Highlights from MACPAC 2019 Winter Meeting Sessions

Overview

On December 12 and December 13, 2019, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its December 2019 MACPAC Public Meeting. Viohl & Associates attended five sessions focused on the new proposed Medicaid Fiscal Accountability Regulation, the 2019 Payment Error Rate Measurement (PERM) results, issues related to a countercyclical Federal Medical Assistance Percentage (FMAP), challenges in integrating care for dually eligible Medicaid beneficiaries, and Medicaid's role in financing maternity care. Each of these session is summarized in detail below.

Review of Proposed Rule on Supplemental Payments and Financing

MACPAC staff highlighted key changes in the Centers for Medicare and Medicaid Services's (CMS) proposed Medicaid Fiscal Accountability Regulation (MFAR) rule published on November 18.

Background

In the background section of the MFAR, several key terms are defined, including base payments and supplemental payments. Base payments are defined as "payments to Medicaid providers on a per claim basis for services rendered to a Medicaid beneficiary in a fee-for-service (FFS) environment," and supplemental payments are defined as payments made to providers that are in addition to the base payment the provider receives for services furnished. In this section, CMS also notes that in the current FFS payment system, aggregate base and supplemental payments for a class of providers cannot exceed the Upper Payment Limit (UPL). Finally, CMS also acknowledges that states are able to finance the non-federal share of Medicaid payments using several sources including state governmental revenues and intergovernmental transfers (IGT) from local governments, certified public expenditures (CPEs) by government owner providers, and health care-related taxes. These financing mechanisms are a key focus of the MFAR.

Proposed Payment Policies

To address their concerns, CMS proposes to limit approval of UPL payments to three years at a time and adds new review requirements:

- States must describe the Medicaid objectives that UPL payments are intended to address
- In order to renew UPL payments, states must submit an evaluation of whether the payment met its objectives and aligned with statutory principles (i.e. access, quality, efficiency)

These changes will align the rules for UPL payments with the rules for managed care directed payments formally adopted in 2016.

In addition, CMS proposes to codify its existing guidance on ways to calculate the UPL. CMS will allow for two methods: the payment-based method, which calculates the UPL based on what Medicare would have paid; and the cost-based method, which calculates the UPL based on Medicare cost principles. CMS also proposes to explicitly define three classes of providers for UPL purposes: "state-government owned or operated", "non-state government owned or operated", and "private."

To address concerns regarding supplemental payments, CMS proposes to limit supplemental payments to 50% of base payment rates (or 75% in rural or health professional shortage areas), reducing supplemental payments by up to $222 million/year. They will also be more closely monitoring supplemental payments going forward.

Proposed Tax Policies

To address concerns related to health care-related taxes, CMS proposes to broaden the definition of "health care-related tax" to include taxes on insurers and taxes that impose higher rates on health care providers. CMS also proposes a new test to evaluate waivers based on the "broad-based" and "uniform" standards; CMS will evaluate whether a tax places a higher burden on providers with high Medicaid activity to determine if a tax is truly broad-based. Further, more scrutiny will be given to tax arrangements with potential "hold harmless" agreements where payers of a health care-related tax are returned their tax payments through some other financing mechanism. Taxes will be evaluated based on the net effect of either direct or indirect tax payments.

Proposed Financing Policies
Similar to the "net effect" standard being used to evaluate hold harmless tax agreements, CMS proposes to evaluate whether donations from private providers hold entities involved in IGTs harmless. The regulation codifies CMS's current policies for ensuring that CPE-financed payments do not exceed costs. CMS also wants providers be able to retain the full amount of payments for their services. The intention of this rule is to limit the ability of states to finance their programs through administrative fees for IGT and CPE transactions.

Provider-Level Reporting
The MFAR proposes that states be required to report provider-level data on the non-federal share of supplemental payments and provider contributions for providers that receive UPL or Section 1115 waiver supplemental payments. These data are not currently available in existing data sources. The charts from MACPAC below illustrate changes in reporting between the current systems and the requirements under the proposed rule:

Financing Data in Current and Proposed Reporting Systems

Type of financing data	CMS-64	T-MSIS	DSH audit	Proposed rule
Source of non-federal share for payment	Incomplete	Unclear	No	No
Provider contribution towards the non-federal share	No	No	No	Provider-level

Notes: CMS-64 is a quarterly expenditure report that states submit to claim federal Medicaid matching funds. T-MSIS is the Transformed Medicaid Statistical Information System. DSH is disproportionate share hospital.

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Payment Data in Current and Proposed Reporting Systems

Type of payment	CMS-64	T-MSIS	DSH audit	Proposed rule
FFS base	Aggregate	Claims-level	Provider-level	Provider-level
DSH	Aggregate	Unclear	Provider-level	Provider-level
UPL	Aggregate	Unclear	Non-DSH supplemental payments in one sum at provider-level	Provider-level
GME	Aggregate	Unclear		Unclear
§1115 supplemental	Aggregate	Unclear		Provider-level
Managed care base	No	Claims-level	Managed care payments in one sum at provider-level	No
Managed care directed	No	Unclear		No

Notes: CMS-64 is a quarterly expenditure report that states submit to claim federal Medicaid matching funds. T-MSIS is the Transformed Medicaid Statistical Information System. DSH is disproportionate share hospital. FFS is fee-for-service. UPL is upper payment limit. GME is graduate medical education. Section 1115 supplemental payments include delivery system reform incentive payments (DSRIP) and uncompensated care pool payments. Managed care directed payments are additional payments to providers authorized under 42 CFR §438.6(c).

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Recouping DSH Overpayments
According to CMS, current data suggest that billions in funds are lost through overpayments. According to DSH audits performed in 2014, 419 hospitals received $2.6 billion in overpayments. In order to more easily recoup disproportionate share hospital overpayments, the proposed rule requires auditors to better quantify DSH payments and streamlines the timeline for overpayment recoupment.

UPL Demonstration Requirements
The proposed rule codifies CMS's existing guidance requiring states to demonstrate compliance with UPL limits annually. In the MFAR, states are given two options to demonstrate compliance: perform prospective estimates of spending, or perform retrospective analysis of actual spending. Currently there is no process in place to reevaluate the UPL if actual spending is different from projected spending.

MACPAC Areas of Concern
While the MFAR does address some of MACPAC's prior recommendations, some concerns were not fully addressed. These concerns include:

- A new provider-level payment data reporting requirement will not include data on all payments for all providers.
- Actual UPL spending data will not be used to enforce UPL requirements.
- Payment and UPL data will not be publicly available.

Additionally, it is unclear how CMS will apply some of the new standards it proposes (i.e. evaluation of whether supplemental payments advance statutory goals).

Further, administrative burdens generated by the proposed rule contradict CMS's stated position on its goal to reduce the burden of access monitoring requirements

Finally, the overall effect of this rule will be reductions in Medicaid provider payments — up to $222 million per year in physician supplemental payments, with additional reductions likely because of new payment and financing rules.

Highlights from Commissioner's Comments
Several MACPAC Commissioners argued that CMS should wait to apply the MFAR until it collects additional data on the effects of the rule. A few Commissioners also suggested CMS re-affirm its requirement for states to review data on access before reducing payments to providers.

Ultimately, Commissioners believed that MACPAC should give a balanced response to CMS, encouraging measures of the MFAR that are consistent with prior recommendations (i.e. data collection requirements that fill the need for more data) while also emphasizing the need to be cautious moving forward since new regulations can have negative effects on providers and access.

MACPAC Review of PERM Findings

MACPAC staff reviewed and presented findings from CMS's 2019 Payment Error Rate Measurement (PERM).

Background
The Payment Error Rate Measurement (PERM) measures the percentage of payments made in error in a state in a given year. A payment is considered "in error" if it did not comply with applicable federal regulations and state policies; note that this does *not* imply intent to commit fraud or the incidence of fraud-- PERM is more of a process than outcomes measure. Seventeen (17) states are measured in each rotation on a three year cycle, each submitting a random set of claims to a contractor who reviews those claims and determines which payments were made in error.

Key Findings from the FY 2019 PERM
For FY 2019, the overall error rate for Medicaid was 14.90%. **In FFS states, the overall error rate was 16.30% compared to 0.12% in managed care states.** The majority (58%) of errors resulted from non-compliance with provider screening and national provider identifier (NPI) requirements and insufficient information provided in claims to determine eligibility**. It is worth noting that the PERM is much higher in FFS states compared to managed care states because managed care payments tend to be automated capitated payments that are subject to simpler rules than FFS payments.**

Overall, the error rate for CHIP was 15.83%. In FFS states, the overall error rate was 13.25% compared to 1.25% in managed care states. The largest share of errors resulted where information required for eligibility determination was missing. Specific to FFS payments, the largest share of errors resulted from state noncompliance with provider screening and enrollment requirements.

Implications of these Findings
There is still little information on why states have not yet fully complied with uniform provider screening and enrollment requirements implemented in 2011 for FFS and in 2018 for managed care providers. From these findings, it is clear that more information is necessary.

The findings suggest that processes should be designed to fulfil the aim of ACA changes intended to reduce complexity and allow determinations to be made quickly and more accurately. An ideal policy would maximize the number of correct decisions vs. incorrect decisions.

Again, it is important to note that a relatively high PERM does not necessarily imply fraud or prevalence of bad actors. Results show that only a small number of errors resulted due to covering ineligible beneficiaries, whereas most errors were due to insufficient documentation.

Recommendations for Corrective Action Plans
MACPAC staff suggested that in order to improve provider screening and enrollment errors, CMS should:

- Provide ongoing guidance and education on federal requirements to enroll providers

- Do site visits to assess provider enrollment compliance and provide technical assistance
- Encourage and facilitate data sharing
- Take steps to address eligibility verification errors which are due mostly to documentation issues

Highlights from Commissioners Comments
One Commissioner said that while PERM is a useful tool to identify provider and beneficiary reporting issues, it also highlights how complex the Medicaid and CHIP claims system is and thus highlights opportunities to simplify or streamline some processes.

Another Commissioner argued that CMS ought to closely examine the variation in state-by-state PERM data to clearly show which states have the most difficult time with reporting, and where common issues with reporting occur.

One Commissioner asserted that the relatively high PERM highlights how complex CMS's rules and regulations have become and supports the position that CMS ought to learn to work better with its current rules rather than introduce new ones.

Issues for a Countercyclical FMAP

MACPAC staff led an in-depth discussion on the challenges of the countercyclical nature of the Medicaid program.

About the FMAP
The Federal Medical Assistance Percentage (FMAP) determines the federal share of health care services provided through Medicaid and is adjusted annually. States with lower per capita incomes relative to the national average receive a higher FMAP as calculated by a standardized formula. This is intended to reflect states' differing abilities to fund Medicaid from their own revenues. The minimum and maximum FMAP allowed by statute is 50% and 83% respectively.

The Problem: Countercyclical Medicaid Demand
When there is an economic recession, Medicaid enrollment and spending increases because fewer people are employed, so fewer people are getting health care coverage through their employer. Since the economy is in a downturn, states have less tax revenue to pay for coverage but generally cannot run deficits to cover their increased costs. This problem is exacerbated by the fact that annual FMAP updates do not take into account more recent changes in per capita income.

In the past two major recessions, Congress enacted stimulus packages that included additional funds for a higher FMAP across the country. However, since this stimulus required congressional action to pass, funds were not available until months after the recession began; an automatic stimulus system would work faster, and ideally, more efficiently.

Design Considerations for Creating an Automatic FMAP Adjustment
An automatic FMAP adjustment statute must consider:
- What specific economic indicator to use trigger an increase
- What determines the start and end points for the increase
- Whether the increase should be uniform or vary by state
- Whether to pair other program changes with the FMAP adjustment
- Each of these considerations will affect the timing and magnitude of changes in federal expenditure and state stimulus

Other Considerations
Lawmakers will have to consider how FMAP increases will work for ACA expansion populations, like childless adults. At the present time, the adult expansion group already receives 90% FMAP.

Lawmakers will also have to consider how to treat CHIP. At present, CHIP enhanced FMAP (E-FMAP) is based on the Medicaid FMAP, and has not been raised by Congress during past recessions.

Finally, lawmakers will need to confront problems with the base FMAP formula not addressed by adjustments.

Highlights from Commissioner's Comments
One Commissioner asserted that additional consideration should be given to children and seniors in the program with complex care needs, and that more work should be done to learn how recessions and changes to FMAP affect these groups. These beneficiaries provide a unique challenge for program financing.

Another Commissioner expressed the need for a high-level resource document that details the issue and documents other potential ways to handle high costs during economic downturns.

Barriers to Integrated Care for Dually Eligible Beneficiaries

MACPAC staff presented on key barriers to state efforts to integrate care for dually eligible beneficiaries.

Key Policy Questions
Existing policy questions provide challenges for lawmakers in confronting barriers to integrating care for dually-eligible beneficiaries. Some key questions are:

- For states already integrating care, what policies can result in greater integration?
- For states that have not yet pursued integrated care, what avenues are available?
- What factors and circumstances in states present barriers to state integration efforts?

Enrollment Challenges
Some factors create challenges for enrolling dually-eligible beneficiaries in integrated care. These factors include programs that use automatic or passive enrollment for eligible individuals into either Medicare or Medicaid, differing guidelines for enrollment between Medicare and Medicaid and brokers that direct dually eligible beneficiaries to non-integrated products.

Integrating care also generally requires states to have Medicare expertise to design programs and develop D-SNP contracts; lack of expertise in states has been a major barrier to states thus far. The need for expertise is especially challenging because expertise is needed on an ongoing basis, not only at launch, and because limited funding and competing priorities may prevent states from dedicating adequate resources to adding staff with Medicare expertise.

There are several policy options available to address these enrollment challenges.

Expanding the Use of Passive Enrollment
States could passively enroll individuals already enrolled in Medicare Advantage into a Medicare-Medicaid Plans (MMPs) under the same parent company. States could also passively enroll individuals who have previously opted out of passive enrollment. This option has advantages and disadvantages; while this plan would increase enrollment, it would limit beneficiaries' choice.

Modifying the Narrower Special Enrollment Period (SEP) for Dually Eligible Beneficiaries
States could adopt the limited special enrollment period mandated by CMS in April of 2018 (Financial Alignment Initiative states opted out and have not adopted this modified timeline). This option also has pros and cons; while one pro would be increased state adoption of the narrower SEP and reduced plan switching, a con would be the increased administrative burden placed on states and plans.

Aligning Open Enrollment Periods
Medicare and Medicaid have different open enrollment periods. CMS could encourage or require states to align these periods for dually eligible beneficiaries with Medicare Advantage. While this option would likely reduce confusion for beneficiaries, it could result in reduced flexibility and a greater administrative burden for states.

Discouraging Brokers from Enrolling Dually Eligible Beneficiaries into Non-Integrated Products
CMS could more clearly define the role of brokers in enrolling dually-eligible beneficiaries and their relationship with integrated products. For example, CMS could impose a fine on brokers who enroll beneficiaries in a non-integrated product where an integrated alternative exists. This option would increase enrollment in integrated products, but would require greater administrative work in tracking enrollment in non-integrated products and enforcing penalties.

Establishing a Grant Program to Help States Build In-House Medicare Expertise
Finally, a grant could be made available for states that have not yet integrated care, states looking to pursue greater integration, or both. To address the expertise issue, funding could be made available for states to either train existing staff or fund a new position. This is a key recommendation as states have cited in-house Medicare expertise as a key factor in the success of integration.

Highlights from Commissioners Comments
In their comments, Commissioners emphasized the importance of states having sufficient Medicare and Medicaid expertise in pursing greater integration of care.

Another Commissioner argued that the principle barrier for integrating care was that there are two titles. They conceded that although MACPAC can't recommend a new, single title focused on the dually eligible population, this was still a major concern

Medicaid's Role in Financing Maternity Care

MACPAC staff presented findings from their in-depth analysis of Medicaid's role in maternal health.

Medicaid's Role in Maternal Health
Medicaid paid for 43% of total births in 2018. It paid for the highest share of births in Louisiana and Mississippi, financing 63% of all births in both states. The lowest share of births financed was in North Dakota, where Medicaid only paid for 25% of total births. One reason for rates of births covered by Medicaid differing between states is that eligibility rates for pregnant women differ widely.

Medicaid paid for a higher share of births among women living in rural areas, age 19 or younger, and among women of Hispanic, African American, American Indian, or Alaskan Native descent.

Key Trends in the Characteristics of Mothers with Medicaid
There were several key similarities in the characteristics of mothers with Medicaid:

- Almost 80% were between the ages of 20 and 34.
- More than half (55%) were white women.
- A large majority of women (84%) were women in urban areas.
- Most rural mothers with Medicaid were young and white.
- 6% of mothers with Medicaid had a prior preterm birth and 25% had a prior cesarean section delivery.
- 1% of women had pre-pregnancy diabetes and 2% had pre-pregnancy hypertension
- More than half of women were overweight or obese and almost 15% smoked prior to pregnancy. Smoking was more common in rural areas.

Setting of, and Attendants present at Medicaid Births
Key data detailing the circumstances of typical Medicaid births are as follows:

- Approximately 99% of Medicaid births occurred in a hospital setting, with little variation among states.
- 90% of Medicaid births were attended by a doctor and 9% were attended by a certified nurse midwife.
- In 23 states, more than 10% of births were attended by a certified nurse midwife.

Data on Access to Prenatal Care among Mothers with Medicaid
While most mothers accessed prenatal care early in pregnancy as a whole, there was great variation between states. Key findings from data include:

- Over two-thirds of women started prenatal care in their first trimester of pregnancy

- More than three-quarters of women received nine or more prenatal care visits
- There was high variation across states in access to prenatal care – for example, only slightly more than half of women in Washington DC began prenatal care in the first trimester compared to 85 percent in Vermont

Birth Outcomes among Mothers with Medicaid
Statistics on birth outcomes among mothers with Medicaid illustrate a need for a greater focus on maternal health outcomes and new policy:

- Almost one-third of women had a cesarean section delivery.
- 11% of infants were born preterm (prior to 37 weeks).
- 10% of infants had low birthweight (less than 2,500 grams).
- Data on maternal mortality and morbidity were not included because of limited CDC data; MACPAC intends to utilize recent data as it is published.

Highlights from Commissioners' Comments
In their comments, MACPAC Commissioners asked for new maternal mortality data to be included in future analyses of maternal care and Medicaid in the future. MACPAC is currently working with the CDC to get newer data published, but noted that states have been slow in transitioning to more regular data collection and reporting.

Commissioners agreed that exploring new avenues to increase access to early prenatal care should be a priority in improving birth outcomes.

Commissioners also noted that expanding access to primary care for mothers should also be a top priority, since that also correlates with maternal health, and is likely an overlooked factor in discussions of maternal health.

One Commissioner noted that while maternal mortality and morbidity is a great tragedy that ought to be addressed, the tremendous public health impact of low birth weight should not be overlooked. More policy steps are necessary to address this key issue.