providing more care to their patients.

Recommendation 2.2

To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services.

Rationale

Publicly available data indicate that few Medicaid beneficiaries appeal denied services. The OIG found 11 percent of prior authorization denials are appealed to the MCO, and 2.1 percent of denied prior authorization requests that MCOs upheld on appeal were appealed to a state fair hearing (OIG 2023). The low rates of appeal and the need for substantial external support speak to the challenging nature of the appeals process for Medicaid beneficiaries.

CMS guidance should help states and MCOs improve the denial notice, explain the requirements on MCOs to provide support, and elaborate on how Medicaid funding can be used to support third-party entities who provide beneficiary assistance. CMS should consider leveraging lessons learned from state beneficiary support systems that are required for beneficiaries who receive long-term services and supports. These support systems provide education and assistance on the appeals and state fair hearing processes (42 CFR § 438.71(d)(2,3)). Once implemented, the agency should monitor and assess the need for future guidance, technical assistance, or rulemaking to improve this process.

Focus group participants, beneficiary advocates, legal aid societies, and providers all expressed concern at the burdensome nature of the appeals process and indicated that external support is critical to navigate the process. The challenging nature of the process starts with the denial notice. Specifically, beneficiaries indicated that the content of notices can be hard to parse, and they can lack a clear reason for why medical necessity is not met. Unclear notices can be problematic if they do not describe what documentation MCOs need to approve the request. Beneficiaries described having to spend hours per day on the phone to seek further information from MCOs and then additional time with providers to obtain the documentation. In our interviews, nearly all stakeholders acknowledged that it is challenging to draft denial notices in a concise manner. It is the Commission's view that CMS has an important role in identifying strategies to improve the readability and understandability of notice content. For example, CMS could consider approaches to summarize the letter contents in plain language.

CMS should also offer states and MCOs guidance on how they can better support beneficiaries in navigating the appeals process. Federal rules require that MCOs provide support through the appeals process for any beneficiary who requests it. However, focus group participants indicated that this assistance is rarely meaningful. Some participants expressed distrust in MCOs and in the information they provide, and others hesitated to seek support from the entity that just denied their service request.

Focus group participants highlighted that external entities, including ombudsperson offices and legal aid societies, were trusted partners in helping navigate the appeals process. These entities can help with filing the appeal, gathering required documentation, and representing beneficiaries in meetings with the MCOs. It is the view of the Commission that CMS should provide states with guidance on how they may use Medicaid funding to ensure that these services from trusted external partners are available for beneficiaries.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation would increase federal discretionary spending to cover administrative activities related to issuing guidance.

States. States may choose to implement CMS guidance and improve how beneficiaries experience the appeals process. This guidance may help states revise their approaches to the appeals process—for example, by leveraging Medicaid dollars to support external entities that assist beneficiaries throughout the process. Additionally, states may choose to use model notices to standardize what is sent to beneficiaries regarding denials.

Enrollees. This recommendation is intended to improve the appeals process for beneficiaries, which may increase their access to the process. As a result of increased accessibility to the appeals process, beneficiaries may see increased access to medically necessary services.

Plans. With guidance from CMS to improve denial notices, states may require that MCOs make changes to their notices. In addition, MCOs may implement strategies offered in the CMS guidance to provide more meaningful support to beneficiaries throughout the appeals process.

Providers. If CMS guidance results in a more accessible appeals process and beneficiary appeals increase, providers will need to supply clinical documentation for a greater number of appeals. However, if the notices are clearer and describe what documentation is needed, providers may experience a lower burden in supplying this information.

Recommendation 2.3

To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in addition to the mailed notice.

Rationale

Written notices delivered by mail can be inadequate for some beneficiaries. Beneficiaries we spoke to noted that mail can be delayed or delivered to the wrong address. Some stakeholder interviewees indicated that these notices often arrive a week or more after the postmarked date, or not at all. This is consistent with findings from previous MACPAC work on eligibility notices, which indicated that beneficiaries who receive notices by mail have shorter windows of time to respond. Furthermore, delivery of mail can frequently be hampered by inaccurate addresses. Medicaid beneficiaries frequently change addresses, making it challenging to keep contact information up to date (MACPAC 2022).

Focus group participants agreed that states and managed care plans should add more ways for enrollees to receive information about denials and appeals decisions (e.g., text, e-mail, phone call). In addition, previous MACPAC work found that providing multiple modes of communication helps ensure that beneficiaries receive important information (MACPAC 2022). The Commission notes that the unwinding of the continuous coverage condition of the COVID-19 public health emergency further supports this approach. This recommendation would provide beneficiaries with more options for receiving information about their care and would align notice delivery rules for denials and appeals with those applying to eligibility notices (42 CFR § 435.918(b)(4)).

CMS should continue to assess the best methods for delivering critical, time-sensitive information. In its 2022 proposed rulemaking, CMS proposed that states attempt to contact beneficiaries by two modalities, including mail and one other method (e.g., phone, electronic notice, text) when they receive returned mail (CMS 2022b). CMS should work with states to assess the effectiveness of other modes of communication and consider whether such methods would be appropriate for improving communication of adverse benefit determinations for beneficiaries in managed care.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that the recommendation would increase federal discretionary spending to cover administrative activities related to conducting rulemaking.

States. States would be required to provide oversight to ensure that MCOs are offering this choice to beneficiaries. States may need to amend managed care contracts and add additional data elements to monitoring and oversight efforts to track adherence.

Enrollees. Allowing enrollees to select additional modes of delivery for notices may improve their access to timely and important information, which in turn could improve access to the appeals process.

Plans. MCOs would need to update systems to identify the communication preferences of enrollees and generate and send electronic notices. Some MCOs may experience an increased burden associated with collecting and maintaining electronic information for beneficiaries that are not already using these modes of communication.

Providers. This recommendation should have no direct impact on providers.

Recommendation 2.4

To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service.

Rationale

Our research identified three issues with accessing continuation of benefits: lack of beneficiary awareness of the right, threat of repayment, and tight beneficiary timelines. To address access barriers related to tight beneficiary timelines, CMS should promulgate regulations to extend the current 10-day timeline for beneficiaries to request continuation of benefits. Focus group participants and beneficiary advocates indicated that the 10-day window to file for continuation of benefits is too short. Beneficiaries often do not receive the denial notice in a timely manner, and since the clock starts on the postmarked date of the notice, many beneficiaries lack sufficient time to file for continuation of benefits. Commissioners discussed whether CMS should consider different timelines for continuation of benefits based on how the beneficiary receives the notice of denial; however, the Commission concluded that this may add an unnecessary level of operational complexity.

CMS should use clarifying guidance to address the two issues of lack of awareness and risk of repayment. This guidance should provide user-tested model language on continuation of benefits to improve denial notices and identify methods to make this information more prominent. Commissioners expressed the importance of ensuring that the notice is in plain language and easy to read.

Guidance should clarify that MCOs are allowed to pursue recoupment only if the state allows repayment under fee for service. Although our research did not identify any instances in which an MCO sought repayment for services, advocates and beneficiaries clearly noted that the possibility of repayment is a barrier for beneficiaries to continue receiving services throughout an appeal. As such, CMS guidance could identify how states can evaluate and modify their recoupment policies to address this barrier. Relatedly, denial notices should not include language describing repayment unless it is allowable in the state.

Implications

Federal spending. Although this recommendation may result in an increase in the number of beneficiaries requesting continuation of benefits, CBO estimated that extending the timeline to request continuation of benefits would not have a substantial effect on the federal budget.

States. Following CMS rulemaking, states will need to ensure that MCOs implement the extended timeline for beneficiaries to request continuation of benefits. Additionally, with CMS guidance on how to make continuation of benefits more accessible, states may choose to implement these approaches to modify policies and procedures for their MCOs.

Enrollees. Beneficiaries could become more aware of this benefit and choose to exercise this option, which would increase access to services during the appeals process.

Plans. With guidance, MCOs will be encouraged to provide information on continuation of benefits in a more meaningful way to beneficiaries. If beneficiaries elect to continue receiving services while an appeal is pending, MCOs may bear the cost of services provided.

Providers. If more beneficiaries request to continue receiving services while an appeal is pending, providers may provide more services to their patients.

Recommendation 2.5

To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. The rules should require that states use these data

to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

Rationale

Current federal monitoring requirements are insufficient and require only limited insight into MCO denials and appeals outcomes. By requiring that states monitor data on denials, states will have greater insight into the extent to which beneficiaries experience denials. States that already collect and monitor these data indicated they are important for assessing whether beneficiaries are experiencing any challenges with access. Some states monitor data on denials and look at deviations from the trend in denial rates to identify potential problems with the authorization process.

The appeals data that are currently required to be collected are limited and do not provide states sufficient information to identify potential issues with inappropriate denials in both the authorization and appeals processes. Monitoring outcomes of MCO appeals can indicate the extent to which beneficiaries are receiving services, help states identify and correct inappropriate denials, and help states better understand the reasons for the initial denial (e.g., unclear documentation requirements). In addition, given the lack of monitoring and oversight of continuation of benefits and how little is known about its accessibility and use, proposed rulemaking should establish requirements for states to monitor beneficiary access to and use of this benefit.

To reduce administrative burden, this recommendation builds on the existing MCPAR requirement. States are already required to submit plan-reported data annually, and under this recommendation, states would be required to also report the number and types of denials, the denial reason, the service types of the denied service or item, and the outcomes of MCO appeals. CMS will also have insight into these trends.

About half of states do not have experience collecting or monitoring these types of data, and federal guidance can help states establish a standardized and effective monitoring program. For states already collecting these data, guidance can help improve existing processes and standardize data collection. The Commission supports CMS offering clear definitions for reporting. For example, in establishing denial data reporting standards, CMS may require separate reporting of partial denials (e.g., reduction in requested service) versus full denials (e.g., no service authorized). In addition, CMS may consider requiring both raw numbers (e.g., number of denials) as well as percentages (e.g., percentage of authorization requests that are denied). By offering standard categories and definitions, CMS can ensure adequate comparisons across plans and states. CMS should consider stratifying these data by types of service (e.g., behavioral health) and demographic characteristics (e.g., age, race, ethnicity, geography).

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that this recommendation would increase federal discretionary spending to cover CMS administrative activities related to conducting rulemaking, issuing guidance, and updating the MCPAR template.

States. States that do not collect these data already would have an increased administrative burden to implement this requirement. States that do collect these data already would likely face less of a burden, but these states may have to adjust current reporting depending on what CMS ultimately requires. This new information will provide state officials with greater insight into their managed care program and provide states an opportunity to improve monitoring and the ability to identify potential access issues. Once these issues are identified, states will be required to use this information to improve the performance of the program.

Enrollees. With improved monitoring, beneficiaries may see improved access to appropriate, medically necessary care.

Plans. Managed care plans would face an increased burden, as they would be required to submit these new data. Although these fields may be a new federal requirement for Medicaid managed care, they are already federally required for MA plans and the plans

on the federally facilitated exchange. MCOs may be able to leverage practices and data collection techniques from other lines of business (e.g., exchange markets) and external accreditation reviews to comply with these new requirements.[28]

Providers. We do not anticipate any direct effect on providers. To the extent that improved monitoring yields greater access to care and a corresponding reduced need for appeals, providers may see a reduction in their administrative burden.

Recommendation 2.6

To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit.

Rationale

Clinical appropriateness audits can be effective at identifying inappropriate denials of care, yet these audits are not required in Medicaid managed care. Among the states voluntarily conducting these clinical audits, several have identified instances of MCOs inappropriately denying prior authorization requests, such as for drug therapies, health screening services for children, and inpatient hospital services (OIG 2023). In our interviews, one state official with experience conducting these reviews noted that they can be an effective tool for oversight and ensuring access to medically necessary care.

The OIG has made a similar recommendation to CMS, which would require states to regularly review the appropriateness of a sample of MCO prior authorization denials (OIG 2023). Similar types of audits are already conducted in the MA program and have identified inappropriate denials (OIG 2022, 2018).

By establishing the clinical appropriateness audit as an optional activity under external quality review, this recommendation would allow states to leverage existing contracts with EQROs and receive enhanced match for this activity. Although all states operating Medicaid managed care programs are statutorily required to conduct an external, independent review of their program using an EQRO, the current protocol does not include a clinical appropriateness review. Furthermore, EQROs already collect some of the needed information to assess clinical appropriateness. Although this recommendation would require that CMS set federal standards for routine clinical appropriateness audits, it would not preclude states from conducting more frequent or ancillary audits as needed throughout the year.

Since most states are not currently conducting these types of audits, guidance will help establish a standardized approach to this new monitoring tool. For states that do conduct these audits, guidance may help improve this process and allow for potential comparison across states and MCOs. As part of the guidance, CMS should allow states the flexibility to identify specific service areas, such as denials for services that may be under the EPSDT benefit, that must be included in the audit.

The Commission discussed, but did not agree on the timing of implementing the requirement for routine clinical audits in relation to the requirement for external medical review (in Recommendation 2.1). Some Commissioners stated that clinical audits should precede implementation of external medical review in order to gather additional evidence about the frequency of inappropriate denials. Other Commissioners stated that clinical audits and external medical review should be simultaneously implemented, citing the need for an independent and clinical review of beneficiary appeals and improved state oversight of denials. Ultimately, the Commission passed these recommendations independently without respect to timing.

The recommendation would also require that CMS update the MCPAR template to include findings from the clinical audit. These reports are provided

to CMS for its review and posted publicly on state websites. This would allow findings from clinical audits, along with other key reporting metrics that are already included in the MCPAR (e.g., appeals), to be accessible.

Implications

Federal spending. CBO estimates that this recommendation would likely increase federal direct spending by less than $500 million over a 10-year period. This recommendation would also increase federal discretionary spending to cover CMS administrative activities related to conducting rulemaking, issuing guidance, and updating the annual managed care reports.

States. States not already conducting these audits would see an increase in administrative burden and spending as a result of conducting the audits. States already requiring such audits may experience less of a burden and cost, depending on how closely current audits mirror the requirements that CMS establishes. If states opt to have the EQRO conduct the audit, the activity would be eligible for enhanced match.

Enrollees. If states use this monitoring and oversight tool to correct any identified issues that result in inappropriate denials, beneficiaries may see improved access to medically necessary care and a reduced administrative burden. Specifically, this may reduce the need for beneficiaries to appeal inappropriate denials.

Plans. MCOs may see an increase in their administrative burden in supplying case files and documents. Some MCOs may currently be subject to these types of audits in the 13 states already implementing them. MCOs in states that already require such audits may experience less of a burden than MCOs in states that do not conduct these audits, depending on how closely aligned these audits are with new requirements from CMS.

Providers. We do not anticipate any direct effect on providers. To the extent that audits yield greater access to care and a corresponding reduced need for appeals, providers may see a reduction in their administrative burden.

Recommendation 2.7

To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan.

Rationale

Currently there is little transparency on MCO approvals and denials of services, limiting what is known about beneficiary access to medically necessary care. This recommendation aims to improve transparency of denials and appeals information by leveraging the MCPARs and QRS websites. These changes would bring greater oversight and accountability to managed care programs and provide beneficiaries with key information on denials and appeals.

By requiring that CMS post all reports to its website, researchers and other stakeholders will be able to more easily access the reports, allowing for analysis of the managed care program as a whole. Although states are currently required to post these reports, at the time of this writing, we have found reports from only six states.[29]

States will be required to set up QRS websites to assist beneficiaries in their selection of a plan. Given the importance of denials and appeals data in beneficiary access, these data should be available to beneficiaries on these websites. The Commission discussed how providing context around these data will be important. For example, websites may need to explain that data between plans are not necessarily comparable without additional information on prior authorization practices. Plans may differ in the extent to which they apply prior authorization, which in turn can affect the denial rate.

Together with Recommendations 2.5 and 2.6, the public would have access to data on managed care denials and appeals outcomes and the findings of

clinical appropriateness audits. This would make program-wide data publicly available for the first time.

This recommendation does not remove or change the requirement for transparency in the final prior authorization rule but instead complements it (CMS 2024). Recommendation 2.7 would apply to denials of outpatient prescription drugs, whereas this new regulatory requirement would not. Additionally, once implemented, MCOs will be required to report similar data (e.g., publicly posting prior authorization denials metrics), and this information can be made available for state oversight and transparency purposes. CMS and states should consider how these data could be incorporated into existing reporting requirements for MCPARs and QRSs.

Implications

Federal spending. CBO does not estimate any changes in federal direct spending as a result of implementing this recommendation. CBO estimates that this recommendation would increase federal discretionary spending to cover CMS administrative activities related to conducting rulemaking and issuing guidance.

States. Including denials and appeals data on state QRS websites will add a modest administrative burden, given that states will already collect this information under Recommendations 2.5 and 2.6. Officials will need to ensure that these data are posted in a usable format for beneficiaries.

Enrollees. Under this recommendation, beneficiaries would have greater insight into the extent to which services may be denied and then overturned through appeals. This information would be at the plan level, helping to inform their plan selection.

Plans. We do not anticipate any direct effect on plans. However, transparency efforts may encourage some plans to improve their authorization and appeals processes.

Providers. We do not anticipate any direct effect on providers. To the extent that transparency yields greater access to care and a corresponding reduced need for appeals, providers may see a reduction in their administrative burden.

Additional Considerations

Congress and CMS should implement the Commission's recommendations to ensure that these improvements apply uniformly to all state Medicaid programs and beneficiaries. However, the Commission acknowledges that states have the primary responsibility to oversee their managed care programs and ensure that beneficiaries have access to appropriate care. Independent of federal action, current rules allow states flexibility to modify and improve the appeals process. For example, states can elect to implement external medical review, even without a federal mandate, to improve trust in the appeals process, reduce potential conflicts of interest, and ensure appropriate access to medically necessary care. In addition, states can require that MCOs offer beneficiaries the option to also receive denial notices electronically. This would help ensure that beneficiaries receive these notices in a timely manner.

In addition, states have flexibility to implement more robust monitoring and oversight systems. Independent of actions by Congress or CMS on these recommendations, states could improve their monitoring and oversight programs by collecting data on denials and appeals outcomes, conducting clinical audits, and publicly reporting key data and findings.

States also can use denials and appeals data and clinical audits to enhance monitoring efforts and should use the tools available to them to respond to any managed care plan performance issues that arise. Specifically, states may need to revisit existing policies or contract requirements to ensure that MCOs are appropriately covering and authorizing services. Furthermore, states should enforce policies and contract requirements for MCOs that inappropriately deny care through the authorization and appeals processes.

Looking Ahead

MACPAC staff will continue to monitor state websites for the MCPARs and investigate further work with newly available data. MACPAC staff are also currently pursuing work on prior authorization policies in Medicaid.

Endnotes

[1] Federal rules governing the managed care authorization and appeals processes apply to MCOs, as referenced in this chapter, but also apply to other managed care entities, including primary care case management plans, prepaid inpatient health plans, and prepaid ambulatory health plans.

[2] We examined states with comprehensive managed care and excluded 10 states due to no or low rates of comprehensive managed care. We excluded states with comprehensive managed care rates of less than 5 percent but included North Carolina due to its recent transition to comprehensive managed care (MACPAC 2023). Excluded states are Alabama, Alaska, Arkansas, Connecticut, Idaho, Maine, Montana, Oklahoma, South Dakota, and Wyoming. Documents reviewed included state quality strategies, managed care contracts, Medicaid dashboards and websites, annual technical reports, and managed care manuals, among other documents.

[3] Twenty-two beneficiaries and caregivers participated in focus groups between June and September 2023. Mathematica engaged community-based organizations, primarily legal assistance agencies and state ombudsperson offices, to recruit beneficiaries for this study. People were eligible to participate in focus groups if they had appealed a Medicaid denial or reduction in service within the last three years. Participants included residents across eight states: Delaware, Louisiana, Massachusetts, Michigan, New Jersey, New York, Ohio, and Washington. Most participants were caregivers to children, a person with a disability, or an elderly parent.

[4] The OIG examined data across seven MCO parent companies with the largest number of people enrolled in comprehensive, risk-based MCOs across all states in 2019. These seven MCO parent companies include 115 MCOs in 37 states, which enrolled a total of 29.8 million people in 2019. The OIG calculated the denial rate as a share of total authorization requests, and as a result, there is no estimated denial rate as a share of total services provided. The OIG did not report on the extent to which services were subject to prior authorization or how this varied by MCO (OIG 2023).

[5] Appeal rates are also low for other federal payers. However, publicly available data are not directly comparable across payers. Among exchange enrollees, the appeal rate was about 0.2 percent in 2021 for all in-network denied claims (Pollitz et al. 2023). In MA, the appeal rate was 1.1 percent between 2014 and 2016, which included appeals for both payment denials and preservice denials (OIG 2018). The OIG calculated the MA appeal rate to include beneficiary appeals of denied services as well as provider appeals of denied payment after the service had been delivered.

[6] Limits may be placed for purposes of utilization control. For example, states may not require prior authorization for EPSDT screening services but may apply prior authorization for certain treatment services. States must review these limits in light of a particular child's needs for determination of medical necessity (CMS 2014).

[7] The focus of this chapter is on two types of denials, or adverse benefit determinations. This includes the denial or limitation of a requested service or item, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit (42 CFR § 438.400(b)(1)). It also includes any reduction, suspension, or termination of a previously authorized service (42 CFR § 438.400(b)(2)). Outpatient prescription drugs are included in this definition. When referring to denials, the Commission is not including denial of payment for services already received (42 CFR § 438.400(b)(3)).

[8] CMS allows any adverse benefit determination to be appealed to the MCO; however, several of these adverse benefit determinations are outside the scope of this chapter. They include a denial of payment to a provider; the MCO's failure to provide services in a timely manner; the failure of an MCO to act within the time frames provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of an beneficiary's request to obtain services outside the MCO network when the beneficiary is a resident of a rural area with one MCO; and the denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities (42 CFR § 438.400(b)(3 –7)).

[9] Grievances are outside the scope of this chapter.

[10] MCO requirements for covered outpatient drugs are described in §1927(d)(5)(A) of the Act.

[11] This final rule will apply changes to interoperability and prior authorization requirements in Medicaid managed care and other programs, including Medicaid fee for service, the State Children's Health Insurance Program, MA, and exchange plan issuers on the federally facilitated exchange. Notably, these changes will not apply to outpatient drugs, including those administered by a physician. In addition

to shortening the time frame for MCOs to make prior authorization decisions, this final rule will make a number of other changes. First, MCOs will be required to implement and maintain an application programming interface (API) to facilitate the prior authorization process. The API is meant to reduce burdens on providers and payers and streamline the prior authorization process. Providers will be able to search individual MCOs' APIs to determine whether a requested service or item is subject to prior authorization and automate the process by compiling the required data for populating the prior authorization request. Through this final rule, CMS will also require that MCOs publicly report aggregated prior authorization data on their websites (CMS 2024).

[12] If state law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal on behalf of the enrollee (42 CFR § 438.402(c)(1)(ii)).

[13] CMS prescribes protocols that EQROs must use in their reviews. EQROs review samples of approved and denied items and services and examine who reviewed the coverage decision, the criteria used, and how and when the MCO communicated decisions with beneficiaries. EQROs assess compliance with timelines, qualifications of staff involved in coverage determinations, and content of notices regarding decisions and rights to appeals (CMS 2023c).

[14] Specific reporting requirements varied by state. In some cases, the reporting template was publicly available, and we were able to identify the specific fields that MCOs must submit. In other cases, the contract, managed care manual, or quality strategy would include general information about reporting requirements or objectives, but specific requirements were not available.

[15] This work was conducted under a contract with Bailit Health. It performed an environmental scan of EQRO reports in 46 states. It is difficult to assess the extent of non-compliance nationally because the EQROs' approach to scoring MCO compliance varies by state. Even within a single state, a finding of non-compliance may refer to one minor area of non-compliance that can be quickly remedied, or it may mean not compliant across various components.

[16] When beneficiaries do not actively enroll in an MCO, states may automatically assign beneficiaries to one. States may use different criteria to assign beneficiaries. Federal rules detail requirements around this process (42 CFR §438.54).

[17] Beneficiary advocates provided seven redacted notices across three plans to MACPAC staff. Among these notices, the length ranged from three to nine pages, and the readability scores ranged from grade 6.1 to 11.3. Additionally, some of the letters used headings and bold text to guide the reader, whereas others used unformatted text throughout the entire notice. We calculated grade-level readability scores using the Flesch-Kincaid grade level score tool available in Microsoft Word. The Flesch-Kincaid grade level is equivalent to the U.S. grade levels of education. A grade level of six indicates that a sixth-grade education is required to understand the given text.

[18] States vary in their required reporting of denials. For example, Hawaii evaluates MCO performance by reviewing denial rates under prior authorization and the percentage of overturned prior authorization denials (HI DHS 2022). In Georgia, a quarterly prior authorization report includes denials by specific service categories (e.g., dental, pharmacy, and medical inpatient and outpatient) (GA DCH 2016). In Florida, MCOs must report monthly on authorizations and denials across more than 56 service types, which include 12 specifically related to behavioral health services (e.g., behavioral inpatient, outpatient, specialized therapeutic services) (FL AHCA 2019).

[19] States are required to collect the resolution at each level of the appeal (42 CFR § 438.416(a)). The MCPAR defines an appeal as resolved when "the MCO has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary has filed a request for a state fair hearing or external medical review." States must report the total number of appeals resolved; however, the current MCPAR template does not require that states report the decision (e.g., the number of appeals favorable or adverse to the beneficiary) (CMS 2023a).

[20] Thirty-one states require National Committee for Quality Assurance (NCQA) health plan accreditation, which includes an assessment of the authorization and appeals systems in place. As a component of this accreditation, NCQA assesses MCO compliance with federal rules regarding coverage and authorization of services and appeals and grievances. NCQA does not currently evaluate for clinical appropriateness as a component of this accreditation process (NCQA 2022).

[21] The OIG made four additional recommendations to CMS. They include that CMS should (1) require states to collect data on MCO prior authorization decisions, (2) issue

guidance to states on the use of MCO prior authorization data for oversight, (3) require states to implement automatic external medical reviews of upheld MCO prior authorization denials, and (4) work with states on actions to identify and address MCOs that may be issuing inappropriate prior authorization denials (OIG 2023).

[22] States include Arkansas, Louisiana, Mississippi, Ohio, Pennsylvania, and Tennessee (AR DHS 2023, LA DOH 2023, MS DOM 2023, OH DOM 2023, PA DHS 2023, Tenncare Medicaid 2023).

[23] CMS has indicated this delay is due to challenges in making MCPARs compliant with accessibility requirements.

[24] MCOs will be required to report a list of all items and services subject to prior authorization; the percentage of standard prior authorization requests that were approved, denied, and approved after appeal; the percentage of prior authorization requests for which the time frame of review was extended and the request was approved; the percentage of expedited prior authorization requests that were approved and denied; and the average and median time to process standard and urgent authorization requests (CMS 2024).

[25] According to the OIG study on prior authorization denials, only 2 percent of upheld denials were appealed to a state fair hearing in 2019. However, when state fair hearings occurred, they fully or partially overturned 38 percent of prior authorization denials in favor of the beneficiary (OIG 2023).

[26] In MA, the beneficiary may file an appeal with their health plan. If the denial is upheld, it is automatically forwarded to the independent review entity. If the denial is still upheld at this level, the beneficiary may file an appeal to the administrative law judge and then the Medicare appeals council (OIG 2023).

[27] For example, New Jersey requires that MCOs bear the cost of the review with the external medical reviewer, regardless of the outcome of the review (NJ DBI 2021).

[28] For example, when applying for accreditation with NCQA, MCOs must provide necessary data for NCQA to evaluate authorization and appeals policies and practices.

[29] States include Arkansas, Louisiana, Mississippi, Ohio, Pennsylvania, and Tennessee (AR DHS 2023, LA DOH 2023, MS DOM 2023, OH DOM 2023, PA DHS 2023, Tenncare Medicaid 2023).

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Commission Vote on Recommendations

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

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

The Commission voted on these recommendations on January 26, 2024.

Denials and Appeals in Medicaid Managed Care

2.1 To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process that can be accessed at the beneficiary's choice, with certain exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing.

2.1 voting results	#	Commissioner
Yes	13	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Heaphy, Hill, Johnson, Killingsworth, Medows, Snyder, Weno
No	3	Giardino, Ingram, McCarthy
Abstain	1	McFadden

2.2 To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services (CMS) should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services.

2.3 To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in addition to the mailed notice.

2.4 To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service.

2.5 To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, using standardized definitions for reporting. The rules should require that states use these data to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

2.6 To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit.

2.7 To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan.

2.2-2.7 voting results	#	Commissioner
Yes	17	Allen, Bella, Bjork, Brooks, Duncan, Gerstorff, Giardino, Heaphy, Hill, Ingram, Johnson, Killingsworth, McCarthy, McFadden, Medows, Snyder, Weno

Chapter 3:

Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

Key Points

- State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid and other low-income patients.
- State DSH spending is limited by federal allotments, which vary widely by state based on states' historical DSH spending before federal limits were established in 1992.
- MACPAC continues to find no meaningful relationship between DSH allotments to states and the following three factors that Congress has asked the Commission to study:
  - the number of uninsured individuals;
  - the amount and sources of hospitals' uncompensated care costs; and
  - the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.
- Under current law, federal DSH allotments are scheduled to be reduced by $8 billion in fiscal year 2024, which is about half of unreduced allotment amounts.
  - At the time of this chapter's drafting, Congress has delayed the implementation of these reductions until March 9, 2024.
  - The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety-net providers.
- MACPAC has made several recommendations for statutory changes to improve Medicaid DSH policy.
  - Congress has partially implemented MACPAC's recommendations on data transparency and the treatment of third-party payments in the definition of Medicaid shortfall.
  - The Commission's recommendations on restructuring DSH allotments and adjusting DSH allotments to account for changes in the federal matching assistance percentage have not yet been implemented.
- The Commission is currently engaging in a long-term work plan to further examine all types of Medicaid payments to hospitals using newly available data on non-DSH supplemental payments and managed care directed payments.
  - In recent years, some states have begun substituting other types of Medicaid payments for DSH payments.
  - In the Commission's view, DSH policy should be assessed in the context of all other Medicaid payments to hospitals.

CHAPTER 3: Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States

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

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

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

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

In this report, we update our previous findings to reflect new information on changes in the number of uninsured individuals and levels of hospital uncompensated care. We also provide updated information on deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. We also update our findings with data on hospital finances in fiscal year (FY) 2021, which include the effects of the COVID-19 pandemic. Although the COVID-19 pandemic disrupted hospital finances, policy responses during the COVID-19 public health emergency (PHE) helped lower the uninsured rate, increased DSH allotments, and provided other fiscal relief to hospitals. Specifically, we find the following:

- A total of 25.9 million people, or 7.9 percent of the U.S. population, were uninsured in 2022, a 0.4 percentage point decline from 2021 (Keisler-Starkey et al. 2023).[2] Some of the decline in the uninsured rate may be attributed to the continuous coverage requirements implemented during the PHE (MACPAC 2022a).[3]
- Hospitals reported $39.3 billion in hospital charity care and bad debt costs on Medicare cost reports in FY 2021. This amount represented a $1.3 billion (0.4 percentage point) decrease in uncompensated care costs from FY 2020. While uncompensated care as a share of hospital operating expense dropped substantially after coverage provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) went into effect, it has largely remained unchanged since 2015.[4]
- In FY 2021, the aggregate operating margin for all hospitals was negative across all hospitals (-0.8 percent) and was lower for deemed DSH hospitals (-4.6 percent).[5] These negative operating margins may be partially attributed to financial disruptions of the COVID-19 pandemic. We also calculated total margin, which accounts for all forms of hospital revenue, including federal provider relief funding authorized during the PHE. The aggregate total margin was similar for both deemed DSH and other hospitals (9.3 vs. 10.1 percent, respectively). Aggregate operating and total margins for deemed DSH hospitals would

have been 3 to 4 percentage points lower without DSH payments.

In this report, we project DSH allotments before and after implementation of federal DSH allotment reductions. DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid and the health insurance exchanges would lead to reductions in hospital uncompensated care and thereby lessen the need for DSH payments. DSH allotment reductions have been delayed several times, and in recent years, Congress has acted to eliminate some of the reductions.

Under current law, $8 billion in federal DSH allotment reductions are scheduled to take effect in FY 2024. However, at the time of this chapter's drafting, Congress has delayed the implementation of these reductions until March 9, 2024 (Further Additional Continuing Appropriations and Other Extensions Act, 2024, P.L. 118-135). The House of Representatives has passed legislation that would eliminate DSH reductions for FY 2024 and FY 2025 and retain DSH allotment reductions of $8 billion annually for FY 2026 and FY 2027 (H.R. 5378). While this legislation has not been taken up by the Senate, a similar delay of the DSH allotment reductions was introduced in the Senate (S. 3430). Due to the uncertainty of when the allotment reductions may be implemented, the analyses in this chapter assume the federal DSH allotment reductions will begin in FY 2026. In FY 2026, the $8 billion reduction is projected to be 48.7 percent of unreduced allotments.

MACPAC has made several recommendations for statutory changes to improve the Medicaid DSH policy (Box 3-1). Congress has partially implemented MACPAC's recommendations on data transparency and the treatment of third-party payments in the definition of Medicaid shortfall. However, the Commission's recommendations on restructuring DSH allotments and adjusting DSH allotments to account for changes in the federal matching assistance percentage (FMAP) have not been implemented. The Commission remains concerned that the magnitude of DSH cuts assumed under current law could affect the financial viability of some safety-net providers but has not taken a position on whether Congress should proceed with reductions in current law. However, if Congress proceeds with DSH allotment reductions, it should change the methodology to phase in reductions and gradually improve the relationship between DSH allotments and measures of need for DSH funds.

The Commission has long held the view that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income uninsured patients and have higher levels of uncompensated care, consistent with the original statutory intent. However, development of policy to achieve this goal must be considered in terms of all Medicaid payments that hospitals receive. To this end, the Commission has begun a long-term work plan to further examine all types of Medicaid payments to hospitals and assess whether payment policies are consistent with the statutory goals of efficiency, economy, quality, and access (MACPAC 2023a).

This chapter begins with a background on Medicaid DSH policy and then reviews the most recently available data on the number of uninsured individuals, the amounts and sources of hospital uncompensated care, and the number of hospitals with high levels of uncompensated care that also provide essential community services. Then the chapter reviews DSH allotment reductions under current law and how they relate to the factors that Congress asked the Commission to consider. The chapter concludes by discussing the relationship between DSH and other types of Medicaid payments and by reviewing next steps for MACPAC's work in this area.

Background

Current DSH allotments vary widely among states, reflecting the evolution of federal policy over time. States began making Medicaid DSH payments in 1981, when Medicaid hospital payment methods and amounts were uncoupled from Medicare payment standards.[6,7] Initially, states were slow to make these payments, and in 1987, Congress required states to make payments to hospitals that serve a high share of Medicaid-enrolled and low-income patients, referred to as deemed DSH hospitals. Total state and federal DSH spending grew rapidly in the early 1990s—from $1.3 billion in 1990 to $17.7 billion in 1992—after Congress clarified that DSH payments were not subject to Medicaid hospital upper payment limits (Matherlee 2002, Klem 2000, Holahan et al. 1998).[8]

BOX 3-1. Prior MACPAC Recommendations Related to Disproportionate Share Hospital Policy

February 2016

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

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

March 2019

Improving the structure of disproportionate share hospital allotment reductions

- If Congress chooses to proceed with disproportionate share hospital (DSH) allotment reductions in current law, it should revise Section 1923 of the Social Security Act to change the schedule of DSH allotment reductions to $2 billion in fiscal year (FY) 2020, $4 billion in FY 2021, $6 billion in FY 2022, and $8 billion a year in FYs 2023–2029, in order to phase in DSH allotment reductions more gradually without increasing federal spending.
  - Note: Since this recommendation was made, Congress has delayed DSH allotment reductions, but it has not adopted a more gradual phase-in of reductions.
- In order to minimize the effects of disproportionate share hospital (DSH) allotment reductions on hospitals that currently receive DSH payments, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to apply reductions to states with DSH allotments that are projected to be unspent before applying reductions to other states.
- In order to reduce the wide variation in state disproportionate share hospital (DSH) allotments based on historical DSH spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of the U.S. Department of Health and Human Services to develop a methodology to distribute reductions in a way that gradually improves the relationship between DSH allotments and the number of non-elderly low-income individuals in a state, after adjusting for differences in hospital costs in different geographic areas.

BOX 3-1. (continued)

June 2019

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

- To avoid Medicaid making disproportionate share hospital (DSH) payments to cover costs that are paid by other payers, Congress should change the definition of Medicaid shortfall in Section 1923 of the Social Security Act to exclude costs and payments for all Medicaid-eligible patients for whom Medicaid is not the primary payer.
  - Note: P.L. 116-260 enacted this recommendation for most DSH hospitals, effective October 1, 2021, while exempting hospitals that treat a large percentage and number of patients who are eligible for Medicare and receive Supplemental Security Income.

June 2023

Automatic Medicaid disproportionate share hospital allotments

- 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 (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 federal medical assistance percentage (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.

DSH allotments

To limit DSH spending, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments, referred to as allotments (Box 3-2). Allotments were initially established for FY 1993 and were generally based on each state's 1992 DSH spending. Although Congress has subsequently made several adjustments to these allotments, the states that spent the most in 1992 still have the largest allotments, and the states that spent the least in 1992 still have the smallest allotments.[9] However, because Medicaid spending has grown faster than DSH allotments, DSH spending as a share of overall Medicaid spending has declined from 15 percent in FY 1992 to 3 percent in FY 2022 (MACPAC 2023e, 2023f; CRS 2023). States are not required to spend their entire allotment and do not receive federal funding for DSH payments that exceed the allotment.

BOX 3-2. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

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

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

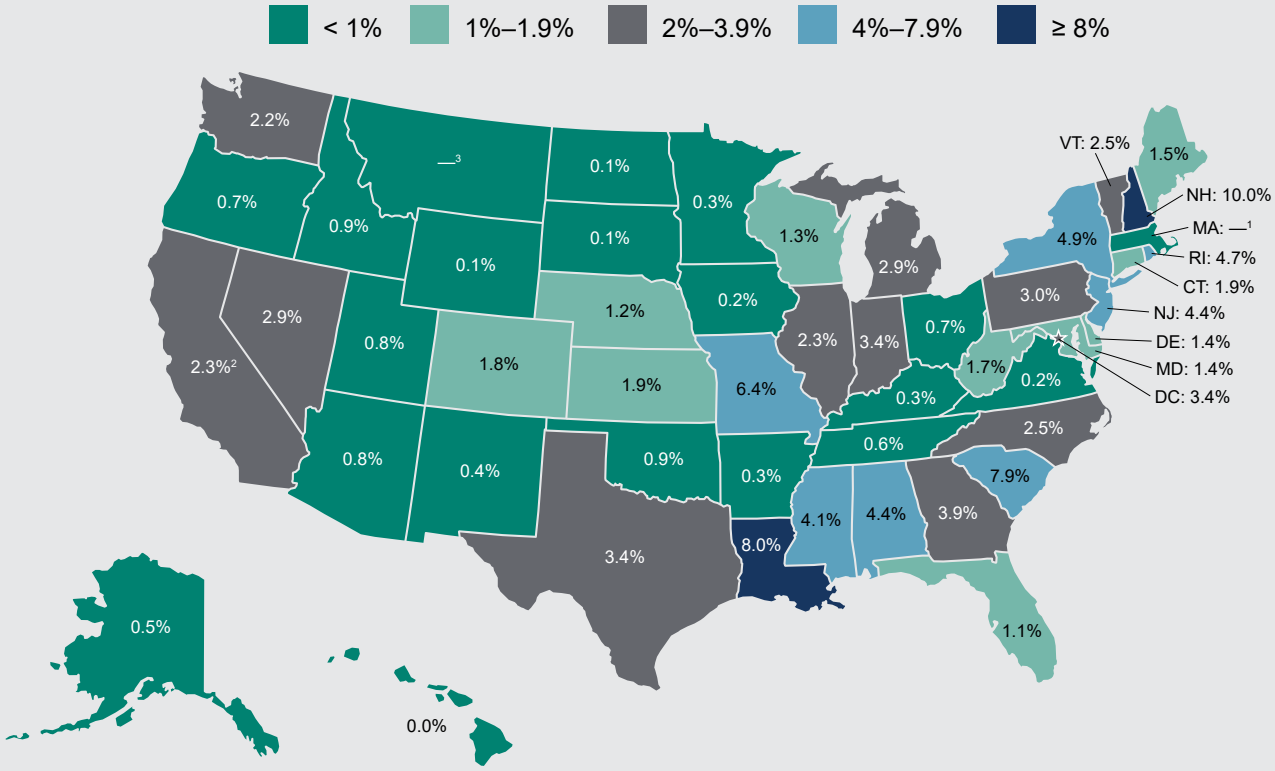
State DSH allotment. The total amount of federal funds available to a state for Medicaid DSH payments. To draw down federal DSH funding, states must provide state matching funds at the same matching rate as other regular Medicaid service expenditures. If a state does not spend the full amount of its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

State total DSH funding. The total amount of state and federal funds available for DSH payments within a state. Assuming a state is able to spend its full allotment in a given year, total DSH funding available to DSH hospitals is equal to the state's allotment divided by its federal medical assistance percentage.

Hospital-specific DSH limit. The annual limit on DSH payments to individual hospitals, equal to the sum of Medicaid shortfall and unpaid costs of care for uninsured patients for allowable inpatient and outpatient costs. For the definitions of Medicaid uncompensated care, see Box 3-3.

Between FY 2020 and FY 2024, Congress temporarily increased DSH allotments as part of the response to the COVID-19 pandemic. Congress increased the FMAP for all Medicaid expenditures, including DSH, by 6.2 percentage points under the Families First Coronavirus Response Act (P.L. 116-127). At the time, Congress did not change federal DSH allotment policy. This statutory change caused total DSH funding (state and federal amounts) to decrease for FY 2020 since DSH payments are capped by federal allotments and states contributed less to the non-federal share for DSH payments. A year later, Congress increased DSH allotments under the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) so that the total available state and federal DSH funding remained the same as it would have been before the FMAP increase. The ARPA adjustments to DSH allotments were retroactive to the second quarter of FY 2020 and lasted until the first quarter of FY 2024.[10] For more on the effects that the FMAP has on DSH allotments, please refer to Chapter 1 of MACPAC's June 2023 report to Congress (MACPAC 2023b).

FIGURE 3-1. DSH Spending as a Share of Total Medicaid Benefit Spending by State, FY 2022



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

— Dash indicates zero.

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

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

[3] Montana reported no DSH spending in FY 2022. States typically have two years to report DSH spending after the close of the fiscal year.

Source: MACPAC, 2024, analysis of CMS-64 financial management report net expenditure data as of May 30, 2023.

In FY 2022, allotments to states for DSH payments totaled $14.9 billion.[11] State-specific DSH allotments that year ranged from less than $15 million in five states (Delaware, Hawaii, North Dakota, South Dakota, and Wyoming) to more than $1 billion in three states (California, New York, and Texas).

Total federal and state DSH spending was $20 billion in FY 2022 and accounted for 3 percent of total Medicaid benefit spending.[12,13] DSH spending as a share of total Medicaid benefit spending varied widely by state, from less than 1 percent in 20 states to 10 percent in New Hampshire (Figure 3-1).

States typically have up to two years to spend their DSH allotments after the end of the fiscal year.[14] As of the end of FY 2023, $1.9 billion (13 percent) in federal DSH allotments for FY 2021 were unspent.[15]

There are two primary reasons that states do not spend their full DSH allotment: (1) they lack state funds to provide the non-federal share and (2) the DSH allotment exceeds the total amount of hospital uncompensated care in the state. As noted previously, DSH payments to an individual hospital cannot exceed that hospital's level of uncompensated care. In FY 2021, over half of unspent DSH allotments were attributable to six states (Connecticut, Indiana, Louisiana, New Jersey, Pennsylvania, and Virginia). All of these states, excluding Indiana and Virginia, had FY 2021 DSH allotments (including both state and federal funds) that were larger than the total amount of hospital uncompensated care in the state reported on 2021 Medicare cost reports, which suggests that these states may not be able to spend their full DSH allotments even if they have available state funds to provide the non-federal share.[16]

There are also regulatory or operational challenges to spend down DSH allotments in a timely manner when there are delays in Centers for Medicare & Medicaid Services (CMS) finalizing DSH allotments.[17] Although CMS provides states with preliminary allotments that they can use to make payments, some states are hesitant to spend their full DSH allotment until it is finalized because of concerns that CMS may later recoup funds if the final allotment is less than what was projected.[18]

DSH payments to hospitals

In state plan rate year (SPRY) 2019, 41 percent of U.S. hospitals received DSH payments (Table 3-1).[19,20] States are allowed to make DSH payments to any hospital that has a Medicaid inpatient utilization rate of at least 1 percent, which is true of almost all U.S. hospitals. More than half of public hospitals (54 percent) and teaching hospitals (63 percent) received DSH payments.

Medicaid DSH is also an important source of funding for rural hospitals. Almost half of all rural hospitals (46 percent) received more than $2 billion in DSH payments in SPRY 2019. Unlike Medicare DSH, Medicaid DSH payments can be used to support critical access hospitals, which receive a special payment designation from Medicare because they are small (fewer than 25 beds) and are often the only provider in their geographic areas.[21] For more information on Medicaid hospital payment policy for rural hospitals, refer to the MACPAC issue brief, *Rural Hospitals and Medicaid Payment Policy* (MAPCAC 2018).

The proportion of hospitals receiving DSH payments varies widely by state (Figure 3-2). In SPRY 2019, six states made DSH payments to fewer than 10 percent of the hospitals in their states (Arkansas, California, Illinois, Iowa, Maine, and North Dakota).[22] Conversely, one state, New York, made DSH payments to 95 percent of its hospitals.

As noted previously, states are statutorily required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid-enrolled and low-income patients. In SPRY 2019, about 12 percent of U.S. hospitals met this standard. These deemed DSH hospitals constituted just more than one-quarter (28 percent) of DSH hospitals but accounted for more than half (59 percent) of all DSH payments, receiving more than $10 billion in DSH payments. States vary in how they target DSH payments to deemed DSH hospitals, from less than 10 percent of DSH payments to deemed DSH hospitals in 6 states (Alabama, Alaska, Arkansas, Connecticut, North Dakota, and Utah) to 100 percent in 5 states (Delaware, Iowa, Illinois, Maine, and Maryland) and the District of Columbia.

TABLE 3-1. Distribution of DSH Spending by Hospital Characteristics, SPRY 2019

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as percentage of all hospitals in category	
Total	**2,464**	**5,940**	**41%**	**$17,224**
Hospital type				
Short-term (General and Specialty) hospitals	1,714	3,190	54	13,455
Critical Access hospital	535	1,358	39	438
Psychiatric hospital	139	625	22	2,933
Long-term hospital	9	347	3	8
Rehabilitation hospital	16	328	5	4
Children's hospital	51	92	55	386
Urban/Rural				
Urban	1,350	3,535	38	15,171
Rural	1,114	2,405	46	2,053
Hospital ownership				
For-profit	338	1,753	19	910
Non-profit	1,471	2,975	49	6,084
Public	655	1,212	54	10,229
Teaching status				
Non-teaching hospital	1,637	4,619	35	4,916
Low-teaching hospital	528	880	60	3,177
High-teaching hospital	299	441	68	9,130
Deemed DSH status				
Deemed	694	694	100	10,230
Not deemed	1,770	5,246	34	6,993

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. Excludes 65 DSH hospitals that did not submit a fiscal year 2021 Medicare cost report. Low-teaching hospitals have an intern-and-resident-to-bed (IRB) ratio of less than 0.25, and high-teaching hospitals have an IRB ratio of 0.25 or greater. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Total DSH spending includes state and federal funds. Analyses of deemed DSH hospitals are limited to hospitals that received DSH payments and exclude 25 hospitals in California and Massachusetts that received funding from safety-net care pools that are financed with DSH funding in demonstrations authorized under waiver expenditure authority of Section 1115 of the Social Security Act. Data for DSH hospitals in Montana were estimated using Montana's SPRY 2018 as-filed DSH audit because SPRY 2019 was unavailable.

Source: MACPAC, 2024, analysis of FY 2021 Medicare cost reports and SPRY 2018–2019 as-filed Medicaid DSH audits.

FIGURE 3-2. Share of Hospitals Receiving DSH Payments and Share of DSH Payments to Deemed DSH Hospitals by State, SPRY 2019

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. The share of DSH payments to deemed DSH hospitals shown does not account for provider contributions to the non-federal share; these contributions may reduce net payments. The analysis excludes Massachusetts and California, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools. Analysis also excludes Montana because its SPRY 2019 as-filed DSH audit was unavailable.

[1] None of the hospitals in Arkansas and Alaska that received DSH payments appear to meet the deemed DSH criteria according to MACPAC's analysis of available data.

Source: MACPAC, 2024, analysis of Medicare cost reports and SPRY 2019 as-filed Medicaid DSH audits.

State criteria for identifying eligible DSH hospitals and how much funding they receive vary but are often related to hospital ownership, hospital type, and geographic factors. States that concentrate DSH payments among a small number of hospitals do not necessarily make the largest share of payments to deemed DSH hospitals (e.g., Arkansas, Connecticut, and North Dakota); conversely, some states that distribute DSH payments across most hospitals still target the largest share of DSH payments to deemed DSH hospitals (e.g., New Jersey) (Figure 3-2).

The methods states use to finance the non-federal share of DSH payments may affect their DSH targeting policies. For example, according to data from the U.S. Government Accountability Office, 10 states primarily financed DSH payments through provider contributions from publicly owned hospitals (intergovernmental transfers or certified public expenditures) in FY 2018. These states directed a larger share of their SPRY 2018 DSH payments to publicly owned providers than states that fund DSH payments through general revenue or a provider tax. Conversely, in the 12 states that predominately used a provider tax to generate the non-federal share of DSH payments, DSH payments are distributed broadly, and these states did not appear to target their DSH payments to a particular class of hospital (MACPAC 2023g; GAO 2021a, 2014). More information about state DSH targeting policies is included in Chapter 3 of MACPAC's March 2017 report to Congress (MACPAC 2017).

TABLE 3-2. Uninsured Rates by Selected Characteristics, United States, 2021 and 2022

Characteristic	2021	2022	Percentage point change
All uninsured	**8.3%**	**7.9%**	**-0.4%***
Age group			
Younger than age 19	5.0	5.4	0.4
Age 19–64	11.6	10.8	-0.8*
Older than age 64	1.2	1.1	-0.1
Race and ethnicity			
White, non-Hispanic	5.2	4.9	-0.3*
Black, non-Hispanic	9.0	8.3	-0.7
Asian, non-Hispanic	6.2	5.9	-0.3
Hispanic (any race)	18.3	17.2	-1.1*
Income-to-poverty ratio			
Less than 100 percent	16.2	16.5	0.3
100–199 percent	13.2	12.7	-0.5
200–299 percent	11.0	9.9	-1.1*
300–399 percent	8.9	7.4	-1.5*
400 percent or more	3.3	3.1	-0.2
Medicaid expansion status in state of residence as of January 1, 2022			
Non-expansion	12.0	11.8	-0.2
Expansion	6.6	6.1	-0.5*

Notes: Uninsured rates are based on the Current Population Survey Annual Social and Economic Supplement. Medicaid expansion status reflects state expansion decisions as of January 1, 2022.

* Indicates change is statistically different from zero at the 90 percent confidence level. MACPAC calculated significance using standard errors from Keisler-Starkey et al. 2023. This statistic includes only states that expanded Medicaid before January 1, 2022.

Source: MACPAC, 2024, analysis of Keisler-Starkey et al. 2023.

State DSH policies change frequently, often as a function of state budgets and financing decisions. The amounts paid to hospitals are more likely to change than the types of hospitals receiving payments: nearly 95 percent of the hospitals that received DSH payments in SPRY 2019 also received DSH payments in SPRY 2018. However, the amount that hospitals receive can change considerably in subsequent reporting years. For example, 21 percent of the hospitals that received DSH payments in both SPRY 2018 and 2019 reported that their 2019 DSH payments changed by more than 50 percent.

Changes in the Number of Uninsured Individuals

In 2022, 25.9 million people (7.9 percent of the U.S. population) were uninsured, a statistically significant decrease from the number and share in 2021 (27.2 million and 8.3 percent, respectively) (Table 3-2) (Keisler-Starkey et al. 2023).

At the beginning of the PHE in 2020, Congress required states to maintain Medicaid coverage and eligibility standards to receive an enhanced FMAP. Beginning April 2023, Congress phased out this continuous coverage requirement, and states have resumed normal eligibility redeterminations.[23] Between February 2020 and March 2023, while this continuous coverage requirement was in effect, Medicaid and CHIP enrollment increased 32.5 percent, from 70.9 million to 93.9 million (CMS 2023a).

The uninsured rate in 2022 was highest for adults younger than age 65, individuals of Hispanic ethnicity, and individuals with incomes below the federal poverty level (Table 3-2). Between 2021 and 2022, the uninsured rate decreased significantly for adults younger than age 65, those who identify as Hispanic; those who identify as white, non-Hispanic; those with incomes between 200 and 399 percent of the federal poverty level; and those living in states that did expand Medicaid (Keisler-Starkey et al. 2023).

In 2022, the uninsured rate in states that did not expand Medicaid under the ACA to adults younger than age 65 with incomes at or below 138 percent of the federal poverty level was nearly twice as high as the uninsured rate in states that expanded Medicaid (11.8 and 6.1 percent, respectively).[24] Missouri and Oklahoma both expanded Medicaid in calendar year 2021 and saw a decline in the uninsured rate between 2021 and 2022 (0.8 percentage points and 2.1 percentage points, respectively) (Table 3-2) (KFF 2023b).

As states continue Medicaid eligibility redeterminations in the coming year, Medicaid enrollment is expected to decline, and the number of uninsured individuals is likely to increase. By October 2023, more than 9 million Medicaid enrollees have been disenrolled due to the end of the continuous coverage requirement (KFF 2024). Some of those who were determined ineligible for Medicaid may now be eligible to receive coverage through the insurance exchanges. The Commission will continue to closely monitor the renewal process and how Medicaid redeterminations may affect Medicaid enrollment, the number of uninsured individuals, and associated levels of hospital uncompensated care.

Changes in the Amount of Hospital Uncompensated Care

DSH payments cover both unpaid costs of care for uninsured individuals and Medicaid shortfall. In states that have expanded Medicaid under the ACA, unpaid costs of care for uninsured individuals have declined substantially relative to pre-2014 levels. However, as the number of Medicaid enrollees has increased after Medicaid expansion, Medicaid shortfall has generally increased as well.

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

Data sources

American Hospital Association (AHA) annual survey. An annual survey of hospitals that provides aggregated national estimates of uncompensated care for community hospitals. The AHA survey has reported information about Medicaid shortfall in prior years but has not reported Medicaid shortfall information since 2020.

Medicare cost report. An annual report on hospital finances that must be submitted by all hospitals that receive Medicare payments (i.e., most U.S. hospitals, with limited exceptions, such as those with no or low Medicare use). Medicare cost reports define hospital uncompensated care costs as charity care and bad debt.

Medicaid disproportionate share hospital (DSH) audit. A statutorily required audit of a DSH hospital's uncompensated care. The audit ensures that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. Forty-two percent of U.S. hospitals were included on DSH audits in 2019, the latest year for which data are available to MACPAC.

Definitions

Medicare cost report components of uncompensated care

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

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

Medicaid DSH audit components of uncompensated care

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

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

Definitions of uncompensated care vary among data sources, complicating comparisons at the hospital level and our ability to fully understand the effects of uncompensated care on hospital finances (Box 3-3). The most recently available data on hospital uncompensated care for all hospitals comes from Medicare cost reports, which define uncompensated care as charity care and bad debt.[25] However, Medicare cost reports do not include reliable information on Medicaid shortfall, which is the difference between a hospital's costs of care for Medicaid-enrolled patients and the total payments it receives for those services. Medicaid DSH audits include data on both Medicaid shortfall and unpaid costs of care for uninsured individuals for DSH hospitals, but these audits are not due to CMS until approximately three years after DSH payments are made and then are not published until CMS reviews the data for completeness (42 CFR 455.304). Furthermore, DSH audits are available only for those hospitals that receive Medicaid DSH payments.

In our analysis of Medicaid DSH audits, we found that DSH payments were used to offset different types of uncompensated care in SPRY 2019 and that this practice was related to whether a state expanded Medicaid under the provisions of the ACA. DSH was primarily used to pay for costs incurred by hospitals related to care provided for the uninsured among non-expansion states, while DSH was used to offset Medicaid costs among expansion states. In the aggregate, Medicaid shortfall was responsible for a larger share of uncompensated care (73 percent) for DSH hospitals among expansion states compared with states that did not expand Medicaid (12 percent).

In the following sections, we review the most recent uncompensated care data available for all hospitals in FY 2021 as well as additional information about Medicaid shortfall reported for DSH hospitals in SPRY 2019. We also summarize the most recent available data on hospital margins.

Unpaid costs of care for uninsured individuals

According to Medicare cost reports, hospitals reported a total of $39.3 billion in charity care and bad debt in FY 2021, or about 3.6 percent of hospital operating expenses. This is a $1.4 billion increase from FY 2019 and a 0.4 percentage point decrease as a share of hospital operating expenses.[26]

Charity care and bad debt, as a share of hospital operating expenses, varied widely by state in FY 2021 (Figure 3-3). In the aggregate, hospitals in states that expanded Medicaid under the ACA before September 30, 2021, reported less than half the uncompensated care that was reported in non-expansion states (2.4 percent of hospital operating expenses in Medicaid expansion states vs. 6.6 percent in states that did not expand Medicaid).

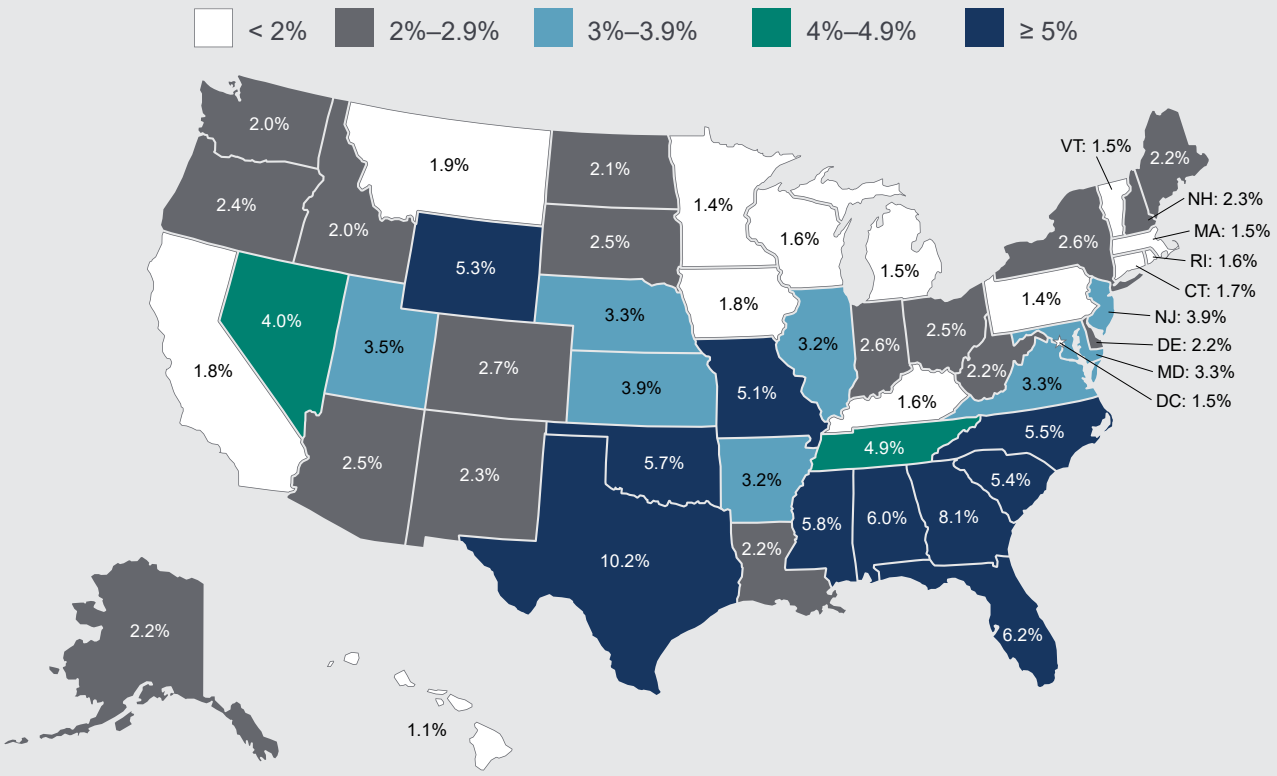
In FY 2021, about 57 percent of reported uncompensated care was for charity care for uninsured individuals ($22.5 billion), 12 percent was for charity care for insured individuals ($4.9 billion), and 31 percent was for bad debt expenses for both insured and uninsured individuals ($12.1 billion).[27]

Uncompensated care for insured individuals is not covered by Medicaid DSH and has been increasing in recent years. These costs occur when individuals are unable to pay their cost sharing for medical expenses (e.g., deductibles, coinsurance, and other forms of cost sharing). From 2016 to 2020, prices for medical care increased by 16 percent, more than double the rate of inflation (CBO 2022, HCCI 2022). Additionally, there has been growth in health insurance costs and the use of high-deductible health plans that may contribute to these uncompensated care costs for insured individuals. The share of workers in high-deductible health plans increased over the last 10 years: 20 percent in 2013 to 29 percent in 2023 (KFF 2023a).

Medicaid shortfall

Medicaid shortfall is the difference between a hospital's costs of providing services to Medicaid-enrolled patients and the total amount of Medicaid payment received for those services (Box 3-3). The American Hospital Association (AHA) did not report 2021 Medicaid shortfall information collected in its most recent annual survey, but a prior survey for 2020 reported a total Medicaid shortfall of $24.8 billion (AHA 2022a). AHA reported the aggregate Medicaid payment-to-cost ratio was 88 percent in 2020, a ratio that has largely been unchanged in recent years (AHA 2022a, 2021, 2015).

FIGURE 3-3. Charity Care and Bad Debt as a Share of Hospital Operating Expenses, FY 2021



Note: FY is fiscal year.

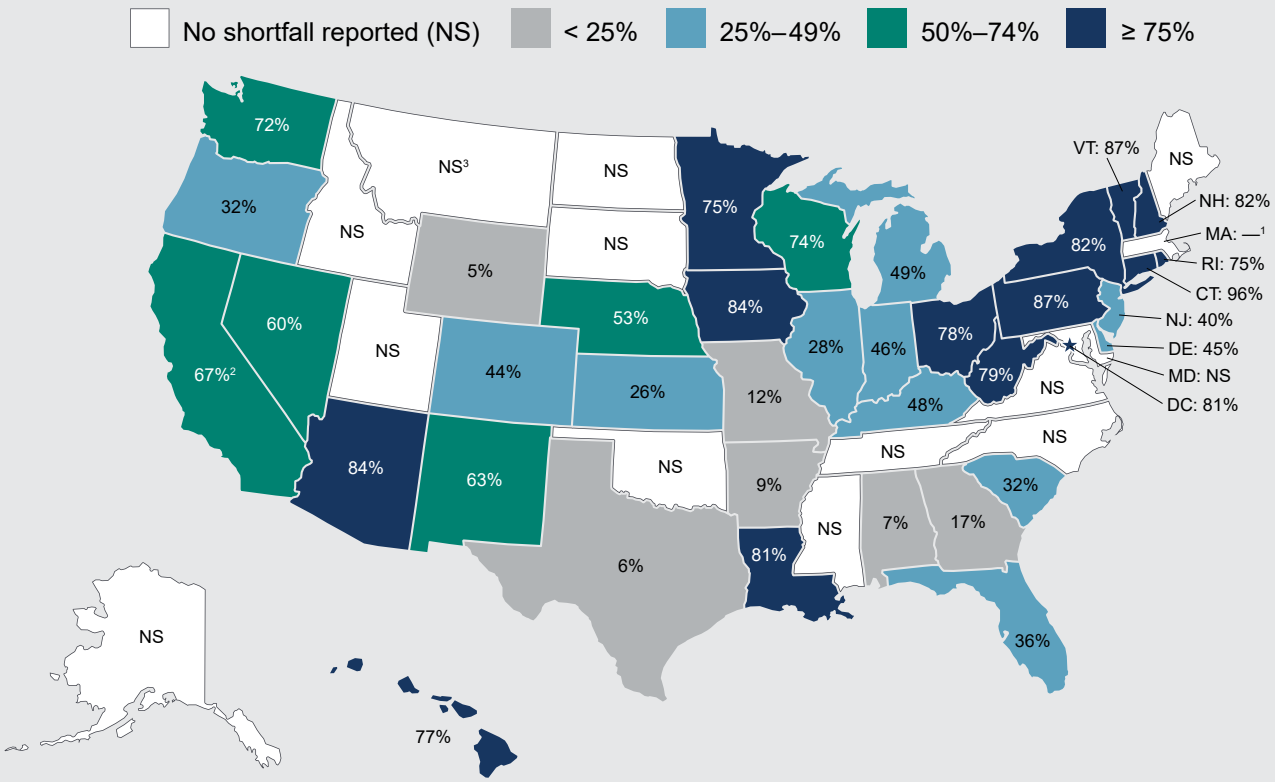
Source: MACPAC, 2024, analysis of FY 2021 Medicare cost reports.

In contrast to the AHA survey, which provides data for all U.S. hospitals, Medicaid DSH audits provide data on Medicaid shortfall for the subset of hospitals that receive Medicaid DSH payments (41 percent of U.S. hospitals in SPRY 2019). In SPRY 2019, DSH hospitals reported a total of $19.1 billion in Medicaid shortfall and an aggregate Medicaid payment-to-cost ratio of 86 percent before DSH payments.

Medicaid shortfall as a share of total uncompensated care for DSH hospitals varies widely across states (Figure 3-4). In SPRY 2019, 13 states reported no Medicaid shortfall for DSH hospitals, and 19 states and the District of Columbia reported shortfall that exceeded 50 percent of DSH hospitals' total uncompensated care costs.

There is also wide variation in Medicaid payment-to-cost ratios for DSH hospitals. In SPRY 2019, DSH hospitals in the 12 states with the lowest Medicaid payment-to-cost ratios received total Medicaid payments that covered 85 percent of the costs of care for Medicaid-enrolled patients in the aggregate, and DSH hospitals in the 12 states with the highest Medicaid payment-to-cost ratios received payments that covered 116 percent of Medicaid costs in the aggregate.[28] Nationwide, aggregate Medicaid payments to DSH hospitals were 96 percent of costs in SPRY 2019 (Figure 3-5).[29] Additional state-level data on base and supplemental payments for DSH hospitals are available in Appendix 3A.

FIGURE 3-4. Medicaid Shortfall as a Share of Total Uncompensated Care Costs by State, SPRY 2019



Notes: SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. NS means no shortfall was reported in SPRY 2019. A total of 2,312 disproportionate share hospitals (DSH) hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2021 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. The analysis also excludes some hospitals in California and Massachusetts, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools.

— Dash indicates zero.

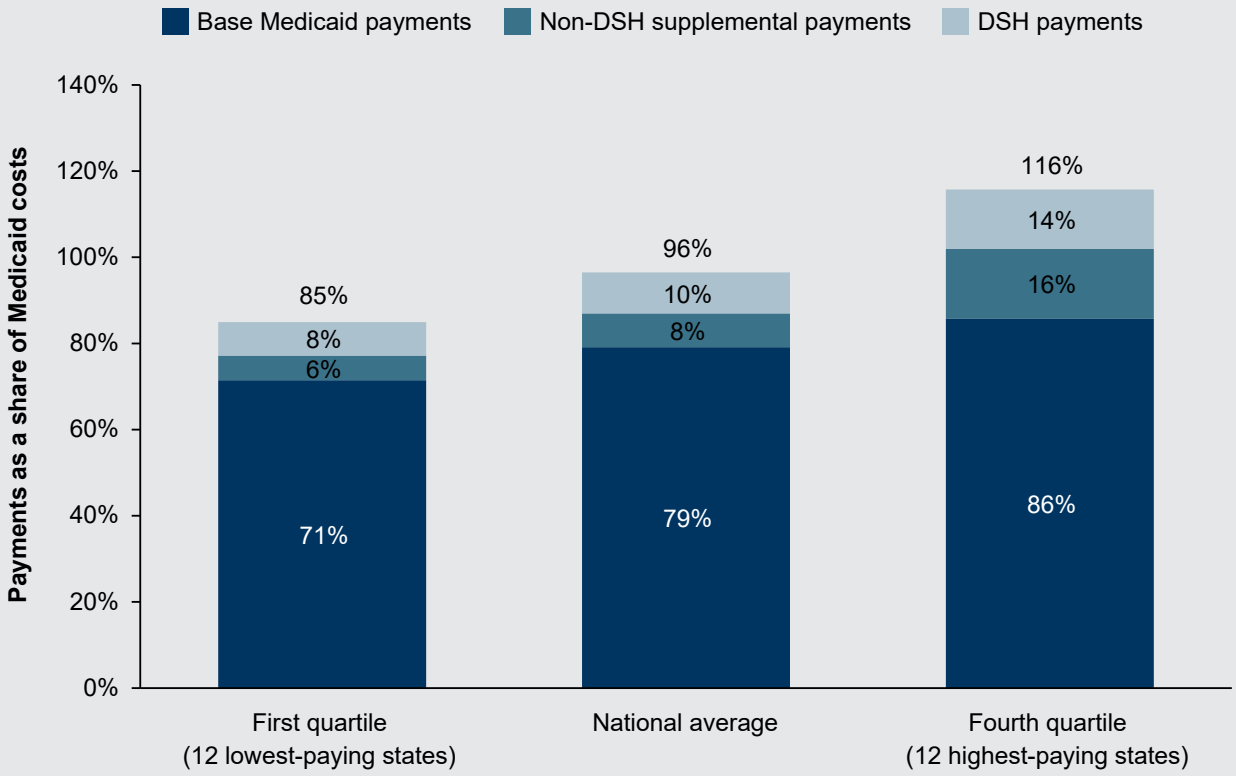
[1] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Social Security Act (the Act) allows it to use all of its DSH funding for the state's safety-net care pool instead.

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

[3] Montana has not submitted a SPRY 2019 as-filed DSH audit. This analysis uses SPRY 2018 Montana DSH audit data.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 as-filed Medicaid DSH audits.

FIGURE 3-5. Medicaid Payments to DSH Hospitals as a Percentage of Medicaid Costs by National Average and Selected Quartiles, SPRY 2019



Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. A total of 2,312 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2021 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. This analysis also excludes some hospitals in California and Massachusetts, which have demonstration waivers under Section 1115 of the Social Security Act that allow them to distribute DSH funding to hospitals through safety-net care pools. This analysis uses SPRY 2018 Montana DSH audit data because Montana had not submitted a SPRY 2019 audit when this analysis was conducted. DSH payments can cover Medicaid and uninsured costs, but this figure calculates DSH and other Medicaid payments as a percentage of Medicaid costs. Quartiles were calculated based on each state's Medicaid-payment-to-cost ratio. Base Medicaid payments include fee for service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on Medicaid DSH audits). States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care base payment or as a supplemental payment. Payments shown do not fully account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers may not sum due to rounding.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 as-filed Medicaid DSH audits.

Aggregate data on Medicaid shortfall for DSH hospitals may not reflect the experience of all hospitals in a state because Medicaid payment rates vary by hospital and because the net payment that a hospital receives may be lower than the total payment reported on DSH audits. For example, in the aggregate, DSH hospitals in North Carolina did not report a Medicaid shortfall in SPRY 2019, but 19 of the 80 hospitals that received DSH payments reported a Medicaid shortfall in that year.[30] Moreover, North Carolina finances DSH payments with provider taxes and intergovernmental transfers, and so net Medicaid payments to hospitals may be below costs after adding the full costs of these provider contributions to the non-federal share (MACPAC 2019).[31]

Hospital margins

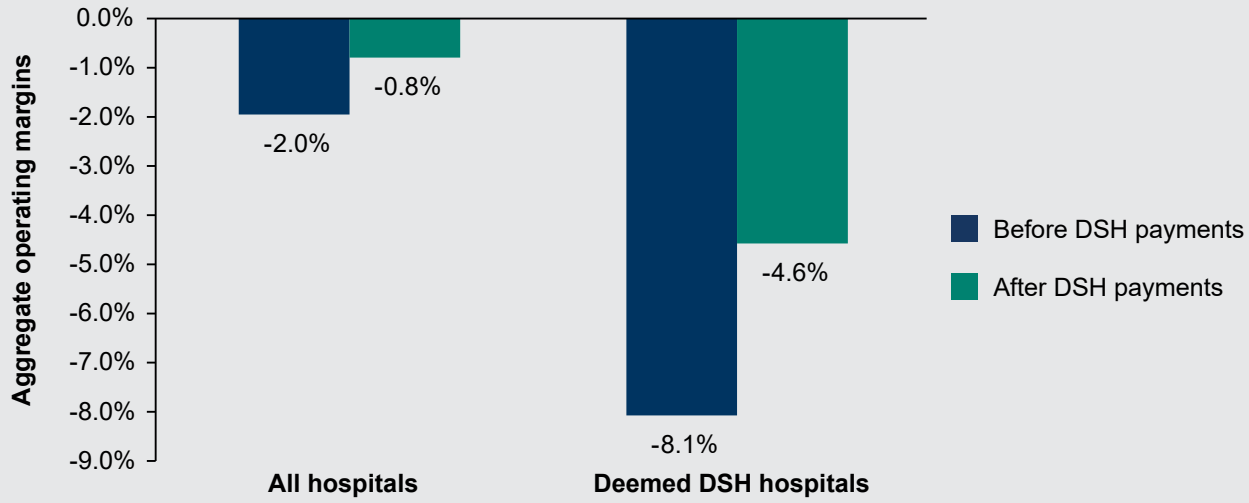
Changes in hospital uncompensated care costs may affect hospital margins. For example, deemed DSH hospitals report higher uncompensated care costs and lower operating and total margins than other hospital types in the aggregate. MACPAC estimates both total and operating margins using a combination of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

COVID-19 relief for hospitals. COVID-19 continued to have a large effect on hospital margins in FY 2021. Hospitals noted greater expenses due to the costs of treating complex COVID-19 hospitalizations and the costs associated with implementing new infection control practices to protect patients and staff, both of which increased hospital uncompensated care costs to the extent that they were not paid for by other sources (AHA 2021). Hospital costs have also increased as a result of workforce challenges exacerbated by the pandemic. During the early phase of the pandemic, hospitals also experienced declines in non-COVID-19 service use as a result of postponed or forgone non-emergent and elective surgeries, which may reduce the amount of overall care (including reduced uncompensated care but also reduced revenue) relative to prior years (AHA 2021; Gallagher et al. 2021; Birkmeyer et al. 2020; Mehrotra et al. 2020a, 2020b, 2020c). While hospital discharges rebounded in 2021 when compared to 2020, discharges remained below prepandemic trends (McGough et al. 2023).

To address pandemic-related financial challenges, Congress provided dedicated relief funding for hospitals through a variety of mechanisms. The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136), the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139), the Consolidated Appropriations Act, 2021, and ARPA made available $186.5 billion in provider relief funding to hospitals and other providers to offset lost revenue or expenses during the pandemic; a portion of this funding was also used to pay for care for uninsured individuals with COVID-19.[32] The Coronavirus Aid, Relief, and Economic Security Act also temporarily increased Medicare payments to hospitals for COVID-19 hospitalizations and established the Paycheck Protection Program for businesses with fewer than 500 employees.[33]

At the time of the initial distribution of funds, MACPAC expressed concern that provider relief funding was not appropriately targeting safety-net providers (MACPAC 2021b, 2020a, 2020b). Since initial disbursements were based on Medicare fee-for-service (FFS) revenue and then updated to be based on all-payer net patient revenue, funding was less targeted toward hospitals that serve a large percentage of the Medicaid population and instead was mostly distributed to hospitals with high patient revenue (Buxbaum and Rak 2021). The U.S. Department of Health and Human Services eventually made additional provider relief funding available to hospitals with a high number of COVID-19 admissions, rural hospitals, children's hospitals, tribal hospitals, and safety-net hospitals (HRSA 2023, GAO 2021b).[34]

FIGURE 3-6. Aggregate Hospital Operating Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2021



Notes: DSH is disproportionate share hospital. FY is fiscal year. Operating margins measure profits (or losses) from patient care divided by net patient revenue. Operating margin before DSH payments in FY 2021 was estimated using state plan rate year (SPRY) 2019 DSH audit data. The analysis excluded outlier hospitals reporting an operating margin greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. This analysis uses Montana's SPRY 2018 DSH audit data because its 2019 audit was unavailable. For further discussion of this methodology and limitations, see Appendix 3B.

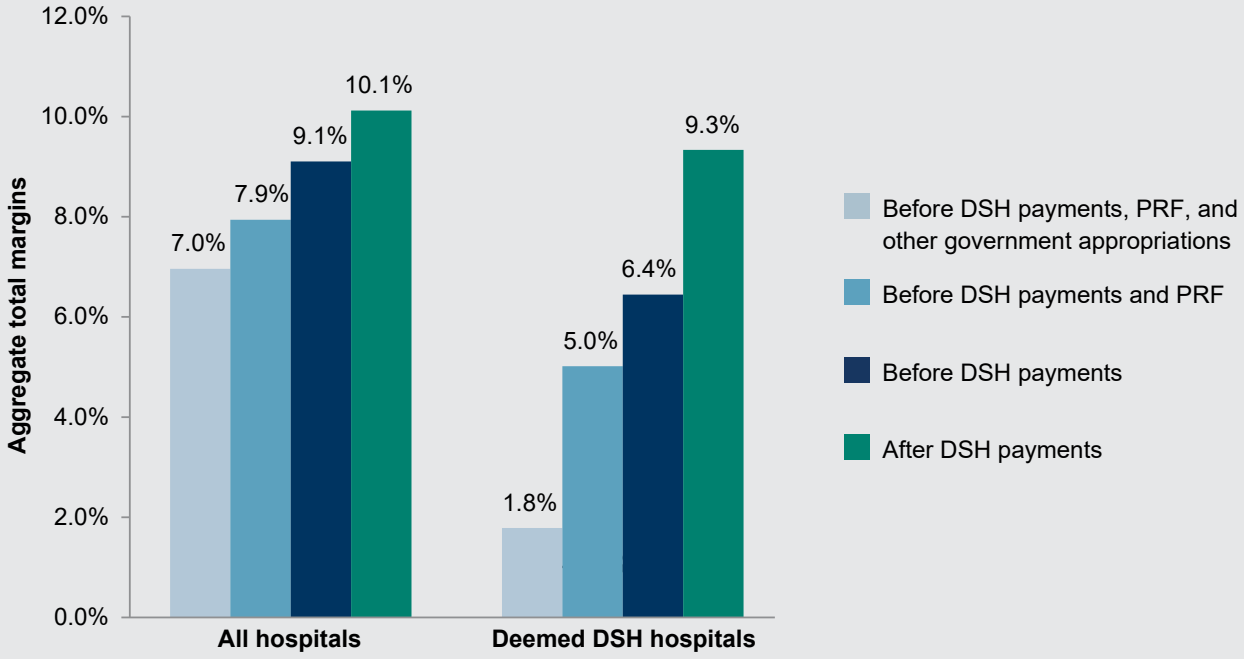
Source: MACPAC, 2024, analysis of FYs 2020–2021 Medicare cost reports and SPRY 2018-2019 as-filed Medicaid DSH audits.

These funding allocations raised questions regarding how to define a safety-net hospital. In 2017, the Commission analyzed other criteria that could be used to identify hospitals that should receive DSH payments (MACPAC 2017). However, because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single, use-based standard that is applicable to all hospitals and would be a clear improvement on current law. Academics, government agencies, and hospital associations have attempted to develop a common definition of a safety-net hospital. Although the specific identification methods tend to vary, most use common factors such as patient mix (e.g. payer, patient demographics), geography, and measurements of hospital finances (e.g., amount of uncompensated care or total margin) (AHA 2022b, Dickson et al. 2022, MedPAC 2022).

Total and operating margins. In FY 2021, the aggregate operating margin was negative across all hospitals after counting DSH payments (-0.8 percent) (Figure 3-6). Deemed DSH hospitals reported even larger negative aggregate operating margins both before and after counting DSH payments (-8.1 percent and -4.6 percent, respectively).

The total margin accounts for all types of income (e.g., investment income) and funding that hospitals received from federal and state governments during the PHE. The aggregate total margin for all hospitals after DSH payments was 10.1 percent in FY 2021, which was 2.9 percentage points higher than in FY 2020 (Figure 3-7). Before counting DSH payments, PHE-related federal spending, and other government appropriations, deemed DSH hospitals reported an aggregate total margin of 1.8 percent in FY 2021. After counting these payments and appropriations, deemed DSH hospitals reported an aggregate total margin of 9.3 percent, slightly less than the aggregate total margin for all hospitals (10.1 percent).

FIGURE 3-7. Aggregate Hospital Total Margin before and after DSH Payments, All Hospitals versus Deemed DSH Hospitals, FY 2021



Notes: DSH is disproportionate share hospital. FY is fiscal year. PRF is provider relief funding and Paycheck Protection Program forgiven loans that were disbursed during the COVID-19 public health emergency and are reported on worksheet G3 of the Medicare cost reports. Total margin includes revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state and local subsidies to hospitals. Total margin before DSH payments in FY 2021 were estimated using state plan rate year (SPRY) 2019 DSH audit data. Other government appropriations include state or local subsidies to hospitals that are not Medicaid payments. Analysis excluded outlier hospitals reporting a total margin greater than 1.5 times the interquartile range from the first and third quartiles. COVID-19 PRF relates to funding that was authorized under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139). Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. This analysis includes hospitals in California and Massachusetts that appear to meet the eligibility criteria for deemed DSH hospitals but did not receive DSH payments because these states instead distributed DSH funding through safety-net care pools authorized under waiver expenditure authority of Section 1115 of the Social Security Act. This analysis uses Montana's SPRY 2018 DSH audit data because its 2019 audit was unavailable. For further discussion of this methodology and limitations, see Appendix 3B.

Source: MACPAC, 2024, analysis of FY 2020–2021 Medicare cost reports and SPRY 2018–2019 as-filed Medicaid DSH audits.

Hospitals with High Levels of Uncompensated Care That Also Provide Essential Community Services

MACPAC is required to provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services. Given that the concept of essential community services is not defined elsewhere in Medicaid statute or regulation, MACPAC has developed a definition based on the types of services suggested in the statutory provision calling for MACPAC's study and the limits of available data (Box 3-4).

Using data from 2021 Medicare cost reports and the 2021 AHA annual survey, we found that among hospitals that met the deemed DSH criteria in SPRY 2019, 92 percent provided at least one of the services included in MACPAC's definition of essential community services, 71 percent provided two or more of these services, and 56 percent provided three or more of these services. By contrast, among non-deemed hospitals, 38 percent provided three or more of these services.

BOX 3-4. Identifying Hospitals with High Levels of Uncompensated Care That Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations

MACPAC's authorizing statute requires that MACPAC provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act). Based on the types of services suggested in the statute and the limits of available data, we included the following services in our definition of essential community services in this report:

- burn services;
- dental services;
- graduate medical education;
- HIV/AIDS care;
- inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital);
- neonatal intensive care units;
- obstetrics and gynecology services;
- primary care services;
- substance use disorder services; and
- trauma services.

We also included deemed DSH hospitals that were designated as critical access hospitals because they may be the only hospital in their geographic areas. See Appendix 3B for further discussion of our methodology and its limitations.

DSH Allotment Reductions

At the time of this writing, DSH allotment reductions are currently scheduled to take effect March 9, 2024. However, because Congress has signaled an intention to further delay DSH allotment reductions, the analyses in this chapter assume that allotment reductions that were scheduled to take effect in FY 2024 and FY 2025 will be delayed (H.R. 5378, S. 3430). If this change takes effect, DSH allotments will be reduced by the following annual amounts beginning October 1, 2025:

- $8 billion in FY 2026; and
- $8 billion in FY 2027.

DSH allotment reductions are applied against the preliminary unreduced DSH allotments—that is, the amounts that states would have received without DSH allotment reductions (42 CFR 447.294).

BOX 3-5. Factors Used in Disproportionate Share Hospital Health Reform Reduction Methodology

The Disproportionate Share Hospital (DSH) Health Reform Reduction Methodology (DHRM), finalized in September 2019, is used by the Centers for Medicare & Medicaid Services to calculate how DSH allotment reductions will be distributed across states. As required by statute, the DHRM applies five factors when calculating state DSH allotment reductions:

Low-DSH factor. Allocates a smaller proportion of the total DSH allotment reductions to low-DSH states based on the size of these states' DSH expenditures relative to their total Medicaid expenditures. Low-DSH states are defined in statute as states with FY 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000. There are 17 low-DSH states, a number that includes Hawaii, whose eligibility is based on a special statutory exception (§§ 1923(f)(5) and 1923(f)(6) of the Social Security Act).

Uninsured percentage factor. Imposes larger DSH allotment reductions on states with lower uninsured rates relative to other states. One-half of DSH reductions are based on this factor.

High volume of Medicaid inpatients factor. Imposes larger DSH allotment reductions on states that do not target DSH payments to hospitals with high Medicaid volume. The proportion of a state's DSH payments made to hospitals with Medicaid inpatient utilization that is one standard deviation above the mean (the same criteria used to determine deemed DSH hospitals) is compared among states. One-quarter of DSH reductions are based on this factor.

High level of uncompensated care factor. Imposes larger reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care. The proportion of a state's DSH payments made to hospitals with above-average uncompensated care as a proportion of total hospital costs is compared among states. This factor is calculated using DSH audit data, which define uncompensated care costs as the sum of Medicaid shortfall and unpaid costs of care for uninsured individuals. One-quarter of DSH reductions are based on this factor.

Budget neutrality factor. Adjusts the high Medicaid and high uncompensated care factors that account for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under waivers under Section 1115 of the Social Security Act as of July 2009. Specifically, DSH funding used for coverage expansions is excluded from the calculation of whether DSH payments were targeted to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care.

Because DSH funding remains an important source of revenue for many safety-net hospitals, the Commission is concerned that the magnitude of cuts in DSH funding under current law may disrupt the financial viability of some safety-net hospitals and the services that they provide. Under current law, DSH allotment reductions will amount to around half of unreduced DSH allotment amounts in FY 2026 (48.7 percent).[35]

DSH allotment reductions will be applied using the DSH Health Reform Reduction Methodology (DHRM). This methodology uses specific statutorily defined criteria, such as applying greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals (Box 3-5).

In FY 2028 and beyond, there are no DSH allotment reductions scheduled. Thus, under current law, state DSH allotments will return to their higher, unreduced DSH allotment amounts in FY 2028.

Reduced versus unreduced DSH allotments

To determine the effects of DSH allotment reductions on state finances and DSH funding, we compared states' reduced DSH allotments to their unreduced amounts. For FY 2026, we estimated DSH allotment reduction factors based on data from CMS.

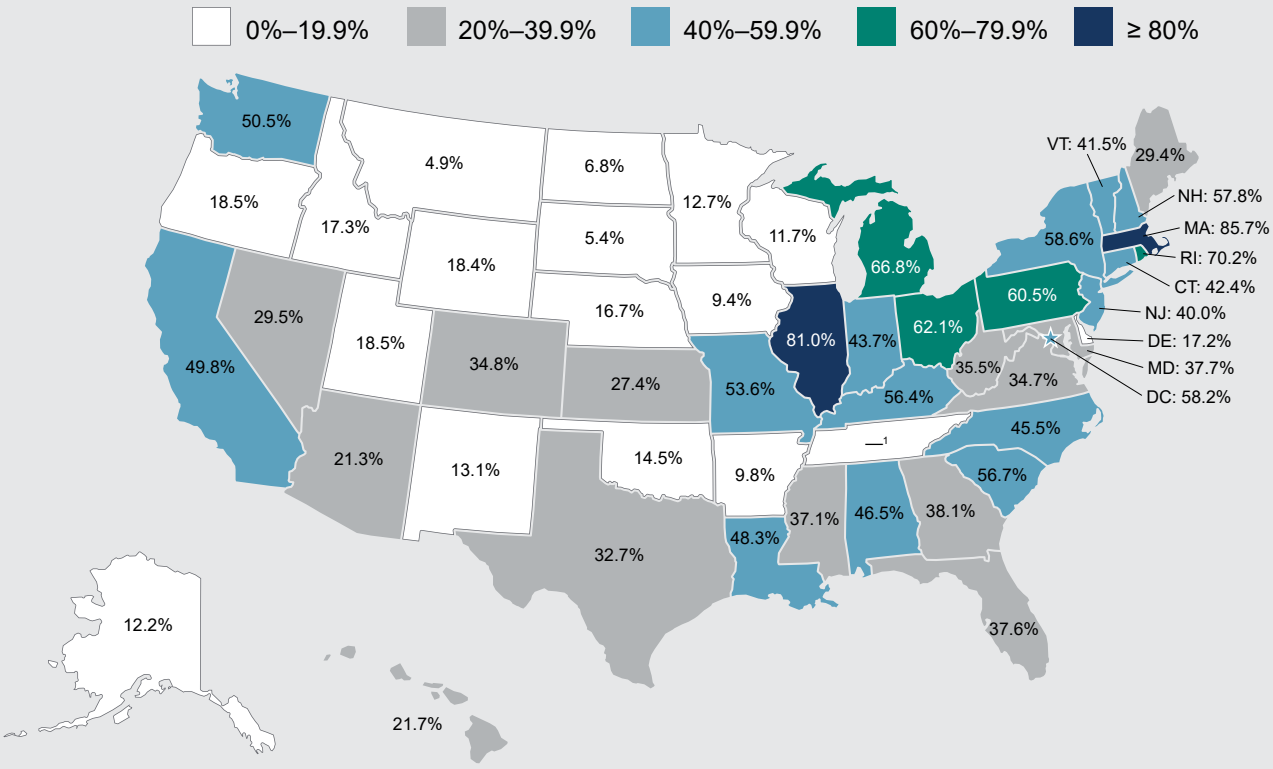
In FYs 2026 and 2027, DSH allotments will be reduced by $8 billion, which translates to a decrease of $14.2 billion in total DSH funding (state and federal amounts). The distribution of DSH allotment reductions among states is expected to be largely the same for these two years, assuming states do not change their DSH targeting policies and there are no changes in uninsured rates across states.

This analysis compares reduced allotments to unreduced allotments in FY 2026. Reductions will affect states differently, with estimated reductions ranging from 4.9 percent to 85.7 percent of unreduced allotment amounts (Figure 3-8). Smaller reductions are applied to states with historically low DSH allotments (low-DSH states). Because of the low-DSH factor, the projected percentage reduction in federal DSH allotments for the 17 states that meet the low-DSH criteria (13.1 percent in the aggregate) is about one-quarter that of the other states (51.1 percent in the aggregate). Among states that do not meet the low-DSH criteria, the projected percentage reduction in federal DSH allotments is larger for states that expanded Medicaid as of January 1, 2022 (54.1 percent in the aggregate) than for states that did not expand Medicaid (39.6 percent in the aggregate). (Complete state-by-state information on DSH allotment reductions and other factors is included in Appendix 3A.)

DSH allotment reductions will result in a corresponding decline in spending only in states that spend their full DSH allotment. For example, 15 states are projected to have FY 2026 DSH allotment reductions that are smaller than the state's unspent DSH funding in FY 2021. This means that these states could make DSH payments from their reduced FY 2026 allotment equal to the payments that they made from their FY 2021 allotment.[36]

We do not know how states will respond to these reductions. As noted previously, some states distribute DSH funding proportionally among all eligible hospitals, while other states target payments to a small number of hospitals. States may also take different approaches to reductions, with some states applying them to all DSH hospitals and others reducing DSH payments only at specific hospitals. Because the DHRM applies larger reductions to states that do not target DSH funds to hospitals with high Medicaid volume or high levels of uncompensated care, states might change their DSH targeting policies to minimize their DSH allotment reductions in future years.[37] However, the DSH audit data used to calculate the DSH targeting factors in the DHRM have a substantial data lag of four to five years. States may be able to offset some of the effects of DSH allotment reductions by increasing other types of Medicaid payments to providers; however, each type of Medicaid payment is subject to its own unique rules and limitations.[38]

FIGURE 3-8. Decrease in State DSH Allotments as a Percentage of Unreduced Allotments by State, FY 2026



Notes: DSH is disproportionate share hospital. FY is fiscal year. This analysis compares reduced allotments with unreduced allotments.

— Dash indicates a 0 percent reduction in state DSH allotments.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act). However, Tennessee receives a virtual DSH fund through its Section 1115 demonstration waiver that may be subject to reductions in FY 2026 if DSH allotment reductions take effect.

Source: MACPAC, 2024, analysis of preliminary unreduced and reduced allotment amounts using CMS 2023c and projected for FY 2026 using CBO 2023.

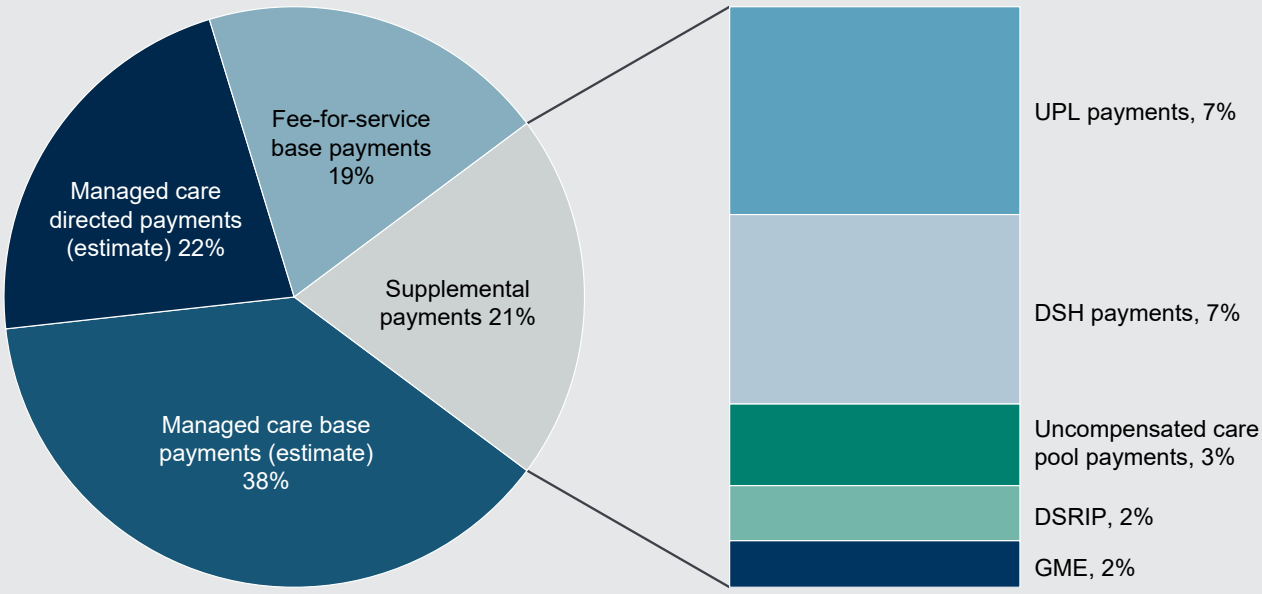
Relationship of DSH Allotments to the Statutorily Required Factors

As in our past reports, we find little meaningful relationship between FY 2024 DSH allotments and the factors that Congress asked MACPAC to consider:

- **Changes in number of uninsured individuals.** FY 2024 DSH allotments range from less than $100 per uninsured individual in 2 states to more than $1,000 per uninsured individual in 11 states and the District of Columbia. Nationally, the average FY 2024 DSH allotment per uninsured individual is $593.

- **Amount and sources of hospital uncompensated care costs.** As a share of hospital charity care and bad debt costs reported on 2021 Medicare cost reports, FY 2024 federal DSH allotments range from less than 10 percent in five states to more than 80 percent in nine states and the District of Columbia. Nationally, these allotments are equal to 39.8 percent of hospital charity care and bad debt costs. At the state level, total FY 2024 DSH funding (including state and federal funds combined) exceeds total reported hospital charity care and bad debt costs in 16 states and the District of Columbia. Because DSH payments to hospitals may not exceed total uncompensated care costs for Medicaid and uninsured patients, states with DSH allotments larger than the amount of charity care and bad debt in their state may not be able to spend their full DSH allotment.[39]
- **Number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.** Finally, there continues to be no meaningful relationship between state DSH allotments and the number of deemed DSH hospitals in the state that provided at least one of the services included in MACPAC's definition of essential community services.

FIGURE 3-9. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2021



Notes: FY is fiscal year. UPL is upper payment limit. DSH is disproportionate share hospital. DSRIP is delivery system reform incentive payment. GME is graduate medical education. DSRIP and uncompensated care pool payments must be authorized under Section 1115 waivers. Managed care payments to hospitals are estimated based on total managed care spending reported by states. Directed payment spending is estimated based on annual spending projected in the most recent rating period for preprints approved as of February 1, 2023.

Source: MACPAC, 2024, analysis of CMS-64 net expenditure data as of June 8, 2022, CMS-64 Schedule C waiver report data as of September 19, 2022, and directed payment preprints approved through February 2023.

Relationship Between DSH and Other Medicaid Supplemental Payments

In the Commission's view, DSH policy should be assessed in the context of other Medicaid payments to hospitals. In particular, many states make large non-DSH supplemental payments to hospitals. In recent years, states have begun making managed care directed payments, which are often used to make large increases in managed care payments to hospitals, similar to supplemental payments in FFS. These payment authorities are subject to different upper limits and different federal matching rates than DSH, which may explain why some states have begun substituting other types of Medicaid payments for DSH in recent years. Additional information about the different types of base and supplemental payments that hospitals can receive is provided in MACPAC's issue brief *Base and Supplemental Payments to Hospitals* (MACPAC 2023d).

In FY 2021, supplemental payments and managed care directed payments accounted for approximately 43 percent of payments to hospitals (Figure 3-9). DSH payment amounts were similar to upper payment limit (UPL) supplemental payments in FFS and smaller than managed care directed payments. Unlike DSH payments that pay for both Medicaid shortfall and unpaid costs of care for the uninsured, these other Medicaid payment authorities are intended only to pay for care provided to Medicaid patients.

UPL payments are lump-sum payments that are intended to fill in the difference between FFS base payments and the amount that Medicare would have paid for the same service. In the aggregate for each class of providers, FFS base and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles.[40] For context, Medicare payments to hospitals covered about 84 percent of costs in 2020, according to the AHA annual survey (AHA 2022).

Managed care directed payments are a newer policy option for states to direct managed care plans to pay providers according to specified rates or methods that CMS added in its 2016 managed care rule. Most directed payment spending within hospitals is attributable to arrangements requiring large uniform rate increases that are intended to offset low managed care base payment rates (similar to FFS supplemental payments).[41] There is currently no regulatory upper limit on the amount of payments states can make through directed payments, and projected spending on directed payments for hospital and non-hospital providers has grown rapidly in recent years, from $25.7 billion as of December 2020 to $69.3 billion as of February 2023 in states with available data (MACPAC 2023c).[42]

CMS recently proposed to cap managed care directed payments to hospitals at the average commercial rate, which is substantially higher than the Medicare payment rate limit used for UPL payments (CMS 2023b). For example, across five recent studies that the Congressional Budget Office reviewed, the average estimate of commercial insurers' hospital prices relative to Medicare's FFS rate was 223 percent (CBO 2022).

Commercial payment rates vary widely by state and hospital. According to the RAND Corporation's hospital transparency study, which used available 2018–2020 data from commercial insurers in all states, estimates of commercial payment rates relative to Medicare ranged from 147 percent in Hawaii to 322 percent in South Carolina (RAND 2023). On average, deemed DSH hospitals reported lower commercial payment rates relative to Medicare (232 percent) than other hospitals that do not serve a high share of Medicaid or low-income patients (264 percent). One reason that deemed DSH hospitals report lower commercial rates could be because they serve a smaller share of privately insured individuals and therefore have less leverage to negotiate higher commercial rates than other hospitals. This dynamic may also contribute to the increased financial challenges that deemed DSH hospitals face.

Increases in non-DSH supplemental payments and directed payments reduce a hospital's uncompensated care costs and thus reduce the amount of DSH payments that a hospital can receive. Because the surplus a hospital could receive from being paid the commercial rate for Medicaid-covered patients is often greater than a hospital's unpaid costs of care for uninsured individuals, some states have chosen to use directed payments instead of DSH payments to support large safety-net hospitals (Miller 2023).

In addition to different payment limits, non-DSH supplemental payments and directed payments are eligible for a higher FMAP in states that have expanded Medicaid under the ACA. Specifically, the portion of the payment that is attributable to the new adult group is matched at a 90 percent FMAP. For example, one state estimates that its managed care directed payment for inpatient hospital services would be matched at an average FMAP of 73 percent, which is about 7 percentage points higher than the state's regular FMAP of 66 percent (CMS 2023d).[43] In contrast, DSH payments are matched at a state's regular FMAP regardless of whether the state has expanded Medicaid.

Next Steps

The Commission is engaging in a long-term work plan to further examine all types of payments to hospitals using newly available data on non-DSH supplemental payments and directed payments. The Consolidated Appropriations Act, 2021 requires the U.S. Department of Health and Human Services to collect and report data on non-DSH supplemental payments beginning October 1, 2021, and these data were recently made available to MACPAC (MACPAC 2023a). In addition, CMS has begun collecting additional information on directed payment amounts on its standard application form (referred to as a preprint) and has begun posting approved preprints on its website (CMS 2023e).

MACPAC's review of these new data will be guided by MACPAC's provider payment framework, which is based on the statutory Medicaid payment goals of efficiency, economy, quality, and access (MACPAC 2015). Specifically, we aim to collect information on payment methods, payment amounts, and the characteristics of hospitals that receive Medicaid supplemental payments to assess the extent to which these payments are achieving their intended goals. We are also mindful of the limitations of available data, particularly the lack of provider-level data on contributions to the non-federal share, which reduce net payments that providers receive. We are concurrently examining policy approaches to improve transparency of Medicaid financing (MACPAC 2023e).

Endnotes

[1] This chapter includes findings for fiscal year (FY) 2021 Medicare cost report data, which includes the period from October 1, 2020, through September 30, 2021, and FY 2022, which covers October 1, 2021, through September 30, 2022. The first determination of a nationwide PHE due to COVID-19 was on January 31, 2020, midway through FY 2020. Thus, FY 2021 findings include the entirety of the PHE.

[2] These uninsured data are based on the Current Population Survey Annual Social and Economic Supplement, which is a different data source than the American Community Survey used in Table 3A-3.

[3] At the beginning of the PHE in 2020, Congress passed the Families First Coronavirus Response Act (P.L. 116-127), which required states to maintain Medicaid coverage and eligibility standards to receive an enhanced federal matching assistance percentage (FMAP) of 6.2 percentage points.

[4] The Medicare cost report and DSH audit data have two distinct definitions of uncompensated care costs. While some charity care and bad debt from Medicare cost reports may factor into hospital-specific DSH limits, it is not automatically eligible for inclusion in the DSH uncompensated care costs. For the definitions and data sources of uncompensated care costs, see Box 3-3.

[5] MACPAC calculates hospital margins two different ways, and both analyses are presented within this report. Operating margin includes only revenues and costs related to patient care, while total margin also includes revenue not directly related to patient care, such as the hospital's investment income, state and local subsidies, government appropriations, and other income, which can include any provider relief funding disbursed to support hospitals during the COVID-19 PHE.

[6] Medicare also makes DSH payments. Hospitals are generally eligible for Medicare DSH payments based on their Medicaid share of total inpatient days and Medicare Supplemental Security Income share of total Medicare days. Historically, the amount of Medicare DSH percentage add-on 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. Since 2018, these Medicare uncompensated care payments have been distributed to hospitals based

on each Medicare DSH hospital's share of all Medicare DSH hospitals' uncompensated care costs. In addition, the ACA linked the total amount of funding for Medicare uncompensated care payments to the uninsured rate.

[7] The Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) and the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) created and expanded the Boren Amendment, which removed the requirement for Medicaid to pay nursing facilities and hospitals according to Medicare cost principles. P.L. 97-35 also required states to consider the situation of hospitals that serve a disproportionate share of low-income patients with special needs when setting Medicaid provider payment rates for inpatient services. These payments are now known as DSH payments. For more on the history of DSH payments, please refer to Chapter 1: Overview of Medicaid Policy on Disproportionate Share Hospital Payments in MACPAC's *March 2016 Report to Congress on Medicaid and CHIP* (MACPAC 2016).

[8] Medicaid DSH payments are not subject to this upper payment limit, but Medicaid DSH payments to an individual hospital are limited to that hospital's uncompensated care costs for Medicaid-enrolled and uninsured patients.

[9] The most recent marginal change to allotments was a temporary enhancement to DSH allotments for the remainder of the COVID-19 PHE. The enhanced DSH allotments did not change the total amount of DSH funding available (state and federal combined amounts) for the PHE but did increase the federal share of available funding by 6.2 percentage points until March 31, 2023. From April 1, 2023, to December 31, 2023, the Consolidated Appropriations Act, 2023 (P.L. 117-238) phased down the enhanced FMAP.

[10] The Consolidated Appropriations Act, 2023 (P.L. 117-238) phased down the enhanced FMAP beginning April 1, 2023, fully eliminating the increase after December 31, 2023. The FMAPs for the first quarter of FY 2024 received a 1.5 percentage point increase.

[11] This amount includes the ARPA increase to DSH allotments, which was made retroactive to FY 2020 and lasted through FY 2023. The Commission estimates that ARPA increased FY 2022 allotments from $13.4 billion to $14.9 billion.

[12] Total DSH spending in FY 2022 was $20.0 billion. Federal spending was $11.5 billion, and state spending was $8.5 billion.

[13] DSH spending in FY 2022 includes spending funded from prior year allotments. Total DSH spending includes an estimate of the portion of California's spending under its demonstration waiver authorized under Section 1115 of the Act, which is based on the state's DSH allotment.

[14] States are required to submit claims for federal Medicaid funding within two years after the payment is made. However, states can sometimes claim federal match for adjusted DSH payments that are made after the initial two-year window (*Virginia Department of Medical Assistance Services*, DAB No. 1838 (2002), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2002/dab1838.html).

[15] Analysis excludes unspent federal DSH funding that is reported for California and Massachusetts ($1.5 billion in FY 2021) because these states use their DSH allotment in the budget neutrality assumptions for their Section 1115 waivers.

[16] Uncompensated care is calculated differently on DSH audits and Medicare cost reports. Medicare cost reports include uncompensated care for individuals with insurance, which is not part of the Medicaid DSH definition of uncompensated care. Medicare cost reports do not include reliable information on Medicaid shortfall, which is part of the Medicaid DSH definition.

[17] During the COVID-19 pandemic, the process for finalizing DSH allotments was delayed longer than usual, and FY 2018 DSH allotments were not finalized until March 2022 (CMS 2022).

[18] Preliminary allotments are shared with states at the start of the fiscal year and published in the Federal Register during the fiscal year, while finalized allotments are not calculated for multiple years later. For example, preliminary FY 2019 allotments were published in the *Federal Register* in February 2019 and were finalized on March 2022 (CMS 2022, 2019).

[19] States report hospital-specific DSH data on a SPRY basis, which often corresponds with the state fiscal year and may not align with the federal fiscal year.

[20] At the time of drafting this report, Montana had not submitted its SPRY 2019 as-filed DSH audit to CMS. Therefore, we are relying on data from Montana's SPRY 2018 as-filed DSH audit in this report.

[21] The Balanced Budget Act of 1997 (P.L. 105-33) created the critical access hospital (CAH) certification to ensure that hospital care is accessible to beneficiaries in rural communities. To be CAH designated, a hospital must meet several criteria, including be located in a rural area, and one of three isolation location requirements: (1) it must be 35 miles from another hospital (including a CAH), (2) it must be located more than a 15-mile drive from another hospital in areas of mountainous terrain or areas with only one-lane state highways or other local roads, or (3) before 2006, it must be designated by the state as a necessary provider. However, a 2013 report found that 64 percent of CAHs did not meet either of the two distance-based location requirements and were CAHs due to being designated necessary providers before 2006 and thus grandfathered into the program (GAO 2013).

[22] California made DSH payments to 6 percent of hospitals as reported on its SPRY 2019 as-filed Medicaid DSH audit. However, California also makes additional payments to public hospitals through its Section 1115 demonstration waiver, which is financed with DSH funds.

[23] Enacted in December 2022, the Consolidated Appropriations Act, 2023 (CAA, P.L. 117-328) decoupled the continuous coverage requirement from the PHE and established an end date of March 31, 2023, for the requirement. The act phased down the enhanced FMAP rate and required states to initiate renewal redeterminations as early as February 2023.

[24] This statistic includes only states that expanded Medicaid before January 1, 2022.

[25] Medicare cost reports define bad debt as debt for non-Medicare beneficiaries and non-reimbursable bad debt for Medicare beneficiaries. The Medicare program reimburses providers for only 65 percent of beneficiary cost sharing that is not paid by the beneficiary or their supplemental insurance Medicare.

[26] It should be noted that although uncompensated care increases every year, it has not increased as a percentage of operating expenses since 2015.

[27] Bad debt expenses for insured and uninsured individuals are not reported separately on Medicare cost reports. The 2021 Medicare cost report data used in this chapter have not been audited, so bad debt and charity care costs may not be reported consistently for all hospitals. CMS began to audit charity care and bad debt costs reported on Medicare cost reports in fall 2018 (CMS 2018).

[28] Analysis of Medicaid payment-to-cost ratios is limited to DSH hospitals with complete DSH audit data. This analysis excludes institutions for mental disease and hospitals that are outside the state in which the Medicaid program operates.

[29] Medicaid DSH audits include data on base payment amounts within fee for service and managed care. States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a base payment within managed care or as a supplemental payment.

[30] Thirty-eight percent of hospitals in North Carolina are not included on the state's SPRY 2019 DSH audit because these hospitals did not receive DSH payments.

[31] The DSH audit data definition of Medicaid shortfall includes the Medicaid share of provider taxes as an allowable Medicaid cost. However, the definition does not include the full cost of provider taxes and does not include the costs of provider contributions through intergovernmental transfers.

[32] COVID-19 relief funding used to pay for care provided to uninsured individuals reduces the amount of unpaid costs of care for uninsured individuals reported on Medicaid DSH audits (CMS 2021).

[33] In addition, the Families First Coronavirus Response Act (P.L. 116-127) provided an option for states to provide Medicaid coverage for diagnostic testing to uninsured individuals with COVID-19.

[34] For the purposes of distributing provider relief funding, the Health Resources and Services Administration defined safety-net providers as acute care facilities with a disproportionate patient percentage (a measure used to calculate Medicare DSH payments) of more than 20.2 percent, annual uncompensated care of more than $25,000 per bed, and a profit margin of 3 percent or less. Children's hospitals were also included if more than 20.2 percent of their inpatients were Medicaid patients (HRSA 2021).

[35] Unreduced allotment amounts are the amounts that states would have received without DSH allotment reductions.

[36] For states to spend the same amount of DSH funding in FY 2026 as they spent in FY 2022, DSH payments to individual hospitals may not exceed those hospitals' uncompensated care costs.

[37] Additional analyses of potential strategic state responses to the DSH allotment reduction methodology proposed by CMS are provided in Chapter 2 of MACPAC's 2016 DSH report (MACPAC 2016).

[38] Additional information on all types of Medicaid payments to hospitals is provided in MACPAC's issue brief *Medicaid Base and Supplemental Payments to Hospitals* (MACPAC 2023d).

[39] For Medicaid DSH purposes, uncompensated care includes Medicaid shortfall, which is not included in the Medicare cost report definition of uncompensated care. As a result, the total amount of uncompensated care reported on Medicare cost reports may differ from the amount of uncompensated care costs that states can pay for with Medicaid DSH funds.

[40] Classes of providers are defined based on ownership (i.e., government, non-state government, and privately owned). States can use a variety of methods to estimate what Medicare would have paid, including a payment-based method (i.e., based on the hospital's aggregate Medicare payments relative to its charges) or a cost-based method (i.e., the hospital's costs according to Medicare cost principles). Additional information about rules for UPL supplemental payments is provided in MACPAC's issue brief Upper Payment Limit Supplemental Payments (MACPAC 2021a).

[41] Most directed payment arrangements are used to set minimum or maximum fee schedules for specific services (similar to base payment rate increases). States can also use directed payment authorities to require hospitals to participate in value-based payment models. However, these arrangements account for only 2 percent of directed payment spending among hospitals (MACPAC 2023c).

[42] Spending estimates are based on the most recently approved preprints with available spending data. Of the $69.3 billion in total directed payment spending approved for all provider types as of February 2023, $47.9 billion was targeted to hospitals.

[43] Analysis excludes the 6.2 percentage point increase in the FMAP added by ARPA during the PHE.

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APPENDIX 3A: State-Level Data

TABLE 3A-1. State DSH allotments, FYs 2024 and 2025 (millions)

State	FY 2024		FY 2025	
	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,416.1**	**$15,643.2**	**$28,084.2**	**$16,024.3**
Alabama	**596.7**	436.3	**611.3**	447.0
Alaska	**58.3**	29.2	**59.8**	29.9
Arizona	**217.2**	144.0	**222.5**	147.5
Arkansas	**85.0**	61.2	**87.1**	62.7
California	**3,140.0**	1,570.0	**3,216.7**	1,608.4
Colorado	**264.9**	132.5	**271.4**	135.7
Connecticut	**572.9**	286.4	**586.9**	293.4
Delaware	**21.6**	12.9	**22.1**	13.2
District of Columbia	**124.3**	87.0	**127.3**	89.1
Florida	**492.2**	285.3	**504.2**	292.3
Georgia	**580.0**	382.2	**594.2**	391.5
Hawaii	**23.7**	13.9	**24.3**	14.2
Idaho	**33.5**	23.3	**34.3**	23.9
Illinois	**602.3**	307.7	**617.0**	315.2
Indiana	**463.3**	304.0	**474.6**	311.4
Iowa	**87.4**	56.0	**89.5**	57.4
Kansas	**96.4**	58.8	**98.7**	60.2
Kentucky	**286.7**	205.8	**293.8**	210.9
Louisiana	**1,440.1**	974.5	**1,475.3**	998.3
Maine	**238.6**	149.5	**244.4**	153.1
Maryland	**218.4**	109.2	**223.7**	111.9
Massachusetts	**873.6**	436.8	**895.0**	447.5
Michigan	**580.5**	377.0	**594.7**	386.2
Minnesota	**207.6**	106.9	**212.6**	109.5
Mississippi	**279.7**	216.2	**286.6**	221.4
Missouri	**1,019.6**	673.7	**1,044.6**	690.1
Montana	**25.3**	16.2	**25.9**	16.5
Nebraska	**68.9**	40.4	**70.5**	41.3

TABLE 3A-1. (continued)

State	FY 2024		FY 2025	
	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,416.1**	**$15,643.2**	**$28,084.2**	**$16,024.3**
Nevada	**108.4**	65.9	**111.1**	67.5
New Hampshire	**458.6**	229.3	**469.8**	234.9
New Jersey	**1,843.9**	921.9	**1,889.0**	944.5
New Mexico	**39.8**	28.9	**40.8**	29.6
New York	**4,600.8**	2,300.4	**4,713.2**	2,356.6
North Carolina	**636.5**	419.5	**652.1**	429.8
North Dakota	**25.4**	13.7	**26.0**	14.0
Ohio	**899.0**	578.0	**921.0**	592.2
Oklahoma	**76.2**	51.5	**78.1**	52.7
Oregon	**108.8**	64.5	**111.5**	66.1
Pennsylvania	**1,481.9**	802.0	**1,518.1**	821.6
Rhode Island	**168.8**	92.8	**172.9**	95.1
South Carolina	**669.1**	465.2	**685.4**	476.6
South Dakota	**28.7**	15.8	**29.4**	16.2
Tennessee[1]	**80.3**	53.1	**80.3**	53.1
Texas	**2,265.6**	1,362.8	**2,321.0**	1,396.1
Utah	**42.3**	27.9	**43.4**	28.6
Vermont	**56.6**	32.1	**58.0**	32.9
Virginia	**244.8**	125.4	**250.8**	128.4
Washington	**529.9**	264.9	**542.8**	271.4
West Virginia	**129.2**	95.8	**132.4**	98.1
Wisconsin	**222.0**	134.7	**227.5**	138.0
Wyoming	**0.6**	0.3	**0.7**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) provided increased DSH allotments to states during the COVID-19 public health emergency. This table assumes no ARPA increased DSH allotments for FY 2024. State and federal totals are different from data reported on the Centers for Medicare & Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES) because MBES estimates apply a traditional federal medical assistance percentage (FMAP) to the ARPA-increased federal allotment.

[1] Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act). However, Tennessee receives a virtual DSH fund through its Section 1115 demonstration waiver that may be subject to reductions in FY 2026 if DSH allotment reductions take effect.

Sources: MACPAC, 2024, analysis of CMS MBES and CBO 2023a.

TABLE 3A-2. DSH Allotment Reductions by State, FY 2026 (millions)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in total DSH funding
Total	**$28,707.0**	**$16,372.1**	**$14,177.9**	**$8,000.0**	**48.9%**
Alabama	**626.7**	458.2	**291.4**	213.1	46.5
Alaska	**61.3**	30.6	**7.5**	3.7	12.2
Arizona	**228.1**	151.2	**48.7**	32.3	21.3
Arkansas	**89.3**	64.3	**8.8**	6.3	9.8
California	**3,297.5**	1,648.8	**1,642.5**	821.3	49.8
Colorado	**278.2**	139.1	**96.8**	48.4	34.8
Connecticut	**601.6**	300.8	**255.1**	127.5	42.4
Delaware	**22.7**	13.6	**3.9**	2.3	17.2
District of Columbia	**130.5**	91.4	**75.9**	53.2	58.2
Florida	**516.9**	299.6	**194.2**	112.5	37.6
Georgia	**609.1**	401.4	**231.8**	152.7	38.1
Hawaii	**24.9**	14.6	**5.4**	3.2	21.7
Idaho	**35.2**	24.5	**6.1**	4.2	17.3
Illinois	**632.5**	323.2	**512.2**	261.7	81.0
Indiana	**486.5**	319.2	**212.6**	139.5	43.7
Iowa	**91.8**	58.8	**8.6**	5.5	9.4
Kansas	**101.2**	61.7	**27.7**	16.9	27.4
Kentucky	**301.1**	216.2	**169.7**	121.8	56.4
Louisiana	**1,512.3**	1,023.4	**729.8**	493.9	48.3
Maine	**250.6**	157.0	**73.6**	46.1	29.4
Maryland	**229.4**	114.7	**86.4**	43.2	37.7
Massachusetts	**917.4**	458.7	**786.3**	393.1	85.7
Michigan	**609.6**	395.9	**407.2**	264.4	66.8
Minnesota	**218.0**	112.2	**27.8**	14.3	12.7
Mississippi	**293.8**	227.0	**109.1**	84.3	37.1
Missouri	**1,070.8**	707.5	**573.5**	378.9	53.6
Montana	**26.5**	17.0	**1.3**	0.8	4.9
Nebraska	**72.3**	42.4	**12.1**	7.1	16.7

TABLE 3A-2. (continued)

State	Unreduced allotment		Allotment reduction		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reductions in total DSH funding
Total	**$28,707.0**	**$16,372.1**	**$14,177.9**	**$8,000.0**	**48.9%**
Nevada	**113.9**	69.2	**33.6**	20.4	29.5
New Hampshire	**481.6**	240.8	**278.2**	139.1	57.8
New Jersey	**1,936.4**	968.2	**775.1**	387.5	40.0
New Mexico	**41.8**	30.4	**5.5**	4.0	13.1
New York	**4,831.6**	2,415.8	**2,832.0**	1,416.0	58.6
North Carolina	**668.4**	440.6	**304.2**	200.5	45.5
North Dakota	**26.6**	14.3	**1.8**	1.0	6.8
Ohio	**944.1**	607.0	**586.1**	376.8	62.1
Oklahoma	**80.0**	54.1	**11.6**	7.9	14.5
Oregon	**114.3**	67.8	**21.1**	12.5	18.5
Pennsylvania	**1,556.3**	842.2	**941.4**	509.5	60.5
Rhode Island	**177.2**	97.5	**124.4**	68.5	70.2
South Carolina	**702.6**	488.5	**398.6**	277.2	56.7
South Dakota	**30.1**	16.6	**1.6**	0.9	5.4
Tennessee[1]	**–**	–	**–**	–	–
Texas	**2,379.3**	1,431.1	**778.0**	468.0	32.7
Utah	**44.5**	29.3	**8.2**	5.4	18.5
Vermont	**59.4**	33.7	**24.7**	14.0	41.5
Virginia	**257.1**	131.7	**89.1**	45.6	34.7
Washington	**556.5**	278.2	**281.3**	140.6	50.5
West Virginia	**135.7**	100.6	**48.2**	35.7	35.5
Wisconsin	**233.2**	141.4	**27.2**	16.5	11.7
Wyoming	**0.7**	0.3	**0.1**	0.1	18.4

Notes: FY is fiscal year. DSH is disproportionate share hospital. Under current law, federal DSH allotments will be reduced by $8 billion in FY 2026. For further discussion of methodology and limitations, see Appendix 3B.

– Dash indicates zero.

[1] Tennessee is not scheduled to have a DSH allotment in FY 2026 and is not subject to DSH allotment reductions because its DSH allotment is specified in statute (§ 1923(f)(6)(A) of the Social Security Act). However, Tennessee receives a virtual DSH fund through its Section 1115 demonstration waiver that may be subject to reductions in FY 2026 if DSH allotment reductions take effect.

Sources: MACPAC, 2024, analysis of CBO 2023a, CBO 2023b, CMS 2023.

TABLE 3A-3. Number of Uninsured Individuals and Uninsured Rate by State, 2021–2022

State	2021		2022		Difference in uninsured (2022–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**28,412**	**8.6%**	**26,529**	**8.0%**	**-1,883**	**-0.6%**
Alabama	489	9.9	437	8.8	-51	-1.1
Alaska	80	11.4	77	11.0	-3	-0.4
Arizona	766	10.7	749	10.3	-17	-0.4
Arkansas	273	9.2	252	8.4	-21	-0.8
California	2,713	7.0	2,492	6.5	-221	-0.5
Colorado	455	8.0	409	7.1	-47	-0.9
Connecticut	184	5.2	185	5.2	1	0.0
Delaware	57	5.7	57	5.6	0	-0.1
District of Columbia	24	3.7	19	2.9	-5	-0.8
Florida	2,598	12.1	2,448	11.2	-151	-0.9
Georgia	1,339	12.6	1,251	11.7	-88	-0.9
Hawaii	54	3.9	49	3.5	-6	-0.4
Idaho	166	8.8	157	8.2	-9	-0.6
Illinois	875	7.0	813	6.6	-62	-0.4
Indiana	504	7.5	469	7.0	-35	-0.5
Iowa	151	4.8	141	4.5	-10	-0.3
Kansas	264	9.2	247	8.6	-17	-0.6
Kentucky	251	5.7	247	5.6	-4	-0.1
Louisiana	345	7.6	312	6.9	-33	-0.7
Maine	78	5.7	90	6.6	12	0.9
Maryland	369	6.1	368	6.1	-1	0.0
Massachusetts	173	2.5	168	2.4	-5	-0.1
Michigan	495	5.0	451	4.5	-44	-0.5
Minnesota	252	4.5	254	4.5	3	0.0
Mississippi	343	11.9	312	10.8	-31	-1.1
Missouri	571	9.4	521	8.6	-50	-0.8
Montana	89	8.2	91	8.3	2	0.1
Nebraska	138	7.1	130	6.7	-8	-0.4
Nevada	362	11.6	349	11.1	-13	-0.5
New Hampshire	71	5.1	68	4.9	-3	-0.2

TABLE 3A-3. (continued)

State	2021		2022		Difference in uninsured (2022–2021)	
	Number (thousands)	Percent of state population	Number (thousands)	Percent of state population	Number (thousands)	Percentage point change
Total	**28,412**	**8.6%**	**26,529**	**8.0%**	**-1,883**	**-0.6%**
New Jersey	657	7.2	627	6.8	-30	-0.4
New Mexico	207	10.0	170	8.2	-37	-1.8
New York	1,019	5.2	945	4.9	-74	-0.3
North Carolina	1,078	10.4	973	9.3	-105	-1.1
North Dakota	59	7.9	49	6.4	-11	-1.5
Ohio	758	6.5	683	5.9	-75	-0.6
Oklahoma	538	13.8	461	11.7	-77	-2.1
Oregon	255	6.1	252	6.0	-3	-0.1
Pennsylvania	702	5.5	681	5.3	-21	-0.2
Puerto Rico	185	5.7	161	5.1	-24	-0.6
Rhode Island	47	4.3	45	4.2	-2	-0.1
South Carolina	512	10.0	470	9.1	-41	-0.9
South Dakota	83	9.5	72	8.1	-12	-1.4
Tennessee	686	10.0	647	9.3	-39	-0.7
Texas	5,224	18.0	4,899	16.6	-325	-1.4
Utah	299	9.0	273	8.1	-26	-0.9
Vermont	23	3.7	25	3.9	1	0.2
Virginia	574	6.8	545	6.5	-29	-0.3
Washington	488	6.4	468	6.1	-20	-0.3
West Virginia	107	6.1	103	5.9	-4	-0.2
Wisconsin	312	5.4	303	5.2	-9	-0.2
Wyoming	69	12.2	66	11.5	-4	-0.7

Notes: 0.0 indicates an amount between -5,000 and 5,000 that rounds to zero; 0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero. Data are taken from the U.S. Census Bureau's American Community Survey.

Source: MACPAC, 2024, analysis of Census 2023.

TABLE 3A-4. State Levels of Uncompensated Care, FYs 2020–2021

State	Total hospital uncompensated care costs, 2020		Total hospital uncompensated care costs, 2021		Difference in total hospital uncompensated care costs, 2021-2020	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	**$40,565**	**3.9%**	**$39,309**	**3.6%**	**-$1,256**	**-0.4%**
Alabama	**799**	6.6	**779**	6.0	**-20**	-0.6
Alaska	**50**	2.6	**48**	2.2	**-2**	-0.3
Arizona	**442**	2.6	**496**	2.5	**54**	0.0
Arkansas	**262**	3.6	**253**	3.2	**-9**	-0.5
California	**2,474**	2.2	**2,393**	1.8	**-81**	-0.4
Colorado	**443**	2.7	**460**	2.7	**17**	0.0
Connecticut	**234**	1.7	**239**	1.7	**5**	-0.1
Delaware	**91**	2.6	**80**	2.2	**-11**	-0.5
District of Columbia	**64**	1.6	**60**	1.5	**-4**	-0.1
Florida	**3,729**	6.8	**3,703**	6.2	**-26**	-0.7
Georgia	**2,540**	9.0	**2,498**	8.1	**-42**	-0.9
Hawaii	**56**	1.6	**44**	1.1	**-12**	-0.5
Idaho	**180**	3.1	**132**	2.0	**-48**	-1.0
Illinois	**1,580**	3.8	**1,415**	3.2	**-165**	-0.6
Indiana	**800**	3.2	**684**	2.6	**-116**	-0.6
Iowa	**208**	2.0	**195**	1.8	**-13**	-0.3
Kansas	**415**	4.1	**426**	3.9	**11**	-0.2
Kentucky	**311**	2.0	**266**	1.6	**-45**	-0.4
Louisiana	**419**	2.7	**371**	2.2	**-48**	-0.5
Maine	**183**	2.8	**155**	2.2	**-27**	-0.6
Maryland	**627**	3.7	**208**	3.3	**-419**	-0.4
Massachusetts	**542**	1.7	**493**	1.5	**-48**	-0.2
Michigan	**606**	1.7	**552**	1.5	**-53**	-0.2
Minnesota	**327**	1.6	**298**	1.4	**-29**	-0.2
Mississippi	**574**	6.9	**519**	5.8	**-55**	-1.1
Missouri	**1,339**	6.1	**1,197**	5.1	**-142**	-0.9
Montana	**91**	2.0	**100**	1.9	**8**	0.0
Nebraska	**291**	4.1	**245**	3.3	**-45**	-0.9

TABLE 3A-4. (continued)

State	Total hospital uncompensated care costs, 2020		Total hospital uncompensated care costs, 2021		Difference in total hospital uncompensated care costs, 2021-2020	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)
Total	**$40,565**	**3.9%**	**$39,309**	**3.6%**	**-$1,256**	**-0.4%**
Nevada	**285**	4.3	**279**	4.0	**-5**	-0.4
New Hampshire	**164**	3.0	**135**	2.3	**-28**	-0.6
New Jersey	**1,055**	3.9	**1,124**	3.9	**68**	0.0
New Mexico	**144**	2.3	**144**	2.3	**1**	-0.1
New York	**2,257**	2.6	**2,350**	2.6	**93**	0.0
North Carolina	**1,899**	6.1	**1,862**	5.5	**-37**	-0.6
North Dakota	**104**	2.4	**101**	2.1	**-3**	-0.3
Ohio	**1,132**	2.7	**1,123**	2.5	**-9**	-0.2
Oklahoma	**767**	6.7	**700**	5.7	**-67**	-1.0
Oregon	**364**	2.7	**355**	2.4	**-9**	-0.2
Pennsylvania	**810**	1.7	**718**	1.4	**-92**	-0.3
Rhode Island	**73**	1.9	**63**	1.6	**-10**	-0.4
South Carolina	**871**	5.8	**877**	5.4	**6**	-0.4
South Dakota	**134**	2.7	**131**	2.5	**-3**	-0.3
Tennessee	**1,126**	5.4	**1,110**	4.9	**-16**	-0.4
Texas	**7,301**	10.7	**7,591**	10.2	**289**	-0.4
Utah	**336**	4.0	**328**	3.5	**-8**	-0.4
Vermont	**47**	1.6	**46**	1.5	**-1**	-0.1
Virginia	**809**	3.7	**790**	3.3	**-18**	-0.3
Washington	**519**	2.1	**512**	2.0	**-7**	-0.1
West Virginia	**194**	2.6	**177**	2.2	**-17**	-0.4
Wisconsin	**403**	1.7	**379**	1.6	**-24**	-0.2
Wyoming	**97**	5.2	**101**	5.3	**4**	0.2

Notes: FY is fiscal year. Uncompensated care is calculated using Medicare cost reports, which define uncompensated care as charity care and non-Medicare and non-reimbursable Medicare as bad debt.

0.0 indicates an amount between -500,000 and 500,000 that rounds to zero; 0.0 percent indicates an amount between -0.05 percent and 0.05 percent that rounds to zero.

Because of changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years.

Source: MACPAC, 2024, analysis of Medicare cost reports for FYs 2020–2021.

TABLE 3A-5. Number and Share of Hospitals Receiving DSH Payments and Meeting Other Criteria by State, FY 2019

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,940**	**2,464**	**41%**	**694**	**12%**	**637**	**11%**
Alabama	114	76	67	4	4	1	1
Alaska	24	10	42	–	–	–	–
Arizona	119	40	34	38	32	30	25
Arkansas	106	3	3	–	–	–	–
California	404	25	6	22	5	19	5
Colorado	106	35	33	10	9	10	9
Connecticut	39	6	15	2	5	2	5
Delaware	14	2	14	2	14	2	14
District of Columbia	12	7	58	5	42	4	33
Florida	248	70	28	27	11	27	11
Georgia	164	125	76	21	13	18	11
Hawaii	26	12	46	2	8	2	8
Idaho	51	25	49	4	8	3	6
Illinois	203	14	7	14	7	12	6
Indiana	167	51	31	10	6	9	5
Iowa	124	10	8	9	7	9	7
Kansas	149	65	44	17	11	16	11
Kentucky	114	72	63	23	20	18	16
Louisiana	208	61	29	32	15	28	13
Maine	38	2	5	2	5	2	5
Maryland	59	10	17	10	17	9	15
Massachusetts	98	–	–	–	–	–	–
Michigan	160	106	66	11	7	11	7
Minnesota	139	36	26	10	7	9	6

TABLE 3A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,940**	**2,464**	**41%**	**694**	**12%**	**637**	**11%**
Mississippi	107	54	50	16	15	15	14
Missouri	137	98	72	17	12	17	12
Montana	66	7	11	4	6	4	6
Nebraska	98	23	23	9	9	9	9
Nevada	56	20	36	3	5	3	5
New Hampshire	30	26	87	3	10	3	10
New Jersey	95	75	79	25	26	24	25
New Mexico	55	10	18	6	11	6	11
New York	192	182	95	47	24	47	24
North Carolina	128	80	63	19	15	19	15
North Dakota	49	2	4	1	2	1	2
Ohio	229	157	69	14	6	14	6
Oklahoma	146	61	42	14	10	13	9
Oregon	63	20	32	9	14	9	14
Pennsylvania	220	159	72	36	16	32	15
Rhode Island	14	10	71	2	14	2	14
South Carolina	85	61	72	12	14	10	12
South Dakota	61	20	33	9	15	9	15
Tennessee	139	63	45	22	16	16	12
Texas	568	180	32	101	18	100	18
Utah	59	42	71	7	12	6	10
Vermont	16	13	81	3	19	3	19
Virginia	106	38	36	4	4	2	2
Washington	103	57	55	15	15	12	12

TABLE 3A-5. (continued)

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Total	**5,940**	**2,464**	**41%**	**694**	**12%**	**637**	**11%**
West Virginia	59	43	73	6	10	5	8
Wisconsin	144	89	62	14	10	14	10
Wyoming	29	11	38	1	3	1	3

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 65 DSH hospitals that did not submit an FY 2021 Medicare cost report. Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of essential community services includes the following services that we could identify based on the limits of available data: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services.

– Dash indicates zero.

[1] None of the hospitals in Alaska and Arkansas that received DSH payments appeared to meet the deemed DSH criteria according to MACPAC's analysis of available data.

[2] Analysis excludes 17 hospitals that received funding under the state's Global Payment Program as authorized under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

[4] Because Montana did not submit a state plan rate year (SPRY) 2019 DSH audit, this analysis uses the state's SPRY 2018 DSH audit data.

Source: MACPAC, 2024, analysis of AHA 2023, Medicare cost reports for FY 2021, and SPRY 2018–2019 DSH audits.

TABLE 3A-6. Number and Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals by State, SPRY 2019

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**815,351**	**437,996**	**54%**	**141,418**	**17%**	**44,471**	**27,226**	**61%**	**12,362**	**28%**
Alabama	14,491	12,223	84	240	2	0	567	79	17	2
Alaska[1]	1,511	917	61	–	–	118	67	56	–	–
Arizona	15,501	7,580	49	7,397	48	1,044	668	64	665	64
Arkansas[1]	9,517	761	8	–	–	379	38	10	–	–
California[2]	72,507	4,791	7	3,280	5	4,916	451	9	310	6
Colorado	10,843	4,505	42	1,622	15	681	344	50	182	27
Connecticut	7,571	1,018	13	400	5	513	56	11	37	7
Delaware	2,666	354	13	354	13	156	37	24	37	24
District of Columbia	3,008	2,206	73	1,106	37	234	182	78	97	41
Florida	56,239	23,950	43	11,953	21	3,252	1,854	57	1,249	38
Georgia	22,384	18,785	84	5,283	24	1,255	1,116	89	483	38
Hawaii	2,694	2,307	86	268	10	181	168	93	48	26
Idaho	42,860	2,461	6	334	1	140	115	82	22	16
Illinois	30,026	2,740	9	2,740	9	1,655	210	13	210	13
Indiana	17,052	6,251	37	2,722	16	920	389	42	237	26
Iowa	7,517	2,707	36	2,666	35	349	225	65	223	64
Kansas	8,435	4,840	57	3,260	39	278	214	77	192	69
Kentucky	14,155	9,398	66	3,374	24	882	539	61	269	30
Louisiana	16,603	8,800	53	2,014	12	883	464	53	123	14
Maine	3,056	143	5	143	5	145	1	1	1	1
Maryland	12,376	2,101	17	2,101	17	805	70	9	70	9
Massachusetts[3]	18,817	–	–	–	–	1,411	–	–	–	–
Michigan	23,777	17,775	75	3,172	13	1,369	1,006	73	323	24
Minnesota	11,362	7,074	62	1,961	17	642	519	81	215	33

TABLE 3A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**815,351**	**437,996**	**54%**	**141,418**	**17%**	**44,471**	**27,226**	**61%**	**12,362**	**28%**
Mississippi	10,027	5,618	56	2,258	23	412	258	63	148	36
Missouri	18,725	13,538	72	2,366	13	950	552	58	148	16
Montana[4]	3,017	351	12	231	8	117	16	14	11	10
Nebraska	5,560	3,369	61	1,514	27	177	148	84	90	51
Nevada	7,391	4,386	59	1,222	17	524	387	74	165	31
New Hampshire	2,818	2,592	92	772	27	127	122	97	78	62
New Jersey	21,091	19,449	92	6,428	30	1,049	994	95	455	43
New Mexico	4,266	1,334	31	351	8	355	117	33	27	7
New York	45,849	44,962	98	10,059	22	3,509	3,452	98	1,004	29
North Carolina	22,506	19,378	86	5,920	26	1,239	1,144	92	416	34
North Dakota	2,496	133	5	25	1	85	0	0	0	0
Ohio	32,406	27,840	86	4,079	13	1,797	1,568	87	448	25
Oklahoma	11,171	6,903	62	1,162	10	486	318	65	43	9
Oregon	7,009	2,921	42	854	12	421	166	39	76	18
Pennsylvania	35,917	31,841	89	6,552	18	1,801	1,690	94	576	32
Rhode Island	2,865	2,145	75	882	31	166	147	88	97	58
South Carolina	12,540	11,135	89	3,250	26	604	580	96	283	47
South Dakota	2,738	1,928	70	1,519	55	88	85	97	79	90
Tennessee	18,179	13,594	75	5,971	33	1,006	884	88	524	52
Texas	68,311	40,072	59	21,754	32	3,733	2,967	79	2,044	55
Utah	5,519	4,668	85	1,044	19	235	221	94	76	32
Vermont	1,138	975	86	494	43	49	49	100	32	64
Virginia	16,555	9,887	60	1,295	8	831	593	71	120	14
Washington	12,062	8,863	73	1,448	12	856	635	74	132	15

TABLE 3A-6. (continued)

State	Number of hospital beds					Number of Medicaid days (thousands)				
	All hospitals	DSH hospitals		Deemed DSH hospitals		All hospitals	DSH hospitals		Deemed DSH hospitals	
		Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	**815,351**	**437,996**	**54%**	**141,418**	**17%**	**44,471**	**27,226**	**61%**	**12,362**	**28%**
West Virginia	5,847	5,163	88	1,052	18	337	323	96	124	37
Wisconsin	12,986	10,483	81	2,394	18	565	497	88	155	28
Wyoming	1,394	782	56	133	10	21	12	58	2	9

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year. Excludes 65 DSH hospitals that did not submit a fiscal year (FY) 2021 Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. For further discussion of the methodology and limitations, see Appendix 3B.

– Dash indicates zero; 0 indicates an amount less than 500 that rounds to zero; 0 percent indicates an amount less than 0.5 percent that rounds to zero.

[1] None of the hospitals in Alaska and Arkansas that received DSH payments appeared to meet the deemed DSH criteria according to MACPAC's analysis of available data.

[2] Analysis excludes 17 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different payment mechanism. These hospitals appear to meet deemed DSH criteria based on available Medicare cost report data.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool. However, at least eight hospitals in Massachusetts appear to meet the criteria for deemed DSH hospitals based on available Medicare cost report data.

[4] Because Montana did not submit a SPRY 2019 DSH audit, this analysis uses the state's SPRY 2018 DSH audit data.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 DSH audits and Medicare cost reports for FYs 2019–2021.

TABLE 3A-7. Medicaid Payments to DSH Hospitals as a Share of Costs by State, SPRY 2019

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**39%**	**79%**	**8%**	**10%**	**96%**	**70%**	**7%**	**8%**	**86%**
Alabama	67	73	25	23	**121**	57	20	18	**95**
Alaska[1]	38	103	0	2	**105**	99	0	2	**102**
Arizona	33	65	9	4	**78**	62	8	4	**74**
Arkansas[1]	2	75	24	20	**119**	70	22	19	**111**
California[1,2]	6	89	5	13	**107**	86	5	12	**104**
Colorado	33	71	23	9	**103**	67	22	8	**97**
Connecticut	8	70	7	9	**86**	69	7	9	**85**
Delaware	7	90	0	21	**111**	79	0	19	**98**
District of Columbia	25	71	3	25	**99**	66	3	23	**93**
Florida	27	76	12	3	**91**	63	10	3	**76**
Georgia	75	86	7	9	**103**	66	6	7	**78**
Hawaii	46	78	15	2	**95**	77	14	2	**93**
Idaho	49	99	2	4	**104**	86	2	3	**91**
Illinois	4	77	8	27	**113**	56	6	20	**82**
Indiana	31	92	0	14	**106**	85	0	13	**98**
Iowa	8	78	4	9	**91**	76	4	8	**88**
Kansas	42	88	4	7	**99**	72	4	6	**82**
Kentucky	58	96	0	7	**103**	93	0	6	**100**
Louisiana	27	68	1	35	**104**	64	1	32	**97**
Maryland	10	102	1	4	**108**	94	1	4	**99**
Michigan	63	93	4	5	**102**	91	4	4	**99**
Minnesota	22	85	4	1	**91**	82	4	1	**87**
Mississippi	50	85	19	15	**120**	71	16	13	**100**
Missouri	65	97	0	16	**114**	81	0	14	**95**

TABLE 3A-7. (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**39%**	**79%**	**8%**	**10%**	**96%**	**70%**	**7%**	**8%**	**86%**
Montana[1,3]	11	76	35	1	**112**	73	33	1	**106**
Nebraska	21	72	2	5	**80**	59	2	4	**65**
Nevada	36	74	13	6	**93**	68	12	5	**85**
New Hampshire	83	65	0	26	**91**	60	0	25	**85**
New Jersey	68	85	4	8	**97**	73	4	7	**84**
New Mexico	18	90	2	5	**98**	87	2	5	**94**
New York	84	72	3	12	**88**	68	3	12	**83**
North Carolina	58	72	35	5	**113**	57	28	4	**89**
North Dakota	2	104	7	1	**112**	93	6	1	**100**
Ohio	67	79	3	6	**89**	76	3	6	**85**
Oklahoma	39	77	31	3	**111**	62	25	2	**89**
Oregon	29	97	1	5	**103**	94	1	5	**100**
Pennsylvania	70	53	11	6	**70**	50	10	6	**66**
Rhode Island	71	87	1	13	**101**	83	1	13	**97**
South Carolina	64	85	5	16	**106**	70	4	13	**86**
South Dakota	31	119	2	1	**122**	90	2	0	**92**
Tennessee	42	85	18	2	**105**	72	15	2	**89**
Texas	29	85	12	16	**113**	62	9	12	**82**
Utah[1]	69	105	38	4	**148**	87	31	4	**121**
Vermont	81	75	0	5	**80**	72	0	5	**77**
Virginia	36	103	12	2	**117**	87	10	2	**99**
Washington	53	87	2	6	**95**	84	2	6	**91**

TABLE 3A-7. (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**39%**	**79%**	**8%**	**10%**	**96%**	**70%**	**7%**	**8%**	**86%**
West Virginia	68	72	14	3	**89**	70	13	3	**86**
Wisconsin	60	86	2	2	**89**	82	2	2	**85**
Wyoming	38	82	16	0	**98**	59	12	0	**71**

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with the state fiscal year and may not align with the federal fiscal year. A total of 2,342 DSH hospitals were used in this analysis. This analysis excludes DSH hospitals that did not submit a fiscal year 2021 Medicare cost report, DSH hospitals that were identified as being out of state, and DSH hospitals that are considered an institution for mental disease. The analysis also excludes Massachusetts, which does not make DSH payments to hospitals because it has a demonstration waiver under Section 1115 of the Social Security Act (the Act) that allows the commonwealth to distribute DSH funding to hospitals through safety-net care pools. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on Medicaid DSH audits). States can categorize directed payments, which are supplemental payments that flow through managed care organizations, as either a managed care payment or as a supplemental payment. Payments shown do not fully account for provider contributions to the non-federal share; these contributions reduce the net payments providers receive. Numbers may not sum due to rounding.

0 percent indicates an amount less than 0.5 percent that rounds to zero.

[1] These states had DSH payments more than 100 percent of Medicaid costs and unpaid costs of care for the uninsured, according to as-filed DSH audits. Because DSH payments cannot exceed a hospital's Medicaid costs and unpaid costs of care for the uninsured, the Centers for Medicare & Medicaid Services (CMS) will recoup these funds. Final DSH payment amounts may change after CMS finalizes its review of DSH audits.

[2] DSH payments in California do not include DSH-financed spending under the state's Global Payment Program, which is authorized under the state's demonstration waiver under Section 1115 of the Act. California also has a special exception to DSH payments, and some hospitals can be paid up to 175 percent of uncompensated care costs.

[3] Montana has not submitted a SPRY 2019 as-filed DSH audit. This analysis uses SPRY 2018 Montana DSH audit data.

Source: MACPAC, 2024, analysis of SPRY 2018–2019 as-filed Medicaid DSH audits.

TABLE 3A-8. DSH Allotment per Uninsured Individual and Non-Elderly Low-Income Individual by State, FY 2024

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per uninsured individual		FY 2024 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$27,419.0**	**$15,644.5**	**$1,039.9**	**$593.3**	**$358.4**	**$204.5**
Alabama	**596.7**	436.3	**1,364.7**	997.9	**418.6**	306.1
Alaska	**58.3**	29.2	**757.8**	379.0	**384.3**	192.2
Arizona	**217.2**	144.0	**290.1**	192.3	**123.5**	81.9
Arkansas	**85.0**	61.2	**337.3**	242.8	**91.3**	65.7
California	**3,140.0**	1,570.0	**1,260.1**	630.1	**352.9**	176.5
Colorado	**264.9**	132.5	**648.5**	324.3	**247.0**	123.5
Connecticut	**572.9**	286.4	**3,098.0**	1,549.0	**920.4**	460.2
Delaware	**21.6**	12.9	**380.5**	227.2	**120.7**	72.1
District of Columbia	**124.3**	87.0	**6,381.4**	4,467.0	**1,020.2**	714.1
Florida	**492.2**	285.3	**201.1**	116.6	**95.0**	55.1
Georgia	**580.0**	382.2	**463.6**	305.5	**213.4**	140.6
Hawaii	**23.7**	13.9	**486.0**	284.6	**89.6**	52.5
Idaho	**33.5**	23.3	**213.8**	149.1	**72.0**	50.2
Illinois	**602.3**	307.7	**740.6**	378.4	**225.4**	115.1
Indiana	**463.3**	304.0	**986.8**	647.6	**282.5**	185.4
Iowa	**87.4**	56.0	**620.6**	398.0	**130.1**	83.4
Kansas	**96.4**	58.8	**390.1**	237.9	**140.6**	85.8
Kentucky	**286.7**	205.8	**1,161.1**	833.4	**223.6**	160.5
Louisiana	**1,440.1**	974.5	**4,612.8**	3,121.5	**1,005.4**	680.3
Maine	**238.6**	149.5	**2,657.7**	1,665.0	**891.0**	558.2
Maryland	**218.4**	109.2	**592.9**	296.4	**199.6**	99.8
Massachusetts	**873.6**	436.8	**5,210.7**	2,605.3	**757.9**	379.0
Michigan	**580.5**	377.0	**1,285.8**	835.0	**244.0**	158.4
Minnesota	**207.6**	106.9	**815.8**	420.1	**205.2**	105.7
Mississippi	**279.7**	216.2	**897.8**	693.8	**295.4**	228.2
Missouri	**1,019.6**	673.7	**1,958.0**	1,293.7	**691.2**	456.7
Montana	**25.3**	16.2	**276.9**	177.0	**99.2**	63.4
Nebraska	**68.9**	40.4	**531.5**	311.4	**162.4**	95.2
Nevada	**108.4**	65.9	**311.0**	189.0	**135.7**	82.5
New Hampshire	**458.6**	229.3	**6,791.5**	3,395.8	**2,489.8**	1,244.9
New Jersey	**1,843.9**	921.9	**2,940.1**	1,470.1	**1,157.0**	578.5

TABLE 3A-8. (continued)

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per uninsured individual		FY 2024 DSH allotment per non-elderly low-income individual	
	Total (federal and state)	Federal	Total (federal and state)	Federal	Total (federal and state)	Federal
Total	**$27,419.0**	**$15,644.5**	**$1,039.9**	**$593.3**	**$358.4**	**$204.5**
New Mexico	**39.8**	28.9	**233.6**	169.6	**62.1**	45.1
New York	**4,600.8**	2,300.4	**4,869.6**	2,434.8	**1,026.3**	513.2
North Carolina	**636.5**	419.5	**654.1**	431.1	**245.7**	161.9
North Dakota	**25.4**	13.7	**521.6**	280.7	**167.3**	90.0
Ohio	**899.0**	578.0	**1,317.1**	846.9	**326.2**	209.7
Oklahoma	**76.2**	51.5	**165.4**	111.7	**63.4**	42.8
Oregon	**108.8**	64.5	**431.0**	255.6	**117.1**	69.5
Pennsylvania	**1,481.9**	802.0	**2,176.3**	1,177.8	**563.9**	305.2
Rhode Island	**168.8**	92.8	**3,719.0**	2,045.8	**881.7**	485.0
South Carolina	**669.1**	465.2	**1,422.1**	988.8	**501.5**	348.7
South Dakota	**28.7**	15.8	**400.8**	220.4	**145.9**	80.2
Tennessee	**83.2**	54.3	**128.6**	83.9	**46.3**	30.2
Texas	**2,265.6**	1,362.8	**462.5**	278.2	**277.2**	166.7
Utah	**42.3**	27.9	**155.3**	102.3	**63.4**	41.8
Vermont	**56.6**	32.1	**2,281.6**	1,294.8	**482.4**	273.8
Virginia	**244.8**	125.4	**449.1**	230.1	**147.0**	75.3
Washington	**529.9**	264.9	**1,133.3**	566.7	**373.7**	186.9
West Virginia	**129.2**	95.8	**1,253.7**	929.0	**251.4**	186.3
Wisconsin	**222.0**	134.7	**733.2**	444.8	**189.4**	114.9
Wyoming	**0.6**	0.3	**9.9**	4.9	**5.1**	2.6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Non-elderly low-income individuals are defined as individuals younger than age 65 with family incomes less than 200 percent of the federal poverty level. Totals show FY 2023 federal allotments that were increased by the American Rescue Plan Act of 2021 (P.L. 117-2). For further discussion of methodology and limitations, see Appendix 3B.

Source: MACPAC, 2024, analysis of Census 2023 and the Centers for Medicare & Medicaid Services Medicaid Budget and Expenditure System.

TABLE 3A-9. FY 2024 DSH Allotment as a Percentage of Hospital Uncompensated Care Costs by State, FY 2021

State	FY 2024 federal DSH allotment (millions)	FY 2024 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021	FY 2024 DSH allotment (state and federal, millions)	FY 2024 total DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021
Total	**$15,644.5**	**39.8%**	**$27,419.0**	**69.8%**
Alabama	436.3	56.0	596.7	76.6
Alaska	29.2	60.4	58.3	120.8
Arizona	144.0	29.0	217.2	43.8
Arkansas	61.2	24.2	85.0	33.6
California	1,570.0	65.6	3,140.0	131.2
Colorado	132.5	28.8	264.9	57.5
Connecticut	286.4	119.8	572.9	239.7
Delaware	12.9	16.1	21.6	27.0
District of Columbia	87.0	144.5	124.3	206.5
Florida	285.3	7.7	492.2	13.3
Georgia	382.2	15.3	580.0	23.2
Hawaii	13.9	31.3	23.7	53.5
Idaho	23.3	17.7	33.5	25.4
Illinois	307.7	21.7	602.3	42.6
Indiana	304.0	44.4	463.3	67.7
Iowa	56.0	28.7	87.4	44.7
Kansas	58.8	13.8	96.4	22.6
Kentucky	205.8	77.4	286.7	107.9
Louisiana	974.5	262.9	1,440.1	388.5
Maine	149.5	96.2	238.6	153.5
Maryland	109.2	52.6	218.4	105.2
Massachusetts	436.8	88.6	873.6	177.2
Michigan	377.0	68.2	580.5	105.1
Minnesota	106.9	35.9	207.6	69.7
Mississippi	216.2	41.6	279.7	53.9
Missouri	673.7	56.3	1,019.6	85.2
Montana	16.2	16.2	25.3	25.4
Nebraska	40.4	16.4	68.9	28.1
Nevada	65.9	23.6	108.4	38.8
New Hampshire	229.3	169.2	458.6	338.5
New Jersey	921.9	82.0	1,843.9	164.1
New Mexico	28.9	20.0	39.8	27.6

TABLE 3A-9. (continued)

State	FY 2024 federal DSH allotment (millions)	FY 2024 federal DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021	FY 2024 DSH allotment (state and federal, millions)	FY 2024 total DSH allotment as a percentage of hospital uncompensated care in the state, FY 2021
Total	**$15,644.5**	**39.8%**	**$27,419.0**	**69.8%**
New York	2,300.4	97.9	4,600.8	195.8
North Carolina	419.5	22.5	636.5	34.2
North Dakota	13.7	13.5	25.4	25.0
Ohio	578.0	51.5	899.0	80.1
Oklahoma	51.5	7.4	76.2	10.9
Oregon	64.5	18.2	108.8	30.7
Pennsylvania	802.0	111.7	1,481.9	206.4
Rhode Island	92.8	147.6	168.8	268.3
South Carolina	465.2	53.0	669.1	76.2
South Dakota	15.8	12.1	28.7	21.9
Tennessee	54.3	4.9	83.2	7.5
Texas	1,362.8	18.0	2,265.6	29.8
Utah	27.9	8.5	42.3	12.9
Vermont	32.1	69.5	56.6	122.4
Virginia	125.4	15.9	244.8	31.0
Washington	264.9	51.8	529.9	103.5
West Virginia	95.8	54.1	129.2	73.0
Wisconsin	134.7	35.5	222.0	58.6
Wyoming	0.3	0.3	0.6	0.6

Notes: DSH is disproportionate share hospital. FY is fiscal year. Uncompensated care is calculated using 2021 Medicare cost reports, which define uncompensated care as charity care and bad debt. Because of recent changes in Medicare cost report definitions that changed uncompensated care reporting for 2015 and subsequent years, these data are not comparable with data for prior years. For further discussion of methodology and limitations, see Appendix 3B.

Source: MACPAC, 2024, analysis of Medicare cost reports for FYs 2020–2021 and the Centers for Medicare & Medicaid Services Medicaid Budget and Expenditure System.

TABLE 3A-10. DSH Allotment per Deemed DSH Providing at Least One Essential Community Service by State, FY 2024

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per deemed DSH hospital (millions)		FY 2024 DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,419.0**	**$15,644.5**	**$39.5**	**$22.5**	**$45.2**	**$25.8**
Alabama	**596.7**	436.3	**149.2**	109.1	**596.7**	436.3
Alaska[1]	**58.3**	29.2	**–**	–	**–**	–
Arizona	**217.2**	144.0	**5.7**	3.8	**7.8**	5.1
Arkansas[1]	**85.0**	61.2	**–**	–	**–**	–
California[2]	**3,140.0**	1,570.0	**142.7**	71.4	**184.7**	92.4
Colorado	**264.9**	132.5	**26.5**	13.2	**29.4**	14.7
Connecticut	**572.9**	286.4	**286.4**	143.2	**286.4**	143.2
Delaware	**21.6**	12.9	**10.8**	6.5	**10.8**	6.5
District of Columbia	**124.3**	87.0	**24.9**	17.4	**31.1**	21.7
Florida	**492.2**	285.3	**18.2**	10.6	**18.2**	10.6
Georgia	**580.0**	382.2	**27.6**	18.2	**32.2**	21.2
Hawaii	**23.7**	13.9	**11.9**	6.9	**11.9**	6.9
Idaho	**33.5**	23.3	**8.4**	5.8	**11.2**	7.8
Illinois	**602.3**	307.7	**43.0**	22.0	**50.2**	25.6
Indiana	**463.3**	304.0	**46.3**	30.4	**51.5**	33.8
Iowa	**87.4**	56.0	**9.7**	6.2	**9.7**	6.2
Kansas	**96.4**	58.8	**5.7**	3.5	**6.0**	3.7
Kentucky	**286.7**	205.8	**12.5**	8.9	**20.5**	14.7
Louisiana	**1,440.1**	974.5	**45.0**	30.5	**68.6**	46.4
Maine	**238.6**	149.5	**119.3**	74.7	**119.3**	74.7
Maryland	**218.4**	109.2	**21.8**	10.9	**24.3**	12.1
Massachusetts[3]	**873.6**	436.8	**–**	–	**–**	–
Michigan	**580.5**	377.0	**52.8**	34.3	**52.8**	34.3
Minnesota	**207.6**	106.9	**20.8**	10.7	**23.1**	11.9

TABLE 3A-10. (continued)

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per deemed DSH hospital (millions)		FY 2024 DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,419.0**	**$15,644.5**	**$39.5**	**$22.5**	**$45.2**	**$25.8**
Mississippi	**279.7**	216.2	**17.5**	13.5	**18.6**	14.4
Missouri	**1,019.6**	673.7	**60.0**	39.6	**60.0**	39.6
Montana	**25.3**	16.2	**6.3**	4.0	**6.3**	4.0
Nebraska	**68.9**	40.4	**7.7**	4.5	**11.5**	6.7
Nevada	**108.4**	65.9	**36.1**	22.0	**36.1**	22.0
New Hampshire	**458.6**	229.3	**152.9**	76.4	**152.9**	76.4
New Jersey	**1,843.9**	921.9	**73.8**	36.9	**76.8**	38.4
New Mexico	**39.8**	28.9	**6.6**	4.8	**6.6**	4.8
New York	**4,600.8**	2,300.4	**97.9**	48.9	**100.0**	50.0
North Carolina	**636.5**	419.5	**33.5**	22.1	**35.4**	23.3
North Dakota[4]	**25.4**	13.7	**25.4**	13.7	**–**	–
Ohio	**899.0**	578.0	**64.2**	41.3	**69.2**	44.5
Oklahoma	**76.2**	51.5	**5.4**	3.7	**5.9**	4.0
Oregon	**108.8**	64.5	**12.1**	7.2	**12.1**	7.2
Pennsylvania	**1,481.9**	802.0	**41.2**	22.3	**46.3**	25.1
Rhode Island	**168.8**	92.8	**84.4**	46.4	**84.4**	46.4
South Carolina	**669.1**	465.2	**55.8**	38.8	**66.9**	46.5
South Dakota	**28.7**	15.8	**3.2**	1.8	**4.8**	2.6
Tennessee	**83.2**	54.3	**3.8**	2.5	**5.2**	3.4
Texas	**2,265.6**	1,362.8	**22.4**	13.5	**22.7**	13.6
Utah	**42.3**	27.9	**6.0**	4.0	**7.1**	4.6
Vermont	**56.6**	32.1	**18.9**	10.7	**18.9**	10.7
Virginia	**244.8**	125.4	**61.2**	31.3	**122.4**	62.7
Washington	**529.9**	264.9	**35.3**	17.7	**66.2**	33.1

TABLE 3A-10. (continued)

State	FY 2024 DSH allotment (millions)		FY 2024 DSH allotment per deemed DSH hospital (millions)		FY 2024 DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal
Total	**$27,419.0**	**$15,644.5**	**$39.5**	**$22.5**	**$45.2**	**$25.8**
West Virginia	**129.2**	95.8	**21.5**	16.0	**32.3**	23.9
Wisconsin	**222.0**	134.7	**15.9**	9.6	**15.9**	9.6
Wyoming	**0.6**	0.3	**0.6**	0.3	**0.6**	0.3

Notes: DSH is disproportionate share hospital. FY is fiscal year. Excludes 65 DSH hospitals that did not submit a Medicare cost report. Deemed DSH status was estimated based on available data on Medicaid inpatient and low-income utilization rates. Our definition of community services includes the following services based on the limits of available data: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, primary care services, substance use disorder services, and trauma services. For further discussion of methodology and limitations, see Appendix 3B.

– Dash indicates that the category is not applicable.

[1] None of the hospitals in Arkansas and Alaska that received DSH payments appear to meet the deemed DSH criteria according to MACPAC's analysis of available data.

[2] Analysis excludes 17 hospitals that received funding under California's Global Payment Program demonstration waiver under Section 1115 of the Social Security Act (the Act), which uses DSH funding to pay hospitals using a different mechanism.

[3] Massachusetts does not make DSH payments to hospitals because the state's demonstration waiver under Section 1115 of the Act allows it to use all of its DSH funding for the state's safety-net care pool instead; for this reason, no hospitals in the state can be categorized as DSH or deemed DSH hospitals.

Source: MACPAC, 2024, analysis of AHA 2023, the Centers for Medicare and Medicaid Services Medicaid Budget and Expenditure System FY 2023, and state plan rate year 2018–2019 as-filed Medicaid DSH audits.

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APPENDIX 3B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. In the following sections, we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

Primary Data Sources

DSH audit data

We used the most recent available state plan rate year (SPRY) DSH audit reports to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types for all states. For all states except Montana, we used SPRY 2019 DSH audits. Since Montana had not submitted a SPRY 2019 DSH audit at the time these data were collected, we used its SPRY 2018 DSH audit and adjusted for inflation. These data were provided by the Centers for Medicare & Medicaid Services (CMS) on an as-filed basis and are subject to change as CMS completes its internal review of state DSH audit reports.

Overall, 2,464 hospitals receiving DSH payments are represented in our analyses of DSH audit data. We did not include audit data provided by states for hospitals that did not receive DSH payments (58 hospitals were excluded under this criterion). Some hospitals received DSH payments from multiple states; we combined the data for duplicate hospitals so that each hospital would appear only once in the dataset.

Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded hospitals in U.S. territories, religious non-medical health care institutions, and hospitals participating in special Medicare demonstration projects. (Ninety-two hospitals were excluded under these criteria.) These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. Hospitals were matched based on their CMS certification number. We excluded 65 DSH hospitals without matching 2021 Medicare cost reports.

When using Medicare cost reports to analyze hospital uncompensated care, we excluded hospitals that reported uncompensated care costs that were greater than hospital operating expenses or had missing uncompensated care fields or the operating expenses. A total of 1,464 hospitals were excluded under this criterion.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that were more than 1.5 times the interquartile range above the highest quartile or below the lowest quartile. (Under this criterion, 404 hospitals were excluded from our analysis of fiscal year (FY) 2021 operating margins.) Operating margins were calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by NPR: (NPR – OE) ÷ NPR. Total margins, in contrast, included additional types of hospital revenue, such as investment income, state or local subsidies, and revenue from other facets of hospital operations (e.g., parking lot receipts).

Definition of Essential Community Services

MACPAC's authorizing statute requires that our analysis include data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education and the continuum of primary through quaternary care, including the provision of trauma care and public health services (§ 1900 of the Social Security Act (the Act)).

In this report, we use the same definition to identify such hospitals that was used in MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. This definition is based on a two-part test:

- Is the hospital a deemed DSH hospital?
- Does the hospital provide at least one essential service?

Deemed DSH hospital status

According to the Act, hospitals must meet one of two criteria to qualify as a deemed DSH hospital: (1) a Medicaid inpatient utilization rate greater than one standard deviation above the mean for hospitals in the state or (2) a low-income utilization rate greater than 25 percent (§ 1923(b)(1) of the Act). Because deemed DSH hospitals are statutorily required to receive DSH payments, we excluded from our analysis hospitals that did not receive DSH payments in 2019.

Calculation of the Medicaid inpatient utilization rate threshold for each state requires data from all hospitals in that state, and we relied on Medicare cost reports to make those calculations and to determine which hospitals exceeded this threshold. A major limitation of this approach is that Medicaid inpatient utilization reported on Medicare cost reports does not include services provided to Medicaid enrollees that were not paid for by Medicaid (e.g., Medicare-funded services for individuals who are dually eligible for Medicare and Medicaid). However, the Medicaid DSH definition of Medicaid inpatient utilization includes services provided to anyone who is eligible for Medicaid, even if Medicaid is not the primary payer. Thus, our identification of deemed DSH hospitals may omit some hospitals with high utilization by dually eligible beneficiaries and overstate the extent to which hospitals with low utilization by dually eligible beneficiaries (e.g., children's hospitals) exceed the threshold.

The low-income utilization rate threshold for deemed DSH hospitals is the same for all states (25 percent), so we were able to use Medicaid DSH audit data to determine whether hospitals met this criterion. However, five DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions may have limited our ability to identify all deemed DSH hospitals.

Both California and Massachusetts distribute DSH funding through waivers authorized under Section 1115 of the Act. Consequently, Massachusetts does not have any hospitals that submit Medicaid DSH audits, while California has 17 public hospitals that do not submit Medicaid DSH audits. For these two states, MACPAC used Medicare cost report data to estimate deemed DSH status. Twenty-five additional hospitals were included from California and Massachusetts using this methodology.

Provision of essential community services

Because the term essential community services is not otherwise defined in statute or regulation, we identified a number of services that could be considered essential community services using available data from 2021 Medicare cost reports and the 2022 American Hospital Association annual survey (Table 3B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the American Hospital Association annual survey.

TABLE 3B-1. Essential Community Services by Data Source

Data source	Service type
American Hospital Association annual survey	Burn services
	Dental services
	HIV/AIDS care
	Neonatal intensive care units
	Obstetrics and gynecology services
	Primary care services
	Substance use disorder services
	Trauma services
Medicare cost reports	Graduate medical education
	Inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital)

For this report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. For deemed DSH hospitals, we also included certain hospital types if they were the only hospital in their geographic areas to provide certain types of services. These hospital types included critical access hospitals because they are often the only hospital within a 25-mile radius.

Projections of DSH Allotments

DSH allotment reductions from FY 2026 were calculated using data provided to the Commission by CMS and the Congressional Budget Office. DSH allotments for FY 2026 were calculated by increasing FY 2024 DSH allotments by the Consumer Price Index projections for All Urban Consumers and allocating the $8 billion in reduction to each state using data provided to us by CMS (CBO 2023, CMS 2023).

Unreduced allotments increase each year for all states except Tennessee, whose DSH allotment is specified in statute (Section 1923(f)(6)(A)(vi) of the Act).

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. E-mail to MACPAC, October 4.

Congressional Budget Office (CBO). 2023. *The budget and economic outlook: 2023 to 2033*. Washington, DC: CBO. https://www.cbo.gov/system/files/2023-02/51135-2023-02-Economic-Projections.xlsx.

Appendix

Authorizing Language (§ 1900 of the Social Security Act)

Medicaid and CHIP Payment and Access Commission

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ''MACPAC'').

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as ''Medicaid'') and the State Children's Health Insurance Program established under title XXI (in this section referred to as ''CHIP'') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

(A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term ''appropriate committees of Congress'' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as ‘‘MedPAC’’) established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 USC 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Biographies of Commissioners

Melanie Bella, MBA, (Chair), is an executive advisor at Cressey & Company and a member of the firm's Distinguished Executives Council. Before this, she was 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. She also 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 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 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 as a deputy director of the Center for Medicaid and CHIP Services, the Center for Consumer Information and Insurance Oversight, and 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 Acentra Health, 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 (LTSS) strategy at CareBridge, a value-based healthcare 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 LTSS 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's degree 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 at Buoy Health, Inc., 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 clinical 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. Most recently, she was president of Providence Population Health Management, where she used 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 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's degree 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 chief executive officer'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.

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