Highlights from MACPAC January 2020 Public Meeting Sessions

Overview

On January 23-24, the Medicaid and CHIP Payment and Access Commission (MACPAC) held its January 2020 public meeting. This summary includes highlights from four sessions centered on two topics: Medicaid's role in maternal health and integrated care for dually-eligible beneficiaries.

Medicaid's Role in Maternity Care

MACPAC Staff Presentation on Substance Use Disorder (SUD), Opioid Use Disorder (OUD), and Neonatal Abstinence Syndrome (NAS)

MACPAC staff discussed ways to address SUD among mothers with Medicaid. Following the presentation, Commissioners led a panel discussion with Medicaid experts Dr. Stephen Patrick, Associate Professor of Pediatrics and Health Policy at Vanderbilt University, Dr. James Becker, Medical Director of West Virginia Medicaid, and Olivia Alford, Director of the Value-Based Purchasing Unit at Maine Medicaid.

Background

According to a 2020 State Health Access Data Assistance Center (SHADAC) analysis of data of the National Survey of Drug Use and Health conducted from 2015 to 2018, on average, about 13% of pregnant women aged 12-44 with Medicaid reported some form of SUD:

- 5.7% reported illicit drug dependence or abuse in the past year.
- 52.9% used alcohol in the past year, and 5.7% reported alcohol dependence or abuse in the past year.
- 3.6% report having ever used heroin, and 12% reported having ever misused pain relievers.

About 20% of pregnant women aged 12-44 with Medicaid received alcohol or drug treatment in a health care setting in the past year.

According to a 2019 analysis from MACPAC, few SUD treatment facilities offer programs and assistance geared towards mothers:

- Less than 25% of SUD treatment facilities offer specialized programming for pregnant or postpartum women.
- Just 8% of SUD facilities offer both specialized programming for pregnant *and* postpartum women and at least one medication approved to treat OUDs.
- Only 6% provide child care for patients' children and accept Medicaid.
- Only 2% of SUD facilities provide residential beds for their patient's children and accept Medicaid.

Neonatal Abstinence Syndrome

NAS is a condition in which newborns experience a set of withdrawal symptoms after being exposed to certain drugs (usually opioids) in the womb. Symptoms of NAS are similar to withdrawal in adults, including body tremors, excessive sweating, and irritability.

According to a 2019 study from the Agency for Healthcare Research and Quality, Kentucky, West Virginia, Pennsylvania, Delaware, Massachusetts, Vermont and Maine, reported high rates of NAS (>30 per 1,000 births). Many other states also reported moderately high rates of NAS- about 18-30 per 1,000 births.

Federal Initiatives to Curb SUD among Mothers and NAS

The Maternal Opioid Misuse (MOM) model provides funding to states to improve treatment options for pregnant and postpartum women with OUD. Goals of the model include improving access to services, coordinating care, and addressing provider shortages. Under the MOM model $50 million was awarded to 10 states for five years.

The Integrated Care for Kids (InCK) model provides funding for states to improve healthcare outcomes for Medicaid and CHIP beneficiaries from birth to age 21. Goals of the program include improving child health, reducing inpatient stays, coordinating care and creating alternative payment models. Through the InCK model, $126 million has been awarded to seven states for seven years.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, enacted by the 115th Congress, contains a provision allowing for a new state plan option to make inpatient or outpatient services available to Medicaid infants with NAS at residential pediatric recovery centers. The Act also contains a provision to require coverage of OUD treatment medication under Medicaid from October 2020-September 2025.

Expert Presentations on OUD, SUD, and NAS

Improving Outcomes for Families Affected by the Opioid Crisis – Dr. Stephen W. Patrick

OUD among pregnant women has steadily risen since 2001. In many cases, but not always, OUD correlates with public health, inability to access mental health services, adverse childhood experiences, and exposure to trauma. OUD is often difficult to treat because of barriers to access to treatment. Insurance acceptance among OUD treatment providers varies wildly and some facilities only use cash pay. Some facilities also have scope of practice issues, and pregnancy sometimes limits the drugs that can be used for treatment.

The incidence of NAS has also slowly increased since the early 2000s. Medicaid has a strong fiscal incentive to reduce and treat NAS, since infants with NAS covered by Medicaid are about five times more expensive to care for than infants without NAS.

Moving forward, hospitals are pursuing new ways to treat OUD and NAS. Clinical definitions of these disorders are being updated, treatment protocols are being developed, and advocates are pushing for proper coding for OUD and NAS treatments. New models of care are prioritizing keeping the mother and baby together, encouraging breastfeeding, methods of trauma-informed care, and expanded use of standardized protocols.

Greater focus is also being placed on optimal discharge models for mothers with OUDs and children with NAS. Pyramid, a new Maternal Opioid Misuse Model (MOM) approved by CMS, is an archetypal model for this approach to care; Pyramid prioritizes holistic, evidence-based "well-woman" care before birth, addiction consultation and drug treatment in the hospital, and home visitation and follow-up after discharge.

SUD Programs in West Virginia – Dr. James Becker

West Virginia's Section 1115 waiver was one of the first of five SUD waivers approved by CMS, and helped the State develop and implement a variety of new SUD treatment benefits. Under its waiver, West Virginia expanded access to screening, brief intervention, and referral to treatment (SBIRT), opioid treatment programs, and access to Naloxone (an overdose reversal drug) for opioid users. They also began exploring longer-term solutions like Residential Adult Services and Withdrawal Management services.

West Virginia also received funding from CMS's MOM model. The State's Department of Health and Human Services intends to use this funding to develop comprehensive care for mothers and children using more modern care approaches.

NAS is also major concern in West Virginia. The State has experienced a sharp uptick in the incidence of NAS over the past decade, with almost one in five newborn babies exhibiting evidence of drug or alcohol exposure. To address the NAS epidemic, West Virginia is working with Perinatal Partnerships on new NAS identification and treatment standards, implementing harm reduction programs in many counties, holding drug summits, and enforcing Center for Disease Control guidelines for primary care physicians prescribing opioids. West Virginia is also innovating with facilities like Lily's Place, a community-based residential treatment facility for infants with NAS. Efforts to address NAS are hampered by a need for better data on the incidence of NAS. Current estimates come from hospital discharge and Medicaid claims data, both of which are often incomplete or lagging.

Expert Insight from Maine Medicaid – Director Olivia Alford

Although Director Alford did not give a formal presentation, she briefly discussed efforts to address OUD, SUD and NAS through Maine's Medicaid program, MaineCare. Maine is unique because it is one of the few states in the U.S. yet to adopt a managed care model.

To address relatively high levels of OUD, SUD and NAS, MaineCare is looking at reforming delivery systems to address the needs of mothers and children suffering from these conditions. Director Alford says Maine wants to create a "no wrong door" system for mothers seeking treatment that breaks down barriers between treatment delivered in a healthcare setting, and through community supports, community-based care, and home visitation.

MaineCare is exploring the idea of using funding from CMS's MOM grant to create a maternal health home for mothers with SUD similar to Lily's Place in West Virginia. In addition, the State of Maine is pursuing four Section 1115 waivers to create pilot programs delivering family and parental care for families in danger of getting involved with Child Protective Services.

Panel Discussion and Comments

Elaborating on concerns raised about data and evidence availability, panelists agreed that sharing information through secure channels is a crucial part of creating effective models of SUD treatment. The panelists also noted that the stigma surrounding SUDs and privacy rules still make crucial data difficult to obtain.

One Commissioner asked if there is any part of Medicaid law hampering delivery of care for opioid users. Panelists said that removing some of the existing barriers to opioid treatment, like prior authorization requirements for opioid treatment drugs, has taken care of most of the major barriers. Still, panelists conceded that MCOs could benefit from more guidance on handling beneficiaries suffering from SUD.

As the panel concluded, Director Alford expressed her opinion that new opioids and other substances like alcohol and methamphetamines still prove to be a difficult challenge, especially since many models of care, like the MOM model, focus solely on opioids. Panelists acknowledged that this reinforced the need for an all-inclusive approach to SUD treatment.

Expert Presentation on Maternal Morbidity among Mothers with Medicaid

MACPAC staff introduced Katy Kozhimannil, the Director of the Rural Health Research Center at the University of Minnesota. Ms. Kozhimannil gave a presentation and led a discussion on the risk of severe maternal morbidity and mortality (SMMM) among Medicaid beneficiaries.

Background

Rates of SMMM in the United States have steadily increased since the 1990s while rates of SMMM in the rest of the world (including in developing countries) are decreasing. Because mothers with Medicaid tend to be poorer, belong to higher risk demographic groups, and live in rural areas, mothers with Medicaid are at a greater risk of SMMM. Adding to the challenge, national and state initiatives to address maternal health do not often address the specific needs of Medicaid beneficiaries.

Analysis and Findings

The University Of Minnesota Rural Health Research Center, under contract by MACPAC, conducted a data analysis on 2007-2015 data from the Healthcare Cost and Utilization Project with a focus on mothers who suffered from SMMM. The goals of this data analysis were to describe differences in SMMM by payer and, among Medicaid beneficiaries, by race, ethnicity and geography, and to accurately describe predictors of SMMM among Medicaid beneficiaries by demographics and geography.

The study found that Medicaid beneficiaries have an 82% greater chance of experiencing SMMM than those who are privately insured. This may be because Medicaid eligibility correlates with other risk factors like income, race, and proximity to good hospitals. Higher risk of SMMM among Medicaid beneficiaries also reflects other health risk factors, including genetic and clinical risk factors.

The study also found that women of color and rural women were at greater risk for SMMM. These mothers tend to be from the lowest income quartile, have Cesarean-section births, or suffer from SUD, depression, or other chronic illness.

Given the high risks of SMMM among Medicaid beneficiaries, Medicaid policy has significant potential to improve nationwide childbirth outcomes and drive down overall rates of SMMM. Given the data surrounding higher rates of SMMM among women of color, poor, and rural women, effective Medicaid policies should focus on addressing structural inequities connected to these demographic characteristics.

Suggested Policy Options
Adjusting reimbursement rates could help address income challenges, given that Medicaid only pays about one half of what private plans pay, leading to financial challenges for hospitals, clinical practices, and poorer beneficiaries attempting to access care.

Another option is offering a one-year postpartum Medicaid extension, since more than 50% of Medicaid beneficiaries have postpartum churn. Given that approximately one-third of maternal deaths happen in the postpartum year, ensuring that these beneficiaries are guaranteed care could drive rates of SMMM down.

Finally, coverage of non-clinical services could also lead to better outcomes. Funding doulas, community health workers, home visitation, transportation, housing, and other services and supports could help improve social determinants of health for beneficiaries and lead to healthier mothers and better outcomes in the long run.

Commissioners Comments
One Commissioner said it seems there is not enough funding in state programs to effectively treat SUDs. This Commissioner felt these funding shortfalls seemed to be a greater challenge than statutory barriers.

Another Commissioner lamented the lack of evidence and data surrounding how MCOs work with states to handle SUDs. Many Commissioners agreed that studying MCOs' role in SUD and OUD treatment is a major area of interest.

One Commissioner argued that state programs should focus on building infrastructure for SUD treatment to facilitate access to care.

Some Commissioners noted that proper billing and coding for opioid and SUD treatment remains a major area of concern and are essential for streamlining care.

Commissioners also focused on social determinants of health as a major factor involved in predicting SMMM. They felt that the Commission should explore the policy proposals mentioned in Ms. Kozhimannil's presentation.

Commissioners' recommendations centered around five key themes:

- Create an inventory of resources to help beneficiaries understand available options for SUD and OUD treatments, and encourage the spread of treatment practices that are working in other states (i.e. West Virginia);
- Explore the possibility of providing Medicaid-covered OUD and SUD drugs through telehealth;
- Closely follow the MOM states and their pilot programs, see what works and apply those plans in target states;
- Focus on developing an effective model of treatment for pregnancy-related care by sharing best practices among the states, and;
- Address social determinants of health as they relate to maternal health outcomes. Focus on socioeconomic factors and tailored Medicaid proposals for high risk groups to close the SMMM gap among demographic groups.

Integrating Care for Dually Eligible Beneficiaries

Analysis of Geographic Availability of Integrated Care

MACPAC staff led the discussion on geographic availability and policy options for integrating care for duals.

Background

Current MACPAC analysis of integrated care builds on recent MACPAC work, including two recent panels and a discussion of integrated care at the last MACPAC public meeting in December 2019. MACPAC intends to include a chapter (or possibly chapters) on integrated care in its report with clear recommendations for CMS.

"Integrated care" describes health plans available for dually-eligible beneficiaries designed to streamline the delivery, payment and administration of Medicare and Medicaid services. Availability of integrated care plans varies by enrollment population and geographic area. Integrated care plans include:

- Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiatives (FAI);
- Medicare Advantage with dual eligible special needs plans (D-SNPs) combined with managed long-term services and supports (MLTSS), including fully integrated dual eligible special needs plans (FIDE-SNPs);
- Managed Fee for Service, and;
- Program of All-Inclusive Care for the Elderly (PACE).

Offerings of integrated care models vary by geography for many reasons, including population density, politics, state capacity, and state expertise.

Discussions around integrated care typically focus on variation in integrated care availability across states, rather than the variation in availability of integrated care models within states. For example, many dual eligible plans are available on a county-only basis. Density of dually eligible beneficiaries also varies widely by county. Metropolitan areas and the South and Northeast tend to have a high density of dually eligible beneficiaries (greater than 10,000 beneficiaries per county).

In their presentation, MACPAC staff showed a variety of different maps illustrating these differences. Plan availability, density of beneficiaries, and FAI demonstrations are shown by state and by county.

Key Takeaways

- The best opportunities to integrate care exist in states and counties where MLTSS and D-SNPs are both available, or there is an active FAI model (for examples of both approaches, see Texas, Michigan, Wisconsin, Florida, and some counties on the MACPAC maps).
- Some states that have implemented integrated care programs may not have implemented them statewide; it is important to look at maps county by county.
- States may need to pursue a combination of approaches to increase the number of dually eligible beneficiaries who can access integrated care plans.

Policy Options for Integrating Care for Dually-Eligible Beneficiaries

Building on their December discussion, MACPAC staff presented 14 policy options to Commissioners for discussion. Policy options were grouped into four categories based on each policy's approach to integration.

- Group 1: Policies encouraging greater enrollment in integrated offerings
- Group 2: Policies that make integrated offerings available to more beneficiaries
- Group 3: Policies promoting greater integration among existing offerings and
- Group 4: Policies that create a new program for dually eligible beneficiaries

Group 1: Policies encouraging greater enrollment in integrated offerings

1. Modify special enrollment periods for dually eligible beneficiaries to allow opt-ins to MMPs at any time.
2. Allow states to passively enroll beneficiaries who previously opted out after passive enrollment.
3. Give clearer guidance to enrollment brokers that clarifies their role in the system.
4. Create common enrollment periods for Medicare and Medicaid for dually eligible beneficiaries enrolled in managed care.

Group 2: Policies that make integrated offerings available to more beneficiaries

5. Provide additional federal funds to enhance states' capacity to implement integrated care.
6. Encourage the development of new non-capitated options. Consider providing more funding for the development of these options.
7. Create permanent authority for MMPs.
8. Encourage states to use Medicare Improvement for Patients and Providers (MIPPA) authorities.
9. Allow D-SNPs to operate in areas where they can meet Medicaid network adequacy standards.

Group 3: Policies promoting greater integration among existing offerings

10. Limit enrollment in D-SNPs to full-benefit duals.
11. Limit D-SNP contracts to companies with MLTSS contracts to encourage integration.
12. Require D-SNP look-alike plans to meet the requirements of D-SNP plans.
13. Default enrollment into D-SNPs.

Group 4: Policies that create a new program for dually eligible beneficiaries

14. Create a new federal program uniquely focused on dually eligible beneficiaries in which all needs are met by a single organization including financing, administration, and so on.

After laying out these 14 policy options, staff re-grouped the options, this time by their level of development to help prioritize options that might be included as recommendations in MACPAC's June report. The groups and policies included in them are as follows:

- Group A: Ready for Draft Recommendation (policies 1, 5 and 6);
- Group B: More Analysis Needed (policies 2, 3, 4, 8, and 13), and;
- Group C: Early Stage of Development (policies 7, 9. 10. 11, 12 and 14).

MACPAC Commissioners discussed policies in more detail and discussed which policies they were likely to recommend in their commentary.

Commissioners' Comments – Integrating Care for Dually-Eligible Beneficiaries

One Commissioner remarked that it is striking to see the differences in availability of integrated care plans by county. They felt that many national analyses only look at the state level, when a state-level view does not accurately show the kinds of geographic barriers. They said that this county-by-county analysis will be useful to bear in mind going forward.

Another Commissioner remarked that some states are still concerned that expanding integrated care could generate a greater administrative burden, when this is not necessarily the case. They reiterated availability of a particular model does not necessarily indicate integration, and felt that a closer analysis of care integration could be useful.

Commissioners indicated interest in recommending policy options 3, 8, and 13. While commissioners also expressed interest in policy options 9, 10, 11, and 12, they felt these options would require more research and exploration before making a recommendation.

Commissioners were curious about the prospect of creating a new federal program uniquely tailored for dually eligible beneficiaries (policy number 14), but ultimately felt that such a proposal would require a lot more research and planning, so they tabled the idea until more analysis could be conducted.