# Highlights from MACPAC February 2020 Public Meeting Sessions

## Overview

The Medicaid and CHIP Payment and Access Commission (MACPAC) held its February 2020 public meeting on February 27 and 28. Viohl & Associates attended six sessions that covered Medicaid initiatives to improve maternal health, promoting value-based payments in Medicaid managed care, third-party liability coordination, how changes in the Medicare Advantage (MA) market affect integration of care for dually-eligible beneficiaries, policy recommendations to improve the integration of care for dually-eligible beneficiaries, and the forthcoming rule on program integrity and eligibility determinations. Each session is summarized below.

## State Medicaid Initiatives to Improve Maternal Health

*Panel Discussion*

MACPAC staff facilitated a panel discussion on state programs addressing high rates of maternal morbidity and mortality in the United States. Medicaid experts representing three states spoke on the panel: Kate Massey, senior deputy director of the Michigan Medical Services Administration, Jennifer Langer Jacobs, assistant commissioner of the New Jersey Division of Medical Assistance and Health Services, and Dr. Shannon Dowler, chief medical officer of North Carolina Medicaid. After the panel, MACPAC Commissioners asked questions, made comments, and indicated the kinds of recommendations they might make in their upcoming report.

MACPAC staff reviewed a Mathematica survey of nearly 350 state initiatives to improve maternal health outcomes, which focused on changes to covered benefits, reforms to payment models and policies, beneficiary and provider education and outreach, and managed care contracting strategies.

Ms. Massey's comments focused on three themes: health equity, home visitation, and Governor Gretchen Whitmer's "Healthy Moms, Healthy Babies" initiative included in the Governor's Fiscal Year 2020 budget proposal. Michigan's annual health equity report breaks down maternal health indicators by race and demographics. Ms. Massey noted Michigan falls behind in some key measures (i.e. timeliness of postpartum care), and in these measures, racial and socioeconomic disparities are especially pronounced. According to Ms. Massey, the health equity report enables Michigan to more precisely address particular areas of need with targeted policymaking; some examples include smoking cessation programs, food "FARMacies", and tailored performance targets. Michigan's Maternal Infant Health Program is the state's home visiting initiative. Ms. Massey explained that healthy moms are eligible for up to eight visits during and after pregnancy and at-risk moms are eligible for up to 30 visits. Michigan partners with a variety of providers to deliver these services, including the Nurse-Family Partnership and Parents as Teachers. The Governor's office is working with health plans to ensure they refer mothers to the best program for their circumstance. Finally, Ms. Massey discussed the Governor's "Healthy Moms, Healthy Babies" program, a budget initiative to allocate funding to home visiting programs, development of inpatient and outpatient maternal health reporting requirements, family planning services, and extending postpartum benefits to 12 months postpartum.

Ms. Jacobs discussed efforts to close racial disparities in maternal health in New Jersey. She noted that First Lady Tammy Murphy is focused on health equity in maternal care and is leading a statewide maternal health initiative. Ms. Jacobs also highlighted the State's other ongoing initiatives, including supporting doula services for Medicaid moms, group therapy for moms with Medicaid, expansion of family planning benefits for long-acting reversible contraceptives (LARCs), implicit bias training, and a new perinatal quality collaborative. Ms. Jacobs said there are still "technical and adaptive challenges" to overcome. She emphasized the importance of person-centered care and stakeholder involvement moving forward.

Dr. Dowler said maternal health outcome disparities among racial and socioeconomic groups in North Carolina are decreasing, but are still persistent. She attributed this decrease to several effective initiatives, including a new model of care that prioritizes partnerships between providers, application of diversified healthcare settings, and an increase in the number of free-standing pregnancy medical homes in her state. In addition to these initiatives, Dr. Dowler mentioned that the state is developing standards focused on treating substance use disorder (SUD), prenatal hypertension, and other maternity-related conditions. Dr. Dowler also noted a slight increase in white maternal morbidity and mortality as a reason for the decreasing disparity.

*Commissioners' Questions and Comments*
One Commissioner noted the success of employing midwives and freestanding birth centers in improving statewide maternal health outcomes, and asked the panelists what they are doing to expand these alternatives to traditional hospital birth in their states. Ms. Jacobs said New Jersey is working on workforce development for birthing professionals and adjusting payment rates for midwives. Dr. Dowler said North Carolina is working on opening new freestanding birth centers and increasing the use of midwives.

Commissioners were generally interested in the increase in popularity of community-based doulas and one Commissioner asked the panelists' what their states are doing to expand such programs. Ms. Jacobs said New Jersey will consider expanding infrastructure for doulas to build statewide capacity. Dr. Dowler said North Carolina is collecting data on how doulas affect maternal health risks. Ms. Massey said Michigan is focused on value-based purchasing for doulas.

One Commissioner asked panelists to elaborate on states' use of family planning benefits to improve maternal health. Panelists pointed to statistics showing better maternal health correlated with family planning and noted that using LARCs to prevent subsequent pregnancies after birth could be helpful in mitigating complications from a second pregnancy or increased financial challenges resulting from additional children.

Panelists agreed that MACPAC should recommend expanding Medicaid coverage to up to six months postpartum. Panelists felt a one-year postpartum extension would be better still, since many maternal deaths happen between six and twelve months postpartum. MACPAC Chair Melanie Bella said MACPAC is interested in expanding benefits, but is cognizant about how expansion would impact federal and state budgets. MACPAC may take a position on a pending House bill, which would allow states to expand Medicaid coverage to up to one year postpartum as a state option and incentive this option by increasing the federal match rate for this coverage.

Some Commissioners said CMS should issue guidance on the importance of SUD and behavioral disorder treatment when postpartum coverage is extended. Commissioners also said expanding community-based care initiatives could be instrumental to increasing the uptake of some covered services that are often not utilized by beneficiaries, like LARCs.

## Promoting the Use of Value-Based Payments

*MACPAC Presentation*
MACPAC staff presented findings from their joint study with Bailit Health on state strategies to promote the use of value-based payments (VBPs) in Medicaid managed care. The study found about 66 percent of all Medicaid payments in value-based arrangements were made in fee-for-service models with no link to quality or value. Five key themes emerged:

1. States and MCOs are tailoring national VBP models to better suit local circumstances;
2. While some existing authorities provide states with multiple tools to promote VBP in managed care, implementation of VBP often requires substantial efforts on the part of states;
3. States face tradeoffs between taking a prescriptive versus a flexible approach;
4. Contract requirements for VBPs are changing MCO behavior but they do not address challenges with provider participation in VBP models, and;
5. Although states are monitoring MCO compliance, plans to formally evaluate VBP efforts are limited, especially in states with less prescriptive models.

*Commissioner Feedback*
MACPAC Commissioners agreed that staff should publish their joint study with Bailit in MACPAC's upcoming June Report to Congress. Commissioners recommended that MACPAC staff seek feedback from the provider community to better understand their perspective on VBPs. One Commissioner was interested in how provider reimbursement levels affect access in VBP models.

*Panel Discussion*
Three Medicaid professionals participated in a panel discussion on state strategies to implement VBP: Dr. Bryan Amick, deputy director of the office of health programs for the State of South Carolina, Catherine Anderson, senior

vice president of policy and strategy at UnitedHealthcare, and Thomas Mattingly, senior vice president, provider networks, at CareSource.

Dr. Amick highlighted VBP challenges in South Carolina. He emphasized the importance of meaningfully improving the quality of care in VBP since discussions about VBP are often dominated by costs. Dr. Amick also said provider consolidation was troublesome since it shifted negotiating power away from states towards providers, resulting in higher rates and issues in controlling costs in value-based arrangements.

Ms. Anderson echoed Dr. Amick's concerns about provider consolidation, noting that large hospitals often consolidate their negotiating power to great effect. Ms. Anderson also said state thresholds and requirements on VBP sometimes result in providers increasing rates as they meet the additional burden of compliance.

Mr. Mattingly called Ohio's approach to VBP "prescriptive". He argued that while a prescriptive approach often leads to requirements designed to help beneficiaries, private stakeholders should be involved in the process.

A Commissioner asked the panel what balance should be struck between prescriptive approaches that often involve specific performance targets and more flexible approaches to VBP. Panelists agreed that while performance targets are important, they can sometimes shift the focus away from meaningful quality of care improvements. One Commissioner suggested that states could pursue other accountability measures, like "microincentives," to find what works for providers, states, and beneficiaries. Panelists then suggested aligning measures between plans and providers to help achieve quality and encourage collaboration.

When asked what VBP issue MACPAC should further research, panelists pointed to data integration. Ms. Anderson also requested the commission support continued funding for innovation in value based models, while Dr. Amick stressed the importance of flexibility in regulation.

## Medicaid and TRICARE: Third-Party Liability Coordination

Following up on a previous session from the MACPAC public meeting in October, staff gave a presentation on liability coordination between Medicaid and TRICARE, the health care program for military service members.

About 867,000 active duty military members and dependents receive healthcare through both TRICARE and Medicaid. Benefits and payments are coordinated between the two programs, but federal law requires Medicaid be the payer of last resort. In practice, however, evidence suggests that Medicaid is paying claims that otherwise should be paid for by TRICARE.

MACPAC identified three key payment issues between Medicaid and TRICARE:

1. Medicaid and TRICARE have no active data sharing agreement;
2. Medicaid and TRICARE conduct infrequent data matches, and;
3. TRICARE sometimes fails to coordinate with Medicaid MCOs.

States are unable to proactively identify Medicaid enrollees who have primary coverage through TRICARE because Medicaid and TRICARE have no active data sharing agreement. Infrequent data matches also result in inaccuracies when sharing claims data between Medicaid and TRICARE. Data match terms have not been updated since the 1990s, leading to inefficiencies in coordination and difficulty tracking payments. Since Defense Health Agency (DHA) policy requires TRICARE to only accept claims for one year from the date of service, inefficiencies that cause delays resulting from infrequent data matches result in unpaid claims or claims being paid by Medicaid that should be paid by TRICARE.

DHA's policy to only coordinate benefits with entities with which it has a billing agreement also creates difficulties for contracted MCOs, since TRICARE carriers will often execute billing agreements with state Medicaid agencies and not with their MCOs. This leads to situations where MCOs are aware of TRICARE enrollment but cannot recoup claims already paid through "pay and chase." These difficulties also mean MCO capitation rates may be based on inaccurate assumptions and data when counting beneficiaries enrolled in Medicaid and TRICARE.

MACPAC staff identified several opportunities to improve third-party liability coordination between Medicaid and TRICARE, including improving coordination among agencies, revisiting data match terms and conducting more frequent data sharing, improving the data match process, or extending the timely filing window.

*Commissioners' Comments*
One Commissioner said data sharing appears to be at the root of coordination problems between Medicaid and TRICARE. One Commissioner also suggested reviewing the three-way agreement between DHA, CMS and states to find where the most challenging data sharing and coordination problems persist. Commissioners, on the whole, believed TRICARE may be a difficult partner for state Medicaid agencies to work with, and suggested that MACPAC explore ways to guide TRICARE or compel it to "play ball" with state agencies. Commissioners discussed recommendation options including statutory changes or guidance from CMS.

## The Influence of the Medicare Advantage (MA) Market on Integrated Care Programs for Dually-Eligible Beneficiaries

MACPAC staff presented on how the MA market influences integrated care programs for dually-eligible beneficiaries and presented analysis from a recent MACPAC study that analyzed Dual Eligible Special Needs Plans (D-SNPs) and look-alike plans. D-SNPs limit enrollment to dually-eligible beneficiaries and are subject to other requirements, while D-SNP look-alike plans are traditional MA plans that are not subject to D-SNP requirements. States can align managed long-term services and supports (MLTSS) programs with D-SNPs to integrate care for dually-eligible beneficiaries, leading to better coordination of benefits. This is where D-SNP look-alikes can be concerning, since some worry they draw beneficiaries away from integrated models.

MACPAC staff analyzed D-SNP look-alike plan availability synthesized from 2019 and 2020 MA data. Key findings are available in the table on slide 9 of their presentation. Staff found that integrated D-SNP programs do compete with D-SNP look-alike programs in states, but the overall effect of look-alike plans on integrated D-SNP enrollment remains unclear.

MACPAC staff interviewed industry stakeholders, including federal officials, state officials and consultants, health plan industry representatives, provider representatives, and beneficiary advocates. Interviewees were asked about their opinions on the drivers of growth in look-alike plans, influences on beneficiary choice, and the consequences of the proliferation of look-alike plans on integrated care programs.

Stakeholders identified the following as factors contributing to growth in look-alike plans:
- Risk-adjusted payment for dual eligibles makes them an appealing population for look-alike plans
- State policy decisions limit D-SNP contracting
- New federal requirements may restrict D-SNPs from effectively competing with look-alike plans

Stakeholders identified the following as factors influencing beneficiary choice:
- Incentives for Medicare enrollment brokers put integrated products at a disadvantage
- Some non-integrated plans engage in misleading marketing practices
- Beneficiary enrollment counselors are confused about how to identify D-SNP look-alike plans

Concern that D-SNP look-alike plans are affecting enrollment in integrated care programs is still prevalent. Stakeholders cited look-alike plans' effects on integrated care program enrollment in Financial Alignment Initiative states, particularly in California. Stakeholders were also concerned that look-alike plans could have a negative impact on the care experience for enrolled dually-eligible beneficiaries.

Bid data analysis showed a projected enrollment growth of 29.1 percent from 2019 to 2020 for Institutional Special Needs Plans (I-SNPs); stakeholders attributed this growth to an increase in provider-owned I-SNPs, financial factors, nursing home frustration about working with MA plans, and formation of provider coalitions.

On February 5, 2020 CMS proposed a new rule pertaining to MA plans. MACPAC intends to comment on the rule before the close of the public comment period on April 6. The rule has several provisions of high interest to the Commission, including:

- The rule proposes to limit look-alike plans by refusing to enter into a contract with or renew a MA plan in which 80 percent or more of projected enrollment are dually-eligible beneficiaries, or if the plan has actual enrollment at this threshold as of January in the current year;
- The rule proposes to lower the threshold for network adequacy in rural areas to ensure beneficiary access to at least one provider or facility of certain specialties within published maximum time and distance standards, and;
- The rule proposes to implement model of care requirements for Chronic Special Needs Plans (C-SNPs) and extend those requirements to D-SNPs and I-SNPs.

*Commissioners' Comments*
MACPAC Commissioners are interested in better understanding how further limiting enrollment of dually-eligible beneficiaries in D-SNP look-alike plans, beyond the threshold in the proposed CMS rule, affects the growth of those plans. Staff may explore this question in the future.

One Commissioner said CMS should consider telehealth when determining network adequacy standards for D-SNPs, especially since telehealth can have a significant impact on networks in rural areas.

Regarding I-SNPs, the Commission was in favor of guidance that strengthens the model of care and encourages integration. MACPAC will include a comment to this effect in their recommendations to CMS, and will continue to explore the prospects of including Special Supplemental Benefits for the Chronically Ill (SSBCI) in integrated plans to help attract dually-eligible beneficiaries to integrated plans.

The Commission expressed interest in more research on I-SNPs. Commissioners said they hoped more research could discover if I-SNPs are driving integration or hampering it.

## Improving Integrated Care for Dually-Eligible Beneficiaries: Decisions on Recommendations to be Included in June Report to Congress

Following up on an earlier discussion from their January public meeting, MACPAC staff discussed policy recommendations to make to CMS on improving integrated care. The Commission will make recommendations on three policies:

1. Make an exception to the Special Enrollment Period (SEP) for dually-eligible beneficiaries in Medicare-Medicaid Plans (MMPs);
2. Enhance state capacity on Medicare, and;
3. Enhance state capacity to implement non-capitated models.

Commissioners felt an exception to the SEP could help encourage enrollment in integrated care plans. In their presentation, MACPAC offered sample language to be included in their recommendation:

> *"MACPAC will recommend that CMS issue subregulatory guidance to create an exception to the special enrollment period for dually-eligible beneficiaries eligible for Medicare-Medicaid plans (MMPs). This exception would allow such individuals to enroll on a continuous (monthly) basis. For purposes of switching plans or disenrolling under the special enrollment period, MMP enrollees should be treated the same as all other dually-eligible beneficiaries."*

States interested in integrating care for dually-eligible beneficiaries need substantial Medicare expertise to design contracts, navigate regulations, and implement integration. These states could benefit from additional funding in the form of a higher federal medical assistance percentage (FMAP) or a grant. On this topic MACPAC offered additional sample language for their second recommendation in their presentation:

> *"To improve integration of care for dually-eligible beneficiaries, Congress should provide additional federal funding to defray state costs associated with developing expertise in Medicare Advantage related to eligibility, benefits, and administrative processes."*

MACPAC staff said states are interested in establishing new integrated care programs but many need additional resources to plan or implement new non-capitated models. The Commission will recommend additional federal

funding to support integration efforts and the development of new non-capitated models; below is sample language for their presentation:

> *"Congress should provide additional federal funds to enhance state capacity to implement integrated care for dually-eligible beneficiaries and defray state costs associated with developing non-capitated models."*

Commissioners felt MACPAC should continue to explore a policy recommendation on default enrollment for the June report. MACPAC staff noted they were also still exploring the idea of a new federal program for dually-eligible beneficiaries.

*Commissioners' Comments*
One Commissioner suggested modifying the sample language from the second recommendation to instead indicate states' interest in shared savings models, rather than focusing on "non-capitated models". Other members of the Commission suggested combining policy recommendations two and three into a single, more complete recommendation for the June report, since both recommendations focus on increasing resources available to states interested in integrated care. One Commissioner suggested revisiting state Medicare Improvements for Patients and Providers (MIPPA) contracts, and consider making a recommendation advising states to more aggressively utilize authority granted from MIPPA contracts.

## Forthcoming Rule on Program Integrity and Eligibility Determination Process

MACPAC staff presented on CMS' forthcoming rule on Medicaid state program integrity and eligibility determinations. Staff detailed forthcoming changes, existing rules and rationale, and areas for recommendation or comment. While few details are available about the forthcoming rule, CMS announced the new rule "would strengthen the integrity of Medicaid eligibility determination processes including verification, changes in circumstance, and redetermination". The rule is scheduled for release in April 2020.

Existing rules require the use of electronic data for verification, annual renewal periods for Medicaid expansion adults, and responses to changes in circumstances. These requirements were intended to reduce administrative complexity and burden for enrollees and states. While current rules and electronic systems can help with administrative simplicity by accelerating processes like eligibility determination, data verification and auto-renewal, there have been cases where systems issues may have played a role in declining enrollment in some states in the past few years. Accuracy can be another concern; according to the Payment Error Rate Measurement (PERM), most eligibility errors result from insufficient information to determine eligibility, which was not as prevalent of a problem when applications were handled primarily in-person and with paper documents. A much greater share of errors occur in fee-for-service models than managed care models.

MACPAC staff identified a variety of areas for potential changes and comments including verification requirements, documentation retention policies, routine data checks, timeliness of renewals, supporting individual success, and continuing implementation of new rules.

*Commissioners' Comments*
One Commissioner believed implementing or revisiting document retention policies would improve program integrity, since it would simplify auditing.

Another Commissioner said that although routine data checks could potentially reduce errors and improve program integrity, income fluctuations during those data checks could result in churn.

Commissioners noted that although frequent renewals help ensure program integrity, such renewals can also cause burdens on beneficiaries and states and potentially be a source of gaps in care. Commissioners felt that preventing churn and gaps in care should be a top priority.

Some Commissioners believes CMS should issue more guidance to states and managed care organizations on providing more timely and accurate consumer information, but noted the priority should be to improve currently in-use systems to preserve program integrity.