Medicaid and CHIP Payment and Access Commission (MACPAC)
February 2013 Meeting Summary

The Medicaid and CHIP Payment and Access Commission (MACPAC) was established in the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) and was later expanded and funded through the Patient Protection and Affordable Care Act (P.L. 111-148). MACPAC is tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the Secretary of Health and Human Services (HHS), and the states on a wide range of issues affecting Medicaid and CHIP populations, including health care reform. On February 12 – 13, the Commission met in Washington, D.C. to discuss its upcoming report to Congress, due in March. Below are summaries of their discussions.

Session 1: Medicaid and public health: Working together

Session 2: Update on Medicaid primary care physician payment increase

Session 3: CMS initiatives to improve data for program operations and evaluation

Session 4: Overview of partial-benefit dual eligible

Session 5: Review of Draft March Report Chapter on the Roles of Medicare and Medicaid for Diverse Dual-eligible Subpopulations

Session 6: Review of New Proposed Medicaid Rule (CMS-2334-P)

Session 7: March Chapter Review: MACStats and Introductory Context Section

Session 8: Review of Recommendations of Eligibility Issues in Medicaid and CHIP: Interactions with the ACA

Session 9: State Medicaid Manage Care Enrollment Policies

Session 1: Medicaid and public health: Working together

Commissioners heard testimony from representatives of the Washington State Department of Health (DOH) and the Washington Health Care Authority (HCA), the state's public health agency and its Medicaid operation, respectively. To accomplish its goals, the DOH has partnered with HCA to explore new ways to deliver services, be more cost effective, boost overall accountability, and improve health outcomes. The two agencies are also exploring new purchasing relationships to facilitate their mutual goals, such as improving access to preventive services and integrated health care for the state's Medicaid beneficiaries. Some examples of key collaborations that have been established include:

- Health Homes: The DOH trains “health home care coordinators” on motivational interviewing, patient activation, and stepped-up treatment for enrollees in Medicaid’s health home program for chronically ill individuals.

- Medication Management: A statewide prescription monitoring program was launched in 2011 to monitor commonly-abused controlled substances to ensure Medicaid enrollees are not taking narcotics in dangerous amounts or combinations.

Session 2: Update on Medicaid primary care physician payment increase
Under a provision included in the ACA, state Medicaid agencies are required to pay at least Medicare rates for primary care services provided by certain physicians (under both fee-for-service and managed care) in calendar years 2013 and 2014. States will receive 100% federal funding for the difference between the required Medicare payment rate and the Medicaid rate as of July 1, 2009. MACPAC conducted structured interviews with Medicaid policy and technical staff, Medicaid managed care providers, and health care provider groups in six states and the District of Columbia in order to assess progress on implementation and better understand the implications of the provision on access to primary care. The preliminary survey findings include:

- The publication date of the final rule (November 6, 2012) delayed state implementation and slowed state communication with managed care plans and health care providers.
- States report technical challenges in implementing the payment increase by March 31, 2013, including modifying claims-processing systems and updating managed care contracts to include provisions related to the payment increase.
- States interviewed after the final rule was issued were pleased with the reduced administrative burden of the self-attestation process vs. the proposed rule verification requirements.
- Many stakeholders were concerned that if rates are rolled back after 2014, providers may perceive this as a rate cut.
- State policymakers and managed care organizations noted that the payment increase may conflict with current payment policy (e.g., subcapitated providers paid by MCOs) and movement towards payment innovations, like value-based payment strategies.

Session 3: CMS initiatives to improve data for program operations and evaluation
CMS is implementing several efforts to improve the collection of accurate, timely, and complete information about state Medicaid programs. These efforts focus on improving the standardization of information collected across state Medicaid programs and collecting data electronically so that it can be more easily used to inform a variety of program management and oversight functions. Major efforts include:

- Transformed Medicaid Statistical Information System (T-MSIS): CMS is updating the system for collecting and validating quarterly state claims, provider, and

beneficiary data to ensure that the data are robust, complete, timely, and accurate.

- Medicaid and CHIP Program System and Portal (MACPro): CMS is converting the official system of record and mechanism for accepting and processing program changes (e.g., state plan amendments, waivers) to a web-based electronic process.

- Encounter data: CMS is providing technical assistance to states to help them improve the quality and timeliness of managed care encounter data and comply with ACA requirements mandating submission of encounter data by MCOs and states.

Staff anticipate revisiting the analysis of Medicaid administrative data included in the March 2011 Report to the Congress.

Session 4: Overview of partial-benefit dual eligibles
Commissioners have previously requested additional information specific to the partial-benefit dual eligible, Medicare enrollees who meet the eligibility requirements for Medicare Savings Programs (MSPs) but have too much income and/or resources to qualify for full Medicaid coverage in their state. In FY 2009, just over 2 million or 23 percent of all Medicare beneficiaries were partial benefit dual eligibles. In this session, staff provided an overview of partial benefit dual eligibles, including some of their characteristics as well as a more comprehensive picture of the role Medicaid plays for this specific population. Some of the data presented include:

- In FY 2009, the majority of partial-benefit dual eligibles were likely to be age 65 and over (60 percent), female (60 percent), and have incomes under poverty with little assets in FY 2009.

- There is considerable variation in the enrollment of partial-benefit dual eligibles as a share of total dual eligibles in a state, ranging from 2% of all dual eligibles in California up to 54% of all dual eligibles in Delaware.

- In FY 2009 average Medicaid per capita spending for partial-benefit dual eligible was $2,305, and total Medicaid federal and state expenditures for all partial-benefit dual eligibles were $4.4 billion (less than 1% of total Medicaid program spending).

Next, Commissioners will provide guidance on what further information is needed for future analyses of the partial-benefit dual eligibles.

Session 5: Review of Draft March Report Chapter on the Roles of Medicare and Medicaid for Diverse Dual-eligible Subpopulations
The March 2013 chapter on dual eligibles has been revised since the January Commission meeting. It has been shortened to focus on the population profile.

The chapter now concludes with a discussion of the Commission's future work on approaches to program improvement for dual-eligible subgroups. That section describes, in general terms, where the Commission is headed with future work and identifies three priorities: (1) continue to assess the diverse needs and circumstances of dual eligibles and opportunities to improve care and services; (2) examine the causes of high spending and assess opportunities for savings; (3) examine state variation and the impact of state policy choices. Examples of the Commissioners key considerations moving forward include:

- The dual eligible population is heterogeneous – including young adults and the very old, people with serious disabilities and cognitive impairments, people who have serious illnesses or multiple and serious chronic conditions, and people who are healthy, but poor.

- Dual eligibles needs vary widely, and so does their service use and spending. Total Medicare and Medicaid program spending (in 2007) for duals who did not use Medicaid financed LTSS was just under $15,000, most of it in Medicare. Average spending increased for higher-need individuals, to nearly $70,000 (most of it in Medicaid) for people using Medicaid-financed nursing home care or other institutional services such as care in intermediate care facilities for people with intellectual disabilities.

But more needs to be learned about which approaches reliably improve care, for which subpopulations, and at what cost. The Commission will examine these approaches to reform in future work.

Session 6: Review of New Proposed Medicaid Rule (CMS-2334-P)
On January 22, 2013, the Centers for Medicare & Medicaid Services (CMS) published proposed regulations pertaining to Medicaid and CHIP eligibility, benefits, and cost sharing. The eligibility provisions build on prior rules implementing the Patient Protection and Affordable Care Act (ACA).

Regarding eligibility, most of the changes in this round further align processes between Medicaid, CHIP, and exchanges—particularly with respect to notices and appeals. This is the first proposed rule to address essential health benefits (EHB) in Medicaid. The proposed rule also updates Medicaid's cost-sharing regulations.

In drafting this letter, the scope of our comments was limited to issues on which we have done prior analyses, that would enhance the Commission's ability to do its work without significant federal or state burden, or on which there have been ample opportunities to assess Commissioners' positions. Thus, the draft letter from MACPAC to the Secretary comments on only two issues discussed in the proposed regulation—12-month continuous eligibility and the move to electronic Medicaid and CHIP state plans.

Session 7: March Chapter Review: MACStats and Introductory Context Section

State-level and national information about the Medicaid and CHIP programs can often be difficult to find and is spread out across a variety of sources. The Commission's Medicaid and CHIP Program Statistics (MACStats) pulls these disparate sources together into a reference guide covering key issues. MACStats will continue to be updated and released along with the Commission's March and June reports to Congress.

Separate from MACStats, the Commission's March 2013 report will include an introductory section that sets the context for the chapters in the report. This introductory section or foreword provides the policy context for the chapters contained in the report. It briefly reviews Medicaid's role in the health care system, highlights the key issues at the forefront for Medicaid and CHIP policymakers, and reviews the Commission's work to date and outlines MACPAC's analytic agenda going forward.

Session 8: Review of Recommendations of Eligibility Issues in Medicaid and CHIP: Interactions with the ACA

January 1, 2014 is the scheduled implementation date for many of the provisions in the Patient Protection and Affordable Care Act (ACA), such as health insurance exchanges and the expansion of Medicaid to previously ineligible non-elderly adults. Thus, MACPAC's 2013 reports offer some of the last opportunities for the Commission to provide recommendations prior to 2014 pertaining to the interaction of Medicaid and CHIP eligibility policies with the ACA.

The draft chapter has been modified to reflect comments from Commissioners and external reviewers. For example, the draft chapter now includes analyses showing one estimate of the impact of 12-month continuous eligibility as well as the estimated levels of income changes individuals might experience in a year in 2014. The Commission has identified two recommendations as potentially meriting congressional intervention: one on twelve-month continuous eligibility and one on transitional medical assistance.

<u>Recommendation: Statutory Option for 12 Month Continue Eligibility</u>

"In order to ensure current options remain available to states in 2014, the Congress should provide explicit statutory authority for 12-month continuous eligibility to children enrolled in CHIP and to adults enrolled in Medicaid."

Rationale

- Would not create new option or expansion, but would ensure continued flexibility for states
- 12-month continuous eligibility reduces churning

Federal spending

- Increased by $50 million to $250 million in 2014
- Increased by less than $1 billion over 2014-2018

<u>Recommendation: Options for TMA</u>

"The Congress should permanently fund current TMA (required for six months, with state option for 12 months), while allowing states that implement the adult group expansion to opt out of TMA."

Rationale

- Permanent funding for TMA would end perennial uncertainty for states about continuation of 6-month-plus TMA
- TMA not as necessary to prevent uninsurance in states that expand to the new adult group; opting out of TMA could reduce confusion and administrative burden

Federal spending

- Increased by $50 million to $250 million in 2014
- Decreased by less than $1 billion over 2014-2018

Session 9: State Medicaid Manage Care Enrollment Policies

States are increasingly interested in using managed care arrangements for populations with extensive health care needs as a potential opportunity to control costs and better coordinate care for these enrollees. This move toward enrolling increasing numbers of persons with disabilities and dual eligible focuses the spotlight on state enrollment practices for populations who may require distinct enrollment processes due to their extensive needs. MACPAC commissioned a study on current state practices for enrolling beneficiaries into comprehensive risk-based managed care in order to have a better understanding of the lessons learned and challenges states may face as they expand their managed care programs to high-need, high-cost enrollees. During this session, staff presented preliminary findings from a case study of 10 states, Arizona, Hawaii, Massachusetts, Michigan, New Mexico, New York, Ohio, Virginia, Washington, and Wisconsin, and their enrollment policies for their Medicaid managed care programs.

Staff found that most states do not substantially vary their enrollment strategies by population, although some states provide additional services, such as enrollment brokers, or outreach materials, that focus specifically on enrollees with disabilities. Almost all the states mandate enrollment for their non-disabled children and adults as well as their enrollees with disabilities, although this policy varies by region in several states. Additionally, seven of the ten states interviewed contract out some of the enrollment process to enrollment brokers, often because the enrollment brokers is perceived as an objective partner in the process and the broker has the ability to hire staff more quickly than the state agency.

States found that a plan's provider network and supplemental benefits provided by the plan are important factors in an enrollee's decision to select one plan over another. States learned that ensuring adequate time for phasing-in implementation and involving all stakeholders when designing the enrollment process is key to its success.

The next steps include discussing whether these findings have any policy implications when developing models of care for high-need, high-cost Medicaid populations. Final report findings will be presented in May for inclusion in a potential chapter in the June 2013 report.