Report to Congress on Medicaid and CHIP

JUNE 2020

MACPAC

Medicaid and CHIP Payment
and Access Commission

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

JUNE 2020

MACPAC | Medicaid and CHIP Payment and Access Commission

Commissioners

Melanie Bella, MBA, *Chair*
Charles Milligan, JD, MPH,
    Vice Chair
Thomas Barker, JD
Tricia Brooks, MBA
Brian Burwell
Martha Carter, DHSc, MBA,
    APRN, CNM
Frederick Cerise, MD, MPH
Kisha Davis, MD, MPH
Toby Douglas, MPP, MPH
Leanna George
Darin Gordon
Christopher Gorton, MD, MHSA
Stacey Lampkin, FSA, MAAA,
    MPA
Sheldon Retchin, MD, MSPH
William Scanlon, PhD
Peter Szilagyi, MD, MPH
Katherine Weno, DDS, JD

Anne L. Schwartz, PhD,
    Executive Director

June 15, 2020

The Honorable Mike Pence
President of the Senate
The Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
The Capitol
Washington, DC 20515

Dear Mr. Vice President and Madam Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the June 2020 *Report to Congress on Medicaid and CHIP*. This June report contains six chapters addressing three fundamental challenges facing Medicaid: (1) improving integration of care for low-income seniors and people with disabilities who are dually eligible for Medicaid and Medicare; (2) ensuring that Medicaid is the payer of last resort when beneficiaries also have coverage from another insurance program; and (3) addressing concerns about high rates of maternal morbidity and mortality.

Although federal and state policymakers are now focused primarily on addressing the COVID-19 pandemic, the analysis and recommendations contained in this report reflect a body of work that the Commission conducted over the past year. While we recognize that the pandemic has pushed other issues to the back burner, when the Commission convened to wrap up its work on this report in April, we decided to finish what we started, knowing that these issues will still be of concern when the pandemic is over. Moreover, concerns about how best to serve the high-cost, high-need population enrolled in both Medicare and Medicaid, as well as low-income pregnant women, are of even heightened importance at this time.

Chapters 1 and 2 focus on integrating Medicaid and Medicare, two separate programs that were not designed to work together, for beneficiaries who are eligible for both programs. Dually eligible beneficiaries account for a disproportionate share of Medicaid and Medicare service use and spending. Integrating the delivery and financing of their care has the potential to better address the totality of their needs and reduce spending.

Although studies have generally found that beneficiaries enrolled in integrated care models have lower rates of hospitalization and readmissions than those who are not enrolled, only about 10 percent of dually eligible beneficiaries are now enrolled in integrated care. Chapter 2 contains two recommendations aimed at increasing the availability of integrated products and the opportunity to enroll in them.

Chapter 3 looks at the Medicare Savings Programs (MSPs) under which Medicaid pays for certain Medicare cost sharing such as premiums and copayments. Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiaries' ability to access care. In Chapter 3, the Commission recommends making two statutory changes to align MSP eligibility rules with those of the Medicare Part D Low Income Subsidy program that should help increase the number of individuals receiving assistance to which they are already entitled, while also easing administration for states.

Chapter 4 pivots to another ongoing challenge in Medicaid: protecting the safety net program's statutory role as the payer of last resort. This is important because ensuring payment from the appropriate party helps preserve Medicaid funds to cover services for beneficiaries and limits cost shifting to states and the federal government. Chapter 4 looks specifically at third-party liability coordination with TRICARE, the health insurer for U.S. Armed Forces military personnel, military retirees, and their dependents, almost 900,000 of whom also have Medicaid coverage. To protect Medicaid from bearing costs that are the responsibility of the Department of Defense (DoD), the chapter contains two recommendations: (1) to facilitate information sharing between state Medicaid programs and DoD, and (2) to implement the same third-party liability policies for TRICARE as for other health insurers, to protect Medicaid from paying claims that are TRICARE's responsibility.

The final section of the June report examines Medicaid's pivotal role in maternal health. Chapter 5 looks at increasing mortality and morbidity among pregnant women and new mothers, and Chapter 6 at the effects of substance use disorder (SUD) on pregnant women covered by Medicaid and their newborns. Although poor maternal outcomes are not limited to women with Medicaid, the program covers 43 percent of births and thus plays an important role in addressing maternal morbidity and mortality. State Medicaid programs can use multiple authorities to tailor benefits for pregnant women with SUD and infants with neonatal abstinence syndrome. However, few states are using all of the available authorities to do so.

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 June 15.

Sincerely,

Melanie Bella, MBA
Chair

MACPAC

Commission Members and Terms

Melanie Bella, MBA, *Chair*
Philadelphia, PA

Charles Milligan, JD, MPH, *Vice Chair*
Albuquerque, NM

Term Expires April 2021

Melanie Bella, MBA
Cityblock Health
Philadelphia, PA

Sheldon Retchin, MD, MSPH
The Ohio State University
Columbus, OH

Leanna George
Beneficiary Representative
Benson, NC

Peter Szilagyi, MD, MPH
University of California, Los Angeles
Los Angeles, CA

Charles Milligan, JD, MPH
Independent Consultant
Albuquerque, NM

Katherine Weno, DDS, JD
Independent Public Health Consultant
Iowa City, IA

Term Expires April 2022

Thomas Barker, JD
Foley Hoag, LLP
Washington, DC

Toby Douglas, MPP, MPH
Kaiser Permanente
Davis, CA

Tricia Brooks, MBA
Georgetown University Center for Children and Families
Bow, NH

Christopher Gorton, MD, MHSA
Germantown, MD

Stacey Lampkin, FSA, MAAA, MPA
Mercer Government Human Services Consulting
Tallahassee, FL

Brian Burwell
Ventech Solutions
Arlington, MA

Term Expires April 2023

Martha Carter, DHSc, MBA, APRN, CNM
Independent Consultant
Culloden, WV

Darin Gordon
Gordon & Associates
Nashville, TN

Frederick Cerise, MD, MPH
Parkland Health and Hospital System
Dallas, TX

William Scanlon, PhD
Independent Consultant
Oak Hill, VA

Kisha Davis, MD, MPH
Aledade
Rockville, MD

Commission Staff

Anne L. Schwartz, PhD, *Executive Director*

Office of the Executive Director

Kathryn Ceja
Director of Communications

Allissa Jones, MTA
Executive Assistant

Breshay Moore
Communications Specialist

Policy Directors

Moira Forbes, MBA

Kate Kirchgraber, MA

Principal Analysts

Kirstin Blom, MIPA
Principal Analyst and Contracting Officer

Martha Heberlein, MA

Joanne Jee, MPH
Principal Analyst and Congressional Liaison

Erin McMullen, MPP

Robert Nelb, MPH

Chris Park, MS

Kristal Vardaman, PhD, MSPH

John Wedeles, DrPH

Senior Analysts

Kacey Buderi, MPA

Aaron Pervin, MPH

Amy Zettle, MPP

Analysts

Kayla Holgash, MPH

Tamara Huson, MSPH

Anna Williams, MPP

Research Assistant

Jerry Mi

Operations and Finance

Ricardo Villeta, MBA, *Deputy Director of Operations, Finance, and Management*

Jim Boissonnault, MA
Chief Information Officer

Kevin Ochieng, *IT Specialist*

Ken Pezzella, CGFM, *Chief Financial Officer*

Kimberley Pringle, *Administrative Assistant*

Brian Robinson, *Financial Analyst*

Eileen Wilkie, *Administrative Officer*

Acknowledgments

Table of Contents

List of Boxes

List of Figures

List of Tables

MACPAC

Executive Summary: June 2020 Report to Congress on Medicaid and CHIP

MACPAC's June 2020 *Report to Congress on Medicaid and CHIP* contains six chapters addressing some fundamental challenges facing Medicaid: (1) improving integration of care for low-income people over age 65 and people with disabilities who are dually eligible for Medicaid and Medicare; (2) ensuring that Medicaid is the payer of last resort when its beneficiaries also have coverage from another insurance program; and (3) addressing concerns about high rates of maternal morbidity and mortality.

The Commission recognizes that confronting the COVID-19 pandemic and the accompanying economic downturn are the most urgent priorities for federal and state policymakers as this report goes to print. However, we decided to maintain our prior areas of focus, reflecting a body of work that the Commission has conducted over the past year. Moreover, addressing the needs of dually eligible beneficiaries and pregnant women and their infants remains a high priority even as the pandemic affects many others. Concerns about how to deliver and pay for their health care are now of heightened importance. Moreover, the issues addressed in the 2020 June report will still be of concern when the pandemic is over.

CHAPTER 1: Integrating Care for Dually Eligible Beneficiaries: Background and Context

Chapter 1 sets the stage for the first set of challenges laid out in the June 2020 report: how to better integrate Medicaid and Medicare benefits to improve the care experience and health outcomes for the 12.2 million individuals who are dually eligible for both programs. This chapter provides important context on dually eligible beneficiaries, delivery systems, and integrated care

models for understanding the policy options and recommendations presented in Chapter 2.

In general, dually eligible beneficiaries—a group that includes people who are age 65 and older as well as younger people with disabilities—have complex care needs. These can include chronic conditions, physical disabilities, behavioral health conditions, and cognitive impairments. On average, dually eligible beneficiaries use more services than those enrolled in only Medicaid or Medicare and incur higher per capita costs. Many also face multiple social risk factors that may affect their health status, such as housing insecurity and homelessness, food insecurity, inadequate access to transportation, and low health literacy. This population is at particular risk during the COVID-19 pandemic due to their age and underlying medical conditions.

Combined, Medicaid and Medicare cover a broad range of health care services. Medicare pays for most acute care and post-acute care. Medicaid is the secondary payer, wrapping around Medicare by providing assistance with Medicare premiums and cost sharing and covering services not covered by Medicare, such as long-term services and supports. These programs were not designed to work together. Covering individuals under two programs can result in fragmented care and promote cost shifting instead of ensuring that beneficiaries receive services that best meet their needs.

Chapter 1 also defines what the term integrated care means in the context of the dually eligible population and identifies the primary models of integrated care now in use. The chapter concludes by describing what evaluations of these models show in terms of their effects on utilization, spending, and health outcomes.

CHAPTER 2: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

Individuals who are dually eligible for Medicaid and Medicare often experience fragmented care and

poor health outcomes due to lack of coordination across the two programs. Integrating care has the potential to improve the health of these individuals and reduce federal and state spending on their care, but as of 2019, only about 10 percent of dually eligible beneficiaries received care through such integrated models.

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided opportunities for the federal government and states to improve coordination between Medicaid and Medicare. Many states use one or more models of integrated care (including those predating the ACA) to improve health outcomes and reduce overall spending for this group. In the Commission's view, more can be done to increase enrollment in integrated products, increase the availability of such models, and encourage greater levels of integration.

The Commission heard directly from states, a health plan, a provider, and a beneficiary advocate at our public meetings about innovative and successful efforts as well as constraints and challenges to integrating care. In this chapter, we make two recommendations, which we consider to be modest but important steps toward increasing the availability of, and enrollment in, integrated care models. Specifically, we recommend the following:

- The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. 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, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

- Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

The chapter also lays out the Commission's concerns about the emergence and growth of dual eligible special needs (D-SNP) look-alike plans, traditional Medicare Advantage plans that do not coordinate Medicaid and Medicare benefits but appear to be drawing dually eligible beneficiaries away from integrated care products. The Centers for Medicare & Medicaid Services (CMS) has recently finalized regulatory changes to restrict D-SNP look-alike growth, which could alleviate concerns about the unintended consequences of strengthening D-SNP contracts with states. The Commission will continue monitoring D-SNP look-alike availability and enrollment and any effects of these regulatory changes.

The Commission's analyses in the June report are the first step in a multiyear inquiry that would focus on a range of policy options that could increase integrated care. For example, we are planning additional work to understand the use of default enrollment as a tool to increase enrollment in D-SNPs aligned with managed long-term services and supports. We will also examine the role of Medicare agents and brokers, in particular, how agent and broker compensation affects enrollment in integrated models. We expect to explore how the integrated Medicare-Medicaid Plan model can be made more widely available and how states can maximize their contracting authority to tailor D-SNP contracts to meet the specific needs of their dually eligible residents and reflect the nature of their managed care markets.

The challenges of integrating care in the current environment have led some stakeholders to begin exploring whether the future of health care coverage for dually eligible beneficiaries requires creating a new program that is uniquely focused on this population and that would no longer require these beneficiaries to navigate two sets of confusing, and often conflicting, rules. In the years ahead, the Commission will review proposals to restructure coverage for dually eligible beneficiaries in a more comprehensive way than is possible while maintaining separate programs.

CHAPTER 3: Improving Participation in the Medicare Savings Programs

Beneficiaries who are dually eligible for Medicaid and Medicare may receive assistance in paying for their Medicare premiums, cost sharing, or both, through the Medicare Savings Programs (MSPs). Qualifying beneficiaries must enroll in the MSPs and have their eligibility redetermined each year through their state Medicaid programs.

Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiary use of services. In recent years, some federal action has been taken to simplify eligibility and enrollment in the MSPs, but participation rates remain relatively low. Over the past year, the Commission examined issues related to MSP enrollment, identifying barriers faced by beneficiaries and states and exploring policies that would increase participation of eligible beneficiaries and improve their access to care. We found that differences in state approaches to program administration, conflicting enrollment and eligibility requirements between the MSPs and federal programs serving similar low-income individuals, and lack of awareness among eligible beneficiaries all contribute to low enrollment in the MSPs.

Coordinating with one federal program that serves a similar population—the Medicare Part D Low-Income Subsidy (LIS) program—could facilitate MSP enrollment. The LIS program provides financial assistance to many of the same low-income Medicare beneficiaries who could qualify for the MSPs; it is federally administered by the Social Security Administration (SSA) and has automatic processes in place to contact and enroll many eligible individuals nationwide.

Nevertheless, different state rules for counting key MSP eligibility factors, such as income, household size, and assets, may limit a state's ability to use the LIS program data to automate its MSP enrollment process. Meanwhile, individuals applying for the MSPs often have to initiate an application or submit additional documentation to meet state

requirements, burdens that may keep many eligible beneficiaries from enrolling in these programs.

Two changes in federal law would improve information sharing between SSA and the states, ease administrative burden for states and beneficiaries, and contribute to increased enrollment in the MSPs. In Chapter 3, we make the following recommendation:

- Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

CHAPTER 4: Medicaid and TRICARE Third-Party Liability Coordination

Chapter 4 addresses another challenge in Medicaid: protecting the safety-net program's statutory role as the payer of last resort. By law, all other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. This requirement is referred to as third-party liability (TPL) because payment is the responsibility of a third party other than the individual or Medicaid.

Coordinating TPL is important for two reasons. First, ensuring that the appropriate party pays for care helps preserve Medicaid funds to cover services for beneficiaries. Second, coordination of TPL limits cost shifting from private insurers and other federal programs to states, which pay more than one-third of program costs, and the federal portion of Medicaid, which pays the remaining two-thirds. Overall, state and federal Medicaid savings

from TPL totaled $13.6 billion in 2011, up from $3.7 billion in 2001.

Chapter 4 focuses on TPL policy related to TRICARE, the Department of Defense (DoD) program for civilian health benefits for U.S. Armed Forces military personnel, military retirees, and their dependents. MACPAC estimates that approximately 867,000 Medicaid enrollees have primary coverage through TRICARE, including approximately 220,000 children. TRICARE is the largest source of third-party public coverage for children enrolled in Medicaid on a basis other than disability; approximately 10 percent of children of active service families covered by TRICARE also have Medicaid.

MACPAC has found that TRICARE is not coordinating benefits with state Medicaid programs, resulting in a cost shift at the federal level from the DoD to the U.S. Department of Health and Human Services and from the federal government to states. We make two recommendations for improving coordination between Medicaid and TRICARE:

- The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

- To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Although reconciling these policy differences would not result in an overall cost savings to the federal government (i.e., liability for claims costs for enrollees with both Medicaid and TRICARE

would return to TRICARE), improved coordination of benefits between the two programs would better maintain the statutory requirement that Medicaid serve as the secondary payer when other coverage sources are available.

CHAPTER 5: Medicaid's Role in Maternal Health

Chapter 5 introduces the final challenge addressed in the June report: the increasing mortality and morbidity among pregnant and postpartum women. Although most births occur without adverse outcomes, poor maternal and infant outcomes are on the rise. Approximately 700 women die annually as a result of pregnancy or related complications, with such deaths occurring over the course of pregnancy and in the postpartum period. Although these worrisome trends are not limited to Medicaid, poor outcomes for many women and infants could be addressed through Medicaid policy.

Medicaid has long played a key role in providing maternity-related services for pregnant women, financing more than two out of every five births in 2018. All states are required to provide Medicaid coverage for pregnant women with incomes at or below 133 percent of the federal poverty level. Currently, all but four states extend Medicaid coverage to pregnant women with higher incomes. The share of births covered by Medicaid varies across states, with Medicaid paying for more than half of births in six states: Arizona, Louisiana, Mississippi, New Mexico, Oklahoma, and Tennessee. Medicaid paid for a greater share of births in rural areas, among young women (under age 19), and for women with lower levels of educational attainment than other payers did. Medicaid also paid for a greater share of deliveries by Hispanic, African American, and American Indian and Alaska Native women. Compared to privately insured women, women covered by Medicaid were more likely to have certain pregnancy risk factors, such as obesity and a history of smoking.

Over the last year, the Commission has been gathering information to understand the experience of pregnant women covered by Medicaid and the efforts by states and the federal government to improve maternal and infant health. We have analyzed birth certificate data, commissioned original research, met with stakeholder organizations, and convened multiple panels at public meetings. The Commission has collected comprehensive information on state and federal initiatives to improve access to care and the quality of services pregnant women in Medicaid receive.

We do not offer recommendations at this time; however, given the importance of this topic to the Medicaid program, the mothers and infants it serves, and the detrimental societal effects of poor maternal and birth outcomes, we plan to spend considerable time over the next year weighing different policy alternatives and highlighting evidence-based solutions. Areas of interest include value-based payment, access to maternity providers, family planning services, and postpartum coverage.

CHAPTER 6: Substance Use Disorder and Maternal and Infant Health

High rates of substance use disorder (SUD), including opioid use disorder (OUD), are taking their toll on families and communities across the United States. MACPAC has previously reported on the opioid epidemic and its disproportionate effect on the Medicaid program. Chapter 6 specifically looks at the effects of SUD on pregnant and postpartum women and their infants.

Substance use can have serious consequences for both maternal and infant health. Pregnant and postpartum women who misuse substances are at risk for poor maternal outcomes, including preterm labor and complications related to delivery.

High rates of SUD also affect their children. Neonatal abstinence syndrome (NAS) is a drug withdrawal syndrome that occurs in infants after they are exposed to certain drugs in utero.

Medications that treat OUD can also result in NAS, but these medications can also prevent more severe neonatal complications, such as preterm birth. Over 80 percent of infants with NAS are covered by Medicaid. In addition, rising rates of overdose deaths have coincided with an increase in the number of children entering foster care, which makes them eligible for Medicaid.

Although pregnant women covered by Medicaid are more likely than pregnant women with other forms of insurance to misuse substances or have SUD, they are also more likely to have ever received treatment for their SUDs. Yet of those beneficiaries, only a small percentage are actually receiving treatment: from 2015 to 2018, just one in five (19.9 percent) pregnant women with SUD enrolled in Medicaid received alcohol or drug treatment in a health care setting during the previous year. Reasons include stigma, fear of punitive repercussions, and limited access to providers, because few SUD treatment facilities offer specialized programming for pregnant women. In some regions, many providers do not participate in Medicaid and accept only cash payments. Women also experience unique obstacles, including balancing caregiver roles with treatment and fear of losing custody of their newborns and possibly other children as a result of their SUD.

Chapter 6 also describes the continuum of care for pregnant and postpartum women with SUD, the extent to which state Medicaid agencies cover SUD treatment services, and the availability of specialty SUD treatment for this population. State Medicaid programs can use multiple authorities, including those under the state plan and waivers, to tailor benefits for pregnant women with SUD and infants with NAS. However, few states are using all the authorities available to them to do so and state systems remain highly fragmented.

The chapter concludes by describing the roles of the criminal justice and child welfare systems, as well as other social service agencies, in the lives of pregnant women with SUD.

Chapter 1:

Integrating Care for Dually Eligible Beneficiaries: Background and Context

Integrating Care for Dually Eligible Beneficiaries: Background and Context

Key Points

- Individuals who are dually eligible for Medicaid and Medicare represent a diverse population that includes low-income beneficiaries age 65 and older and younger people with disabilities. In 2019, there were 12.2 million dually eligible beneficiaries.

- Medicare is the primary payer for acute and post-acute care services for dually eligible beneficiaries. Medicaid is the secondary payer, assisting with Medicare premiums, cost sharing, and covering services not covered by Medicare, such as long-term services and supports (LTSS).

- On average, dually eligible beneficiaries have greater health care needs and report worse health status than Medicare-only beneficiaries.

- Dually eligible beneficiaries comprise a disproportionate share of Medicaid and Medicare service use and spending. In 2013, 15 percent of Medicaid enrollees were dually eligible, but these enrollees accounted for 32 percent of total Medicaid spending. Similarly, 20 percent of Medicare enrollees were dually eligible, but these enrollees accounted for 34 percent of total Medicare spending.

- Dually eligible beneficiaries must navigate two separate systems that were not designed to work together, which can affect care delivery. For example, although Medicaid's coverage of durable medical equipment (DME) is broader, Medicare is the primary payer. Most states require that Medicare first deny a DME claim before a DME supplier files a claim with Medicaid; this can delay beneficiary receipt of DME.

- The benefit structures of the two programs also lead to cost shifting. Ideally, beneficiaries should receive inpatient care, post-acute care, and LTSS based on their health and social needs and not on which program pays for which services.

- The federal government and states administer a variety of integrated care models to improve the care provided to dually eligible beneficiaries. The level of clinical and administrative integration varies from model to model.

- Recent integration efforts include implementation of Medicare-Medicaid Plans under the Financial Alignment Initiative and increased alignment of dual eligible special needs plans with managed LTSS programs.

- Studies of integrated care models generally find that enrolled beneficiaries have lower rates of hospitalizations and readmissions than those who are not enrolled, while their effect on other services varies. Findings on Medicare savings are mixed, and most evaluations do not assess Medicaid savings due to data limitations.

- Despite considerable efforts at both the state and federal levels, only about 1 million (about 10 percent) of dually eligible beneficiaries are now enrolled in integrated care models.

CHAPTER 1: Integrating Care for Dually Eligible Beneficiaries: Background and Context

In 2019, 12.2 million individuals were enrolled in both Medicaid and Medicare (CMS 2020a).[1] These so-called dually eligible beneficiaries include both those age 65 and older and younger beneficiaries with disabilities. They are a diverse group; while many have complex care needs, including multiple chronic conditions, physical disabilities, behavioral health conditions, and cognitive impairments, others are relatively healthy (MACPAC 2020a). On average, dually eligible beneficiaries use more services than those enrolled in only Medicaid or Medicare with higher per capita costs.

Many also face multiple social risk factors that may affect their health status, such as housing insecurity and homelessness, food insecurity, inadequate access to transportation, and low health literacy (Sorbero et al. 2018). This population may be at particular risk during the COVID-19 pandemic due to their age and underlying medical conditions (CDC 2020).

Combined, Medicaid and Medicare cover a broad range of health care services, including preventive services, primary care, inpatient and outpatient services, long-term services and supports (LTSS), and behavioral health for dually eligible beneficiaries. For most, Medicare is the primary payer for acute and post-acute care services. Medicaid is the secondary payer and wraps around Medicare by providing assistance with Medicare premiums and cost sharing and covering services not covered by Medicare, such as LTSS.

The division of coverage between the two programs, however, can result in fragmented care. For example, beneficiaries admitted to the hospital under their Medicare benefits may need home- and community-based services (HCBS) to safely transition back into the community. Because HCBS are covered under Medicaid, there may not be a mechanism in place to notify the beneficiary's HCBS provider of a hospital stay, making it more difficult for the HCBS provider to work towards a smooth transition.

Lack of coordination also creates opportunities for cost shifting between the two programs. For example, Medicaid covers LTSS while Medicare covers inpatient stays. Given that these policies were not designed to work together, their structure does not create appropriate incentives to ensure that services are provided based on what is best for the beneficiary.

Integrated care is intended to address these concerns by aligning delivery, payment, and administration of Medicaid and Medicare services. The goal of integrating care is to improve care for dually eligible beneficiaries, eliminate incentives for cost shifting, and reduce spending that may arise from duplication of services or poor care coordination.

Many states use one or more models of integrated care aimed at improving health outcomes and reducing overall spending for dually eligible beneficiaries. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided opportunities for the federal government and states to improve coordination between Medicaid and Medicare. Even so, as of 2019, only about 10 percent of dually eligible beneficiaries received care through these integrated models (CMS 2020a). In the Commission's view, more can be done to increase enrollment in integrated products, increase the availability of such models, and encourage greater levels of clinical, financial, and administrative integration.

In Chapter 2 of this report, the Commission examines barriers to integration and some potential solutions and presents initial recommendations. This chapter provides context for that discussion. It begins with background information on dually eligible beneficiaries including pathways for

Medicaid and Medicare eligibility, demographic characteristics, health status, and patterns in use of services and spending. It then outlines the benefits to which dually eligible beneficiaries are entitled and the available forms of health care delivery. The chapter goes on to describe current challenges of receiving care through two distinct systems; it defines integrated care in the context of the dually eligible population; and it identifies the primary models of integrated care used by states. The chapter concludes by describing key findings from available evaluations of these models.

Characteristics of Dually Eligible Beneficiaries

The number of dually eligible beneficiaries has steadily increased over the past decade, from 8.6 million in 2006 to 12.2 million in 2019, an average annual growth rate of 2.9 percent (CMS 2020a, 2019a).[2] Below we describe how individuals become eligible for both Medicaid and Medicare, their demographic characteristics, and the benefits they receive. We then compare the needs, outcomes, and use of services among dually eligible beneficiaries to Medicare-only beneficiaries, a comparison group more similar to dually eligible beneficiaries than the Medicaid-only population. This is because Medicare generally covers only those over age 65 and people with disabilities, while Medicaid also covers children, pregnant women, and non-disabled adults.

Eligibility

Dually eligible beneficiaries must qualify separately for Medicaid and Medicare. Individuals can qualify for Medicare by virtue of age (65 and older), disability, or, for a small number of individuals (less than 1 percent), because they have end-stage renal disease.[3]

Medicaid eligibility, which is determined based on both financial and functional criteria, varies from state to state. However, most dually eligible beneficiaries qualify for Medicaid on the basis of income, are designated as medically needy, or receive Supplemental Security Income (MACPAC and MedPAC 2018). The medically needy pathway allows states to cover individuals with high medical expenses relative to their incomes after spending down to a state-set income level. States may offer these beneficiaries full Medicaid benefits or a limited set of benefits as defined by the state, within certain parameters.[4]

In recent years, the number of dually eligible beneficiaries initially qualifying for Medicare on the basis of disability has surpassed that of beneficiaries initially qualifying due to age (CMS 2019a). In 2006, a slight majority of dually eligible beneficiaries qualified on the basis of age, but by 2008 most dually eligible beneficiaries qualified on the basis of disability (Figure 1-1). More recently, this trend has leveled off, with the percentage of beneficiaries initially qualifying on the basis of disability remaining steady at 53 percent from 2012 through 2018.

FIGURE 1-1. Original Eligibility Pathway for Medicare Enrollment among Dually Eligible Beneficiaries, 2006–2018
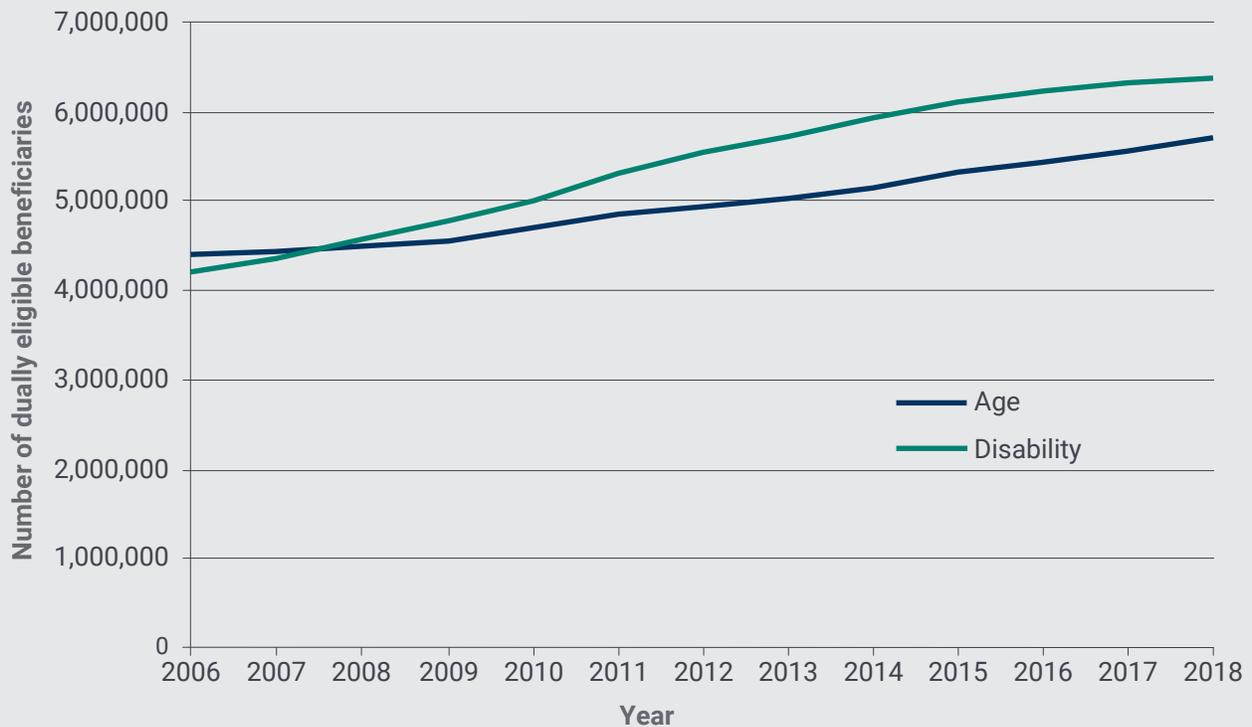
Note: Disability includes individuals who qualified for Medicare on the basis of disability alone and on the basis of disability and end-stage renal disease.

Source: MACPAC, 2020, analysis of CMS 2019a.

Demographic characteristics

The dually eligible population differs from the Medicare-only population with respect to age and gender. Dually eligible beneficiaries are younger, with 39 percent under the age of 65, compared to 9 percent of Medicare-only beneficiaries

(Table 1-1). A disproportionate share of dually eligible beneficiaries are female, at 61 percent, compared to Medicare-only beneficiaries, of whom 52 percent are female. Dually eligible and Medicare-only beneficiaries identify themselves as members of four broad racial and ethnic groups in roughly the same proportion.

TABLE 1-1. Demographic Characteristics of Dually Eligible and Medicare-Only Beneficiaries, 2018

Demographic characteristics	Dually eligible beneficiaries	Medicare-only beneficiaries
Age		
Under age 65	39%	9%
Age 65 and older	61	91
Gender		
Female	61	52
Male	39	48
Race or ethnicity		
Hispanic	16	11
White, non-Hispanic	57	61
Black, non-Hispanic	21	25
Other non-white, non-Hispanic	7	3

Note: Percentages in each demographic category may not sum to 100 due to rounding.

Source: MACPAC, 2020, analysis of CMS 2019a.

Health status and social determinants of health

Dually eligible beneficiaries have more health care needs and report worse health status than Medicare-only beneficiaries. Dually eligible beneficiaries have an average of six chronic health conditions, compared to an average of four among Medicare-only beneficiaries (Burke et al. 2016). They are also more likely to have limitations in activities of daily living (ADLs) such as walking, eating, bathing, and getting in and out of bed. Among dually eligible beneficiaries, 28 percent report three or more limitations in ADLs, compared to 9 percent of Medicare-only beneficiaries (MedPAC 2019). Dually eligible beneficiaries are also less likely to self-report excellent or very good health than Medicare-only beneficiaries (22 percent versus 51 percent) (MACPAC and MedPAC 2018).

Dually eligible beneficiaries are more likely than Medicare-only beneficiaries to experience homelessness, food insecurity, inadequate access to transportation, and low health literacy (Sorbero et al. 2018). As a result, they may have less access to primary and preventive care, which can in turn contribute to adverse health outcomes (Sorbero et al. 2018). Individuals with multiple social risk factors have worse outcomes on preventive care measures, such as screening for cancer, and clinical outcome measures, such as diabetes control and hospital readmission (ASPE 2016). In addition, beneficiaries of color experience additional barriers to access when navigating both Medicaid and Medicare (Sharma 2014).

Use of services and spending

Due to their complex needs, many dually eligible beneficiaries require intensive use of services such as hospitalization and LTSS; as a result, spending on dually eligible beneficiaries is disproportionately high in both Medicare and Medicaid (Bynum et al. 2017). In 2013, 20 percent of Medicare enrollees

were dually eligible for Medicaid and Medicare, but accounted for 34 percent of total Medicare spending (MACPAC and MedPAC 2018). Similarly,

15 percent of Medicaid enrollees were dually eligible and accounted for 32 percent of total Medicaid spending (Figure 1-2) (MACPAC 2020a).

FIGURE 1-2. Dually Eligible Beneficiaries as a Share of All Medicare and Medicaid Beneficiaries and Spending, by Program, 2013

Legend:
- Dually eligible beneficiaries
- Program spending on dually eligible beneficiaries

Medicare: Dually eligible beneficiaries 20%, Program spending on dually eligible beneficiaries 34%
Medicaid: Dually eligible beneficiaries 15%, Program spending on dually eligible beneficiaries 32%
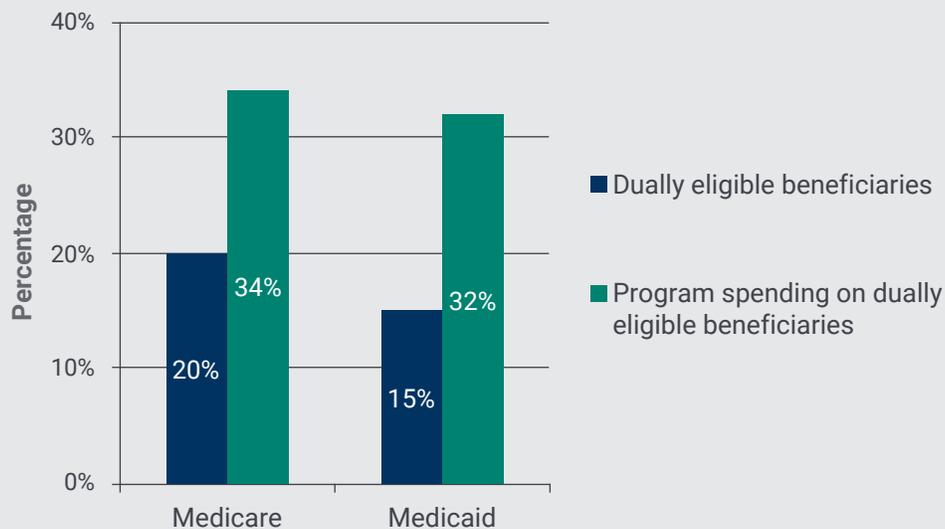
Source: MACPAC and MedPAC 2018.

Overall, dually eligible beneficiaries have higher rates of service use across all covered services and higher spending per beneficiary than other Medicare beneficiaries (MACPAC and MedPAC 2018). For example, in 2013, 26 percent of full-benefit dually

eligible beneficiaries in Medicare fee for service (FFS) used inpatient hospital care compared to 16 percent of all other Medicare beneficiaries in Medicare FFS (Figure 1-3).

FIGURE 1-3. Percentage of Fee-for-Service Dually Eligible Beneficiaries and Fee-for-Service Medicare-Only Beneficiaries Using Various Medicare Services, 2013
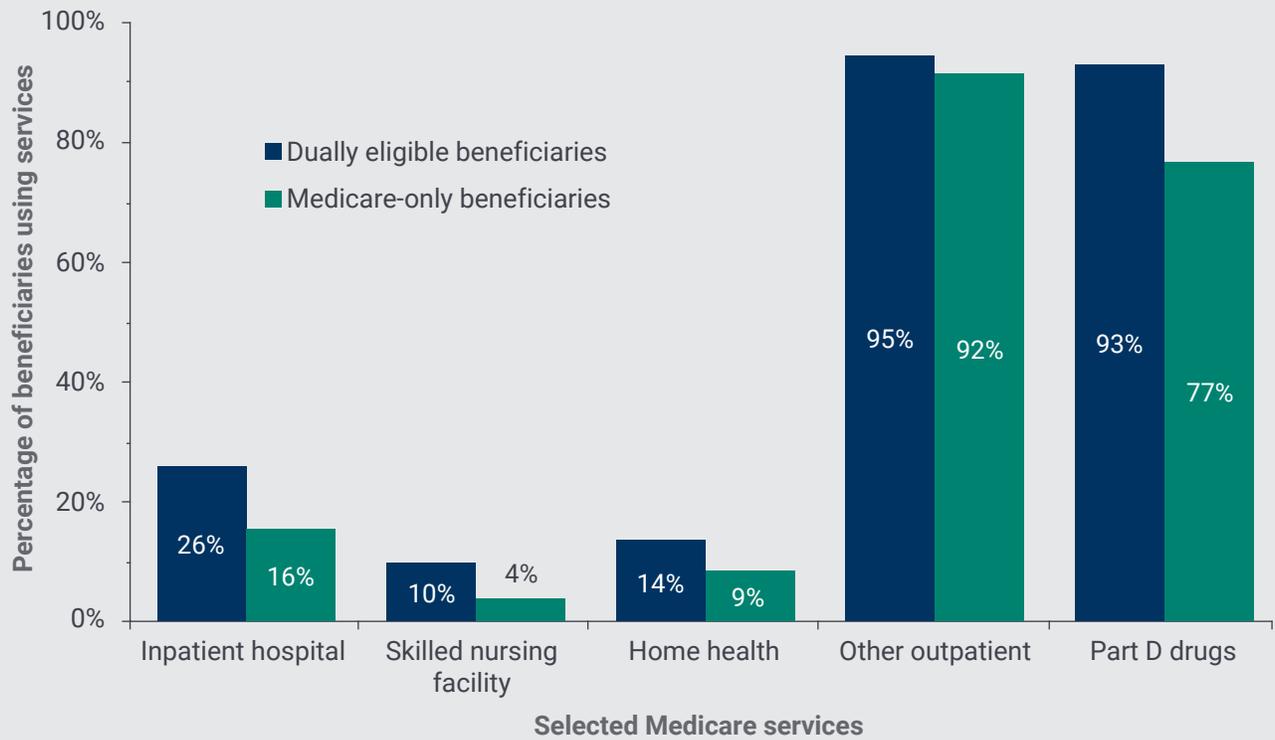
Note: Dually eligible beneficiaries are limited to full-benefit dually eligible beneficiaries for the purposes of this figure.

Source: MACPAC, 2020, analysis of MACPAC and MedPAC 2018.

Full-benefit dually eligible beneficiaries also had higher spending per admission in 2013, with an average of $19,580 per inpatient hospital stay compared to $16,263 among Medicare-only beneficiaries using inpatient care (Figure 1-4) (MACPAC and MedPAC 2018).

FIGURE 1-4. Average Spending per Beneficiary on Medicare Services among Fee-for-Service Dually Eligible Beneficiaries and Fee-for-Service Medicare-Only Beneficiaries, 2013
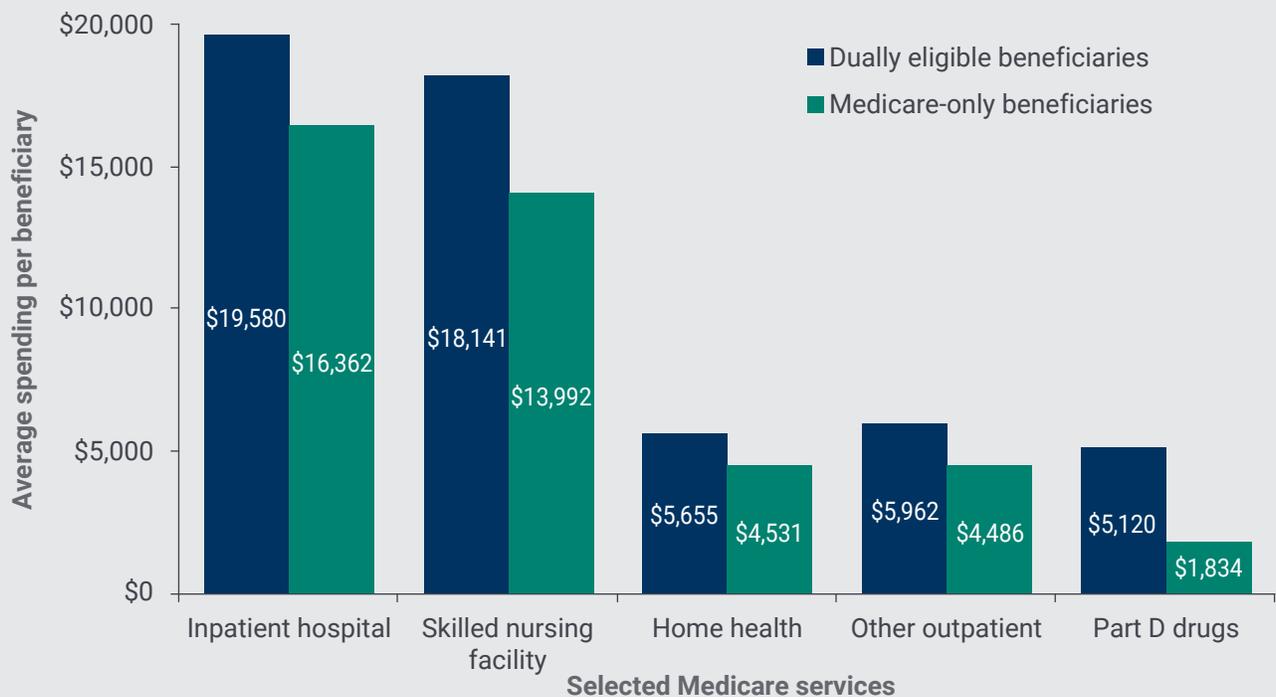
Note: Dually eligible beneficiaries are limited to full-benefit dually eligible beneficiaries for the purposes of this figure.

Source: MACPAC, 2020, analysis of MACPAC and MedPAC 2018.

Dually eligible beneficiaries also account for a disproportionate share of LTSS use and spending. More than 40 percent of dually eligible beneficiaries use LTSS (Soper and Menelas 2019). They are more than twice as likely to use LTSS as Medicaid-only beneficiaries and more than five times as likely as Medicare-only beneficiaries (CBO 2013). In 2011, 62 percent of Medicaid spending on dually eligible beneficiaries was attributed to LTSS (Reaves and Musumeci 2015).

Benefits

All dually eligible beneficiaries receive the same Medicare benefits: primary care, preventive care, inpatient and outpatient acute care, post-acute skilled care, and most prescription drugs. Medicare

is the primary payer and Medicaid serves as the secondary payer for these services.

However, not all dually eligible beneficiaries receive the same Medicaid coverage. Partial-benefit dually eligible beneficiaries are Medicare beneficiaries who receive Medicaid assistance only with Medicare premiums and, in some cases, Medicare cost sharing, through the Medicare Savings Programs (MSPs). (For more information on MSPs, see Chapter 3 of this report.) In 2018, there were 3.5 million partial-benefit dually eligible beneficiaries, comprising 29 percent of all dually eligible beneficiaries (CMS 2019a).

Full-benefit dually eligible beneficiaries receive all services that are covered by Medicaid that are

not covered by Medicare, but they may or may not receive Medicaid assistance with Medicare premiums and cost sharing. Medicaid services offered to full-benefit dually eligible beneficiaries vary by state, because states have flexibility in whether to cover certain services, and may include nursing facility services, HCBS, and some behavioral health services. In 2018, 8.7 million, or 71 percent, of dually eligible beneficiaries received full Medicaid benefits (CMS 2019a).

Delivery system

Although Medicaid and Medicare services have traditionally been delivered to beneficiaries through FFS, many beneficiaries now receive services through managed care (CMS 2020b). In managed care arrangements, health plans provide benefits in exchange for a capitated payment, typically paid on a per member per month basis (MACPAC 2020b). Because there are multiple delivery systems for both Medicaid and Medicare, dually eligible beneficiaries may be in FFS for both, may be in managed care for both, or may be in managed care for one program and FFS for the other. However, even when the individual is enrolled in a managed care plan for both Medicare and Medicaid, they may be enrolled in different plans and the plans do not necessarily coordinate with each other.

Fee for service. Under FFS, providers receive a separate payment for each service provided to a beneficiary. Beneficiaries may receive services through any provider accepting this coverage. A majority of dually eligible beneficiaries, 63 percent, receive their Medicare benefits through FFS (CMS 2020b).

Medicare Advantage. Through Medicare Advantage (MA), also referred to as Medicare Part C, beneficiaries enroll in MA plans that provide coverage of Medicare Parts A and B, and often, Part D drug benefits. MA plans may also cover services such as vision, hearing, and dental that are not otherwise covered by Medicare. Beneficiaries enrolled in MA plans receive care through the plan's closed network.[5] Enrollment in MA plans has steadily increased in recent years among both dually eligible beneficiaries and Medicare-only beneficiaries. From 2006 to 2018, enrollment of dually eligible beneficiaries in Medicare managed care plans—including MA plans and other integrated products described later in this chapter—increased substantially, from 12 percent to 37 percent (Figure 1-5) (CMS 2020b).

FIGURE 1-5. Percentage of Medicare Managed Care Enrollment by Beneficiary Type, 2006–2018
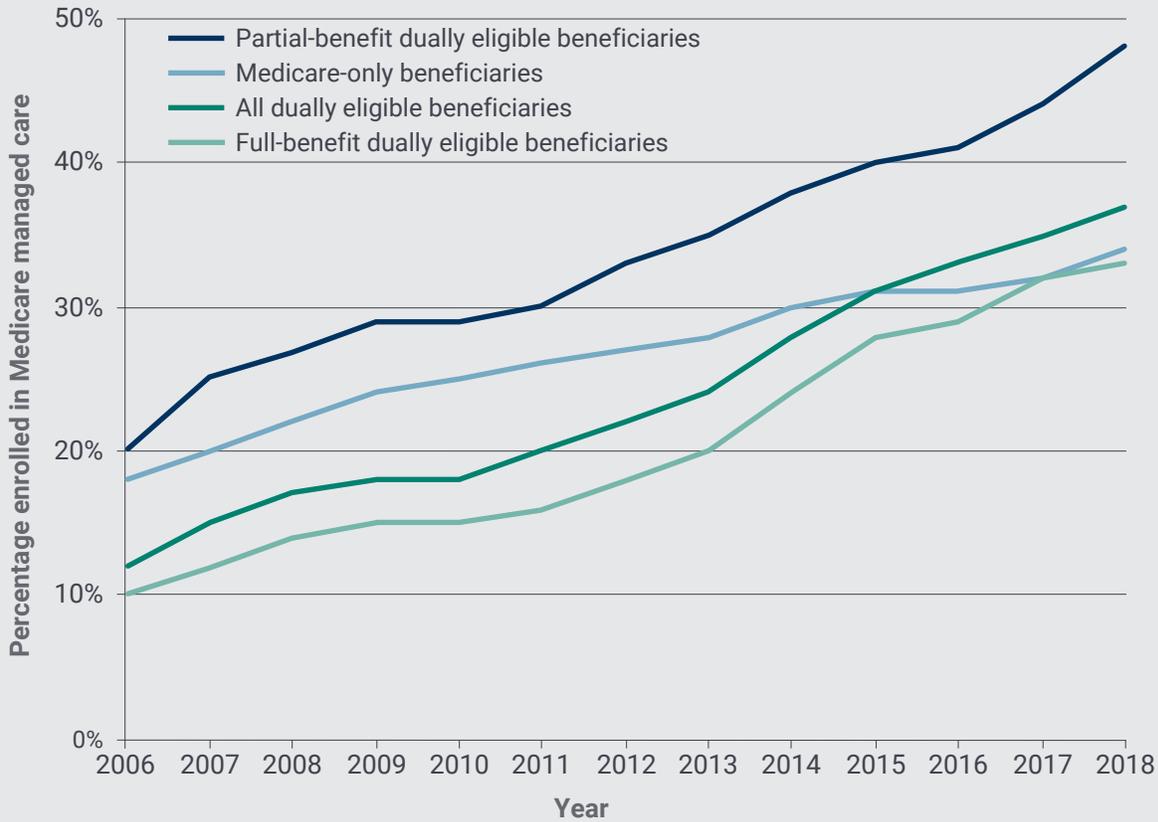
Note: Full-benefit dually eligible beneficiaries enrolled in Medicare Advantage plans, Medicare-Medicaid Plans, and Program of All-Inclusive Care for the Elderly are included as enrolled in managed care; data are based on December enrollment of each calendar year.

Source: MACPAC, 2020, analysis of CMS 2020b.

Medicaid managed care. States initially used managed care for younger and less complex populations, but many states are now expanding its use to include dually eligible beneficiaries (GAO 2020).

In 2017, just under 25 percent, or 2.6 million dually eligible beneficiaries, received their Medicaid benefits through Medicaid managed care organizations (MCOs) (CMS 2017).

Many states make capitated payments to MCOs to provide managed long-term services and supports

(MLTSS); while some MLTSS models cover only LTSS, others cover the complete range of Medicaid benefits (Lewis et al. 2018). The number of states offering MLTSS has increased from 8 in 2004 to 24 in 2019, although most programs are not statewide (Appendix 1A, Table 1A-1) (Lewis et al. 2018 and ADvancing States 2020). As of 2017, there were 1.8 million Medicaid beneficiaries enrolled in MLTSS programs (Lewis et al. 2018).[6]

Lack of Coordination Creates Challenges

Medicaid and Medicare were not designed to work in tandem. As a result, dually eligible beneficiaries must navigate two separate systems. Several benefits covered by Medicaid and Medicare overlap but are not identical, with rules for coverage that may be difficult to understand. State Medicaid payment policies also often allow states to pay less than the full amount of Medicare cost sharing, which may discourage providers from serving dually eligible beneficiaries. As a result, the beneficiary care experience may be confusing and disjointed and lead to poor health outcomes and high costs (MACPAC 2015).

Misaligned program rules

There are several misalignments between Medicaid and Medicare. In some instances, services are covered by both programs but operate under different sets of rules. For example, durable medical equipment (DME) is covered by both Medicaid and Medicare, but Medicare has more restrictive coverage than Medicaid and limits DME coverage to items used primarily in the home. Medicaid's more expansive coverage includes equipment and supplies that can also be used in the community, that is, wherever normal life activities take place (42 CFR 440.70(b)(3)). Because Medicare is the primary payer for dually eligible beneficiaries, most state Medicaid programs require DME suppliers to first submit a claim to Medicare and receive a payment denial before they can request payment from Medicaid. As a result of this complex process, beneficiaries may face longer wait times to receive DME, and suppliers may be reluctant to supply DME to dually eligible beneficiaries (ICRC 2020a).

Navigating Medicaid and Medicare appeals processes can also be confusing to beneficiaries. For example, Medicaid covers some DME that Medicare does not. If beneficiaries must first receive a Medicare denial before Medicaid will cover the service, they may receive a Medicare denial notice and not be aware that they are still eligible for the DME under their Medicaid coverage.

Insufficient care coordination

Care coordination typically involves a person or team that helps a beneficiary manage care transitions, coordinate Medicaid and Medicare benefits, and address social needs. Beneficiaries could have an improved experience if all services were coordinated, a key goal of integrated care approaches (Barth et al. 2019). For example, Medicare covers inpatient stays but not any subsequent HCBS that a beneficiary may need to safely transition back to the community. In the absence of care coordination, there may be no mechanism in place for the HCBS provider to participate in the beneficiary's care transition.

Cost shifting between programs

In some circumstances, Medicaid and Medicare may avoid certain actions that, if undertaken, could reduce spending in the other program and improve outcomes for the beneficiary. For example, hospital readmissions are covered by Medicare, so state Medicaid agencies may not have financial incentives to provide additional services after the beneficiary is initially discharged from the hospital that would prevent readmission. This is because the financial risks of subsequent hospitalizations are borne by Medicare, not Medicaid. Incentives to shift costs can also exist between Medicaid and Medicare health plans (Grabowski 2007).

Similarly, providers face different incentives depending upon which program is paying for care. For example, because Medicaid covers LTSS while Medicare covers inpatient stays and limited post-acute care, beneficiaries may move among multiple settings as a function of those incentives (Grabowski 2007). Ideally these incentives should work so that beneficiaries receive inpatient care, post-acute care, and LTSS based on their health and social needs, rather than considerations such as who will pay for which services.

Medicaid policies for covering Medicare cost sharing

As noted above, many states do not cover the full amount of Medicare cost sharing. The Balanced Budget Act of 1997 (P.L. 105-33) allowed state Medicaid programs to pay less than the full Medicare cost-sharing amount if paying the full amount would cause a provider to receive more than the state's Medicaid rate for the service. For a given Medicare service received by a dually eligible beneficiary, states have the option to pay the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount by which Medicaid's rate for the same service exceeds what Medicare has already paid (known as a lesser-of policy). If the Medicaid rate is lower than the Medicare payment, states pay nothing. When Medicaid does not cover the full cost-sharing amount, dually eligible beneficiaries cannot be charged the remaining balance, which is generally absorbed by the provider. Lesser-of policies vary across service types with nine states covering the full payment for hospital inpatient services, eight covering the full payment for hospital outpatient services, eight covering the full payment for nursing facility services, and six covering the full payment for physician services (MACPAC 2018a).

Providers may be less inclined to provide services to dually eligible beneficiaries in states that use lesser-of policies, limiting beneficiary access to care. A study conducted for MACPAC by Haber and colleagues (2014) compared use among dually eligible beneficiaries whose providers were paid a high cost-sharing payment amount (100 percent) and a low cost-sharing payment amount (66 percent) to Medicare-only beneficiaries. When providers were paid the full amount of Medicare cost sharing, dually eligible beneficiaries had a small but statistically significant increase in the likelihood of having an office or other outpatient evaluation and management visit than Medicare-only beneficiaries (84.8 percent compared to 84.2 percent). When providers were paid 66 percent of Medicare cost sharing, dually eligible beneficiaries were statistically less likely to receive these services (83.9 percent compared to 85.6 percent). The report

also found that although dually eligible beneficiaries were less likely to receive a flu shot than Medicare-only beneficiaries, dually eligible beneficiaries were more likely to receive a flu shot when providers were paid 100 percent of cost-sharing liability. A similar, but smaller, effect was noted for mammogram services (Haber et al. 2014).

Defining Integrated Care

To address challenges that arise when individuals are dually enrolled in Medicaid and Medicare, policymakers have developed models to integrate benefits for dually eligible beneficiaries. We define integrated care as an approach that is intended to align the delivery, payment, and administration of Medicaid and Medicare services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination.

Beneficiaries enrolled in integrated care models may have better access to the full range of covered services in both programs. A key feature of integrated plans is use of care coordinators or care teams that establish person-centered care plans that meet the unique needs of individuals; such care plans are meant to be shared with other service providers to ensure that they are aware of all beneficiary needs and who is involved in addressing them.

Integrated Care Authorities

Congress has created a number of authorities to encourage integration of Medicaid and Medicare and provide a more seamless experience for beneficiaries (Table 1-2). These include establishing the Program of All-Inclusive Care for the Elderly (PACE); creating and refining dual eligible special needs plans (D-SNPs), a type of MA plan; and designating offices within the Centers for Medicare & Medicaid Services (CMS) that coordinate Medicaid and Medicare and develop innovative payment and delivery models.

TABLE 1-2. Federal Legislative Milestones: Integrated Care for Dually Eligible Beneficiaries, 1997–2018

Year	Legislative milestone and key provisions
1997	**Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)** • Establishes the Program of All-Inclusive Care for the Elderly (PACE) as a permanent Medicare program. (Previously, PACE had operated as a pilot program.)
2003	**Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)** • Establishes Medicare Advantage. • Authorizes three types of special needs plans (SNPs) to serve the needs of subsets of the Medicare population, including dual eligible special needs plans (D-SNPs). • SNPs initially authorized to operate from 2006 through December 31, 2008, but the authority has been extended repeatedly through subsequent legislation.
2008	**Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)** • Requires all D-SNPs to have contracts with the states in which they operate by 2013. • MIPPA regulations require these contracts to have eight elements, including, but not limited to, the organization's responsibility to provide or arrange for Medicaid benefits, the Medicaid benefits covered under the D-SNP, the cost-sharing protections, and the identification and sharing of information on Medicaid provider participation.
2010	**Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)** • Section 2602 of the ACA creates the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (MMCO), within CMS. MMCO is designed to improve care and reduce spending on care for dually eligible beneficiaries. • Section 3021 of the ACA creates the Center for Medicare and Medicaid Innovation within CMS to test innovative payment and delivery models.
2018	**Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123)** • Permanently authorizes SNPs. • BBA 2018 requires D-SNPs to meet one of three criteria to improve integration or coordination of care beyond what was required in MIPPA and unifies the grievance and appeals process for some D-SNPs. • Strengthens the authority of MMCO to develop rules and guidance related to D-SNPs, with the goals of improving integration, coordinating grievances and appeals, and providing resources to states to support integrated models.

Source: MACPAC, 2020, analysis of legislation and 42 CFR 422.107.

The main focus of integrating care is on full-benefit dually eligible beneficiaries. It is more difficult to design integrated models for partial-benefit dually eligible beneficiaries because they are not eligible for Medicaid services that could be coordinated with Medicare.

States may choose how they will deliver care to full-benefit dually eligible beneficiaries. Some states use more than one model of integrated care to address the needs of different types of beneficiaries, due to differences between geographic regions in the state, or to offer choices to beneficiaries (Appendix 1A, Table 1A-1).

In 2010, the ACA created within CMS the Federal Coordinated Health Care Office, commonly referred to as the Medicare-Medicaid Coordination Office (MMCO). MMCO is charged with improving coordination between the federal government and states to improve access to care for beneficiaries and to make the system as cost-effective as possible (CMS 2020c). Since its establishment, MMCO has encouraged states to offer integrated care through a variety of models.

Enrollment into integrated care plans has increased over the past several years, from 160,000 dually eligible beneficiaries enrolled in integrated care programs in 2011 to just over 1 million enrolled in 2019 (CMS 2020a).[7] We discuss each model of integrated care in greater detail below.

Integrated Care Models

Integrated care models offer varying degrees of clinical and administrative integration. Managed fee for service (MFFS) offers care coordinated through a single point of contact. D-SNPs aligned with MLTSS provide more integration. Highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs) are D-SNPs that cover some or all Medicaid services and typically provide a greater level of integration than D-SNPs without these designations. Medicare-Medicaid Plans (MMPs) and PACE provide the highest level of integration, because all services are provided by a single organization that receives capitated payments from Medicaid and Medicare. Below we describe each of these integrated care models, beginning with MMPs, a widely used model that offers the highest level of integration.

The Financial Alignment Initiative's Medicare-Medicaid Plans

The Financial Alignment Initiative (FAI) is a demonstration program authorized under Section 1115A of the Social Security Act (the

Act) designed to improve the way dually eligible beneficiaries receive health care and to align financial incentives in Medicaid and Medicare (CMS 2020c). State participation in the FAI is optional, and currently 11 states participate (Table 1-3). The earliest demonstrations began in July 2013, and several have been extended beyond the initial demonstration period. CMS has also encouraged more states to participate in the FAI through existing or new demonstration models (CMS 2019c).

The FAI offers multiple models of integrated care, including a capitated model that establishes MMPs, an MFFS model, and an option for states to develop an alternative model.[8] Because each demonstration is developed and implemented through a partnership between the state and MMCO, each demonstration differs in terms of its target population, benefits, and care coordination services. Most participating states have chosen the capitated MMP model in which plans receive a capitated prospective monthly payment to provide services to enrollees.

MMPs are health plans that provide a high level of integration by enabling dually eligible individuals to enroll in a single plan that is responsible for all aspects of their coverage. MMPs operate under a three-way contract with the state and with CMS (Ormond et al. 2019). All MMP contracts specify that enrollees must have health risk assessments, individual care plans, and access to a care coordinator and an interdisciplinary care team (Oromond et al. 2019).

MMPs operate under a capitated arrangement. They receive a blended payment that combines Medicaid and Medicare Part A, Part B, and Part D. The portion of that payment related to Medicaid and Medicare Parts A and B is reduced by a percentage based on the amount of expected savings the demonstration will generate. The percentage reduction is set by CMS and each participating state for each year of the demonstration. The savings percentage varies but is generally 1 percent in the first year, from 1 to 2 percent in the second year, and 2 to 5 percent in subsequent years (MACPAC 2018b). MMPs are

also subject to a quality withhold in which a portion of the payment rate is withheld pending plans' performance against certain quality measures. The quality withhold is typically 1 percent in the first year, 2 percent in the second year, and 3 percent in years thereafter. For more information on the payment framework in the FAI capitated model, see MACPAC's January 2018 issue brief, *The Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare* (MACPAC 2018b).

MMPs are the most common FAI model and they operate in nine states (Table 1-3). Minnesota developed an alternative model focused on administrative alignment, and Washington is using an MFFS model. The New York Fully Integrated Duals Advantage and Virginia MMP demonstrations have already ended. Colorado's MFFS demonstration has also ended.

TABLE 1-3. Active Financial Alignment Initiative Demonstrations, February 2020

State	Type of model	Beneficiaries enrolled	Scheduled end date
California	Capitated	110,690	December 31, 2022
Illinois	Capitated	57,415	December 31, 2022
Massachusetts	Capitated	26,590	December 31, 2020
Michigan	Capitated	40,182	December 31, 2020
Minnesota	Alternative	39,315	December 31, 2020
New York, FIDA–IDD	Capitated	1,593	December 31, 2020
Ohio	Capitated	73,365	December 31, 2022
Rhode Island	Capitated	13,578	December 31, 2020
South Carolina	Capitated	18,016	December 31, 2020
Texas	Capitated	42,902	December 31, 2020
Washington	MFFS	11,544	December 31, 2020

Notes: FIDA–IDD is Fully Integrated Duals Advantage–Intellectual and Developmental Disabilities. MFFS is managed fee for service. Enrollment totals are for February 2020. Demonstration scheduled end dates may be extended at the joint discretion of CMS and the state.

Source: MACPAC, 2020, analysis of CMS monthly enrollment reports and state memoranda of understanding, Minnesota Department of Human Services health care programs managed care enrollment totals as of February 2020, and Washington State Health Care Authority FFS dual eligible demonstration monthly report as of February 2020.

Under the demonstration waiver authority, states may try to increase participation in MMPs by using passive enrollment, in which an eligible beneficiary is automatically enrolled in an MMP but maintains the ability to opt out.[9] Prior to the use of passive enrollment by MMPs, dually eligible beneficiaries had not typically been subject to passive enrollment into MA plans. Several states, however, have

mandated enrollment into Medicaid MCOs. At the start of the demonstrations, all participating states used passive enrollment (MedPAC 2018). Passive enrollment in the MMPs has been controversial, however, due to concerns that it limits beneficiary choice (Stein 2019). Many beneficiaries have opted out of the MMP or left the MMP shortly after passive enrollment (MedPAC 2018).

Despite efforts to increase participation in MMPs, enrollment has been lower than expected. As of June 2017, about 28 percent of eligible beneficiaries were enrolled across the nine participating states (MedPAC 2018). Ohio had the highest participation rate, at about 68 percent. The Medicare Payment Advisory Commission (MedPAC) found that from October 2013 to April 2016, about 41 percent of passively enrolled beneficiaries opted out, although the rate varied across states (MedPAC 2018). With the exception of the California and New York demonstrations, all MMP demonstrations continue to use passive enrollment in some form, generally for people who become newly eligible for coverage under both programs (MedPAC 2018).

MA dual eligible special needs plans aligned with managed long-term services and supports

MA D-SNPs were introduced under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) as a type of MA plan designed to serve the specific needs of dually eligible beneficiaries. They were made permanent under the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123). Each D-SNP must develop a model of care that describes the unique characteristics and needs of the dually eligible population served and establishes processes for coordinating care and conducting health risk assessments for enrolled beneficiaries (CMS 2016).

MLTSS plans receive a capitated payment from states to provide LTSS covered by Medicaid. These services and supports can include long-stay nursing facility services and services provided at home and in the community, such as personal care, respite care, meal delivery, adult day care, and transportation.

A D-SNP and MLTSS plan can be aligned, meaning beneficiaries can be enrolled for their Medicare and Medicaid services through the same entity.[10] This arrangement can simplify care for enrollees and increase efficiency, while providing greater

opportunities for care coordination among services covered by Medicaid and Medicare.

Statutory changes have incrementally improved the ability to integrate Medicaid and Medicare through D-SNPs. The Medicare Improvements for Patients and Providers Act 2008 (MIPPA, P.L. 110-275) and BBA 2018 both sought to increase care coordination for full-benefit dually eligible beneficiaries. MIPPA requires D-SNPs to hold a contract with the state Medicaid agency in any state in which they seek to operate (Table 1-2). Thus, such contracts are sometimes referred to as MIPPA contracts. This requirement expanded states' ability to integrate care for dually eligible beneficiaries. For example, in their MIPPA contracts, states can require D-SNPs operating in their state to offer an aligned MLTSS plan. Alternatively, states can require any MLTSS plan to offer a companion D-SNP (GAO 2020).

BBA 2018 made the authority for special needs plans, including D-SNPs, permanent. In addition, beginning in 2021, D-SNPs must meet new information-sharing requirements to further coordinate the delivery of Medicaid services. Within the parameters set forth in federal regulations, D-SNPs that are not designated as a FIDE SNP or HIDE SNP must identify within their MIPPA contracts a process to share information with the state or its designee when certain full-benefit dually eligible beneficiaries are admitted to a hospital or skilled nursing facility (42 CFR 422.107(d)). The state must specify the group of high-risk individuals for whom a notification must be sent and the time frame and process for sending notifications to either the state or a designee of the state's choosing.[11]

In 2020 there are D-SNPs, including FIDE SNPs, operating in 42 states and the District of Columbia, with enrollment totaling 2.6 million beneficiaries (CMS 2020d).[12] Although D-SNPs are available in most states, companion MLTSS programs may not operate in the same areas, limiting opportunities for integration through a D-SNP (Figure 1-6).

FIGURE 1-6. Availability and Type of Dual Eligible Special Needs Plan Model, by State, 2020
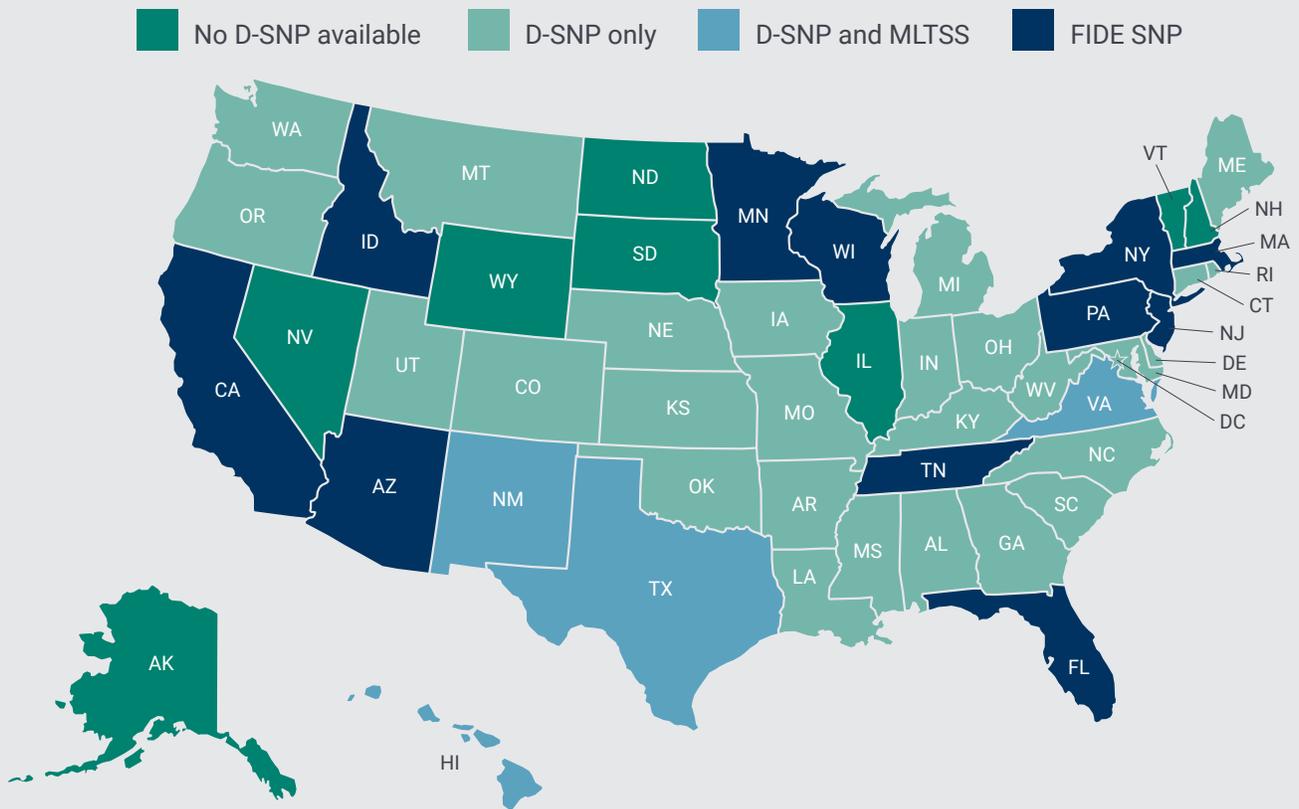
Notes: D-SNP is dual eligible special needs plan. MLTSS is managed long-term services and supports. FIDE SNP is fully integrated dual eligible special needs plan. Figure shows highest level of integration available in each state. FIDE SNPs represent the highest level of D-SNP integration.

Source: MACPAC, 2020, analysis of Medicare Advantage special needs plan landscape file for 2020, ADvancing States 2020, Kruse and Soper 2020, Lewis et al. 2018, and state websites.

HIDE SNPs and FIDE SNPs. HIDE SNPs and FIDE SNPs are D-SNPs that meet a higher level of integration by covering at least some Medicaid benefits or by providing a companion MLTSS plan, behavioral health organization, or Medicaid MCO that covers behavioral health services to full-benefit dually eligible beneficiaries (CMS 2020e).

CMS has changed the definition of HIDE SNPs beginning in 2021. To meet the new CMS criteria for designation as a HIDE SNP, the D-SNP, or a Medicaid plan affiliated with the D-SNP, must hold a MIPPA

contract with the state to cover either Medicaid LTSS or behavioral health services.[13]

To meet the criteria for designation as a FIDE SNP, a D-SNP or companion MCO under the same legal entity must cover Medicaid MLTSS, establishing its coordination through a state MIPPA contract. However, in states where behavioral health services are carved out of the capitated rate, FIDE SNPs are not required to cover behavioral health services (CMS 2020e). Likewise, where a limited scope of LTSS coverage is carved out, a D-SNP may still

qualify as a FIDE SNP or HIDE SNP.[14] FIDE SNPs must also cover at least 180 days of nursing facility services per plan year. Plans that meet these additional requirements to be designated by CMS as a FIDE SNP are considered to be more integrated than a regular D-SNP. They can further integrate benefits and increase administrative alignment.

HIDE SNPs and FIDE SNPs receive capitated payments. FIDE SNPs may also receive additional Medicare payment through a frailty adjustment if CMS determines that the beneficiaries enrolled in a FIDE SNP have an average level of frailty similar to that of enrollees in PACE (CMS 2016). States may require some or all D-SNPs operating in the state to provide capitated Medicaid benefits under a Medicaid MCO; these D-SNPs may meet the criteria for designation as a HIDE SNP or FIDE SNP (CMS 2020e).

The reach of FIDE SNPs is limited but is increasing. As of February 2020, there were FIDE SNPs in 11 states, enrolling 280,000 beneficiaries, up from 9 states and 131,471 enrollees in 2016 (Figure 1-6) (CMS 2020d and Verdier et al. 2016).[15]

The Financial Alignment Initiative's managed fee-for-service model

MFFS is a FAI demonstration model for integrating care. As the name implies, beneficiaries enrolled in this model receive care through FFS, rather than through a capitated arrangement. Each beneficiary is assigned a care coordinator to coordinate benefits and help the beneficiary meet care needs. Under MFFS, a state provides the up-front investment in care coordination and is then eligible for a retrospective performance payment if it meets an established quality threshold and Medicare achieves a target level of savings (CMS 2012).

To date, the MFFS model has only been used by two states. Washington initiated its demonstration in 2013 and continues to use the model. Colorado's demonstration began in 2014 and ended in December 2017 when enrollees transitioned to

Colorado's Accountable Care Collaborative delivery system (CMS 2019d).

Under the Washington demonstration, the state uses Medicaid health homes to coordinate care for participating dually eligible beneficiaries.[16] The state launched the FAI demonstration and the health homes program at the same time, making it possible to use the enhanced Medicaid matching rate available under the health homes option to fund some of the up-front investment.[17] The beneficiary has a multidisciplinary care team, which includes a care coordinator. Because the program uses FFS Medicaid, beneficiaries may be seen by any Medicaid-enrolled provider participating with a qualified health home. This demonstration also promotes access to community supports and services such as housing assistance (CMS 2012). The demonstration operates statewide and, as of February 2020, had enrolled 11,544 dually eligible beneficiaries, or 39 percent of those eligible (HCA 2020).

Program of All-Inclusive Care for the Elderly

PACE provides health care services to certain frail individuals age 55 and older who meet criteria for a nursing home level of care but are able to live safely in the community. Almost all PACE beneficiaries—90 percent—are dually eligible for Medicaid and Medicare (NPA 2019).

The first PACE site opened in the 1970s as a demonstration, and the program was permanently authorized by the Balanced Budget Act of 1997 (P.L. 105-33). PACE sites are designed to serve a specific geographical area, providing a range of care needs, including primary care, social services, and meals. PACE organizations have a physical site and staff who provide many services through an adult day program that serves beneficiaries at the site, in their homes, and in the community. PACE organizations also contract with providers and specialists in the community to provide health care to beneficiaries (CMS 2020h).

PACE operates through a three-way partnership between CMS, the state, and the PACE organization. Programs receive separate capitated payments from Medicare and the state Medicaid agency.

PACE programs operate in 31 states. The number of PACE organizations available varies by state, ranging from 1 organization operating in 12 states to 19 organizations operating in Pennsylvania (ICRC 2020b).

PACE serves relatively few beneficiaries; in April 2020, total PACE enrollment was about 49,000, less than 1 percent of dually eligible individuals, and the average PACE site serves fewer than 200 members (ICRC 2020b, NPA 2019). Low enrollment reflects both the resource intensity of establishing a PACE site and competition with state-operated programs (Gross et al. 2004).

Evaluations of Integrated Care Models

There is a limited but growing body of evidence examining whether models of integrated care improve health outcomes and access to care and reduce spending.[18] Studies to date have generally found decreased rates of hospitalization and readmission for dually eligible beneficiaries. Findings regarding use of other services, such as emergency department (ED) visits and LTSS, have been mixed. Several studies estimated effects on per-person Medicare spending. However, due to a lack of recent Medicaid data, most evaluations to date are not able to evaluate effects on Medicaid spending. For more information on integrated care evaluations, see MACPAC's July 2019 issue brief (MACPAC 2019b).

Medicare-Medicaid Plans

CMS has funded formal evaluations of the FAI, which are published on a rolling basis, with evaluations planned for every year of each demonstration. Preliminary results have been mixed (MACPAC 2019b).

MMP enrollment is associated with decreased inpatient admissions, decreased skilled nursing facility admissions, and reductions in ED use across several demonstrations (CMS 2020i). Effects on other services, such as nursing facility admissions and experiences with care coordination, vary. For example, the evaluation report for the first year of Michigan's demonstration found decreases in inpatient admissions, ambulatory care sensitive condition admissions, ED visits, preventable ED visits, and physician evaluation and management visits (Holladay et al. 2019). There was no change in the rate of 30-day all-cause readmission rates or the probability of a follow-up visit after mental health inpatient discharge within 30 days. The evaluation found that the rate of long-stay nursing facility admissions increased and also found reduced barriers to accessing prescription drugs (Holladay et al. 2019).

Where preliminary results regarding spending are available, the results are also mixed. Some demonstrations reported reduced Medicare spending while others did not (MACPAC 2019b).[19] For example, the evaluation report of Ohio's FAI found Medicare savings in the first demonstration period, but showed no statistically significant changes in Medicare spending when the first and second demonstration periods were combined (Bayer et al. 2018).

Dual eligible special needs plans

Evaluations of integrated care under D-SNPs have found evidence of reduced hospitalizations, readmissions, and nursing facility admissions. For example, in a study of Visiting Nurse Services of New York's CHOICE health plan, which uses continuous care management for dually eligible beneficiaries, hospitalization for enrollees decreased by 54 percent over 24 months, readmissions within 30 days dropped by 24 percent, and ED visits decreased by 27 percent. There was

also a 21 percent relative reduction in the trend for the 30-day all-cause readmission rate between 2009 and 2011 (Bihrle Johnson and McCarthy 2013).

There is also some evidence of decreased per-person Medicare spending. One study found that increased D-SNP penetration (the share of dually eligible beneficiaries enrolled in D-SNPs) was associated with reduced Medicare per-person spending (Zhang and Diana 2017). A 1 percent increase in D-SNP penetration was associated with a 0.2 percent reduction in Medicare spending per-person. The study found no effect on Medicaid spending.

Managed fee for service

The most recent formal evaluation of Washington State's MFFS demonstration shows mostly positive results, including decreased inpatient admissions, skilled nursing facility admissions, and long-stay nursing facility use (Justice et al. 2019). However, there has been an increase in the all-cause readmission rate and the rate of preventable ED visits. The evaluation report also identified gross reductions in Medicare spending of $213.9 million during the initial 42 months of the demonstration (Justice et al. 2019).[20] Washington was able to share in these Medicare savings.

An evaluation of the Colorado MFFS demonstration, which ended in December 2017, found that Medicare spending per member per month increased in the first demonstration period, decreased in the second, and afterward returned to baseline spending (Sandler et al. 2019b, Wilkin et al. 2017).

Program of All-Inclusive Care for the Elderly

A number of studies found that PACE was associated with lower inpatient hospital use (Segelman et al. 2017, Jones et al. 2013, Meret-Hanke 2011, Beauchamp et al. 2008). However, there are mixed results on nursing facility use among PACE participants. Some studies have

shown increases in nursing facility use (Ghosh et al. 2015, Beauchamp et al. 2008). But one study found a decrease on this measure (Segelman et al. 2017).

Similarly, some evaluations find increased Medicaid spending (Ghosh et al. 2015, Foster et al. 2007). Others show decreased spending (Wieland et al. 2013, Foster et al. 2007). Considering the comprehensiveness of the PACE benefit and the level of impairment among participants, a showing of comparative savings in a given study may be dependent on whether the study compares PACE participants to HCBS waiver enrollees or to nursing facility residents.

The Future of Integrated Care

Despite the development of multiple models for integrating care and the considerable work at both the state and federal levels, only about 10 percent of dually eligible beneficiaries are now enrolled in integrated care, that is, about 1 million beneficiaries (CMS 2020a). In the Commission's view, integrated care can lead to better care for individuals and more effective and efficient coordination between Medicaid and Medicare. In the next chapter, we discuss policy mechanisms to achieve these goals and make initial recommendations aimed at increasing enrollment in and availability of integrated care models.

Endnotes

[1] This count is on an ever-enrolled basis. Individuals are counted as ever-enrolled if they were enrolled in Medicare and Medicaid at the same time for at least one month of the calendar year.

[2] This growth rate outpaces the rate of growth for Medicare-only beneficiaries, which was 2.7 percent over the same time period, increasing from 37.0 million to 50.7 million individuals. Unless otherwise noted, dually eligible beneficiaries refers to both full-benefit dually eligible beneficiaries and partial-benefit dually eligible beneficiaries.

[3] Individuals must pay Medicare taxes through work for at least forty quarters (10 years) for the individual and his or her spouse to qualify for coverage of Medicare Part A premiums at age 65. Individuals eligible for Social Security Disability Insurance (SSDI) benefits or Railroad Retirement Board (RRB) benefits are eligible for Medicare after qualifying for SSDI or RRB for 24 months (CMS 2019b).

[4] For more information on the pathways to Medicaid eligibility for dually eligible beneficiaries, see the eligibility topic page on the MACPAC website at https://www.macpac.gov/subtopic/dually-eligible-beneficiaries-eligibility/.

[5] MA plans were first authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), replacing the previous Medicare+Choice program that was authorized under the Balanced Budget Act of 1997 (P.L. 105-33).

[6] Most programs limit enrollment to older adults and people with physical disabilities; dually eligible beneficiaries with intellectual or developmental disabilities are enrolled in MLTSS in only a few states.

[7] Integrated care programs include Medicare-Medicaid Plans (MMPs), fully integrated dual eligible special needs plans (FIDE SNPs), Program of All-Inclusive Care for the Elderly (PACE), managed fee for service (MFFS), and integrated dual eligible special needs plans (D-SNPs) where enrollees receive Medicaid and Medicare services from companion or aligned Medicaid managed care plans and D-SNPs.

[8] Minnesota chose to continue its longstanding program called Minnesota Senior Health Options in partnership with MMCO under the FAI to increase administrative alignment. MFFS uses the original Medicaid and Medicare payment model, and pays providers based on the services used.

[9] The use of passive enrollment differs across Medicaid and Medicare. In Medicaid, it is common for non-dually eligible populations to be automatically enrolled in managed care. States can automatically enroll dually eligible beneficiaries under a waiver, but are prohibited from doing so otherwise. In Medicare Advantage, automatic enrollment is not widely used for any population.

[10] To be considered aligned, the state's MLTSS plan contract may be held either with the legal entity providing the D-SNP, the parent organization of the D-SNP, or a subsidiary owned and controlled by the parent organization of the D-SNP.

[11] An example of a state already imposing a D-SNP data-sharing requirement is Pennsylvania. The state requires D-SNPs to send a notification of hospital and skilled nursing facility admissions for all D-SNP enrollees. The D-SNP shares information directly with the beneficiary's MLTSS plan within 48 hours of admission (ICRC 2019).

[12] This count excludes the 20 D-SNPs operating in Puerto Rico, which enroll 277,000 beneficiaries (CMS 2020d).

[13] To qualify as a HIDE SNP, a D-SNP must cover LTSS or Medicaid behavioral health services under a state contract, either directly with the legal entity providing the D-SNP, the parent organization of the D-SNP, or a subsidiary owned and controlled by the parent organization of the D-SNP (CMS 2019c).

[14] Such carve outs must be consistent with state policy. CMS will determine whether a plan may be designated as a FIDE SNP or HIDE SNP based on the specific circumstances (CMS 2020e).

[15] As of February 2020, FIDE SNPs operate in Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Tennessee, and Wisconsin. However, the FIDE SNPs in Florida had not yet enrolled any beneficiaries (CMS 2020d).

[16] Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services. Health homes use an interdisciplinary care team that may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or other professionals that would provide services to the enrolled population (CMS 2020f).

[17] Section 1945 of the Act (established in section 2703 of the ACA) gives states the option under their state plans to establish health homes to coordinate care for people with chronic conditions. States choosing this option receive 90 percent federal match for the first eight quarters that the program is in operation (CMS 2020g).

[18] To assess the status of research on the performance of integrated care models, MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to compile an inventory of existing evaluations of integrated care models. SHADAC conducted a systematic review to identify peer-reviewed studies and gray literature (i.e., government-sponsored and other non-peer reviewed reports) published between January 2004 and November 2018. We updated the inventory to July 2019 with evaluations of the FAI (MACPAC 2019a).

[19] Savings and loss calculations for the MMPs are calculated based on the capitated payment made to the MMPs, and are not based on the cost of services used (MACPAC 2019b).

[20] The Washington MFFS demonstrations began on July 1, 2013, and the initial evaluation period ended on December 31, 2016. Separate Medicare savings are calculated for the Washington MFFS demonstration using an actuarial approach. Although the purpose and methods of calculating these savings differ, both show statistically significant savings as a result of the Washington demonstration (Sandler et al. 2019a).

References

ADvancing States. 2020. MLTSS Map. Arlington, VA: ADvancing States. http://www.advancingstates.org/initiatives/managed-long-term-services-and-supports/mltss-map.

Assistant Secretary for Planning and Evaluation (ASPE). U.S. Department of Health and Human Services. 2016. *Report to Congress: Social risk factors and performance under Medicare's Value-Based Purchasing Programs*. Washington, DC: ASPE. https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.

Barth, S., S. Silow-Carroll, E. Reagan, et al. 2019. Care coordination in integrated care programs serving dually eligible beneficiaries: Health plan standards, challenges and evolving approaches. Report to the Medicaid and CHIP Payment and Access Commission. Lansing, MI: Health Management Associates. https://www.macpac.gov/publication/care-coordination-in-integrated-care-programs-serving-dually-eligible-beneficiaries-health-plan-standards-challenges-and-evolving-approaches/.

Bayer, E.J., S. Holladay, D. Justice, et al. 2019. *Financial Alignment Initiative Texas dual eligible integrated care demonstration project: First evaluation report*. Report to CMS, contract no. HHSM-500-2014-00037i TO#7. Waltham, MA: RTI International. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXEvalReportDY1042019.pdf.

Beauchamp, J., V. Cheh, R. Schmitz, et al. 2008. *The effect of the Program of All-Inclusive Care for the Elderly (PACE) on quality*. Report to CMS, contract no. 500-00-0022(01). Princeton, NJ: Mathematica Policy Research. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Beauchamp_2008.pdf.

Bihrle Johnson, M., and D. McCarthy. 2013. *The Visiting Nurse Service of New York's Choice Health Plans: Continuous care management for dually eligible Medicare and Medicaid beneficiaries*. New York, NY: Commonwealth Fund. http://www.commonwealthfund.org/~/media/files/publications/case-study/2013/jan/1659_mccarthy_care_transitions_vnsny_case_study_v2.pdf.

Burke, S., H. Claypool, C. Jennings, et al. 2016. *Delivery system reform: Improving care for individuals dually eligible for Medicare and Medicaid*. Washington, DC: Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Dual-Eligible-Recommendations.pdf.

Bynum, J.P.W., A. Austin, D. Carmichael, and E. Meara. 2017. High-cost dual eligibles' service use demonstrates the need for supportive and palliative models of care. *Health Affairs* 36, no. 7: 1309-1317. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0157.

Centers for Disease Control and Prevention (CDC). U.S. Department of Health and Human Services. 2020. People who are at higher risk for severe illness. Atlanta, GA: CDC. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020a. *FY 2019 Report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020b. *Data analysis brief: Managed care enrollment trends among dually eligible and Medicare-only beneficiaries, 2006 through 2018*. Baltimore, MD: CMS. https://www.cms.gov/files/document/managedcareenrollmenttrendsdatabrief.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020c. About the Medicare-Medicaid Coordination Office. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Coordination/Medicare-Medicaid-Coordination-Office.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020d. *SNP comprehensive report 2020 02*. Baltimore, MD: CMS. https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldataspecial-needs/snp-comprehensive-report-2020-02.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020e. Letter from Sharon Donovan to Dual Eligible Special Needs Plans regarding "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)." January 17, 2020. https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020f. *Medicaid health homes: An overview*. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020g. Health homes. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020h. PACE. Baltimore, MD: CMS. https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2020i. State-specific evaluation reports. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2019a. Annual (Medicare-Medicaid Duals) Enrollment Trends (Ever-enrolled). September 2019. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2019b. Original Medicare (Part A and B) eligibility and enrollment. November 2019. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2019c. Letter from Seema Verma to state Medicaid directors regarding "Three new opportunities to test innovative models of integrated care for individuals dually eligible for Medicaid and Medicare." April 24, 2019. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19002.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2019d. Colorado managed fee-for-service financial alignment model demonstration. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Colorado.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2017. 2017 Managed care enrollment by program and population (duals). 2017. Baltimore, MD: CMS. https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/388z-vsy3.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2016. Chapter 16B: Special needs plans. In *Medicare managed care manual*. (Rev.123, 8-19-16). Baltimore, MD: CMS. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2012. CMS and Washington state partner to coordinate care for Medicare-Medicaid enrollees. October 2012 fact sheet. Baltimore, MD: CMS. https://www.cms.gov/newsroom/fact-sheets/cms-and-washington-state-partner-coordinate-care-medicare-medicaid-enrollees.

Congressional Budget Office (CBO). 2013. *Dual-eligible beneficiaries of Medicare and Medicaid: Characteristics, health care spending, and evolving policies*. June 2013. Washington, DC: CBO. https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf.

Foster, L., R. Schmitz, and P. Kemper. 2007. *The effects of PACE on Medicare and Medicaid expenditures*. Report to CMS, contract no. 500-00-0033(01). Princeton, NJ: Mathematica Policy Research. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Foster_PACE_2009.pdf.

Ghosh, A., R. Schmitz, and R. Brown. 2015. *Effect of PACE on costs, nursing home admissions, and mortality: 2006–2011*. Report to Office of Disability, Aging, and Long-Term Care Policy, Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, contract no. HHSP23320095642WC. Washington, DC: ASPE. https://aspe.hhs.gov/system/files/pdf/76971/PACEeffect_0.pdf.

Grabowski, D.C. 2007. Medicare and Medicaid: Conflicting incentives for long-term care. *The Milbank Quarterly* 85, no. 4: 579-610. https://www.milbank.org/quarterly/articles/medicare-and-medicaid-conflicting-incentives-for-long-term-care/.

Gross, D.L., H. Temkin-Greener, S. Kunitz, and D.B. Mukamel. 2004. The growing pains of integrated health care for the elderly: Lessons from the expansion of PACE. *The Milbank Quarterly* 82, no. 2: 257–282. https://www.milbank.org/quarterly/articles/the-growing-pains-of-integrated-health-care-for-the-elderly-lessons-from-the-expansion-of-pace/.

Health Care Authority (HCA), Department of Social and Health Services, State of Washington. 2020. *Washington State's fee-for-service dual eligible demonstration monthly report*. March 2020. Olympia, WA: HCA. https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf.

Haber, S., N.T. Zheng, S. Hoover, and Z. Feng. 2014. *Effect of state Medicaid payment policies for Medicare cost sharing on access to care for dual eligibles*. Report to MACPAC. November 2014. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-Payment-for-Cost-Sharing.pdf.

Holladay, S., E.J. Bayer, I. Dave et al. 2019. *Financial Alignment Initiative Michigan MI health link: First evaluation report*. Report to CMS, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://innovation.cms.gov/Files/reports/fai-mi-firstevalrpt.pdf.

Integrated Care Resource Center (ICRC). 2020a. Medicare 101 and 201: Key issues for states. Presentation from an ICRC webinar, February 2020. https://www.integratedcareresourcecenter.com/webinar/medicare-101-and-201-key-issues-states-0.

Integrated Care Resource Center (ICRC). 2020b. Program of All Inclusive Care for the Elderly (PACE) total enrollment by state and organization. Accessed April 2020. Washington, DC. https://www.integratedcareresourcecenter.com/resource-library?&field_resource_category%5B0%5D=271.

Integrated Care Resource Center (ICRC). 2019. Update on state contracting with D-SNPs: The basics and meeting new federal requirements for 2021. Presentation from an ICRC webinar, July 9, 2019. https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021.

Jones, D., N. Duda, B. Schmitz, et al. 2013. *Study of access and quality of care in for-profit PACE*. Report to CMS, contract no. HHSM-500-2005-00025I/HHSM-500-T0005. Cambridge, MA: Mathematica Policy Research. https://innovation.cms.gov/pace-access-qualityreport.pdf.

Justice, D., E. Bayer, M. Toth, et al. 2019. *Financial Alignment Initiative Washington Health Homes MFFS demonstration: Third evaluation report*. Report to CMS, contract no. HHSM-500-2014-00037i TO#7. Waltham, MA: RTI International. https://innovation.cms.gov/Files/reports/fai-wa-thirdevalrpt.pdf.

Kruse, A., and M.H. Soper. 2020. *State efforts to integrate care for dually eligible beneficiaries: 2020 update.* Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf.

Lewis, E., S. Eiken, A. Amos, and P. Saucier. 2018. *The growth of managed long-term services and supports programs: 2017 Update*. Ann Arbor, MI: Truven Health Analytics. http://www.advancingstates.org/sites/nasuad/files/mltssp-inventory-update-2017.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Dually eligible beneficiaries. Washington, DC: MACPAC. https://www.macpac.gov/topics/dually-eligible-beneficiaries.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Provider payment and delivery systems. Washington, DC: MACPAC. https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. *Inventory of evaluations of integrated care programs for dually eligible beneficiaries*. Washington, DC: MACPAC. https://www.macpac.gov/publication/inventory-of-evaluations-of-integrated-care-programs-for-dually-eligible-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. *Evaluations of integrated care models for dually eligible beneficiaries: Key findings and research gaps*. July 2019 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018a. *State Medicaid payment policies for Medicare cost sharing*. September 2018 state policy compendium. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018b. Financial Alignment Initiative for beneficiaries dually eligible for Medicaid and Medicare. January 2018 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 6: Effects of Medicaid coverage of Medicare cost sharing on access to care. In *March 2015 Report to Congress on Medicaid and CHIP*. March 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/effects-of-medicaid-coverage-of-medicare-cost-sharing-on-access-to-care/.

Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission (MACPAC and MedPAC). 2018. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MACPAC and MedPAC. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

Medicare Payment Advisory Commission (MedPAC). 2019. *A data book: Health care spending and the Medicare program*. June 2019. Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0.

Medicare Payment Advisory Commission (MedPAC). 2018. Chapter 9: Managed care plans for dual-eligible beneficiaries. In *Report to the Congress: Medicare and the health care delivery system*. June 2018. Washington, DC: MedPAC. http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf.

Meret-Hanke, L. 2011. Effects of the Program of All-Inclusive Care for the Elderly on hospital use. *Gerontologist* 51, no. 6: 774–785. https://doi.org/10.1093/geront/gnr040.

National PACE Association (NPA). 2019. *PACE by the numbers*. Alexandria, VA: NPA. https://www.npaonline.org/sites/default/files/3186_pace_infographic_update_121819_combined_v1.pdf.

Ormond, C., G. Khatutsky, T. Thach, et al. 2019. *Financial Alignment Initiative California Cal MediConnect: First evaluation report*. Report to CMS, contract no. HHSM-500-2014-00037i TO #7. Durham, NC: RTI International. https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf.

Reaves, E.L., and M. Musumeci. 2015. *Medicaid and long-term services and supports: A primer*. December 2015. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

Sandler, M., L. Zhao, A. Simms, et al. 2019a. *Report for Washington managed fee-for-service (MFFS) final demonstration year 3 and preliminary demonstration year 4 Medicare savings estimates: Medicare-Medicaid Financial Alignment Initiative*. Report to CMS, contract no. HHSM-500-2014-00037i TO#7. Durham, NC: RTI International. https://innovation.cms.gov/Files/reports/fai-wa-finalyr3preyr4.pdf.

Sandler, M., L. Zhao, T. Trapnell, et al. 2019b. *Preliminary savings report for Colorado managed fee-for-service (MFFS) demonstration period 2: Medicare-Medicaid Financial Alignment Initiative*. Report to CMS, contract no. HHSM-500-2014-00037i. Durham, NC: RTI International. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/COCostReportDY2012019.pdf.

Segelman, M., X. Cai, C. Reenen, and H. Temkin-Greener. 2017. Transitioning from community-based to institutional long-term care: Comparing 1915c waiver and PACE enrollees. *Gerontologist* 57, no. 2: 300–308. https://academic.oup.com/gerontologist/article/57/2/300/2631971.

Sharma, L. 2014. *Miles to go: Progress on addressing racial and ethnic health disparities in the dual eligible demonstration projects*. Boston, MA: Community Catalyst. https://www.communitycatalyst.org/resources/publications/document/Miles-to-Go-Health-Disparities-in-the-Dual-Eligible-DemonstrationsFINAL.pdf.

Soper, M.H. and H. Menelas. 2019. *Facilitating community transitions for dually eligible beneficiaries*. Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/resource/facilitating-community-transitions-for-dually-eligible-beneficiaries/.

Sorbero, M.E., A.M. Kranz, K.E. Bouskill, et al. 2018. *Addressing social determinants of health needs of dually eligible beneficiaries in Medicare Advantage plans*. Report to ASPE, contract no. HHSP23320095649WC-TO38. Santa Monica, CA: RAND Corporation. https://aspe.hhs.gov/system/files/pdf/259896/MAStudy_Phase2_RR2634-final.pdf.

Stein, M. 2019. CMS to extend duals demo, invites other states to join. *Inside Health Policy.* April 24. https://insidehealthpolicy.com/daily-news/cms-extend-existing-duals-demos-invites-other-states-join.

U.S. Government Accountability Office (GAO). 2020. *Medicare and Medicaid: Alignment of managed care plans for dual-eligible beneficiaries*. Report no. GAO-20-319. Washington, DC: GAO. https://www.gao.gov/assets/710/705345.pdf.

Verdier, J., A. Kruse, R. Lester, et al. 2016. *State contracting with Medicare Advantage dual eligible special needs plans: Issues and options*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Issues__Options.pdf.

Wieland, D., B. Kinosian, E. Stallard, and R. Boland. 2013. Does Medicaid pay more to a Program of All-Inclusive Care for the Elderly (PACE) than for fee-for-service long-term care? *Journal of Gerontology Medical Sciences* 68, no. 1: 47–55. https://doi.org/10.1093/gerona/gls137.

Wilkin, J., L. Zhao, T. Trapnell, et al. 2017. *Preliminary savings report for Colorado managed fee-for-service (MFFS) demonstration period 1: Medicare-Medicaid Financial Alignment Initiative*. Report to CMS, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://innovation.cms.gov/Files/reports/fai-co-prelimyr1savings.pdf.

Zhang, Y., and M. Diana. 2017. Effects of early Dual-Eligible Special Needs Plans on health expenditure. *Health Services Research* 53. no 4: 2165–2184. https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.12778.

APPENDIX 1A: Integrated Care Models

TABLE 1A-1. Models of Integrated Care for Dually Eligible Beneficiaries, by State, 2020

State	D-SNP	MLTSS	Aligned D-SNP and MLTSS	FIDE SNP	FAI	PACE
Total	**43**	**24**	**12**	**11**	**11**	**31**
Alabama	✓	—	—	—	—	✓
Alaska	—	—	—	—	—	—
Arizona	✓	✓	✓	✓	—	—
Arkansas	✓	—	—	—	—	✓
California	✓	✓	✓	✓	✓	✓
Colorado	✓	—	—	—	—	✓
Connecticut	✓	—	—	—	—	—
Delaware	✓	✓	—	—	—	✓
District of Columbia	✓	—	—	—	—	—
Florida	✓	✓	✓	✓[1]	—	✓
Georgia	✓	—	—	—	—	—
Hawaii	✓	✓	✓	—	—	—
Idaho	✓	✓	—[2]	✓	—	—
Illinois	—	✓	—	—	✓	—
Indiana	✓	—	—	—	—	✓
Iowa	✓	✓	—	—	—	✓
Kansas	✓	✓	—	—	—	✓
Kentucky	✓	—	—	—	—	—
Louisiana	✓	—	—	—	—	✓
Maine	✓	—	—	—	—	—
Maryland	✓	—	—	—	—	✓
Massachusetts	✓	✓	—[2]	✓	✓	✓
Michigan	✓	✓	—	—	✓	✓
Minnesota	✓	✓	✓	✓	✓[3]	—
Mississippi	✓	—	—	—	—	—
Missouri	✓	—	—	—	—	—
Montana	✓	—	—	—	—	—
Nebraska	✓	—	—	—	—	✓
Nevada	—	—	—	—	—	—

TABLE 1A-1. (continued)

State	D-SNP	MLTSS	Aligned D-SNP and MLTSS	FIDE SNP	FAI	PACE
New Hampshire	–	–	–	–	–	–
New Jersey	✓	✓	–[2]	✓	–	✓
New Mexico	✓	✓	✓	–	–	✓
New York	✓	✓	✓	✓	✓	✓
North Carolina	✓	✓[4]	–	–	–	✓
North Dakota	–	–	–	–	–	✓
Ohio	✓	✓	–	–	✓	✓
Oklahoma	✓	–	–	–	–	✓
Oregon	✓	–	–	–	–	✓
Pennsylvania	✓	✓	✓	✓	–	✓
Rhode Island	✓	✓[5]	–	–	✓	✓
South Carolina	✓	✓[5]	–	–	✓	✓
South Dakota	–	–	–	–	–	–
Tennessee	✓	✓	✓	✓	–	✓
Texas	✓	✓	✓	–	✓	✓
Utah	✓	–	–	–	–	–
Vermont	–	–	–	–	–	–
Virginia	✓	✓	✓	–	–	✓
Washington	✓	–	–	–	✓	✓
West Virginia	✓	–	–	–	–	–
Wisconsin	✓	✓	✓	✓	–	✓
Wyoming	–	–	–	–	–	✓

Notes: D-SNP is dual eligible special needs plan. MLTSS is managed long-term services and supports. FIDE SNP is fully integrated dual eligible special needs plan. FAI is Financial Alignment Initiative. PACE is Program of All-Inclusive Care for the Elderly.

✓ Check mark indicates the model is available in the state.

– Dash indicates the model is not available in the state.

[1] Florida has a FIDE SNP, but as of March 2020, there are no reported enrolled beneficiaries.

[2] All D-SNPs in Idaho, Massachusetts, and New Jersey are FIDE SNPs, and therefore are not categorized as Aligned D-SNPs and MTLSS.

[3] Minnesota has developed a demonstration outside the capitated or managed fee-for-service models and is focused on administrative alignment.

[4] North Carolina currently limits its MLTSS program to beneficiaries with intellectual and developmental disabilities.

[5] In Rhode Island and South Carolina, MLTSS programs only serve enrollees in the Financial Alignment Initiative, and do not align with D-SNPs.

Sources: MACPAC, 2020, analysis of Medicare Advantage special needs plan landscape file for 2020, ADvancing States 2020, ICRC 2020b, and state websites.

Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

Recommendations

2.1 The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. 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, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

2.2 Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Key Points

- Dually eligible beneficiaries may experience fragmented care and poor health outcomes when their Medicaid and Medicare benefits are not coordinated. Integrating care for this high-cost, high-need population has the potential to improve care and reduce federal and state spending, but only about 10 percent of dually eligible beneficiaries are enrolled in integrated care programs.

- MACPAC's work is focusing on strategies to increase enrollment in integrated models, make integrated products more widely available, and promote greater integration in existing products. The Commission has heard from a variety of stakeholders about innovative and successful efforts to integrate care as well as about the challenges associated with implementing these programs.

- Given lower than expected enrollment in Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative, changes in policy are needed to promote higher enrollment and retention of enrollees. The Commission's recommendation would allow eligible beneficiaries to enroll into MMPs at any time but limit opportunities to change plans and disenroll.

- States face resource constraints and competing priorities that impede the development of essential Medicare expertise and limit their ability to finance the up-front costs of establishing integrated care models. To enhance state capacity, the Commission recommends additional federal funding to train state staff in Medicare and to cover up-front costs of designing and implementing new models.

- The Commission's work in this area is a multiyear project that will focus on a range of policy options that further integrated care. For example, we are planning additional work to understand state use of default enrollment as a tool to increase enrollment in dual eligible special needs plans (D-SNPs) aligned with managed long-term services and supports. We also expect to explore how the MMP model could be made more widely available and how states can maximize their contracting authority to tailor D-SNP contracts.

CHAPTER 2: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

Individuals who rely on both Medicaid and Medicare for coverage may experience fragmented care and poor health outcomes when delivery of health services and administration of benefits are not coordinated across the two programs. These 12.2 million dually eligible beneficiaries represent about one-third of total costs to the federal government and to states in each program (CMS 2020a). Integrating care has the potential to improve their health and reduce federal and state spending. Higher rates of morbidity and mortality from COVID-19 among individuals who are older or have underlying health conditions—many of whom may be dually eligible—suggest an even greater need for care coordination during this pandemic (CDC 2020).

States and the federal government have been working together to develop and implement a variety of integrated care models and increase the number of beneficiaries enrolled in them. Although some models have been in use for many years and newer options are maturing, the number of beneficiaries enrolled in integrated care remains relatively low, at about 10 percent of dually eligible beneficiaries, or about 1 million people (CMS 2020a).

There is also room for growth in the number of states participating in various integrated care models and the number of enrolled beneficiaries:

- Medicare-Medicaid Plans (MMPs), the most highly integrated option tested and available to the largest share of dually eligible beneficiaries, are available in only nine states.

- Dual eligible special needs plans (D-SNPs), including fully integrated dual eligible special needs plans (FIDE SNPs), that are aligned with managed long-term services and supports (MLTSS) programs, allowing high levels of coordination between Medicaid managed care and Medicare Advantage (MA) plans, are available in 15 states (Appendix 1A, Table 1A-1).

- States can increase integration through default enrollment of existing Medicaid managed care enrollees into affiliated D-SNPs when they become newly eligible for Medicare (previously referred to as seamless conversion); seven states currently do so (ICRC 2020a).

In the Commission's view, increasing both the availability of integrated care and the number of people enrolled in integrated models is a path to better care for individuals and more effective and efficient coordination between Medicaid and Medicare. The Commission also supports increasing the level of integration in existing models where possible to achieve an improved care experience for beneficiaries and to eliminate conflicts between Medicaid and Medicare rules and processes as well as misaligned financial incentives. Over the past year, MACPAC has focused its examination of integrated care on four key areas: increasing enrollment in integrated care, making integrated products available to more dually eligible beneficiaries, promoting greater integration in existing products, and exploring the future of coverage for dually eligible beneficiaries under a new program.

States are key actors in integrating care for dually eligible beneficiaries; their leadership in designing and implementing models appropriate to the health care needs of their residents and the available resources in their communities is crucial. At its public meetings, the Commission heard directly from states about innovative and successful efforts to integrate care. We also heard about the constraints states face, some of which the recommendations in this chapter would address. Similarly, we heard from a panel of experts representing health plan, provider, and beneficiary advocate perspectives about the challenges and opportunities associated with increasing integration.

States can use current law to promote integration, particularly through models that align MLTSS with D-SNPs; from the Commission's perspective, states should use existing authorities to the greatest extent possible. Specifically, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) provides states with the authority to design integrated care contracts with D-SNPs that go beyond minimum requirements. Along with new requirements for integration under the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), states have a great deal of flexibility to tailor contracts that meet the specific needs of dually eligible beneficiaries in their states and that reflect the nature of their managed care markets. We also note that some states may be interested in making greater use of existing authorities but do not have sufficient Medicare expertise to do so effectively.

The Commission also recognizes that states do not operate in a vacuum. We are troubled by the emergence and growth of D-SNP look-alike plans, traditional MA plans that do not coordinate Medicaid and Medicare benefits but appear to be drawing dually eligible beneficiaries away from integrated care products. Stakeholders have commented that state contracting decisions may be driving such growth. The Centers for Medicare & Medicaid Services (CMS) has recently finalized regulatory changes to restrict D-SNP look-alike growth, which could alleviate concerns about the unintended consequences of strengthening D-SNP contracts with states. Still, as states consider leveraging existing authorities, they should be mindful about the potential for growth in D-SNP look-alike plans.

The Commission's work in these areas is still developing and there are a number of policy options to promote in integrated care (discussed later in this chapter) that we will be focused on in the future. In this chapter, we make two recommendations, which we consider to be modest but important steps toward increasing the availability of, and enrollment in, integrated care models. Specifically, the Commission recommends the following:

- The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. 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, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

- Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Future Commission work on integrated care will further examine approaches to increase enrollment in integrated products, make those products more widely available, and promote greater integration in existing products. We are planning additional work to understand the role of Medicare agents and brokers in bringing eligible people into integrated products and state use of default enrollment as a tool to increase enrollment in D-SNPs aligned with MLTSS. We expect to explore ways that the MMP model could be made more widely available. We will also review how states are using MIPPA authority and plan to explore any potential issues around differing network adequacy standards between Medicaid and Medicare. We anticipate taking a deeper look at the effects of enrolling partial-benefit dually eligible beneficiaries in integrated products and the potential benefits of limiting state contracts with D-SNPs to those whose parent organization offers an MLTSS plan. We will also continue to track the growth of D-SNP look-alike plans to assess how they may be affecting integration efforts.

The chapter focuses on three themes that have guided our work:

- increasing enrollment in integrated models,

- making integrated products more widely available, and

- promoting greater integration in existing products.

We also describe our analytic plan for the future. Finally, the Commission presents the rationale for its recommendations and their expected impact on federal and state spending and on stakeholders, including beneficiaries, plans, and providers.

Increasing Enrollment in Integrated Models

Despite federal and state efforts to develop integrated care programs, only about 1 million dually eligible beneficiaries, or about 10 percent, are enrolled in integrated care models (CMS 2020a). Enrollment has been lower than expected in the Financial Alignment Initiative (FAI); of the nine states operating capitated models, only Ohio, with about 68 percent of eligible beneficiaries enrolled, had a participation rate above 50 percent as of June 2017 (MedPAC 2018).[1] California and Texas both had participation rates below 30 percent. Factors associated with low enrollment in the FAI include the unwillingness of long-term services and supports (LTSS) providers to participate and the ability of beneficiaries to make frequent plan changes, including disenrolling at any time (Lipson et al. 2018). As is discussed later in this chapter, stakeholders have also expressed concern that D-SNP look-alike plans are drawing beneficiaries away from integrated care models. On the other hand, the use of default enrollment into D-SNPs has helped facilitate integration in some states. It requires Medicaid managed care and may be easiest with an MLTSS program and data sharing processes that are not in place in every state.

Given these challenges, the Commission has focused its attention over the past year on policies that could increase both enrollment of eligible individuals into integrated products and state development of integrated care models. At this time, the Commission is ready to make a modest but important recommendation to increase

enrollment in MMPs through an exception to the special enrollment period (SEP), described in more detail later in this chapter.

The Commission's inquiry has surfaced some additional opportunities to increase enrollment in integrated models, but more analysis is needed to understand their dynamics. The Commission is also working to understand the role of Medicare agents and brokers in potentially directing dually eligible beneficiaries to non-integrated products. Below we share some preliminary thoughts regarding default enrollment and Medicare agents and brokers.

Default enrollment

Under current law, default enrollment, previously known as seamless conversion, is the primary automatic enrollment mechanism available to states and MA plans for enrolling Medicaid managed care beneficiaries into affiliated D-SNPs when they become eligible for Medicare but is not widely used.[2] As of March 2020, only seven states are using this tool. Arizona, Colorado, Kentucky, Oregon, Pennsylvania, Tennessee, and Virginia each have at least one D-SNP approved for default enrollment (ICRC 2020a). The limited take-up may be due to a lack of infrastructure needed for implementation, such as Medicaid managed care plans and D-SNPs operating under the same parent company.

State authority under current law. Default enrollment into D-SNPs requires state approval. Individuals eligible for default enrollment into a D-SNP are Medicaid beneficiaries who retain their eligibility for full Medicaid benefits after they become eligible for Medicare and remain enrolled in a comprehensive Medicaid managed care plan (Stringer and Kruse 2019).[3] Under Medicare rules, beneficiaries can opt out of default enrollment and instead receive their Medicare benefits through Medicare fee for service (FFS) or another MA plan.

Data sharing. States seeking to increase integration could make default enrollment into D-SNPs easier by establishing a process to obtain

Medicare eligibility data and sharing it with D-SNPs. States can do this by identifying the CMS data they will use, reviewing data at least monthly to monitor future eligibility for Medicare, and determining both the mechanism and the frequency with which the state will share data with D-SNPs (Stringer and Kruse 2019).

Medicaid eligibility redeterminations. States using default enrollment must also promptly redetermine Medicaid eligibility so D-SNPs have enough time to notify beneficiaries at least 60 days in advance of default enrollment, as required by law. Federal regulations require states to periodically review Medicaid eligibility and make redeterminations promptly if necessary (Stringer and Kruse 2019).[4] In states that redetermine Medicaid eligibility when an individual becomes eligible for Medicare, that redetermination should occur before the default enrollment process begins (Stringer and Kruse 2019). At that time, the state can notify the D-SNP that the individual will become eligible for Medicare and remain eligible for Medicaid. Potential D-SNP enrollees who do not retain Medicaid coverage upon enrolling in Medicare will not be dually eligible and therefore do not qualify for enrollment in a D-SNP.

State take-up. States that contract with at least one D-SNP that offers a Medicaid managed care plan are best positioned to use default enrollment because D-SNPs must link to a Medicaid managed care entity to implement default enrollment (ICRC 2020a). States with MLTSS programs and D-SNPs that have overlapping parent companies are best positioned to use this mechanism.

Ongoing Commission work. The Commission plans to examine use of default enrollment in states, particularly those with MLTSS programs, and opportunities for facilitating its use. As part of this work, the Commission will work to identify barriers to default enrollment, given that the authority to use this mechanism is already in place under current law.

Understanding the role of Medicare agents and brokers

Medicare agents and brokers can affect enrollment in integrated products but the role they play in doing so is not well documented or understood.[5] Some policymakers have voiced concerns that Medicare agents and brokers acting on behalf of companies that contract with Medicare may have incentives to steer dually eligible beneficiaries away from integrated products (Lipson et al. 2018). MA plans rely heavily on Medicare agents and brokers who market directly to potential beneficiaries and receive compensation from multiple plans for doing so (Verdier and Chelminsky 2017).

In contrast, this type of unsolicited direct marketing is generally not permitted under Medicaid managed care (Verdier and Chelminsky 2017). State Medicaid programs typically contract with enrollment brokers who are independent of plans and thus work on behalf of beneficiaries in helping them choose a plan. However, these Medicaid enrollment brokers may be unfamiliar with Medicare and may not be prepared to assist beneficiaries in enrolling in Medicare products (Verdier and Chelminsky 2017). The Integrated Care Resource Center (ICRC), a national initiative of CMS to provide technical assistance to states interested in developing integrated care programs, published technical assistance for states participating in the FAI aimed at improving the effectiveness of Medicaid enrollment brokers in counseling beneficiaries on Medicare products (Chelminsky et al. 2017).[6]

MMPs have generally been prohibited from compensating brokers for steering eligible beneficiaries toward their plans, but in 2018, CMS provided an exception in California, allowing compensation in the state (CMS 2018a). It is too early to know the impact of this policy. States may benefit from additional clarification, either in federal regulation or in guidance, regarding the role of Medicare agents and brokers in the FAI and more broadly, including when compensation is permissible.

Ongoing Commission work. The Commission will focus on the role of Medicare agents and brokers in the next report cycle. As part of this work, we will explore compensation for agents and brokers employed by a single plan or by multiple plans and the effect on plan enrollment.

Exception to the special enrollment period for dually eligible beneficiaries in MMPs

Federal regulations at 42 CFR 423.38 permit dually eligible beneficiaries to qualify for an SEP for MA plans and Medicare Part D that allows them to enroll, switch plans, or disenroll outside of the annual open enrollment period. Until January 1, 2019, that SEP was continuous, meaning that dually eligible beneficiaries could enroll, disenroll, or switch plans monthly; after that date, the SEP was modified to once per quarter for the first nine months of the year (i.e., three times per year) (CMS 2018b, ICRC 2018). Although the SEP is an MA policy, it also applies to MMPs under the FAI (CMS 2018b, ICRC 2018).

States participating in a capitated model under the FAI were given the option to waive the narrower SEP, and all states did so for 2019 and 2020, primarily because of concerns that the narrower SEP would reduce opportunities for beneficiaries to enroll at any time (ICRC 2018, Lakhmani 2020). Thus, unlike other dually eligible beneficiaries, beneficiaries in MMPs can enroll, switch between MMPs, and disenroll at any time through the end of 2020.

The Commission's recommendation, which is described in greater detail below, would maintain the continuous SEP for purposes of enrolling in MMPs, but apply the narrower SEP to switching plans or disenrolling. This change would allow MMP-eligible individuals to benefit from the continuity of care that the narrower SEP was intended to promote while continuing to allow eligible beneficiaries to enroll at any time.

CMS made a similar proposal in the Medicare-Medicaid Coordination Office (MMCO) fiscal year

(FY) 2019 annual report to Congress (CMS 2020a). The proposal would limit the SEP to dually eligible beneficiaries seeking to switch plans after being auto-assigned to a Medicare Part D prescription drug plan or to enroll in an integrated product (CMS 2020a). For all other coverage changes, dually eligible beneficiaries would use the same annual enrollment period as all other MA beneficiaries.[7] It appears that this legislative proposal also applies to MMPs because it does not explicitly exempt them from the change. The CMS proposal goes further than MACPAC's recommendation in that it applies to all beneficiaries enrolled in MA plans, rather than only dually eligible beneficiaries enrolled in MMPs, and it sets more limits on coverage changes. Because it requires a change in Medicare policy, a step which is beyond MACPAC's statutory authority to recommend, our recommendation focuses on MMPs. The Commission may examine the implications of this broader policy on Medicaid in the future.

Ongoing Commission work. In this chapter, the Commission recommends continuing to allow monthly enrollment into MMPs but applying the narrower SEP to switching plans and disenrolling (Recommendation 2.1). In future work, the Commission will continue to look for ways to increase enrollment in integrated care models.

Making Integrated Products More Widely Available

The goals of integrated care programs—to improve the quality of care (including the beneficiary experience) and program efficiency—can only be achieved if these models are widely available to beneficiaries. Many beneficiaries, however, do not have access to an integrated care model. The Commission is exploring policies that would make integrated products more widely available to dually eligible beneficiaries or position states to take advantage of existing opportunities to integrate care. Although MMPs are the most highly integrated model outside of the Program of All-Inclusive Care

for the Elderly (PACE), they are not widely available. As noted above, only nine states operate MMPs and, in most cases, only in a portion of the state; only Rhode Island has a statewide MMP (EOHHS 2020). In the other FAI states with capitated models, MMPs are generally located in population centers with the largest share of dually eligible beneficiaries (MACPAC 2020a). CMS encouraged additional states to participate in the FAI in an April 2019 letter to state Medicaid directors, but states have expressed little interest in pursuing this opportunity (CMS 2019a, Gifford et al. 2019).

Other integrated options are similarly limited in terms of take-up; for example, even in states that operate MLTSS programs aligned with D-SNPs, D-SNPs are not always available statewide. According to our analysis of CMS data on D-SNP availability in 2020, D-SNPs are available in 42 states and the District of Columbia, and are offered statewide in 23 states (Appendix 1A, Table 1A-1, MACPAC 2020a). However, in 19 states, D-SNPs are only available in certain counties. Where D-SNPs are unavailable, beneficiaries are generally limited to receiving their Medicare benefits only through FFS or a traditional MA plan (including D-SNP look-alike plans), neither of which coordinates with beneficiaries' Medicaid benefits.

Improving state capacity on Medicare

Integrating care for dually eligible beneficiaries requires states to design programs and develop D-SNP contracts; doing so requires expertise in Medicare both at program launch and on an ongoing basis. Because Medicaid and Medicare operate largely independently of each other, there has not been much incentive for state staff to develop such expertise. States have no role in administering the Medicare program and are not necessarily familiar with its rules and regulations. States have not typically coordinated coverage of Medicaid services with Medicare, in part because the dually eligible population, even today, mostly receives their services through FFS (MACPAC and MedPAC 2018). Although states can coordinate

care for dually eligible beneficiaries in the FFS environment, such as by using health homes, formal integrated care models have primarily been implemented under the umbrella of managed care (CMS 2020a).

Many states do not have resources to invest in gaining Medicare expertise (Kruse and Soper 2020). States have many competing priorities related to high-cost, high-need populations, including implementation of both electronic visit verification for personal care services and the home- and community-based services (HCBS) settings rule (MACPAC 2019a, 2019b). In addition, staff responsible for integrated care activities are often also responsible for other managed care programs or LTSS initiatives (Kruse and Soper 2020). In many states, expansion to the new adult group under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) continues to be a focal point for Medicaid agency staff.

CMS, directly and through the ICRC, has made technical assistance on Medicare available to states, including webinars, sample contract language, and technical briefs (ICRC 2020b, 2019, 2017, Libersky et al. 2017). However, technical assistance is often not a sufficient substitute for dedicated in-house expertise in state agencies; officials from Arizona and Virginia—states with long histories of integrated care efforts—told the Commission in 2018 about the importance of having state staff who are knowledgeable about Medicare (Betlach and Kimsey 2018). Arizona has staff assigned to Medicare issues such as D-SNP contracting, commenting on regulations regarding D-SNP quality, and interacting with plans. Similarly, Virginia developed a Medicare unit to inform its work with D-SNPs; the state defined this as a priority need and reassigned positions to achieve its goal. The Virginia official noted that additional funds would be useful to assist state efforts, because not every state has the same level of support from its administration and legislature (Betlach and Kimsey 2018).

In the Commission's view, providing states with additional resources to finance the development of Medicare expertise would advance integrated care efforts (Recommendation 2.2). Similar efforts were made for states interested in the FAI in 2011, when CMS granted 15 states up to $1 million each to develop new care models for dually eligible beneficiaries (CMS 2011). States used those funds to develop proposals to participate in the demonstration as well as to hire staff, engage external contractors, and support data analytics. New resources could help states overcome existing capacity limits, as described in the recommendations section later in this chapter.

Ongoing Commission work. In this chapter, the Commission recommends additional federal funding for states to help them develop the Medicare expertise necessary to integrate care for their dually eligible populations. The Commission will continue to monitor state capacity to implement integrated care programs and how it is affected by new demands, including responding to the COVID-19 pandemic.

Funding up-front costs of establishing integrated care models

States interested in establishing new integrated care programs may not have sufficient financial resources to plan and implement those programs. Integrating care for dually eligible beneficiaries requires states to make up-front investments to design programs and build infrastructure. States also incur ongoing expenses to maintain programs once they are launched. Even when there is interest in integrating care, however, states have many competing priorities, and resources are often tight. For example, it may be difficult for states to dedicate existing staff to a new integrated care model when staff time is already committed to other Medicaid initiatives, particularly in states where there is no specific unit or division in the Medicaid agency dedicated to dually eligible beneficiaries. Staff must be pulled in from a number

of different units or new staff may be needed to both set up and maintain these programs.

Creating a dedicated funding source could also help additional states develop a managed fee-for-service (MFFS) model; for instance, when Washington State developed its MFFS model under the FAI, the state was able to take advantage of other resources to launch its program. Washington's model includes a retrospective shared savings component in which the state and CMS share savings generated by the demonstration, a feature that may be attractive to other states (Archibald et al. 2019a). Because any shared savings would be retrospective, however, the up-front investment required by this model may pose challenges for many states. Washington was able to overcome this issue because it was also launching a health homes program at the same time as it established its demonstration. The health homes option under section 1945 of the Social Security Act includes an enhanced federal medical assistance percentage (FMAP) available for two years. States not incorporating health homes into their MFFS models would not have access to the enhanced FMAP, so creating a dedicated funding source could help pay for staff and other up-front costs in states seeking to develop an MFFS model.

In 2019, CMS issued guidance outlining opportunities for states to develop alternative models to the existing capitated options (CMS 2019a). CMS expressed willingness to consider state suggestions as well as MFFS models such as the one developed by Washington State (CMS 2019a). States may be more likely to pursue a new model if funding is made available.

Ongoing Commission work. In Recommendation 2.2, the Commission recommends additional funding for states. In the future, the Commission will continue to monitor state needs and how available funding affects state action on integrated care.

Strengthening Medicare-Medicaid Plans

The MMPs operating under the FAI represent the most fully integrated model currently available to the largest number of dually eligible beneficiaries; coverage under the two programs is seamless to the beneficiary, who is enrolled in just one plan. Financing for MMPs is integrated because CMS and the states jointly develop Medicaid and Medicare capitation rates as part of their contract negotiations (CMS 2020b). MMPs operate in the nine states with capitated models and have 386,331 enrollees as of February 2020 (ICRC 2020c). In this section, we discuss potential options to strengthen MMPs and explore the possibility of expanding the MMP model beyond the FAI.

Studies have obtained feedback from beneficiaries about their experiences in the MMPs: The CMS evaluations, conducted by RTI International (RTI), included findings from beneficiary focus groups and found that beneficiaries who used care coordinators were pleased with the service (Ptaszek et al. 2017). An analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a beneficiary survey that MMPs are required to conduct every year, found that 63 percent of enrollees gave their MMPs the highest possible rating in 2017. Beneficiaries also noted improvements in overall health care quality and ease of making appointments and obtaining prescription drugs (MedPAC 2018). In the CAHPS, MMPs ranked similarly to other MA plans and Medicare FFS (MedPAC 2018). Other studies found mixed results around care coordination, with some beneficiaries reporting positive experiences with their care coordinators, such as improved goal setting and fewer disruptions in health care coverage, while others could not identify their care coordinators (MACPAC 2019c).

Strengthening MMPs. Because of the high level of integration possible in MMPs, the Commission is interested in exploring ways to strengthen existing MMPs and to expand the MMP model beyond the FAI. One approach would be to create a frailty

adjustment to the capitation rate to account for the population mix an MMP may serve.[8] Such an adjustment could offset some of the costs to plans associated with providing coverage to a high-cost, high-need population like dually eligible beneficiaries. The Commission may also explore the value of creating a permanent authority for MMPs or an MMP-like model pending completion of the remaining FAI evaluations. We will also look into current limitations on MMP enrollment, including limits on who may enroll (e.g., individuals under age 65) and limits on what services are covered (e.g., carving out behavioral health services).

Expanding the MMP model. MMPs provide Medicare-covered services and Medicaid-covered services and they are required to provide care coordination (CMS 2020b). All MMPs operate under a three-way contract with the state and CMS (CMS 2020b). To apply the MMP model to health plans outside of the FAI, the Secretary of the U.S. Department of Health and Human Services (the Secretary) could be authorized to establish health plans similar to MMPs. The Commission will investigate the possibility of establishing plans outside of the FAI that are based on the MMP model.

Ongoing Commission work. The Commission plans to explore ways to strengthen the MMPs as described above. This work could include discussions with CMS to understand the possibility of applying a frailty adjustment to an MMP and discussions with states, to the extent feasible, to gauge interest in expansions of the MMP model.

Addressing network adequacy standards for D-SNPs

As noted earlier, D-SNPs are not available statewide in 19 states. There are no federal requirements that D-SNPs be made available in every county although states can include requirements in their MIPPA contracts that plans serve certain geographic areas (42 CFR 422.107, Verdier et al. 2016). Medicare network adequacy requirements may be a barrier to

plan entry into some areas (Archibald et al. 2019b). A 2019 report released by the U.S. Department of Health and Human Services notes concerns from states and plans that MA network adequacy standards do not fully account for state geography (Archibald et al. 2019b). In one instance, state officials noted that D-SNPs were told by CMS to include providers located across a lake. While the distance across the lake was short, getting there by road required a full day's drive; the state had accounted for this in its own Medicaid network adequacy standards, but CMS had not (Archibald et al. 2019b).

The Commission is concerned that the reach of integrated care programs is limited in part because D-SNPs cannot meet network adequacy requirements in certain areas where they could otherwise likely provide sufficient beneficiary access to services. One solution might be to develop a process for state input into CMS review of D-SNP networks (Archibald et al. 2019b). This approach has been used at least once before: Archibald and colleagues (2019b) report that CMS consults with the state of Minnesota on network standards as part of the administrative alignment model under the FAI demonstration. In particular, CMS took the state's input into consideration as it assessed provider networks and reviewed network exceptions requests. Both CMS and the state's FIDE SNPs gave positive feedback on this process and its effects (Archibald et al. 2019b).

Another potential solution would be to allow D-SNPs to operate in areas where they meet certain Medicaid requirements, even if they do not meet Medicare requirements.[9] Finally, in assessing D-SNP networks, CMS could take into account the extent to which the Medicaid non-emergency medical transportation benefit (NEMT) can help enrollees access providers in a broader geographic area.

Ongoing Commission work. The Commission plans to explore the feasibility of these options and their potential effects on D-SNP availability and beneficiary access to care. This work might include interviews with states and plans to understand the

effects of differing network adequacy standards in Medicaid and Medicare. Other planned MACPAC work on NEMT may also shed light on the extent to which this benefit is addressing access concerns.

Promoting Greater Integration in Existing Products

Since the late 1990s, Congress has provided states with a variety of authorities to integrate care for dually eligible beneficiaries, including the Balanced Budget Act of 1997 (P.L. 105-33) which established the PACE program and MIPPA, which established D-SNP contract requirements. A continuum of integrated care has evolved from these authorities. At the least integrated end of that continuum are D-SNPs that only meet minimum requirements for state contracts under MIPPA. These requirements ensure that a relationship with the Medicaid agency exists, but they do not require D-SNPs to cover any Medicaid benefits (42 CFR 422.107). Some states have pursued greater integration by aligning their D-SNP contracts with MLTSS programs; D-SNPs may or may not cover Medicaid benefits in these arrangements, but MLTSS and D-SNP contracts are coordinated to promote integration. D-SNPs that assume capitation for certain Medicaid benefits include FIDE SNPs and highly integrated special needs plans (HIDE SNPs). An alternative to capitated models relying on D-SNPs is the MFFS model that Washington currently operates under the FAI. At the highest end of the integration continuum are PACE and MMPs under the FAI. For descriptions of each model and how they are being used by states, see Chapter 1 of this report.

Many states have pursued multiple paths to integrating care for dually eligible beneficiaries; for example, Ohio participates in the FAI and has PACE sites. As noted earlier under the FAI, nine states operate a capitated model, Washington operates an MFFS model, and Minnesota has an alternative model. State approaches to D-SNP contracting include 11 states with FIDE SNPs and 12 that align

MLTSS and D-SNPs. (Some states have both.) PACE programs operate in 31 states (Appendix 1A, Table 1A-1).

State choices regarding integrated care options are guided by a variety of factors. In addition, as states gain experience with integrated care, their programs may evolve. For example, it may be difficult for states with no integrated products to move directly to a HIDE SNP or FIDE SNP. Instead, they might engage in D-SNP contracting aligned with a new or existing MLTSS program, building upon MIPPA requirements over time to tailor contracts that best meet their needs. Having plans manage LTSS or behavioral health services may then become a logical next step after those initial efforts.

It is the Commission's view that federal policy should support state efforts to move along the integrated care continuum. We have been studying several policies that could promote greater integration for dually eligible beneficiaries in models that already exist, such as those using D-SNPs. Moving forward, we will explore ways to encourage states to make better use of existing contracting authorities and selectively contract with D-SNPs, seek further insight into the growth of D-SNP look-alike plans, and examine the potential of limiting enrollment in D-SNPs to full-benefit dually eligible beneficiaries only.

Maximizing state use of D-SNP contracting authorities

D-SNP contracting authorities were delineated under MIPPA and refined in BBA 2018. As described below, some state D-SNP contracting activities go beyond these requirements.

MIPPA. MIPPA required D-SNPs to have a contract with a state Medicaid agency to operate in that state, and specified certain requirements for those contracts; these were further detailed in regulation (42 CFR 422.107, CMS 2019b). For example, contracts between D-SNPs and state Medicaid agencies must document the plan's responsibility for coordinating Medicaid benefits, the Medicaid benefits and cost-sharing protections covered under the D-SNP, and the service area covered (Box 2-1).

BOX 2-1. Regulatory Requirements for Dual Eligible Special Needs Plan Contracts with States

42 CFR 422.107 Special needs plans and dual eligibles: Contract with state Medicaid agency.

(a) *Definition.* For the purpose of this section, a contract with a State Medicaid agency means a formal written agreement between an MA [Medicare Advantage] organization and the State Medicaid agency documenting each entity's roles and responsibilities with regard to dual eligible individuals.

(b) *General rule.* MA organizations seeking to offer a dual eligible special needs plan must have a contract consistent with this section with the State Medicaid agency.

(c) *Minimum contract requirements.* At a minimum, the contract must document—

    (1) The MA organization's responsibility to—

        (i) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and

        (ii) If applicable, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services.

BOX 2-1. (continued)

(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP [special needs plan], including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act.

(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee's eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in § 422.561, a requirement for the use of the unified appeals and grievance procedures under §§ 422.629 through 422.634, 438.210, 438.400, and 438.402.

(d) *Additional minimum contract requirement*. For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid agency, individuals or entities designated by the State Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. The State Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with this requirement.

(e) Date of Compliance.

(1) Effective January 1, 2010—

(i) MA organizations offering a new dual eligible SNP must have a State Medicaid agency contract.

(ii) Existing dual eligible SNPs that do not have a State Medicaid agency contract—

(A) May continue to operate through the 2012 contract year provided they meet all other statutory and regulatory requirements.

(B) May not expand their service areas during contract years 2010 through 2012.

(2) MA organizations offering a dual eligible SNP must comply with paragraphs (c)(9) and (d) of this section beginning January 1, 2021 (42 CFR 422.107).

Note: Paragraphs (c)(9), (d), and (e)(2) become effective January 1, 2021.

BBA 2018. BBA 2018 made the authority for special needs plans, including D-SNPs, permanent. It also mandated that D-SNPs meet at least one of three requirements regarding the integration of Medicaid and Medicare benefits beginning January 1, 2021.[10] CMS has further defined these requirements in regulation and guidance (42 CFR 422.107, CMS 2020c, 2019c):

- D-SNPs can meet requirements of FIDE SNPs if they are offered by a legal entity that has a state contract to provide Medicaid benefits, including LTSS and behavioral health services, consistent with state policy. Plans can still be considered FIDE SNPs if they do not cover behavioral health services in cases where the state has decided to carve out that benefit from the capitated rate, or where they have an LTSS carve out of a minimal scope.

- D-SNPs can meet the requirements of HIDE SNPS if the legal entity offering the D-SNP, parent organization, or a subsidiary of the parent organization has a contract with the state Medicaid agency to provide LTSS, behavioral health services, or both under capitation, consistent with state policy.

- If D-SNPs do not satisfy one of the criteria above, they must notify the Medicaid agency (or other entities or individuals designated by the Medicaid agency) of hospital and skilled nursing facility admissions for high-risk full-benefit dually eligible beneficiaries. States will select the subpopulations requiring D-SNP attention and establish their own notification procedures as well as protocols, time frames, and method of notification.

BBA 2018 also directed the Secretary to unify grievance and appeals procedures for D-SNPs. To do so, CMS has established a new process for unifying grievance and appeals procedures at the health plan level for a subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment in which one organization is responsible for both Medicaid and Medicare coverage, although that may occur through separate contracts (CMS 2019c). CMS has given these plans until 2021 to unify appeals and grievances (CMS 2019c).

State activities beyond minimum requirements. Many states have gone beyond the MIPPA requirements and have been using their D-SNP contracts to further integrate care. A MACPAC-funded analysis of care coordination requirements in integrated care models found that several states had detailed care coordination requirements in their D-SNP contracts (Barth et al. 2019). For example, Virginia requires that D-SNPs train care coordinators on Medicaid benefits, coordination of Medicaid and Medicare benefits, and cost sharing (Barth et al. 2019). Given that care coordination has been cited as a benefit of enrolling in an integrated care product, these provisions show that states can use contract authorities to strengthen the ability of D-SNPs to deliver integrated care (Barth et al. 2019).

A 2016 analysis of D-SNP contracts in 13 states provides further evidence of state actions that exceed the minimum MIPPA requirements, including review of marketing materials, encounter data submission, quality improvement and external quality review, and beneficiary cost-sharing protections (Verdier et al. 2016). For example, 8 of the 13 states required D-SNPs to submit marketing materials to the state for its review (Verdier et al. 2016). To analyze beneficiary service use across Medicaid and Medicare, nine states required that D-SNPs submit encounter data, which could be linked to Medicaid data (Verdier et al. 2016).

Ongoing Commission work. The Commission encourages states to use existing authorities to the greatest extent possible. MIPPA and BBA 2018 gave states a great deal of flexibility to tailor contracts to meet the specific needs of dually eligible beneficiaries in their states and reflect the nature of their managed care markets. The Commission plans to continue work to understand the variety of state MIPPA contracts and consider what states need to maximize their use of existing authorities. In addition, the Commission plans to track state and plan implementation of requirements in BBA

2018 that would move D-SNPs toward increased alignment with Medicaid.

Increasing selective contracting with D-SNPs

Some states are using MLTSS and D-SNP contracting authorities to leverage D-SNPs in ways that best fit their integrated care approaches. Some require that their MLTSS contractors offer companion D-SNPs. Others require that a companion D-SNP continue to contract with other D-SNPs that do not have an MLTSS contract, while some states only contract with D-SNPs that are a companion to an MLTSS product (GAO 2020). A recent study of a sample of states with MLTSS and D-SNPs found that in 2019, Arizona, New Jersey, and Virginia limited D-SNPs to only those plans that had a companion MLTSS plan, while Pennsylvania and Tennessee contracted only with new D-SNPs that had a state contract, but maintained contracts with D-SNPs that had been in place prior to that policy change (GAO 2020).

Selective contracting can be beneficial because it enables dually eligible beneficiaries to receive Medicaid and Medicare benefits through plans operated by the same parent company. However, in 2019, only 44 percent (690,000 of almost 1.6 million) of full-benefit dually eligible beneficiaries were enrolled in D-SNPs in areas where the parent company also operated an MLTSS plan (MedPAC 2019a). Increasing that proportion could increase enrollment in integrated care programs.

On the other hand, selective contracting has its own challenges. First, some states may need more experience with D-SNP contracting in general before they are ready to engage in selective contracting. State procurements of MLTSS contracts also play a role, as states periodically rebid their MLTSS contracts through a competitive process that permits a limited number of plans to offer MLTSS; this may result in existing managed care organizations (MCOs) losing contracts and new MCOs entering the market. For the new MCOs to

have a companion D-SNP ready to launch, they must begin planning before knowing if they will be awarded an MLTSS contract. One plan association estimated it takes a minimum of 18 to 24 months to launch a companion D-SNP product in conjunction with an MLTSS procurement (SNP Alliance 2018). In states that do not selectively contract, plans might still be able to launch that D-SNP if they do not win an MLTSS contract. However, plans may not want to take the risk of investing in developing a D-SNP that will not be allowed to operate at all if the state only contracts with MLTSS awardees.

Selective contracting may also disrupt existing provider relationships. One recent study found two states that are now requiring MLTSS plans to have D-SNPs are continuing to allow existing D-SNPs to operate, and these states cite the potential disruption of beneficiary-provider relationships as the basis for that decision (GAO 2020). In addition, when an MLTSS contract is reprocured, and the state has chosen to align its MLTSS and D-SNP contracts, beneficiaries enrolled in a D-SNP offered by a parent company that loses its MLTSS contract will also have to change D-SNPs to remain in an integrated product. If the plan networks differ, beneficiaries will have to change providers; this is especially true if either D-SNP uses a narrow network. Finally, selective contracting may encourage the growth of D-SNP look-alike plans, discussed in the next section.

Ongoing Commission work. The Commission is interested in further exploring how states make decisions about their contracting strategies and how the dynamics of the MA bid process factor into those decisions.

Diminishing the potential for D-SNP look-alike plans to affect integrated care programs

D-SNP look-alike plans are traditional MA plans that appear to offer benefits targeted to dually eligible beneficiaries, based on their cost-sharing structure and supplemental benefits (MedPAC 2019a, 2018).[11]

Even though these plans are not permitted to limit enrollment to subgroups of Medicare beneficiaries, a large share of their enrollment is comprised of dually eligible beneficiaries. However, they are not subject to the specific requirements for D-SNPs, such as having contracts in the states where they operate or an approved model of care (42 CFR 422.101, 42 CFR 422.107).

The primary concern about look-alike plans is that they draw beneficiaries away from integrated models, acting at cross purposes to federal and state efforts to promote integration.[12] Although enrollment growth in look-alike plans may be less of a concern in states that do not have MLTSS programs or are not participating in the FAI, awareness of the potential of encouraging look-alike plan growth may affect state willingness to pursue such strategies. The Commission previously voiced concerns about the growth in D-SNP look-alike plans in a December 2018 comment letter on proposed MA regulations (MACPAC 2018). It reinforced those statements in an April 2020 comment letter on proposed rules to address D-SNP look-alike plans (MACPAC 2020b).

Availability of D-SNP look-alike plans in 2020.
Look-alike plans were first identified in California, most notably in areas where the state is offering MMPs through the FAI (MedPAC 2018). To develop figures on the current availability of such plans nationally, MACPAC analyzed MA bid data, using methods consistent with prior analyses (MedPAC 2019a). In their bids, MA plans project their total member months and how many of those months will cover dually eligible beneficiaries.[13] We used the projected member months to estimate full-year equivalent (FYE) enrollees.[14] We considered D-SNP look-alike plans to be plans where dually eligible beneficiaries comprised over 50 percent of FYE enrollees (Table 2-1).

We found that:

- The number of traditional MA plans with projected enrollment of over 50 percent dually eligible beneficiaries increased from 94 in 2019 to 98 in 2020. The number of plans with projected enrollment of over 80 percent and over 90 percent dually eligible beneficiaries also increased over this time period.

- Projected D-SNP look-alike plan enrollment grew substantially from 2019 to 2020. Total projected enrollment in these plans in 2020 was 271,080, about 23.4 percent higher than enrollment in such plans in 2019. This projected growth far exceeded projected growth in enrollment in D-SNPs and other MA plans that had dually eligible beneficiary enrollment of 50 percent or less over the same time period.

- The only plan type with projected enrollment growth exceeding that of D-SNP look-alike plans was institutional special needs plans (I-SNPs), which limit enrollment to beneficiaries who need an institutional level of care.

- In contrast, plans that enrolled over 80 percent and over 90 percent of dually eligible beneficiaries were expected to draw fewer beneficiaries from 2019 to 2020. Although there were more plans that met this threshold in 2020, their average size was smaller.

TABLE 2-1. Availability of and Projected Total Enrollment in Medicare Advantage Plan Types, 2019 and 2020

Plan type	Number of states where available		Number of plans			Projected total enrollment		
	2019	2020	2019	2020	Percent change	2019	2020	Percent change
D-SNPs	43	43	458	532	16.2%	2,363,748	2,691,834	13.9%
I-SNPs	40	45	125	150	20.0	90,102	116,360	29.1
C-SNPs	28	30	117	158	35.0	357,139	348,777	-2.3
D-SNP look-alike plans: More than 50 percent of enrollees are dually eligible beneficiaries	35	28	94	98	4.3	219,610	271,080	23.4
D-SNP look-alike plans: More than 80 percent of enrollees are dually eligible beneficiaries	13	22	54	66	22.2	193,483	182,561	-5.6
D-SNP look-alike plans: More than 90 percent of enrollees are dually eligible beneficiaries	11	18	35	44	25.7	66,231	62,479	-5.7
Other MA plans: 50 percent or less of enrollees are dually eligible beneficiaries	50	50	2,590	3,019	16.6	13,903,562	14,975,308	7.7

Notes: D-SNP is dual eligible special needs plan. I-SNP is institutional special needs plan. C-SNP is chronic condition special needs plan. MA is Medicare Advantage. D-SNP look-alike plans are defined as traditional MA plans in which dually eligible beneficiaries comprise greater than 50 percent of projected total enrollment. Other MA plans include traditional MA plans that are not D-SNP look-alike plans, D-SNPs, I-SNPs, or C-SNPs. Dually eligible beneficiaries include both full-benefit and partial-benefit dually eligible beneficiaries. Figures exclude plans that do not provide drug coverage as well as employer plans, Medical Savings Account plans, and plans that operate only in Puerto Rico. Total enrollment includes dually eligible and Medicare-only beneficiaries. Data may somewhat undercount projected enrollment of dually eligible beneficiaries due to how certain beneficiaries are classified in bid data; thus the number of look-alike plans may be undercounted.

Source: MACPAC, 2020, analysis of 2019 and 2020 Medicare Advantage bid data from the Centers for Medicare & Medicaid Services.

D-SNP look-alike plan availability differs by state.

- The state with the most look-alike plans was California, with 40, followed by 6 in Florida and Illinois.

- Of the 98 D-SNP look-alike plans offered in 2020, 14 (14.3 percent) were offered in states that do not have D-SNPs. For example, Nevada does not contract with D-SNPs, but has three look-alike plans.

- States with multiple D-SNP look-alike plans include Arizona and Virginia. These states have integrated care programs that compete with D-SNP look-alike plans for enrollment.

- Multiple look-alike plans are also present in several states that do not have integrated care programs but where D-SNPs are available, including Connecticut, Louisiana, and Mississippi. We do not know if MCOs offering D-SNP look-alike plans first unsuccessfully pursued a D-SNP in these states, or if they chose to offer a D-SNP look-alike plan for other reasons. The effect of D-SNP look-alike plans in these states is unclear, as they are not competing with an integrated care program for beneficiaries.

Although we are unable to assess the effects of increasing enrollment in look-like plans on integrated care models, the fact that their enrollment growth exceeded D-SNPs is of concern, because many states are using D-SNPs combined with MLTSS plans as a model for integrating care for dually eligible beneficiaries.

Supplemental benefits provided by D-SNP look-alike plans. D-SNP look-alike plans may draw beneficiaries away from integrated care models due to their benefit design, including the supplemental benefits they offer (MedPAC 2019a). These supplemental benefits are not covered under Medicare FFS, but MA plans can choose to provide them using the rebate they receive if their bids are below a regional benchmark or bonuses they receive based on quality ratings (MedPAC 2019b).

Our analysis of data submitted by MA plans for their 2020 benefits packages shows that D-SNP look-alike plans provide certain supplemental benefits at rates similar to D-SNPs. For example, D-SNP look-alike plans cover non-emergency transportation and over-the-counter drugs at rates more similar to D-SNPs than to other MA plans that had dually eligible beneficiary enrollment of 50 percent or less (Table 2A-1). This suggests that D-SNP look-alike plans are tailoring their plans to provide benefits that are attractive to dually eligible beneficiaries, potentially drawing beneficiaries away from integrated products.

Concerns about D-SNP look-alike plans. The Commission has been concerned that state and federal efforts to integrate care for dually eligible beneficiaries are being undermined by the growth of D-SNP look-alike plans. In the Commission's view, it is important to understand whether enrollment growth in D-SNP look-alike plans is happening to the detriment of enrollment in integrated care plans. To gain insights into these concerns, MACPAC worked with RTI and the Center for Health Care Strategies to interview federal officials, state officials, consultants, health plan industry representatives, provider representatives, and beneficiary advocates.[15] From these interviews, we learned that:

- Stakeholders agreed that federal and state efforts to promote integrated care have inadvertently contributed to the growth of D-SNP look-alike plans. Federal efforts include regulations implementing provisions of BBA 2018 that include requiring D-SNPs to cover certain Medicaid benefits or share data on hospital and skilled nursing facility admissions of certain high-risk beneficiaries with states or the states' designees (CMS 2019b).

- Regarding state actions that might drive look-alike growth, several interviewees cited California's restrictions in the FAI, which did not allow new D-SNPs to be offered in demonstration counties (MedPAC 2018). Other state efforts cited by interviewees included selective contracting policies, discussed previously in this chapter, and state decisions not to contract with any D-SNPs.

- Stakeholders also indicated that incentives for Medicare agents and brokers put integrated products at a disadvantage and increase enrollment growth in D-SNP look-alike plans. In particular, MA plans can compensate the agents and brokers who sell their products, but this practice is often prohibited in the FAI. In addition, stakeholders shared anecdotes of misleading marketing practices by contracted agents and brokers for look-alike plans, such as marketing materials indicating a

relationship with the Medicaid program. This could lead a beneficiary to assume inaccurately that a level of coordination existed with the state to provide Medicaid benefits.

- Advocates said that beneficiary enrollment counselors, such as those with State Health Insurance Assistance Programs, are confused about what look-alike plans are and how to identify them. This is important because these counselors help dually eligible beneficiaries make plan choices and do not have financial incentives to enroll beneficiaries into specific plans.

- Stakeholders were concerned that D-SNP look-alike plans are affecting enrollment in integrated care programs. In particular, they often referred to the effects of D-SNP look-alike plans on enrollment in the FAI, particularly in California. Several also cited evidence of a small number of dually eligible beneficiaries in Minnesota disenrolling from D-SNPs to enroll in a look-alike product.

- State officials and beneficiary advocates raised concerns about the potential for negative effects on the dually eligible beneficiary care experience, although effects may depend on individual needs.

Efforts to limit D-SNP look-alike plans. CMS recently finalized regulatory changes affecting both D-SNPs and D-SNP look-alike plans (42 CFR 422.514). Beginning in 2022, CMS will not enter into an MA plan contract if 80 percent or more of projected enrollees in the plan bid are dually eligible beneficiaries. Beginning in 2023, CMS will not renew an MA plan contract if the plan has actual enrollment at this threshold as of January of the current year, unless the plan has been active for less than one year and has 200 or fewer enrollees. For example, CMS will review January 2023 plan enrollment and not renew for 2024 any plans that exceed this threshold. This requirement will apply only in states where D-SNPs or another product are authorized to exclusively enroll dually eligible beneficiaries (e.g., MMPs).

In comments submitted to CMS on the proposed rule, the Commission voiced support for a similar provision, which was in line with our prior comments urging the agency to monitor this issue and take action (MACPAC 2020b, 2018). The Commission suggested that after finalizing the rule, CMS should continue monitoring look-alike plans and, if plans under the 80 percent threshold continue to grow, consider whether a lower threshold is warranted.

Ongoing Commission work. The Commission will continue monitoring D-SNP look-alike availability and enrollment and any effects of CMS's finalized regulatory changes.

Limiting D-SNP enrollment to full-benefit dually eligible beneficiaries

Some policymakers and stakeholders have suggested that limiting D-SNP enrollment to full-benefit dually eligible beneficiaries could improve integration of Medicaid and Medicare for this population (GAO 2020, MedPAC 2019a). Currently, state decisions affect whether partial-benefit dually eligible beneficiaries can enroll in D-SNPs; as of 2019, 35 states and the District of Columbia permitted such enrollment (MedPAC 2019a).[16] About one-third of partial-benefit dually eligible beneficiaries enrolled in MA plans chose a D-SNP.

Benefits of excluding partial-benefit dually eligible beneficiaries from D-SNPs. D-SNPs were designed to coordinate care across Medicaid and Medicare for dually eligible beneficiaries. Partial-benefit dually eligible beneficiaries may not benefit from this feature, because they are not eligible for the Medicaid services that could be coordinated across the two programs, such as LTSS and behavioral health services.

Allowing partial-benefit dually eligible beneficiaries to enroll in D-SNPs may dilute care coordination efforts designed for full-benefit dually eligible beneficiaries, because D-SNPs must develop a specific model of care for the population they intend to serve (42 CFR 422.101). When plan enrollees are eligible for different services, it is more difficult to

develop a single process for coordinating Medicaid and Medicare needs and to provide materials explaining benefits covered in integrated programs.

Benefits of maintaining state option to enroll partial-benefit dually eligible beneficiaries in D-SNPs. There are several arguments for retaining state flexibility to enroll this population. First, partial-benefit dually eligible beneficiaries currently enrolled in D-SNPs may at some point have a change in eligibility status and become full-benefit dually eligible beneficiaries. If these beneficiaries cannot initially enroll in D-SNPs, there is greater potential for disruptions in care when they become eligible for full Medicaid benefits, because they would have to change plans to gain the benefits of integrated care. For example, over the course of three years, from January 2013 to January 2016, 10 percent of partial-benefit dually eligible beneficiaries had a change in eligibility status that qualified them as full-benefit dually eligible beneficiaries (MedPAC 2018).

Second, D-SNPs may be better positioned than traditional MA plans to provide support specific to partial-benefit dually eligible beneficiaries. Through a health risk assessment process, required of all D-SNPs, that is tailored to the dually eligible population, D-SNPs may recognize the additional benefits that partial-benefit dually eligible beneficiaries qualify for, such as a state HCBS waiver slot, or help connect them to other community resources (CMS 2014).[17] The D-SNP may even help a partial-benefit dually eligible beneficiary identify that they qualify for full Medicaid benefits and update their eligibility status. The member could then remain in the D-SNP with uninterrupted care.

Although removing currently enrolled partial-benefit dually eligible beneficiaries from D-SNPs may disrupt their care, this disruption could be mitigated if they are able to enroll in an MA plan offered by the same parent organization if it has a similar provider network (MedPAC 2018). In 2016, the parent organizations of 93 percent of D-SNP plans also offered a regular MA plan in the same service

area (MedPAC 2018). If partial-benefit dually eligible beneficiaries switch to the parent organization's regular MA plan, the providers available to them may not change, resulting in minimal disruption.

Ongoing Commission work. The Commission plans to explore the potential effects of limiting D-SNP enrollment to full-benefit dually eligible beneficiaries. This work might include studying the prevalence of churn between eligibility for full and partial Medicaid benefits. We also expect to examine alternative policy options, such as requiring plans to remove partial-benefit dually eligible beneficiaries from D-SNPs but allowing them to enroll such beneficiaries into a separate plan with a similar network that focuses on this population.

Commission Recommendations

In this report, the Commission makes two recommendations to further integration efforts by making it easier for eligible individuals to enroll in integrated plans and enhancing state capacity to integrate care.

Recommendation 2.1

The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. 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, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

Rationale

Under current law, the SEP allows dually eligible beneficiaries to enroll, switch plans, or disenroll outside of the annual open enrollment period.

Until January 1, 2019, that SEP was open-ended or continuous, meaning that dually eligible beneficiaries could enroll, disenroll, or switch plans monthly. After that date, CMS modified the SEP to limit changes to coverage to once per quarter for the first nine months of the year (i.e., three times per year).

The SEP is an MA regulatory policy, but it also applies to MMPs under the FAI (CMS 2018b, ICRC 2018).[18] States participating in a capitated model under the FAI were given the option to waive the narrower SEP and all states did so for 2019 and 2020. As a result, unlike other dually eligible beneficiaries, beneficiaries in MMPs can enroll, switch between MMPs, and disenroll on a continuous basis. States waived the narrower SEP because it would limit enrollment to only three times per year. Given lower than expected enrollment in the MMPs across all participating states, states and plans are interested in policies that would increase enrollment. MACPAC's recommendation would maintain the continuous SEP for purposes of enrollment, but apply the narrower SEP for switching plans and disenrolling. This would allow MMP-eligible individuals to benefit from the continuity of care that the narrower SEP was intended to promote while retaining state preferences to enroll eligible beneficiaries on a continuous (monthly) basis. Federal officials told us this could be done without a regulatory change.

Implications

Federal spending. This recommendation would not have a direct effect on federal spending.

States. This recommendation would require all states with MMPs to conform to the same standard regarding beneficiaries' ability to switch MMPs or disenroll from an MMP.

Enrollees. Beneficiaries would have less flexibility to switch between MMPs or to disenroll from an MMP but could benefit from the continuity of care possible with less plan switching.

Plans and providers. MMPs would experience more continuity of enrollment under this

recommendation, because beneficiaries could switch plans or disenroll quarterly for only the first three quarters of the year.

Recommendation 2.2

Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Rationale

The Commission recommends additional federal funding to enhance state capacity to integrate care in two ways: by training state staff in Medicare and by financing the up-front costs of designing and implementing new models. States are operating with limited resources and additional federal funding could be used to help states interested in integrating care that have not yet established an integrated program. This funding would be made available to states interested in establishing any type of model identified by CMS, including capitated, MFFS, or an alternative, state-specific model (CMS 2019a).

Medicare expertise is essential for states interested in integrating care for their dually eligible beneficiaries. For example, states have discretion to set parameters for D-SNPs through contracts with the state Medicaid program, which are required for D-SNPs to operate in a state, but many states have not fully used their existing authorities, in part because of a lack of familiarity with the MA program. Designing a contract with a D-SNP requires expertise in Medicare eligibility rules, benefits, and processes (e.g., appeals and grievances) that may differ from Medicaid. It also requires familiarity with available authorities granted to states under laws like MIPPA, which allows states to establish requirements for D-SNPs before approving a contract. In addition, states have competing demands on their resources, and staff working on integrated care may have other substantial responsibilities, which make it difficult to devote resources to developing Medicare expertise.

New integrated care models require extensive planning and dedicated staff to establish them. The up-front costs may be substantial and state Medicaid agencies would generally need approval from state legislatures for the added Medicaid expense. Even if the new integrated model ultimately reduces state spending through better coordination of care, as has been shown in Washington State, states still need to finance the up-front costs of establishing the model before any potential savings can be realized.

The additional funding could take the form of an enhanced FMAP similar to the 90 percent FMAP available under current law for the transition to the Transformed Medicaid Statistical Information System (T-MSIS), available on a temporary or permanent basis. It could also be provided through a grant program, modeled after the $1 million grants made available to states participating in the FAI to cover their up-front costs (CMS 2011).

Implications

Federal spending. This recommendation would increase federal spending by the amount of the FMAP increase or the grant amount. It could also affect spending based on the extent to which states' strategies affect integration, although this may be difficult to quantify.

States. This recommendation would increase state Medicare expertise, reducing one of the barriers of moving to an integrated care model. It would enable states to leverage their MIPPA authority to integrate care through D-SNPs. It would also help states that are interested in participating in the FAI, whether they wished to use existing models or to establish a new model.

Enrollees. There is no direct effect on beneficiaries, but the eventual effect on beneficiaries will depend upon which actions states take.

Plans and providers. There is no direct effect on plans and providers, but states would be better informed in dealing with plans and might also be able to help providers adjust to new models.

Looking Ahead

Improving the implementation of integrated care for dually eligible beneficiaries, understanding the challenges faced by state and federal policymakers, and developing viable solutions are high priorities for the Commission. As noted earlier, we view our work on integrated care for dually eligible beneficiaries as a multiyear project because of the difficulty of coordinating benefits between two distinct programs for a complex population. As such, we will continue exploring the policy options described above and assess the potential for making additional recommendations in future reports.

Addressing fragmented care and high costs associated with coverage for individuals enrolled in both programs is not an easy task. In this chapter, we have discussed the varying integrated care models currently in use but we have also shown that those models are not present in all states and that many beneficiaries who have access to integrated products are not enrolled. The challenges of integrating care in the current environment have led some stakeholders to begin exploring whether the future of health care coverage for dually eligible beneficiaries requires creating a new program that is uniquely focused on this population that would no longer require these beneficiaries to navigate two sets of confusing, and often conflicting, rules. In the years ahead, the Commission will review proposals that would restructure coverage for dually eligible beneficiaries in a more comprehensive way than is possible while maintaining separate programs.

Endnotes

[1] The capitated model in the FAI establishes Medicare-Medicaid Plans (MMPs) through a three-way contract between states, health plans, and the Centers for Medicare & Medicaid Services (CMS). This model uses a capitated prospective monthly payment made to plans to provide services to enrollees. For more detailed information on the capitated model, see Chapter 1 in this report.

[2] See 42 CFR 422.66(c) for federal requirements for default enrollment.

[3] Individuals receiving Medicaid benefits through limited benefit plans or under other arrangements such as managed fee for service (MFFS) or health homes are not eligible for default enrollment (Stringer and Kruse 2019).

[4] Regulations at 42 CFR 435.916(d) require that states redetermine Medicaid eligibility promptly whenever the state receives information about a change that may affect Medicaid eligibility.

[5] For our purposes, the term Medicare agents and brokers is used to refer to entities that sell Medicare plans for companies that contract with Medicare, not employees of particular MA plans. They differ from Medicaid enrollment brokers who contract with states to assist Medicaid beneficiaries with selecting Medicaid managed care plans.

[6] The ICRC, coordinated by Mathematica and the Center for Health Care Strategies, provides technical assistance to states with support from CMS.

[7] Under CMS's proposal, dually eligible beneficiaries would use the same annual enrollment period as all other Medicare Advantage beneficiaries for everything related to coverage other than (1) switching after auto-assignment into a Part D plan or (2) enrolling in an integrated plan.

[8] This frailty adjustment would be similar to the adjustment applied to fully integrated dual eligible special needs plans (FIDE SNPs) under current law.

[9] In some cases Medicare requirements are broader than Medicaid requirements (Archibald et al. 2019b).

[10] BBA 2018 specifies that for 2021 through 2025, the Secretary may impose a sanction preventing a D-SNP

from enrolling new members if it does not meet the new integration standards. While sanctioned D-SNPs cannot enroll new members, they can continue to serve previously enrolled beneficiaries (CMS 2019b).

[11] The cost-sharing structures of D-SNP look-alike plans are not appealing to Medicare beneficiaries who do not receive the cost-sharing assistance that dually eligible beneficiaries do (MedPAC 2018).

[12] Two features of the MA market have implications for plan and beneficiary behavior relevant to the growth of look-alike plans: First, dually eligible beneficiaries may choose among FFS and multiple MA plans, including D-SNPs and others. Second, plan offerings (D-SNPs, look-alikes, and other MA plans) are the result of business decisions about different markets. In short, beneficiaries are not locked into certain types of plans and plans are not required to offer these options.

[13] Companies interested in offering an MA plan for the next contract year undergo a variety of steps to gain approval, including submitting a bid pricing tool that contains information on the cost of providing MA benefits to enrollees (CMS 2019d, ICRC 2017).

[14] These figures do not represent actual enrollment, which would have to be obtained after the plan year begins.

[15] In total, 17 interviews were conducted from October 2019 to January 2020.

[16] The states offering D-SNPs that do not allow partial-benefit dually eligible beneficiaries to enroll are Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, and Virginia.

[17] To be eligible for an HCBS waiver, beneficiaries must meet certain functional criteria, which could be identified through the health risk assessment that D-SNPs must provide (CMS 2014, 42 CFR 422.101).

[18] See 42 CFR 423.38 for federal regulations on SEPs.

References

Archibald, N., K. Moses, and L. Rava. 2019a. *Using health homes to integrate care for dually eligible individuals: Washington State's experiences*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/Washington%20case%20study_Final.pdf.

Archibald, N., M. Soper, L. Smith, et al. 2019b. *Integrating care through dual eligible special needs plans (D-SNPs): Opportunities and challenges*. Washington, DC: Assistant Secretary for Planning and Evaluation (ASPE). https://aspe.hhs.gov/pdf-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges.

Barth, S., S. Silow-Carroll, E. Reagan, et al. 2019. *Care coordination in integrated care programs serving dually eligible beneficiaries: Health plan standards, challenges and evolving approaches*. Report to the Medicaid and CHIP Payment and Access Commission. Lansing, MI: HMA. https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf.

Betlach, T., and K. Kimsey. 2018. State experiences integrating care for dually eligible beneficiaries: Panel on state perspectives. Presentation before the Medicaid and CHIP Payment and Access Commission, October 26, 2018, Washington, DC. https://www.macpac.gov/wp-content/uploads/2018/10/October-2018-Meeting-Transcript.pdf.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020. People who are at higher risk for severe illness. Atlanta, GA: CDC. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Medicare-Medicaid Coordination Office FY 2019 Report to Congress*. February 10, 2020. Baltimore, MD: CMS. https://www.cms.gov/files/document/mmco-report-congress.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Financial alignment initiative. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. Memo from Sharon Donovan regarding "Additional guidance on CY 2021 Medicare-Medicaid integration requirements for Dual Eligible Special Needs Plans (D-SNPs)." January 17, 2020. https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Letter from Seema Verma to state Medicaid directors regarding "Three new opportunities to test innovative models of integrated care for individuals dually eligible for Medicaid and Medicare." April 24, 2019. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19002.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Medicare and Medicaid programs: Policy and technical changes to the Medicare Advantage, Medicare prescription drug benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid fee-for-service, and Medicaid managed care programs for years 2020 and 2021. Final rule. *Federal Register* 73, no. 83 (April 16) 15680–15844. https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019c. CMCS informational bulletin regarding "Medicare-Medicaid integration and unified appeals and grievance requirements for state Medicaid agency contracts with Medicare Advantage dual eligible special needs plans (D-SNPs) for contract year 2021." November 14, 2019. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111419-2.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019d. Instructions for completing the Medicare Advantage Bid Pricing Tools for contract year 2020. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2020.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. Memo from Lindsay P. Barnette regarding "California MMPs: Update to agent/broker compensation policy for contract year 2019." June 11, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAAgentBrokerCompensationPolicyUpdateCY2019_06112018.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. Medicare program: Contract year 2019 policy and technical changes to the Medicare Advantage, Medicare Cost Plan, Medicare fee-for-service, the Medicare prescription drug benefit programs, and the PACE program. Final rule. *Federal Register* 83, no. 73 (April 16): 16440–16757. https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. *Medicare managed care manual: Chapter 5—Quality assessment*. Baltimore, MD: CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. 15 states win contracts to develop new ways to coordinate care for people with Medicare and Medicaid. April 14, 2011, press release. Baltimore, MD: CMS. https://edit.cms.gov/newsroom/fact-sheets/15-states-win-contracts-develop-new-ways-coordinate-care-people-medicare-and-medicaid.

Chelminsky, D., J. Stone, and C. Postman. 2017. *Tips for states using enrollment brokers in the Capitated Financial Alignment Demonstrations: Beneficiary FAQs and suggested responses*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/EnrollmentBrokersCFAMemo.pdf.

Executive Office of Health & Human Services (EOHHS), State of Rhode Island. 2020. *Fact sheet: Neighborhood INTEGRITY, Rhode Island's Medicare-Medicaid Plan*. Cranston, RI: EOHHS. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/ICI2_FactSheet_v2.pdf.

Gifford, K., E. Ellis, A. Lashbrook, et al. 2019. *A view from the states: Key Medicaid policy changes. Results from a 50-state Medicaid budget survey for state fiscal years 2019 and 2020*. Washington, DC: Kaiser Family Foundation and the National Association of Medicaid Directors. http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes.

Integrated Care Resource Center (ICRC). 2020a. Phone call with MACPAC. January 31.

Integrated Care Resource Center (ICRC). 2020b. Working with Medicare. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/resource-library?&field_resource_type%5B0%5D=306&field_resource_type%5B1%5D=307.

Integrated Care Resource Center (ICRC). 2020c. *Monthly enrollment in Medicare-Medicaid Plans by plan and by state, February 2019 to February 2020*. Accessed March 2020. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/resource/monthly-enrollment-medicare-medicaid-plans-plan-and-state-february-2019-february-2020.

Integrated Care Resource Center (ICRC). 2019. *Sample language for state Medicaid agency contracts with dual eligible special needs plans*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_SMACSampleLanguage_FINAL.pdf.

Integrated Care Resource Center (ICRC). 2018. *Enrollment periods for dually eligible beneficiaries in capitated model Financial Alignment Initiative (FAI) demonstrations.* Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/content/enrollment-periods-dually-eligible-beneficiaries-capitated-model-financial-alignment.

Integrated Care Resource Center (ICRC). 2017. *Key Medicare Advantage dates and action items for states contracting with dual eligible special needs plans.* Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf.

Kruse, A., and M.H. Soper. 2020. *State efforts to integrate care for dually eligible beneficiaries: 2020 Update.* Hamilton, NJ: CHCS. https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf.

Lakhmani, E.W., Mathematica. 2020. Email to MACPAC, January 31.

Libersky, J., J. Verdier, and R. Stringer. 2017. *Medicare basics: An overview for states seeking to integrate care for Medicare-Medicaid enrollees.* Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Medicare_Basics_Updated_June_2017.pdf.

Lipson, D., E. Lakhmani, A. Tourtellotte, and D. Chelminsky. 2018. *The complex art of making it simple: Factors affecting enrollment in integrated care demonstrations for dually eligible beneficiaries.* Washington, DC: Mathematica. https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Geographic availability of integrated care models for dually eligible beneficiaries. Presentation before MACPAC, January 23, 2020, Washington, DC. https://www.macpac.gov/publication/geographic-availability-of-integrated-care-models-for-dually-eligible-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Comment letter on proposed rule: CMS-4190-P Medicare and Medicaid Programs; contract year 2021and 2022 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, Medicaid program, Medicare Cost Plan program, and Programs of All-Inclusive Care for the Elderly (April 6, 2020). https://www.macpac.gov/publication/comments-on-proposed-rule-on-medicare-advantage/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. *Electronic visit verification for personal care services: Status of state implementation.* Washington, DC: MACPAC. https://www.macpac.gov/publication/electronic-visit-verification-for-personal-care-services-status-of-state-implementation/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. *Implementation of the home- and community-based services settings rule.* Washington, DC: MACPAC. https://www.macpac.gov/publication/implementation-of-the-home-and-community-based-services-settings-rule/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019c. *Evaluations of integrated care models for dually eligible beneficiaries: Key findings and research gaps.* July 2019 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Comment letter on proposed rule: CMS-4185-P Medicare and Medicaid programs; policy and technical changes to the Medicare Advantage, Medicare prescription drug benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid fee-for-service, and Medicaid managed care programs for years 2020 and 2021 (December 28, 2018). Washington, DC: MACPAC. https://www.macpac.gov/publication/comments-on-proposed-changes-to-medicare-advantage-dual-eligible-special-needs-plans/.

Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission (MACPAC and MedPAC). 2018. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MACPAC and MedPAC. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

Medicare Payment Advisory Commission (MedPAC). 2019a. Chapter 12: Promoting integration in dual-eligible special needs plans. In *Report to the Congress: Medicare and the health care delivery system*. June 2019. Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.

Medicare Payment Advisory Commission (MedPAC). 2019b. *Medicare Advantage program payment system*. Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_ma_final_sec.pdf?sfvrsn=0.

Medicare Payment Advisory Commission (MedPAC). 2018. Chapter 9: Managed care plans for dual-eligible beneficiaries. In *Report to the Congress: Medicare and the health care delivery system*. June 2018. Washington, DC: MedPAC. http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf.

Ptaszek, A., A. Chepaitis, A. Greene, et al. 2017. *Beneficiary experience: Early findings from focus groups with enrollees participating in the Financial Alignment Initiative*. Report to CMS, contract no. HHSM500201000021i TO 3. Baltimore, MD: Centers for Medicare & Medicaid Services. https://innovation.cms.gov/files/reports/fai-focusgroup-issuebrief.pdf.

SNP Alliance. 2018. *Enrollment alignment is essential to fully integrated care for Medicare-Medicaid beneficiaries*. Washington, DC: SNP Alliance. https://www.snpalliance.org/wp-content/uploads/2020/04/enrollment-alignment-and-integration-10-5-2018-002.pdf.

Stringer, R., and A. Kruse. 2019. *Using default enrollment to align coverage for dually eligible Medicare-Medicaid beneficiaries*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries.

U.S. Government Accountability Office (GAO). 2020. *Medicare and Medicaid: Alignment of managed care plans for dual-eligible beneficiaries*. Report no. GAO-20-319. Washington, DC: GAO. https://www.gao.gov/assets/710/705345.pdf.

Verdier, J., and D. Chelminsky. 2017. *State and health plan strategies to grow enrollment in integrated managed care plans for dually eligible beneficiaries*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf.

Verdier, J., A. Kruse, R.S. Lester, et al. 2016. *State contracting with Medicare Advantage dual eligible special needs plans: Issues and options*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Issues__Options.pdf.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP 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, fulfills 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 on integrating care for dually eligible beneficiaries. 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 Recommendation 2.1 and Recommendation 2.2 on April 2, 2020.

Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

2.1 The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. 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, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
		1	Not present
Not present:	Barker		

2.2 Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Szilagyi, Weno	15	Yes
		1	Abstain
		1	Not present
Abstain:	Scanlon		
Not present:	Barker		

MACPAC

APPENDIX 2A: Supplemental Benefits Offered by Medicare Advantage Plans

TABLE 2A-1. Selected Supplemental Benefits Offered in 2020, by Plan Type

Benefit	All MA plans		D-SNP look-alike plans		D-SNP		I-SNP		C-SNP		Other MA plans	
	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans
All plans	**3,944**	**100%**	**98**	**100%**	**531**	**100%**	**150**	**100%**	**158**	**100%**	**3,007**	**100%**
Hearing services	**3,619**	**91.8**	**91**	**92.9**	**462**	**87.0**	**126**	**84.0**	**153**	**96.8**	**2,787**	**92.7**
Hearing exams	3,597	91.2	91	92.9	453	85.3	124	82.7	153	96.8	2,776	92.3
Hearing aids	3,375	85.6	91	92.9	458	86.3	126	84.0	151	95.6	2,549	84.8
Dental services	**3,704**	**93.9**	**76**	**77.6**	**476**	**89.6**	**113**	**75.3**	**158**	**100.0**	**2,881**	**95.8**
Preventive dental	3,687	93.5	74	75.5	466	87.8	108	72.0	158	100.0	2,881	95.8
Comprehensive dental	3,461	87.8	75	76.5	456	85.9	105	70.0	149	94.3	2,676	89.0
Vision services	**3,859**	**97.8**	**94**	**95.9**	**493**	**92.8**	**144**	**96.0**	**157**	**99.4**	**2,971**	**98.8**
Eye exams	3,831	97.1	94	95.9	470	88.5	143	95.3	157	99.4	2,967	98.7
Eyewear	3,612	91.6	94	95.9	491	92.5	143	95.3	157	99.4	2,727	90.7
Preventive health services	**3,852**	**97.7**	**97**	**99.0**	**497**	**93.6**	**105**	**70.0**	**156**	**98.7**	**2,997**	**99.7**
Annual physical exam	3,183	80.7	81	82.7	316	59.5	73	48.7	80	50.6	2,633	87.6
Health education	1,152	29.2	15	15.3	133	25.0	22	14.7	60	38.0	922	30.7
Nutritional or dietary benefit	385	9.8	5	5.1	43	8.1	1	0.7	32	20.3	304	10.1
Smoking and tobacco cessation counseling	1,014	25.7	11	11.2	172	32.4	6	4.0	32	20.3	793	26.4
Fitness benefit	3,593	91.1	85	86.7	456	85.9	29	19.3	149	94.3	2,874	95.6
Enhanced disease management	277	7.0	6	6.1	14	2.6	–	–	–	–	257	8.5

TABLE 2A-1. (continued)

Benefit	All MA plans		D-SNP look-alike plans		D-SNP		I-SNP		C-SNP		Other MA plans	
	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans
Telemonitoring services	259	6.6%	6	6.1%	46	8.7%	3	2.0%	33	20.9%	171	5.7%
Remote access technologies	2,644	67.0	65	66.3	340	64.0	31	20.7	113	71.5	2,095	69.7
Bathroom safety devices	284	7.2	5	5.1	51	9.6	–	–	5	3.2	223	7.4
Counseling services	83	2.1	1	1.0	10	1.9	–	–	–	–	72	2.4
In-home safety assessment	141	3.6	6	6.1	7	1.3	1	0.7	7	4.4	120	4.0
Personal emergency response system	627	15.9	56	57.1	256	48.2	7	4.7	36	22.8	272	9.0
Medical nutrition therapy	406	10.3	12	12.2	127	23.9	1	0.7	21	13.3	245	8.1
Postdischarge in-home medication reconciliation	98	2.5	–	–	4	0.8	1	0.7	3	1.9	90	3.0
Readmission prevention	86	2.2	7	7.1	16	3.0	7	4.7	9	5.7	47	1.6
Wigs for hair loss related to chemotherapy	223	5.7	9	9.2	110	20.7	–	–	2	1.3	102	3.4
Weight-management programs	153	3.9	8	8.2	12	2.3	–	–	6	3.8	127	4.2
Alternate therapies	115	2.9	2	2.0	1	0.2	7	4.7	2	1.3	103	3.4
Therapeutic massage	186	4.7	3	3.1	35	6.6	2	1.3	12	7.6	134	4.5
Adult day health services	78	2.0	2	2.0	21	4.0	–	–	15	9.5	40	1.3
Home-based palliative care	55	1.4	–	–	3	0.6	–	–	–	–	52	1.7
In-home support services	209	5.3	15	15.3	73	13.7	1	0.7	26	16.5	94	3.1
Support for caregivers of enrollees	121	3.1	9	9.2	48	9.0	1	0.7	20	12.7	43	1.4

MACPAC

TABLE 2A-1. (continued)

Benefit	All MA plans		D-SNP look-alike plans		D-SNP		I-SNP		C-SNP		Other MA plans	
	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans
Clinical services	**3,044**	**77.2%**	**90**	**91.8%**	**477**	**89.8%**	**134**	**89.3%**	**147**	**93.0%**	**2,196**	**73.0%**
Chiropractic services	855	21.7	37	37.8	199	37.5	15	10.0	49	31.0	555	18.5
Podiatry services	1,566	39.7	63	64.3	316	59.5	131	87.3	113	71.5	943	31.4
Acupuncture	834	21.1	39	39.8	152	28.6	6	4.0	56	35.4	581	19.3
Nicotine replacement therapy	2,129	54.0	85	86.7	407	76.6	82	54.7	106	67.1	1,449	48.2
Auxiliary services	**3,333**	**84.5**	**95**	**96.9**	**517**	**97.4**	**136**	**90.7**	**157**	**99.4**	**2,428**	**80.7**
Non-emergency transportation	1,763	44.7	89	90.8	436	82.1	128	85.3	137	86.7	973	32.4
Meal benefit	1,909	48.4	49	50.0	390	73.4	8	5.3	111	70.3	1,351	44.9
Over-the-counter drugs	2,855	72.4	94	95.9	501	94.4	104	69.3	144	91.1	2,012	66.9

Notes: MA is Medicare Advantage. D-SNP is dual eligible special needs plan. I-SNP is institutional special needs plan. C-SNP is chronic condition special needs plan. D-SNP look-alike plans are defined as traditional MA plans in which dually eligible beneficiaries comprise greater than 50 percent of projected total enrollment. Other MA plans include traditional MA plans that are not D-SNP look-alike plans, D-SNPs, I-SNPs, or C-SNPs. Figures exclude plans that do not provide drug coverage as well as employer plans, cost plans, Medical Savings Account plans, and plans that operate only in Puerto Rico.

– Dash indicates zero.

Source: MACPAC, 2020, analysis of 2020 Medicare Advantage bid and plan benefits package data from the Centers for Medicare & Medicaid Services.

Chapter 3:

Improving Participation in the Medicare Savings Programs

Improving Participation in the Medicare Savings Programs

Recommendation

3.1 Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

Key Points

- Many beneficiaries who are dually eligible for Medicaid and Medicare are eligible to receive assistance paying for their Medicare premiums, cost sharing, or both, through the MSPs. Under these programs, state Medicaid programs pay for such assistance for Medicare enrollees who are low-income adults age 65 and older or people with disabilities.

- Qualifying beneficiaries must enroll in the MSPs and have their eligibility redetermined each year through their state Medicaid programs.

- Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiaries' ability to access care. Although some federal action has been taken to simplify eligibility and enrollment, participation rates remain relatively low.

- The Commission focused on the interplay between the MSPs and the Medicare Part D LIS program to increase enrollment because both provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs. Although LIS eligibility data are shared with states, different state rules for counting key MSP eligibility factors, such as income, household size, and assets, may keep states from using LIS data to determine MSP eligibility. As a result, individuals applying for the MSPs may have to submit a new application or additional documentation, which may keep many eligible beneficiaries from enrolling.

- If adopted, the recommendation would increase enrollment and retention in the MSPs while allowing states that currently use less restrictive income and asset limits to continue to do so. We also expect that it would improve access to care for beneficiaries who are unable to afford Medicare cost sharing and reduce state administrative spending. On the other hand, enrollment growth would increase state and federal spending on Medicaid and Medicare benefits. However, many of those who would enroll in the MSPs as a result of this policy change would already be eligible to participate.

CHAPTER 3: Improving Participation in the Medicare Savings Programs

Many beneficiaries who are dually eligible for Medicaid and Medicare are eligible to receive assistance in paying for their Medicare premiums, cost sharing, or both, through the Medicare Savings Programs (MSPs). Under the MSPs, state Medicaid programs pay for such assistance for Medicare enrollees who are low-income adults age 65 and older or people with disabilities. Qualifying beneficiaries must enroll in the MSPs and have their eligibility redetermined each year through their state Medicaid program.

Low enrollment in the MSPs has been an ongoing concern for policymakers because cost-sharing assistance can affect beneficiary use of services. In recent years, some federal action has been taken to simplify eligibility and enrollment in the MSPs, but participation rates remain relatively low.

Over the past year, the Commission has examined issues related to MSP enrollment, identifying barriers faced by beneficiaries and states and exploring policy options aimed at increasing participation of eligible beneficiaries and thus improving their access to care. The Commission found that varying state approaches to program administration, conflicting enrollment and eligibility requirements between the MSPs and related federal programs serving similar low-income individuals, and lack of awareness among eligible beneficiaries all contribute to low enrollment in the MSPs.

In considering how to increase enrollment, the Commission had multiple lengthy discussions of policy options of varying levels of complexity. These options ranged from a simple increase in federal funding for outreach, to streamlining eligibility and enrollment to align more closely with similar federal programs, to consolidating the multiple MSPs into

one program covering Medicare premiums and cost sharing for beneficiaries age 65 and older and people with disabilities with incomes up to 135 percent of the federal poverty level (FPL). The Commission focused much of its discussion on the interplay between the MSPs and the Medicare Part D Low-Income Subsidy (LIS) program because both programs provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs. While the Social Security Administration (SSA) administers the LIS program, which has automatic processes in place to contact and enroll many eligible individuals nationwide, the MSPs are administered by state Medicaid programs that develop their own outreach and enrollment processes. Although SSA shares LIS program eligibility data with states, different state rules for counting key MSP eligibility factors, such as income, household size, and assets, may limit a state's ability to use the LIS program data to automate their MSP enrollment process. As a result, individuals applying for the MSPs may have to initiate an application and submit additional documentation to meet state requirements, burdens that may keep many eligible beneficiaries from enrolling in the program.

In the Commission's view, two changes in federal law would improve information sharing between SSA and the states, ease administrative burden for states and beneficiaries, and contribute to increased enrollment in the MSPs. Specifically, MACPAC makes the following recommendation:

- Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

We expect that this recommendation, if adopted, would increase enrollment and retention in the MSPs while allowing states that currently use less restrictive income and asset limits to continue to do so. We also expect that adoption of the recommendation would improve access to care for beneficiaries who have foregone care due to the financial burden associated with Medicare cost sharing and that it would reduce state administrative spending. On the other hand, the resulting growth in enrollment would increase state and federal spending on Medicaid and Medicare benefits. It is important to note, however, that many of those who would enroll in the MSPs as a result of this policy change would already be eligible to participate.

The chapter begins with a brief overview of Medicaid and Medicare coverage for dually eligible beneficiaries. It then describes the MSPs and discusses participation rates and factors affecting enrollment, including state policies, program administration, and outreach. The chapter concludes with the Commission's recommendation and its rationale for adopting it.

Coverage for Dually Eligible Beneficiaries

Medicaid and Medicare cover some of the same services, but when benefits overlap, Medicare is the primary payer. As a result, Medicare generally pays for physician services, inpatient and outpatient acute care, post-acute skilled care, and prescription drugs for dually eligible beneficiaries.

All Medicare beneficiaries are eligible for the same benefits, and all are required to pay premiums and cost sharing, which can be challenging for low-income beneficiaries. For example, in 2020, premiums for Medicare Part B coverage (which covers physician services and outpatient care) are $144.60 per month and the annual deductible is $198 (CMS 2020a). Once beneficiaries meet this deductible, they typically pay 20 percent of the Medicare-approved amount for physician services,

outpatient therapy, and durable medical equipment. Medicare beneficiaries may also pay premiums and deductibles for Medicare Part A and Part D, although most people qualify for premium-free Part A because of their work history and payment of Medicare taxes.[1] Medicare beneficiaries may purchase private supplemental insurance (generally referred to as Medigap) to cover the cost of many of these copayments, coinsurance, and deductibles; the cost of such plans varies widely (CMS 2019a).

Medicaid wraps around Medicare's coverage for dually eligible beneficiaries by paying Medicare premiums and cost sharing and by covering services not covered by Medicare, such as long-term services and supports. Dually eligible beneficiaries receive either full or partial Medicaid benefits, and both groups may receive assistance through the MSPs. Partial-benefit dually eligible beneficiaries, about 29 percent of the dually eligible population (3.5 million people), are Medicare beneficiaries who qualify for the MSPs but do not receive full Medicaid benefits (MMCO 2020). They become dually eligible when they enroll in the MSPs, but outside of Medicaid assistance with their Medicare costs, they do not receive Medicaid benefits.

The majority of the dually eligible population, about 71 percent (8.7 million people), is eligible for full Medicaid benefits, but these beneficiaries may or may not qualify for an MSP (MMCO 2020). Medicaid and MSP eligibility criteria vary by state because federal law gives states flexibility in how they administer their programs. For example, states have the option to make the eligibility rules for MSPs more generous than federal standards by effectively removing asset limits or by raising income limits (MACPAC 2017). To enroll in an MSP, full-benefit dually eligible beneficiaries must meet both their state's Medicaid eligibility criteria and the income and asset limits for one of the MSPs in their state. Individuals who qualify through optional Medicaid pathways such as medically needy or special income level, referred to as other full-benefit dually eligible beneficiaries, do not meet the MSP income and asset criteria, regardless of state-set limits (CMS 1999).

Overview of the Medicare Savings Programs

Four separate MSPs provide varying levels of assistance and have different eligibility criteria (Table 3-1). They include the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, the Qualifying Individual (QI) program, and the Qualified Disabled and Working Individuals (QDWI) program. State Medicaid programs receive their regular federal medical assistance percentage (FMAP) under all of the MSPs except the QI program, which is fully federally funded.

Qualified Medicare Beneficiary program

The QMB program began in 1986 and is the most expansive of the MSPs in terms of the number of enrollees it covers and the benefits it provides. Originally a state option, Congress made the QMB program mandatory in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) (Rosenbach and Lamphere 1999). It helps pay for Medicare Part A premiums (paid only by people with fewer than 40 quarters of work history in their lifetimes) and Medicare Part B premiums, as well as Medicare coinsurance, deductibles, and copayments for individuals with incomes at or below 100 percent FPL and limited assets.

In addition to receiving assistance with their Medicare premiums and cost sharing, most QMB enrollees also qualify for full Medicaid benefits through eligibility pathways available to individuals who receive Supplemental Security Income (SSI) benefits, individuals who are low-income and age 65 and older, or people with a disability.[2] The QMB program is an entitlement, meaning that if beneficiaries meet the eligibility requirements, they are entitled to coverage (Rupp and Sears 2000).

Specified Low-Income Medicare Beneficiary program

The SLMB program was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508); it originally covered beneficiaries with limited assets and incomes between 101 percent and 110 percent FPL, a limit that was later increased to 120 percent FPL (MACPAC 2017, GAO 2012, Rosenbach and Lamphere 1999). The SLMB program provides assistance with Medicare Part B premiums only. Like the QMB program, the SLMB program is an entitlement (Rupp and Sears 2000).

Qualifying Individual program

The QI program was enacted in the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33). Initially authorized to provide assistance with the Medicare Part B premium for beneficiaries with incomes between 120 percent and 175 percent FPL and limited assets, the upper income eligibility limit was lowered to 135 percent FPL in 2002. Unlike the QMB and SLMB programs, QI program funding is provided to states through a federal allotment that is set at a specific amount each year. States receive 100 percent federal match up to the amount of the allotment.[3]

Qualified Disabled and Working Individuals program

The QDWI program was enacted as part of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). It helps pay for the Medicare Part A premium, which in 2020 can be as high as $458 per month for people under age 65 with a disability who have lost premium-free Part A coverage because they have returned to work (CMS 2019b, Merlis 2005). The QDWI program is the smallest of the MSPs in terms of enrollment because it is designed for a specific subset of dually eligible beneficiaries and covers Medicare premiums that most people are not required to pay.

TABLE 3-1. Medicare Savings Programs: Eligibility and Benefits, 2020

Program	Income range (percentage of FPL)	Helps pay for	Asset limit	
			Individual	Couple
Qualified Medicare Beneficiary (QMB)	≤ 100%	Part A premiums, Part B premiums, coinsurance, deductibles	$7,860	$11,800
Specified Low-Income Medicare Beneficiary (SLMB)	101–120	Part B premiums	$7,860	$11,800
Qualifying Individual (QI)	121–135	Part B premiums	$7,860	$11,800
Qualified Disabled and Working Individuals (QDWI)	≤ 200	Part A premiums	$4,000	$6,000

Notes: FPL is federal poverty level. The income and asset limits shown here are the federal standards; states cannot use more stringent standards but can raise the income and asset limits. In 2020, 15 states set their income or asset limits higher than federal levels.

Sources: CMS 2020b, MACPAC and MedPAC 2018.

Enrollment and Participation Rates

Individuals must apply to their state Medicaid program to enroll in the MSPs, and, like anyone applying for Medicaid, they must provide documentation to verify their eligibility. There are several ways to enroll in the MSPs. States may screen people who apply for Medicaid to see if they are also eligible for the MSPs or offer a streamlined application specifically for MSP enrollment (GAO 2012). Another point of entry is through eligibility for SSI, which provides an automatic link to Medicaid; in most states, an SSI application is also a Medicaid application (SSA 2019a). The Centers for Medicare & Medicaid Services (CMS) automatically enroll such individuals in Medicare Part B with the state paying the premium, effectively enrolling them into the MSPs (GAO 2012).[4]

Enrollment

Medicare administrative data tracks enrollment in each MSP for both full- and partial-benefit dually eligible beneficiaries. In 2018, approximately 9.9 million dually eligible beneficiaries received Medicaid assistance with their Medicare costs through the MSPs (Table 3-2). The majority of these 9.9 million enrollees, 79 percent, were enrolled in the QMB program.

TABLE 3-2. Medicare Savings Program Enrollment, 2018

Program	Enrollment	
	Number (millions)	**Percentage of total**
Total enrollment	**9.9**	**100%**
Qualified Medicare Beneficiary (QMB)	7.8	79
Specified Low-Income Medicare Beneficiary (SLMB)	1.5	15
Qualifying Individual (QI)	0.7	7
Qualified Disabled and Working Individuals (QDWI)	0.0	0

Note: 0.0 indicates a number between 0 and 0.05 that rounds to zero. Components may not sum to 100 percent due to rounding.

Source: Acumen LLC, 2019, analysis of Medicare data from the Common Medicare Environment and Medicare Enrollment Database.

Annual redeterminations. Once beneficiaries are enrolled in an MSP, federal law requires that states redetermine their eligibility at least once every 12 months. Although subject to minimum federal requirements, states have flexibility in setting up the redetermination process. If feasible, states must conduct an ex parte renewal, which means using information available to the state Medicaid agency, including information from electronic data sources, to renew eligibility without requiring additional beneficiary action. Where the state lacks sufficient information to renew eligibility or has information that would result in a loss of eligibility, states may send beneficiaries a prepopulated form containing the information available to the agency with instructions to provide any requested information and report relevant changes (42 CFR 435.916(b)).

Although dually eligible beneficiaries typically do not have big fluctuations in income that are likely to make them ineligible for Medicaid, few states have automatic renewal policies in place for the MSPs. As of 2016, four states used ex parte renewals, five states used prepopulated forms, and four states used automatic renewals for enrollees who did not have major changes in circumstances (NCOA 2016). Nevertheless, individuals have been dropped from the program for failure to produce paperwork that simply verifies that their situations have not changed. A recent study found

that almost 30 percent of new full-benefit dually eligible beneficiaries lost Medicaid coverage for at least one month during the 12 months after they became dually eligible (ASPE 2019). Of the people who lost coverage, nearly 30 percent had short breaks in coverage of one to three months, likely for administrative reasons such as lack of familiarity with Medicaid policies and eligibility verification procedures (ASPE 2019).

Participation rates

There have been a limited number of studies examining participation rates in the MSPs. Such studies are difficult to conduct in part because federal household surveys, administered by the U.S. Census Bureau and others, do not collect information on MSP participation and there are no administrative data sources that identify the universe of individuals eligible for the MSPs. Some studies have linked household survey data with administrative data, but have not distinguished among the different types of MSPs (Sears 2002, Rupp and Sears 2000).

In a 2017 report for MACPAC, the Urban Institute studied participation rates in each of the MSPs. Using data from 2009 and 2010, this analysis filled a gap in the research on MSP participation by linking survey data from the Survey of Income and Program

Participation with administrative data from the Medicaid Statistical Information System (MSIS) to estimate program-specific participation rates for the MSPs and to identify variations in participation rates by individual characteristics and geographic location. We estimated participation rates in each MSP measured by enrollees as a share of eligible beneficiaries (Table 3-3).

TABLE 3-3. Medicare Savings Program Participation Rates, 2009 and 2010

Program	Participation rate		
	All	**Age 18–64**	**Age 65 and older**
Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB)	**51%**	61%	46%
QMB	**53**	63	48
SLMB	**32**	42	28
Qualifying Individual (QI)	**15**	18	15

Notes: Participation rates are calculated using average monthly enrollment for 2009 and 2010. Inconsistencies in the data that resulted from simulating Medicare Savings Program (MSP) eligibility meant that some individuals appeared to be ineligible for any MSP even though they were already enrolled in one. To address these inconsistencies, we expanded the income and asset eligibility categories and made MSP enrollees' eligibility status consistent with the MSP they were enrolled in. As a result, MSP eligibility is not mutually exclusive across MSPs. The Qualified Disabled and Working Individuals program is excluded because enrollment in the program is too small to study with survey data. The reference period for this analysis is best interpreted as mid-to-late 2009 and mid-to-late 2010. The lack of specificity is a result of how Survey of Income and Program Participation (SIPP) interviews are administered. This analysis uses the SIPP 2008 panel.

Source: Caswell and Waidmann, 2017, analysis of SIPP and Medicaid Statistical Information System (MSIS) data for 2009 and 2010.

We found low participation rates across all MSPs and all age groups (MACPAC 2017). The QMB program had the highest participation rate at 53 percent across all age groups. Of SLMB-eligible beneficiaries, 32 percent participated. Of QI-eligible beneficiaries, 15 percent participated. Previous studies also found low MSP participation rates. One study found that about 63 percent of non-institutionalized eligible individuals had enrolled in the QMB and SLMB programs in 1999 (Rupp and Sears 2000). Another study estimated a combined participation rate of 64 percent in 2001 (Haber et al. 2003).

The 2017 Urban Institute study also examined the characteristics of MSP enrollees and MSP-eligible but not enrolled individuals. The analysis found that individuals enrolled in the MSPs were less likely than eligible non-enrollees to have private health insurance coverage, and were more likely to be younger, under age 65, have lower assets, and be eligible for Medicaid on the basis of a disability. Enrolled beneficiaries were also more likely to be receiving benefits from other government programs, such as SSI and the Supplemental Nutrition Assistance Program. Enrollment in these other government programs may serve as a touchpoint for beneficiaries who are eligible for the MSPs.

The 2017 study found that full-benefit dually eligible beneficiaries were the most likely to participate in an MSP. Among individuals eligible but not enrolled in the MSPs, about 16 percent were full-benefit dually eligible beneficiaries (Table 3-4). This finding makes sense considering that most of these individuals were enrolled in an MSP due to their eligibility for SSI, which has an automatic link to Medicaid, or because they were receiving full Medicaid benefits.[5] Fewer partial-benefit dually eligible beneficiaries were enrolled in the MSPs, likely because they would not have had prior contact with the Medicaid program, and therefore would not

have been familiar with the MSPs or how to enroll. Eligible but not enrolled individuals were also more likely to have private health insurance coverage, suggesting that some may not have perceived a need for additional coverage. This cohort was also more likely to be age 65 and older.[6]

TABLE 3-4. Selected Characteristics of Individuals Enrolled in the Qualified Medicare Beneficiary or Specified Low-Income Medicare Beneficiary Programs and Individuals Eligible but Not Enrolled, 2009 and 2010

Characteristic	Share of all enrollees in QMB or SLMB programs	Share of population eligible for QMB or SLMB programs but not enrolled
Age 18–64	42%	29%
Age 65 and older	58	72
Covered by private health insurance	12	36
Enrolled in SNAP	43	12
Enrolled in SSI	39	12
Enrolled in full-benefit Medicaid	70	16
Eligible for Medicaid on the basis of a disability	49	11

Notes: QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. SNAP is Supplemental Nutrition Assistance Program. SSI is Supplemental Security Income. Statistics in this table are based on a sample of person-month observations.

Source: Caswell and Waidmann, 2017, analysis using the Survey of Income and Program Participation (SIPP) 2008 panel and the Medicaid Statistical Information System (MSIS), executed at the U.S. Census Bureau, Research Data Center. https://www.macpac. gov/publication/medicare-savings-program-enrollees-and-eligible-non-enrollees/.

Factors Affecting MSP Enrollment

As noted above, many beneficiaries who are eligible for an MSP are not enrolled in one. A number of reasons have been cited for low enrollment, including conflicting enrollment and eligibility requirements between the MSPs and related federal programs, program rules and administration, and lack of awareness among eligible beneficiaries (CMS 2018, NCOA 2020a). Federal policymakers have taken some steps to simplify and encourage enrollment in the MSPs with limited success—these issues are discussed below.

State policies

State policy choices can affect enrollment in the MSPs and may be inconsistent with standards used by other states and the federal government for other programs serving a similar population. In some cases, those inconsistencies may help increase enrollment; for example, state-specific income and asset limits that are more generous than the federal standards enable more beneficiaries to enroll in the MSPs. But in other cases, they may act as barriers that limit enrollment; for example, if state policies for counting income, assets, and household size for MSP eligibility differ from federal policies for programs that serve similar low-income populations, such as the Medicare Part D LIS program, then automating and streamlining MSP enrollment becomes difficult.

More generous income and asset levels. Income and asset limits for the MSPs are established in statute.[7] States have the option, however, to set guidelines that are more generous than the federal standard, and 14 states and the District of Columbia do so for one or more MSP categories (Table 3-5). Some states with more generous rules, such as Connecticut and Maine, have enrolled a higher share of eligible beneficiaries in the MSPs and reduced state administrative burden. Alabama, Mississippi, and New York have all reported administrative savings in time and money from eliminating asset tests (NCOA 2016). (Detail on income and asset levels for all 50 states and the District of Columbia can be found in Appendix 3A, Table 3A-1.)

TABLE 3-5. States with Beneficiary Income and Asset Eligibility Limits More Generous than the Federal Standard for Medicare Savings Programs, 2020

State	Monthly income limit, as a percentage of FPL			Asset limit
	QMB	SLMB	QI	
Federal standard	100% plus $20 disregard	120% plus $20 disregard	135% plus $20 disregard	$7,860 (single); $11,800 (married)
Alabama	Federal standard			No limit
Arizona	Federal standard			No limit
Connecticut[1]	211%	231%	246%	No limit
Delaware	Federal standard			No limit
District of Columbia	300%	–	–	No limit
Illinois	Federal standard plus $25 disregard			Federal standard
Indiana	150%	175%	185%	Federal standard
Louisiana	Federal standard			No limit
Maine[2]	150% plus $75 disregard	175% plus $75 disregard	185% plus $75 disregard	$58,000 (single); $87,000 (married)
Massachusetts	130%	150%	165%	$15,720 (single); $23,600 (married)
Minnesota	Federal standard			$10,000 (single); $18,000 (married)
Mississippi	Federal standard plus $50 disregard			No limit
New York	Federal standard			No limit
Oregon	Federal standard			No limit
Vermont	Federal standard			No limit

Notes: FPL is federal poverty level. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. The Qualified Disabled and Working Individuals program is not included in this table. States with no limit have eliminated the asset test.

– Dash indicates that the category is not applicable.

[1] Connecticut does not include the standard $20 income disregard in their income levels.

[2] Maine's asset limits apply to liquid assets only.

Source: MACPAC analysis of data from National Council on Aging as of February 2020 (NCOA 2020b).

Differences with Part D LIS. The MSPs and the Medicare Part D LIS program all provide financial assistance to low-income Medicare beneficiaries to cover out-of-pocket Medicare costs.[8] The LIS program is administered by SSA and CMS, and has automatic processes in place to contact and enroll many eligible individuals.[9] The MSPs, on the other hand, are administered by state Medicaid programs, which develop their own outreach and enrollment processes.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires SSA to transfer LIS application information to states, and requires states to use that information to initiate an MSP application.[10] SSA sends files daily (except on weekends and holidays) to state Medicaid agencies. Data transferred by SSA contain demographic information, household composition, income, assets, whether SSA approved or denied LIS program enrollment, and the reasons for a denial (Lakhmani 2019, GAO 2012).

But in many states, SSA's data are not comparable to those used by the state for enrolling beneficiaries in MSPs. For example:

- SSA does not count in-kind support from family as income, but states may count it.

- SSA does not count the cash value of a life insurance policy, but states may count it (term life insurance policies are excepted). If a state does count cash value, then beneficiaries must contact the life insurance company to determine the policy's cash value, and that value is counted as an asset.

- SSA assumes beneficiaries will use some of their assets for funeral or burial expenses and applies a disregard of $1,500 for an individual's assets ($3,000 for a couple's assets) to account for that. In some states, beneficiaries cannot get the same disregard for MSP eligibility unless they can prove that they have set aside that money in a burial trust.

- Under SSA rules, household size is defined as the individual, his or her spouse if married, and any additional relatives who live with the individual and are dependent on the individual or the individual's spouse for at least one-half of their income. States may use the narrower SSI-based interpretation that counts only the individual or the individual and spouse.

Different state rules for counting key MSP eligibility factors, such as income, assets, or household size, may limit a state's ability to use SSA data to automate its MSP enrollment process (CMS 2018). As a result, a determination of eligibility for the LIS program by SSA does not necessarily provide enough information for a state to determine an individual's eligibility for an MSP (CMS 2018). In such cases, individuals whose information came from SSA who are applying for the MSPs may have to submit a separate application or provide additional documentation to the state to verify what may be minor differences in countable assets or income (Lakhmani 2019).

Federal action

Federal statutes, guidance, and funding have been used to encourage both eligible beneficiaries to enroll in the MSPs and states to streamline and automate program administration. These efforts, however, have had limited success.

Program administration. As noted above, in 2008, MIPPA required SSA to transfer data from LIS applications and required states to use that information to initiate MSP applications. MIPPA also changed the asset limits used for the MSPs to match the asset limits for full LIS benefits in an effort to expand eligibility and eliminate barriers to MSP enrollment (GAO 2012, CBO 2008). MSP enrollment increased by about 5 percent in 2010 and in 2011, the first two years that the MIPPA requirements were in effect, although it is difficult to determine what share of that growth, if any, can be attributed to the SSA application transfer (GAO 2012).

In 2018, CMS released new guidance for states that included an opportunity to simplify eligibility and enrollment in the MSPs (CMS 2018). Following that, the Integrated Care Resource Center, a CMS initiative that provides technical assistance to states, described steps states could take to improve the MSP eligibility determination process, including the use of LIS program policies for counting income and assets or for determining household size. Although states can use Section 1902(r)(2)(A) of the Social Security Act (the Act) to accomplish this, few states use this authority (CMS 2010).

Outreach. Policymakers have also been concerned that beneficiaries' lack of awareness of their eligibility for an MSP may be limiting enrollment. For example, beneficiaries who do not qualify for full Medicaid benefits might not know they are eligible for an MSP because they are unlikely to have prior contact with a state Medicaid program (Haber et al. 2003).

Federal law requires SSA to identify individuals potentially eligible for the MSPs and LIS program and notify them about the programs. SSA mails outreach letters to individuals who are potentially eligible for the QMB, SLMB, QI, and LIS programs in May and June each year, asking beneficiaries to contact their state or local Medicaid office, social service, or welfare office about the MSPs and to contact SSA about the LIS program.[11] Federal law also requires SSA to share the lists of potentially eligible individuals with state Medicaid agencies. SSA transmits files electronically to each state at about the same time it sends its letters to beneficiaries, and also notifies the state Medicaid agency how many and which beneficiaries will receive an outreach letter (SSA 2019b). States may then conduct outreach to such individuals to inform them of how and where to apply for benefits.

To increase MSP enrollment, MIPPA provided outreach grants totaling $20 million to state health insurance assistance programs, area agencies on aging, and aging and disability resource centers, starting in fiscal year (FY) 2009 (GAO 2012). This funding has been reauthorized a number of times,

including in the Bipartisan Budget Act of 2018 (P.L. 115-123), which made $25.5 million available each year for FY 2018 and FY 2019, and through a series of laws that ultimately made $25.5 million available for FY 2020 (P.L. 116-69, P.L. 116-94, P.L. 116-136).

Grantees have used this funding to conduct outreach and to enroll low-income Medicare beneficiaries into the LIS program and the MSPs, and to promote the use of Medicare preventive services. Outreach has been targeted to multiple audiences, including people with disabilities, tribal populations, veterans, caregivers, and people experiencing homelessness (NCOA 2017).

Commission Recommendation

After weighing the potential impact on enrollment and costs to states and the federal government, the Commission makes one recommendation containing two companion statutory changes aimed at increasing enrollment in the MSPs and simplifying the enrollment and eligibility redetermination process for beneficiaries and states.

Recommendation 3.1

Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

Rationale

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-27) amended Section 1905(p)(1)(C) of the Act to make the asset limits used for the MSPs conform to the asset limits for full LIS program benefits. Although this change was intended to expand eligibility and eliminate barriers to MSP enrollment, many states still use asset counting rules that differ from those used by SSA for the LIS program. This can prevent states from using the SSA data to assess eligibility for the MSPs and may require beneficiaries to submit additional documentation. For example, SSA does not count the cash surrender value of life insurance policies as an asset, but some states do, requiring beneficiaries to contact their life insurance companies to determine the policy's cash value so they can report it on their applications (Lakhmani 2019). Similarly, SSA assumes beneficiaries will use some of their assets for funeral or burial expenses and applies a disregard of $1,500 for an individual or $3,000 for a couple to account for that. Some states will not apply the same disregard for MSP eligibility unless beneficiaries can prove they have set aside that money in a burial trust.

Even though states have the authority under Section 1902(r)(2)(A) of the Act to define assets in the same manner as SSA, as of 2012, 29 states required reverification of asset data transferred from SSA because the definitions did not match (GAO 2012). Requiring states to adopt SSA definitions of income, household size, and assets for purposes of the MSPs eliminates the need to reverify the SSA data and enables states to process the applications transferred from SSA without requiring additional information from beneficiaries, an additional step that can create a barrier to the completion of their applications (GAO 2012). This recommendation would not prevent states from using less restrictive definitions of income and assets, as 14 states and the District of Columbia currently do for one or more MSP categories. In addition, requiring SSA to send continuing LIS eligibility data to states on an annual basis will provide states with sufficient data to conduct ex parte eligibility redeterminations,

reducing administrative burden for both states and beneficiaries, and enabling more beneficiaries to retain coverage.

Implications

Federal spending. Increased enrollment in the MSPs would increase federal costs for both the Medicaid and Medicare programs, including costs related to matching payments to state Medicaid programs, increased spending on Medicare Parts A and B, and increased enrollment in the LIS program. The Congressional Budget Office (CBO) was unable to provide an estimate of the specific budgetary effects of this recommendation. According to CBO, development of such an estimate would require access to data that are not currently available. For example, complete information on the number of people who are eligible for but not enrolled in each MSP is not available at this time. In a 2017 study conducted for MACPAC by the Urban Institute, the number of individuals who were eligible but not enrolled could be estimated at the national level, but not at the state level due to sample size limitations (Caswell and Waidmann 2017). Even if the number of individuals eligible but not enrolled in each MSP category in each state were known, we do not know how the enrollment rate among eligible individuals differs between states already using SSA counting rules and the other states. In addition, the effect of the change in policy on the relative distribution of enrollment in each MSP is difficult to predict. Requiring states to use the SSA calculation of income, assets, and household size could change the distribution of enrollment among the QMB, SLMB, and QI programs. Because the QI program is fully federally funded, a large increase in the number of enrollees in that program would increase federal costs more than a similar enrollment increase in the QMB or SLMB programs, which are matched at the regular FMAP.

The adoption of this policy would have additional consequences for Medicaid and Medicare. To the extent that some individuals who enroll in the MSPs as a result of this policy will also qualify for full Medicaid benefits, overall Medicaid costs

would increase. If this policy results in any new MSP enrollment outside of the enrollment that results directly from the application transfers from SSA, enrollment in the LIS program would increase because individuals enrolled in the QMB, SLMB, or QI programs are deemed eligible for the LIS program. This policy could also have spillover effects on Medicare Parts A and B because it could improve access to services for beneficiaries who receive Medicaid assistance with Medicare cost sharing; these spillover effects are difficult to quantify.

States. Increased enrollment would increase state Medicaid costs. At the same time, simplifying the eligibility determination and redetermination processes would reduce state administrative burden and related costs. State payments for Medicare cost sharing would increase as enrollment increases, but some costs could be offset if more Medicaid beneficiaries enroll in Medicare Parts A and B, making Medicare the primary payer for services that Medicaid had been covering.

Enrollees. This policy would increase enrollment and retention of eligible beneficiaries in the MSPs, improving access to care for beneficiaries who have foregone care due to the financial burden associated with Medicare cost sharing. This policy would reduce the burden on beneficiaries of having to submit additional paperwork to demonstrate their eligibility for the MSPs. In some states, however, beneficiaries seeking full Medicaid benefits may have to submit additional paperwork to show they meet the state's eligibility criteria for those benefits.

Plans and providers. This recommendation would not have a direct effect on plans or providers.

Endnotes

[1] Although most beneficiaries are not required to pay a premium for Part A coverage (hospital insurance), they are required to pay a deductible ($1,408 in 2020) and copayments for inpatient hospital stays exceeding 60 days. Medicare beneficiaries pay no coinsurance for the first 60 days of an inpatient hospital stay. Coinsurance is $352 per day for days 61–90 and $704 per day for days 91–150 (CMS 2020a).

[2] Some QMB enrollees do not qualify for full Medicaid benefits. Such beneficiaries receive Medicaid assistance only for help with Medicare premiums and cost sharing. Individuals who do qualify for full Medicaid benefits are referred to as QMB Plus enrollees. They qualify for full Medicaid through a non-MSP eligibility pathway that can be either mandatory or optional in their state of residence. A similar structure exists for the SLMB program, in which SLMB enrollees who also qualify for full Medicaid benefits are eligible through a non-MSP pathway and are referred to as SLMB Plus enrollees.

[3] Originally, the QI program had two parts: QI-1 for individuals with incomes of at least 120 percent but less than 135 percent of the FPL and QI-2 for individuals with incomes of at least 135 percent but less than 175 percent FPL (GAO 2004). In December 2002, the QI-2 program was allowed to expire but the QI-1 program was reauthorized (GAO 2004). It was subsequently reauthorized a number of times before being made permanent with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10). That legislation funded the QI program through 2016 and established a formula for calculating funding allocations for all future years (CRS 2015).

[4] In most states, receipt of SSI confers Medicaid eligibility.

[5] Individuals applying for full Medicaid benefits are screened for MSP eligibility.

[6] We do not have coverage details regarding benefits covered or enrollee expenses.

[7] Federal standards for the MSPs are found in Section 1902(a)(10)(E) of the Social Security Act (the Act) and state flexibility to establish more generous standards is found in Section 1902(r)(2).

8 The LIS program, also called Extra Help, provides subsidized prescription drug coverage to Medicare beneficiaries with low income and assets. The Social Security Administration (SSA) determines eligibility and enrolls beneficiaries. Eligible beneficiaries may qualify for a full subsidy if their incomes are below 135 percent FPL and their assets in 2020 do not exceed $7,860 for an individual or $11,800 for a married couple; they may qualify for a partial subsidy if their incomes are less than 135 percent FPL and their assets are between $7,860 and $12,890, or if income is between 135 percent and 150 percent FPL and assets do not exceed $13,110 for an individual and $26,160 for a married couple.

9 Many individuals are deemed eligible for the Medicare Part D LIS program (CMS 2019d). Such individuals receive a notice of their eligibility to enroll in a Part D plan from CMS and can either select a plan on their own or be auto-enrolled in one. Individuals deemed eligible for the LIS program include full-benefit dually eligible beneficiaries, individuals receiving SSI benefits, and individuals already enrolled in the QMB, SLMB, or QI programs. QDWI enrollees are not deemed eligible for LIS (SSA 2019c). Medicare beneficiaries with limited income and resources who are not deemed eligible must apply for LIS through SSA or their state Medicaid programs, either of which can determine their eligibility (CMS 2009).

10 MIPPA amended Section 1144(c)(3) of the Act to require SSA to transmit data from LIS applications to state Medicaid agencies for the purpose of initiating MSP applications. Section 1935(a)(4) of the Act requires states to accept data transmitted under Section 1144(c)(3) and to act on such data as if they constituted an application for MSP benefits that had been submitted directly by an applicant (Lakhmani 2019).

11 Letters to individuals potentially eligible for QDWI are mailed at the end of November, shortly before the Medicare general open enrollment period begins so that potential enrollees will contact their Medicaid offices prior to contacting SSA (SSA 2019b).

References

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2019. *Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications.* Washington, DC: ASPE. https://aspe.hhs.gov/basic-report/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-and-implications.

Caswell, K.J., and T.A. Waidmann. 2017. *Medicare savings program enrollees and eligible non-enrollees.* August 2017 contractor report. Washington, DC: Urban Institute. https://www.macpac.gov/publication/medicare-savings-program-enrollees-and-eligible-non-enrollees/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *2020 Medicare costs.* Baltimore, MD: CMS. https://www.medicare.gov/Pubs/pdf/11579-medicare-costs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. CMCS informational bulletin regarding "2020 federal poverty level standards". March 3, 2020. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib020320.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Costs of Medigap policies. Baltimore, MD: CMS. https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap/medigap-costs/costs-of-medigap-policies.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Medicare Savings Programs. https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019c. Medicare costs at a glance. Baltimore, MD: CMS. https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019d. Limited income and resources. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Seema Verma to state Medicaid directors regarding "Ten opportunities to better serve individuals dually eligible for Medicaid and Medicare." December 19, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2010. Letter from Cindy Mann to state Medicaid directors regarding "Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)". February 18, 2010. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2009. Guidance to states on the low income subsidy. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 1999. List and definition of dual eligibles. Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/downloads/Buy-InDefinitions.pdf.

Congressional Budget Office (CBO). 2008. *H.R. 6331, Medicare Improvements for Patients and Providers Act of 2008*. Cost estimate, July 23, 2008. Washington, DC: CBO. https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/costestimate/hr6331pgo0.pdf.

Congressional Research Service (CRS). 2015. *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*. Washington, DC: CRS. https://crsreports.congress.gov/product/pdf/R/R43962.

Haber, S., N.T. Zheng, S. Hoover, and Z. Feng. 2014. *Effect of state Medicaid payment policies for Medicare cost sharing on access to care for dual eligibles*. Waltham, MA: RTI. https://www.macpac.gov/publication/effect-of-state-medicaid-payment-policies-for-medicare-cost-sharing-on-access-to-care-for-dual-eligibles/.

Haber, S., W. Adamache, E.G. Walsh, et al. 2003. *Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs*. Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/HaberVol2.pdf.

Lakhmani, E.W. 2019. *Alignment of Medicare Savings Program eligibility with the Medicare Part D Low Income Subsidy program*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/resource/alignment-medicare-savings-program-eligibility-medicare-part-d-low-income-subsidy-program.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *State Medicaid payment policies for Medicare cost sharing*. September 2018 state policy compendium. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Medicare Savings Programs: New estimates continue to show many eligible individuals not enrolled*. August 2017 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicare-savings-programs-new-estimates-continue-to-show-many-eligible-individuals-not-enrolled/.

Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission (MACPAC and MedPAC). 2018. Table 1: Medicaid eligibility and benefits by type of dual-eligible beneficiary. In *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. January 2018. Washington, DC: MACPAC. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

Medicare-Medicaid Coordination Office (MMCO), Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. 2020. *FY 2019 report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf.

Merlis, M. 2005. *Eligibility standards for Medicare/Medicaid dual eligibles: Issues and options for reform*. Washington, DC: National Academy of Social Insurance. https://www.nasi.org/research/2005/eligibility-standards-medicaremedicaid-dual-eligibles-issues.

National Council on Aging (NCOA). 2020a. *Benefits outreach toolkit: What the research says*. Arlington, VA: NCOA. https://www.ncoa.org/centerforbenefits/outreach-toolkit/what-the-research-says/.

National Council on Aging (NCOA). 2020b. *Medicare Savings Programs (MSPs): Eligibility and coverage (2020)*. Arlington, VA: NCOA. https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf.

National Council on Aging (NCOA). 2017. *MIPPA at a glance*. Arlington, VA: NCOA. https://web.archive.org/web/20170829072324/https://www.ncoa.org/wp-content/uploads/MIPPA-at-a-glance.pdf.

National Council on Aging (NCOA). 2016. *State policies can streamline access to Medicare Savings Programs for low-income older adults*. Arlington, VA: NCOA.

Rosenbach, M., and J. Lamphere. 1999. *Bridging the gaps between Medicare and Medicaid: The case of QMBs and SLMBs*. Washington, DC: AARP. https://www.aarp.org/health/medicare-insurance/info-1999/aresearch-import-603-9902.html.

Rupp, K., and J. Sears. 2000. Eligibility for the Medicare buy-in programs, based on a Survey of Income and Program Participation simulation. *Social Security Bulletin* 63, no. 3: 13–25. https://www.ssa.gov/policy/docs/ssb/v63n3/v63n3p13.pdf.

Sears, J. 2002. *Note: Comparing beneficiaries of the Medicare Savings Programs with eligible nonparticipants. Social Security Bulletin* 64, no. 3: 76. https://www.ssa.gov/policy/docs/ssb/v64n3/v64n3p76.html.

Social Security Administration (SSA). 2019a. Understanding Supplemental Security Income (SSI) and other government programs—2019 edition. Woodlawn, MD: SSA. https://www.ssa.gov/ssi/text-other-ussi.htm.

Social Security Administration (SSA). 2019b. Outreach to low-income Medicare beneficiaries—Extra Help and Medicare savings programs. In Program Operations Manual System (POMS). SSA publication no. HI 00815.035. Woodlawn, MD: SSA. https://secure.ssa.gov/poms.nsf/lnx/0600815025.

Social Security Administration (SSA). 2019c. Medicare Part D Extra Help (low-income subsidy or LIS). In Program Operations Manual System (POMS). SSA publication no. HI 03001.005. Washington, DC: SSA. https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001005.

U.S. Government Accountability Office (GAO). 2012. *Medicare Savings Programs: Implementation of requirements aimed at increasing enrollment*. Washington, DC: GAO. https://www.gao.gov/products/GAO-12-871.

U.S. Government Accountability Office (GAO). 2004. *Medicare Savings Programs: Results of Social Security Administration's 2002 outreach to low-income beneficiaries*. Washington, DC: GAO. https://www.gao.gov/products/GAO-04-363.

Commission Vote on Recommendation

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP 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, fulfills 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 recommendation on improving participation in the Medicare Savings Programs. 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 Recommendation 3.1 on April 2, 2020.

Improving Participation in the Medicare Savings Programs

3.1   Congress should amend Section 1902(r)(2)(A) of the Social Security Act to require that when determining eligibility for the Medicare Savings Programs (MSPs), states use the same definitions of income, household size, and assets as the Social Security Administration (SSA) uses when determining eligibility for the Part D Low-Income Subsidy (LIS) program. To reduce administrative burden for states and beneficiaries related to MSP redeterminations, Congress should amend Section 1144 of the Social Security Act to require SSA to transfer continuing LIS program eligibility data to states on an annual basis.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
		1	Not present
Not present:	Barker		

MACPAC

APPENDIX 3A: Medicare Savings Programs

TABLE 3A-1. Medicare Savings Program Beneficiary Income and Asset Eligibility Limits, by State, 2020

State	Monthly income limit, as a percentage of FPL			Asset limit
	QMB	SLMB	QI	
Federal standard	100% plus $20 disregard	120% plus $20 disregard	135% plus $20 disregard	$7,860 (single); $11,800 (married)
Alabama	Federal standard			No limit
Alaska	Federal standard			Federal standard
Arizona	Federal standard			No limit
Arkansas	Federal standard			Federal standard
California	Federal standard			Federal standard
Colorado	Federal standard			Federal standard
Connecticut[1]	211%	231%	246%	No limit
Delaware	Federal standard			No limit
District of Columbia	300%	–	–	No limit
Florida	Federal standard			Federal standard
Georgia	Federal standard			Federal standard
Hawaii	Federal standard			Federal standard
Idaho	Federal standard			Federal standard
Illinois	Federal standard plus $25 disregard			Federal standard
Indiana	150%	175%	185%	Federal standard
Iowa	Federal standard			Federal standard
Kansas	Federal standard			Federal standard
Kentucky	Federal standard			Federal standard
Louisiana	Federal standard			No limit
Maine[2]	150% plus $75 disregard	175% plus $75 disregard	185% plus $75 disregard	$58,000 (single); $87,000 (married)
Maryland	Federal standard			Federal standard
Massachusetts	130%	150%	165%	$15,720 (single); $23,600 (married)
Michigan	Federal standard			Federal standard
Minnesota	Federal standard			$10,000 (single); $18,000 (married)
Mississippi	Federal standard plus $50 disregard			No limit
Missouri	Federal standard			Federal standard

MACPAC

TABLE 3A-1. (continued)

State	Monthly income limit, as a percentage of FPL			Asset limit
	QMB	SLMB	QI	
Montana	Federal standard			Federal standard
Nebraska	Federal standard			Federal standard
Nevada	Federal standard			Federal standard
New Hampshire	Federal standard			Federal standard
New Jersey	Federal standard			Federal standard
New Mexico	Federal standard			Federal standard
New York	Federal standard			No limit
North Carolina	Federal standard			Federal standard
North Dakota	Federal standard			Federal standard
Ohio	Federal standard			Federal standard
Oklahoma	Federal standard			Federal standard
Oregon	Federal standard			No limit
Pennsylvania	Federal standard			Federal standard
Rhode Island	Federal standard			Federal standard
South Carolina	Federal standard			Federal standard
South Dakota	Federal standard			Federal standard
Tennessee	Federal standard			Federal standard
Texas	Federal standard			Federal standard
Utah	Federal standard			Federal standard
Vermont	Federal standard			No limit
Virginia	Federal standard			Federal standard
Washington	Federal standard			Federal standard
West Virginia	Federal standard			Federal standard
Wisconsin	Federal standard			Federal standard
Wyoming	Federal standard			Federal standard

Notes: FPL is federal poverty level. QMB is Qualified Medicare Beneficiary. SLMB is Specified Low-Income Medicare Beneficiary. QI is Qualifying Individual. The Qualified Disabled and Working Individuals (QDWI) program is not included in this table. States with no asset limit have eliminated the asset test.

– Dash indicates that the category is not applicable.

[1] Connecticut does not include the standard $20 income disregard in its income levels.

[2] Maine's asset limits apply to liquid assets only.

Source: MACPAC analysis of data from the National Council on Aging as of February 2020 (NCOA 2020).

Medicaid and TRICARE Third-Party Liability Coordination

Medicaid and TRICARE Third-Party Liability Coordination

Recommendations

4.1 The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

4.2 To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Key Points

- Medicaid is generally the payer of last resort. By law, most other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. This requirement is referred to as third-party liability (TPL) because payment is the responsibility of a third party other than the individual or Medicaid.

- TPL recoveries are important to Medicaid programs for two reasons. First, ensuring that the appropriate party pays for care helps preserve Medicaid funds to cover services for beneficiaries; and second, they limit cost-shifting from private insurers and other federal programs to Medicaid, which is financed in part (38 percent) by states.

- MACPAC estimates that almost 1 million Medicaid beneficiaries have primary coverage through TRICARE, the Department of Defense health benefits program for U.S. Armed Forces military personnel, military retirees, and their dependents.

- Efforts to coordinate benefits between Medicaid and TRICARE have been constrained by differences in how the two programs are administered, including different policies for sharing enrollee data, accepting claims, and coordinating with delegated entities such as managed care organizations.

- While Congress has enacted changes to the Social Security Act to protect Medicaid from improper payment of claims that are the responsibility of a third party, it is not clear whether these provisions apply to government programs such as TRICARE.

- The Commission's recommendations focus on improving coordination of benefits between Medicaid and TRICARE and preserving Medicaid's role as the payer of last resort, through both administrative and congressional action.

CHAPTER 4: Medicaid and TRICARE Third-Party Liability Coordination

Medicaid is generally the payer of last resort; by law, all other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual.[1] This requirement is referred to as third-party liability (TPL) because payment is the responsibility of a third party other than the individual or Medicaid (42 CFR 447.10). A large proportion of Medicaid beneficiaries have third-party sources of insurance coverage. The U.S. Government Accountability Office (GAO) estimates that out of the 56 million people enrolled in the Medicaid program in 2012, 7.6 million had private coverage and 10.6 million had access to other public coverage through Medicare, the Indian Health Service, the U.S. Department of Defense (DoD), and the U.S. Department of Veterans Affairs (GAO 2015) (Box 4-1).

Coordinating TPL is important for two reasons: first, ensuring that the appropriate party pays for care helps preserve Medicaid funds to cover services for beneficiaries; and second, coordination of TPL limits cost shifting from private insurers and other federal programs to states, which pay more than one-third of program costs, and the federal portion of Medicaid, which pays the remaining two-thirds. Given the large proportion of Medicaid enrollees with access to other sources of coverage, the potential savings to the program through effective prospective and retrospective TPL activities are substantial. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) estimated that state and federal Medicaid savings from TPL totaled $13.6 billion in 2011, up from $3.7 billion in 2001 (OIG 2013). GAO has also noted that although states have improved TPL efforts over time, the growing number of Medicaid enrollees with third-party coverage

creates additional opportunities to avoid improper payments and recover Medicaid funds (GAO 2015).

As part of its ongoing work to strengthen Medicaid program integrity activities, MACPAC is now focusing on the interaction between Medicaid TPL policy and other insurers. After Medicare, the largest public sources of third-party coverage for Medicaid enrollees are the DoD and the U.S. Department of Veterans Affairs.[2] TRICARE is the DoD program for civilian health benefits for U.S. Armed Forces military personnel, military retirees, and their dependents. MACPAC estimates based on the 2017 American Community Survey indicate that almost 1.5 percent or approximately 867,000 Medicaid enrollees have primary coverage through TRICARE, including approximately 220,000 children. For children enrolled in Medicaid on a basis other than disability, TRICARE is the largest source of third-party public coverage. Approximately 10 percent of children of active service families covered by TRICARE also have Medicaid (TFK 2018).

Despite the fact that a large number of Medicaid enrollees also have TRICARE coverage, MACPAC has found that the two programs have not effectively coordinated benefits, resulting in a cost shift at the federal level from the DoD to HHS and from the federal government to states. Many of the barriers to effective coordination of benefits result from differences in how Medicaid and TRICARE are administered, including different policies for sharing enrollee data, accepting claims, and coordinating with delegated entities such as managed care organizations (MCOs). Although reconciling these policy differences would not result in an overall cost savings to the federal government (i.e., liability for claims costs for enrollees with both Medicaid and TRICARE would return to TRICARE), improved coordination of benefits between the two programs would better maintain the statutory requirement that Medicaid serve as the secondary payer when other coverage sources are available.

This chapter presents the Commission's findings and recommendations for improving coordination between Medicaid and TRICARE.

Specifically, the Commission recommends:

- The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

- To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits

for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

This chapter focusing on the specific issue of coordination with the TRICARE program is the result of the Commission's ongoing examination of opportunities to improve the effectiveness and efficiency of the Medicaid program.

BOX 4-1. Medicaid and Other Public Payers

Many Medicaid beneficiaries also have health coverage from other programs, including Medicare, the U.S. Department of Defense (DoD), and the U.S. Department of Veterans Affairs.

Of the three programs mentioned, Medicare enrolls the largest number of individuals who also have Medicaid coverage, with 12.2 million dually eligible beneficiaries enrolled in fiscal year 2019 (CMS 2020). Medicare is the primary payer for acute and post-acute care services. Medicaid wraps around Medicare by providing assistance with Medicare premiums and cost sharing and by covering some services that Medicare does not cover, such as long-term services and supports (LTSS). Medicare and Medicaid deliver services under fee for service (FFS) and managed care, and many beneficiaries are covered under both arrangements. The mechanisms for coordinating eligibility and benefits among the federal government, states, and managed care plans under contract to Medicare and Medicaid have been the subject of several MACPAC studies and Commission recommendations, including those described in Chapters 1 through 3 of this report to Congress.

The DoD provides civilian health benefits for U.S. Armed Forces military personnel, military retirees, and their dependents through the TRICARE program. MACPAC estimates that approximately 867,000 Medicaid enrollees have primary coverage through TRICARE, including approximately 220,000 children. TRICARE is the largest source of third-party public coverage for children enrolled in Medicaid on a basis other than disability: approximately 10 percent of children of active service members covered by TRICARE also have Medicaid (TFK 2018). TRICARE is the primary payer for acute care and pharmacy services, which are delivered through FFS and managed care programs operated by private insurance companies under contract to DoD. Medicaid covers TRICARE cost sharing for active duty military families who qualify on the basis of income and also provides coverage for services not included in TRICARE's benefit package. For example, Medicaid wraps around TRICARE by covering certain home- and community-based LTSS, and some children of active duty military families are enrolled in Section 1915(c) waivers or other programs to obtain specialized Medicaid wraparound services that are not covered by TRICARE (Shin et al. 2005).

BOX 4-1. (continued)

The U.S. Department of Veterans Affairs operates the Veterans Health Administration (VHA), which provides health care to eligible veterans through an integrated system that includes acute, outpatient, and LTSS. MACPAC estimates that approximately 960,000 Medicaid enrollees are also receiving health care through the VHA. The VHA does not provide comprehensive health coverage to all veterans, and the availability of some services may be limited based on a prioritized ranking of need. Eligibility is based on military tenure and the degree of service-connected disability, although some veterans may become eligible in part based on financial need. Medicaid covers the costs for services delivered to eligible individuals who are not covered by the VHA when these services are not related to a service-connected condition and are provided outside of the VHA system. However, if an individual is eligible for both VHA benefits and Medicaid, the VHA does not bill Medicaid for any care it provides to treat a non-service-connected condition.

A small number of public programs have been statutorily designated as payers of last resort after Medicaid (e.g., the Ryan White HIV/AIDS Program, Title V Maternal and Child Health Block Grant Program, Indian Health Service, Individuals with Disabilities Education Act programs, and World Trade Center Health Program) or are not considered to be legally liable third parties (such as schools, public health programs, and family service and child welfare agencies carrying out their general responsibilities to ensure access to needed health care).

Medicaid Third-Party Liability Policies

Medicaid generally coordinates benefits with other insurers as a secondary payer to all other payers. This means that if an insurer and Medicaid both provide coverage of a given benefit, the other payer is liable for paying the claim and Medicaid is responsible only for any balance covered under Medicaid payment rules.

In most situations, if the state is aware that a Medicaid enrollee has potential third-party coverage when the claim is filed—for example, if the eligibility file contains information on potential TPL—the state must reject the claim and instruct the provider to submit it to the potential primary payer (42 CFR 433.139). After the potential primary payer has processed the claim, the provider can resubmit a claim to Medicaid, which will pay if the Medicaid payment amount exceeds the amount of the primary payment. GAO has noted that this type of

cost avoidance accounts for most of the savings to Medicaid associated with TPL (GAO 2015).

However, if a Medicaid program is unaware that an enrollee has other coverage at the time a claim is paid, it may pay the full amount, then later seek reimbursement from the primary insurer for the amount that insurer is liable, a process known as pay and chase (42 CFR 433.139). Although Medicaid is always legally the payer of last resort, from a fiduciary standpoint it is better to avoid the cost of paying a claim when there is another liable third party than to pay and chase, because not all paid claims can be recovered.

If a state has a Medicaid managed care program, it has several options for managing third-party liability (42 CFR 438.5). States can exclude enrollees with other insurance coverage from enrollment in a Medicaid managed care plan, although few states have chosen this option. States can also choose to enroll beneficiaries with other insurance coverage into managed care plans, and either retain

responsibility for administering TPL or delegate that responsibility to the managed care plan. The contract between the state and the managed care plan must describe the terms and conditions under which the plan assumes TPL responsibility and payment rates must be adjusted to take into account TPL recoveries. Most states delegate responsibility for TPL and build into the capitation payments an assumption regarding the amount of TPL the plans should be able to avoid or collect.

Medicaid TPL policies are governed by Medicaid statute and regulation (42 CFR 433 Subpart D). Federal rules require states to take reasonable measures to identify potentially liable third parties and process claims accordingly. States have two main sources of information on whether there may be a liable third party for a particular claim: (1) Medicaid enrollees themselves and (2) data matches with other insurers or data clearinghouses. States request information about other health coverage and potentially liable third parties as part of the Medicaid enrollment and renewal process. States also conduct a variety of data matches to identify third-party resources. States can conduct these matches themselves or, because they are permitted to delegate their authority to obtain information from third parties to a contractor, they may hire contractors to complete the required matches.[3]

States are required by federal statute to have laws that compel health insurers in the state to support identification of TPL (§ 1902(a)(25) of the Social Security Act (the Act)). Health plans are required to provide these files to the state Medicaid agency for purposes of identifying potential TPL. However, states do not have the ability to require federal insurance programs (e.g., TRICARE) to cooperate in data matches.

Federal statutes also assign responsibility when both sources of coverage are public programs. Generally, Medicare and other state and federal programs, including TRICARE, can be liable third parties unless specifically excluded by federal statute. A few public programs have been statutorily designated as payers of last resort after Medicaid, including

the Ryan White HIV/AIDS Program and the Title V Maternal and Child Health Block Grant Program.

Congress has made additions and clarifications to the statute over time to further protect Medicaid from improper payment of claims that are the responsibility of a third party. For example, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) added a number of provisions related to TPL and coordination of benefits for Medicaid beneficiaries (CMS 2006). This statute amended Section 1902(a)(25) of the Act to require health insurers (defined as self-insured plans, MCOs, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to do the following:

- provide coverage information to the state upon request;

- accept the state's right of recovery;

- respond to claims inquiries submitted by the state up to three years after the date of the provision of a health care item or service; and

- agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim or the type or format of the claim form.[4]

In 2012, the Centers for Medicare & Medicaid Services (CMS) provided a policy clarification regarding implementation of the DRA provisions, noting that "when TPL responsibilities are delegated to an MCO, third parties are required to treat the MCO as if it were the state Medicaid agency," including providing access to third-party eligibility and claims data to identify individuals with third-party coverage (CMS 2014).

Health insurance is regulated by the states, so the DRA provisions, which amend federal statute, created a federal requirement that states pass their own laws requiring health insurers doing business in their state to comply with the above provisions. However, under a wholly separate section of

law that predates the DRA, Congress explicitly exempted TRICARE from state and local laws related to health insurance (10 USC § 1103). The legislative history does not clearly indicate whether Congress intended the DRA provisions to supersede these provisions. These differences could be reconciled by HHS and DoD coming to agreement, by Congress clarifying its intent, or it could be decided by the courts.

Coordination between Medicaid and TRICARE

As noted above, there are approximately 867,000 Medicaid enrollees who have health insurance through TRICARE and, given that Medicaid is designated by statute as the payer of last resort, their TRICARE plan is the primary payer for most of their primary and acute services and prescription drugs. TRICARE offers several different levels of coverage that eligible service members can choose from, with different deductibles, copayments, and catastrophic limits. TRICARE also offers optional dental plans for family members of active service members.

Medicaid covers the cost sharing for active service military families who qualify on the basis of income and provides coverage for services not included in TRICARE. For example, TRICARE does not cover home- and community-based services to the extent that Medicaid does, and many children of active service military families are enrolled in Section 1915(c) waivers or other programs to obtain specialized Medicaid services that are not covered by TRICARE (Shin et al. 2005). TRICARE informs enrollees that if they also have Medicaid coverage it will pay first, and provides an Other Health Insurance questionnaire for enrollees to populate with information about their Medicaid coverage to support coordination of benefits. However, there is no process for the information from this questionnaire to be routinely shared with states (DHA 2019a).

Although CMS has agreements with TRICARE governing the exchange of information regarding enrollee eligibility for financial assistance for coverage through state-based or federally facilitated health insurance exchanges, there is no active agreement for the exchange of information regarding Medicaid- or Medicare-eligible beneficiaries (HHS 2019).[5] Until 2017, the DoD conducted a data match with states once a year to identify enrollees who had coverage through both Medicaid and TRICARE. This data match was governed by a memorandum of understanding (MOU) between CMS and the Defense Health Agency (DHA), which administers TRICARE. This MOU expired in 2017 and has not been renewed. As of 2020, the only source of information for state Medicaid agencies on TRICARE coverage is self-reported enrollee information.

The DRA's provisions apply to all health insurers in a state but, as noted above, Congress has exempted TRICARE from state and local laws related to health insurance. TRICARE does not follow the DRA requirement that all insurers in a state accept TPL claims from Medicaid for at least three years (32 CFR 199.7(d)). Instead, it treats TPL claims from Medicaid according to its own policies, which require claims to be filed within one year of either the date of service or the date of the last data match with the state (DHA 2019b). In addition, TRICARE only reimburses states and will not issue reimbursement or explanations of benefits directly to providers (DHA 2015). Finally, as noted above, many states with Medicaid managed care programs have delegated TPL responsibility to contracted MCOs, which must coordinate benefits with other health insurers. However, TRICARE does not share data with or process claims it receives from Medicaid MCOs, including those with delegated TPL responsibilities; it will only coordinate benefits with and accept claims from state Medicaid agencies (DHA 2015).

In 2011, the HHS OIG found that the differences in TPL policies between Medicaid and TRICARE make it challenging for state Medicaid agencies

to identify and recover third-party payments from TRICARE (OIG 2013). CMS has had discussions with DoD about TRICARE limitations and requirements and has provided technical assistance to help states coordinate with TRICARE (OIG 2013). However, there is evidence that states perceive these interagency efforts to have fallen short. For example, in an amendment to its Section 1115 demonstration waiver filed in 2019, Tennessee noted that "states' ability to seek payments from other parties that may be legally responsible for the cost of care provided to Medicaid beneficiaries is currently inhibited by inconsistent and conflicting federal policies," and "[the 12-month claims limitation] inappropriately shifts healthcare costs that should be the responsibility of the federal government to states" (TennCare 2019).

Barriers to Effective Coordination of Benefits

Despite the coverage overlap between Medicaid and TRICARE, there are several barriers to effective coordination of benefits. As a result of these policies, states have difficulty administering their Medicaid TPL responsibilities for TRICARE members who are also enrolled in Medicaid, resulting in a cost shift from the federal government to states.

Lack of a data sharing agreement between DHA and states

States conduct a variety of data matches to identify third-party resources; for example, many states conduct data matches with large insurers and data clearinghouses on a daily, weekly, or monthly basis to identify other health coverage or changes in other coverage that may not have been reported by enrollees. To encourage insurer cooperation with these processes, states have developed standardized file layouts, contracted with national data clearinghouses and other partners, and reimbursed insurers for the costs incurred in

providing the requested information. States typically ask insurers to disclose a large number of fields to support automated data matching, ensure the accuracy and reliability of the match, and limit the number of mismatches and inaccurate personal health information disclosures. States can use the standardized Payer Initiated Eligibility/Benefit (PIE) Transaction developed by CMS to accomplish this or they can use state-developed or proprietary transaction formats (CMS 2010). As noted above, improvements in state efforts to coordinate directly with insurers correlated with increases in Medicaid recoveries (GAO 2015). However, without a mechanism to conduct data matches with the DoD, state Medicaid programs cannot identify all enrollees who have primary coverage through TRICARE, which leads to Medicaid improperly paying some of those claims and shifting DoD health care costs to the states and HHS.

In 1986, the DoD established an agreement with the Health Care Financing Administration (HCFA)—the name of the agency was changed to CMS in 2001—to match records between the Defense Enrollment Eligibility Reporting System (DEERS) and state Medicaid agencies (DLA 1986). This initial system of database matches, created to identify the extent to which Medicaid enrollees were eligible for military health benefits, identified DHA as the matching agency and state Medicaid agencies as the source agencies. That is, the official data sharing agreement specified a system whereby the state Medicaid agencies would submit information on Medicaid enrollees (e.g., name, date of birth) to DHA, which would link the two files and return the state's file, with the same data elements originally provided, with an additional flag to indicate which Medicaid enrollees were also on file with the DHA. This agreement also provided assurances from HCFA regarding security of the data. Because the files returned to the states did not include information on military health coverage start and end dates, they were mainly used for state identification of enrollees for follow-up regarding potential TPL. Then, in the late 1990s, states were given access to the DEERS database, which allowed

Medicaid staff to look up eligibility and coverage periods for individual enrollees (HCFA 1998).

In 2017, as part of the periodic review and renewal of the data sharing agreement, CMS determined that it was no longer able to certify the data security provisions of the agreement. Specifically, the agreement between the DoD and CMS required CMS to ensure the security of the data provided by DHA to states. However, TRICARE's TPL data matching system uses a direct data exchange between DHA and state Medicaid agencies, and CMS never collects any DoD or state data related to the match. Because CMS does not participate in the exchange of data itself, it has not conducted a specific security assessment of state information systems that would allow it to certify to the DoD that the DHA data are secure. Therefore, beginning in 2017, CMS determined that it could not sign an agreement with DoD that requires such certification. This was not the result of a change in the data match process, but rather the result of changes in CMS's standards for data sharing and its internal process for reviewing data security agreements. Without a signed agreement, DHA stopped sharing files with state Medicaid agencies, and so those agencies are no longer able to exchange enrollment information needed to coordinate benefits with TRICARE.

Infrequent data matches and one-year timely filing window

The lack of an active data sharing agreement between CMS and DHA is the biggest roadblock to coordination of benefits between Medicaid and TRICARE, but the procedures outlined in the prior agreement and the terms of that agreement also limited the effectiveness of efforts to coordinate benefits.

For example, under the procedures outlined in the original agreement, each state would send a flat file (e.g., a spreadsheet) listing all enrollees to DHA and receive the same file back with an additional column of data that indicated whether or not DHA had identified a match in DEERS

(e.g., an eligible sponsor with TRICARE coverage or an eligible dependent on a TRICARE policy). State TPL staff would then have to look up each individual in the DEERS system to get the additional information needed to coordinate benefits (e.g., the insurer identifier, coverage start and end dates as applicable, or the policy number). Because the data did not include fields such as the Social Security number, address, and other details that help identify individuals, staff sometimes made incorrect matches which then required further research or created additional delays in payment processing. Depending on the number and accuracy of the matches, this manual research process could take up to six months.

In addition, the data match provided information on TRICARE coverage only as of the time of the data match; information about changes in TRICARE coverage that could affect TPL (e.g., a child aging out of family coverage) between annual data matches would not be passed on to the states as those changes occurred. The annual manual matching procedures outlined in the 1986 data sharing agreement are no longer used by most insurers; to improve Medicaid TPL collections, most states conduct frequent (e.g., weekly or monthly) data matches with other insurers for automated verification of other health insurance coverage and use more sophisticated data matching procedures.

In addition, as noted above, in 2005, Congress took action to improve Medicaid recoveries, such as requiring insurers to provide coverage information to state Medicaid agencies and to accept TPL claims for up to three years after the date of service. However, it did not extend these provisions to government health programs, and the DHA did not voluntarily renegotiate the agreement with CMS to reflect these terms or waive the claims filing deadline to align with the DRA provision for Medicaid despite having the administrative authority to do so (32 CFR 199.7(d)). Instead, although DHA allows states access to the DEERS database to look up individual enrollees, DHA will exchange data files with states only when there is an active MOU with CMS, and will accept TPL claims for only one year

from date of service or one year from the date of the last data match (DHA 2019c).

These two operational limitations contribute to a cost shift to Medicaid. First, when there was an active MOU in place, the DHA would conduct a data match with each state only once per year on a schedule established by the DHA. Depending on when a person became eligible for Medicaid, it could be up to 11 months before the next data match, meaning that the state could potentially pay claims for almost a year before learning that the enrollee had other health coverage through TRICARE that would enable it to start the TPL process. GAO has noted that cost avoidance comprises a much greater proportion of Medicaid TPL savings than the pay and chase approach (GAO 2015). Thus, it is likely that identifying Medicaid enrollees with TRICARE coverage once per year instead of monthly or quarterly limits states' ability to avoid paying most TRICARE TPL claims and results in states improperly paying claims that are the responsibility of DoD.

Second, federal Medicaid rules require states to give providers one year from the date of service to submit a claim for payment and states then have up to 90 days to pay most claims (42 CFR 447.45). Because it may take states more than one year from the date of service to receive and review a claim within the normal course of business, Congress created the statutory provision requiring insurers to accept TPL requests from states for up to three years after the date of service. TRICARE's one-year limit on TPL claims also likely results in states improperly paying claims that are the responsibility of DoD. A 2011 survey by the OIG found that 92 percent of states reported TRICARE's one-year timely filing limit to be "very challenging" to their ability to recover payments (OIG 2013).

Finally, these two policies have compounding effects on each other. By the time a state has conducted the annual data match, researched TRICARE coverage, and identified a potential claim subject to TPL, more than a year may have passed from the date of service even if the claim was submitted and paid promptly by Medicaid. TRICARE carriers have also provided conflicting guidance to states on whether they will use the later date—one year from the date of the data match or one year from the date of service—when accepting claims (OIG 2013). In a 2011 OIG survey, 74 percent of states reported that these two factors limited states' ability to identify and recover third-party payments from TRICARE (OIG 2013).

Lack of coordination with Medicaid MCOs

A third—but growing—issue is the lack of coordination between TRICARE carriers and the Medicaid MCOs that pay claims for over half of Medicaid beneficiaries and have TPL responsibilities. When the DoD and HCFA first began coordination in 1986, fewer than 3 percent of Medicaid beneficiaries were enrolled in managed care (HCFA 1995). However, as of July 1, 2017, over 68 percent of beneficiaries were enrolled in comprehensive managed care plans, which accounted for nearly half of Medicaid benefit spending (MACPAC 2019a).

From the Medicaid perspective, MCOs are state contractors and can be delegated insurance functions, including TPL responsibilities, by the state agency. In 2012, CMS provided a policy clarification regarding implementation of the DRA provisions, noting that "when TPL responsibilities are delegated to an MCO, third parties are required to treat the MCO as if it were the state Medicaid agency," including providing access to third-party eligibility and claims data to identify individuals with third-party coverage (CMS 2014). However, these provisions do not apply to government health programs, including TRICARE. As a matter of policy, DHA does not share data with Medicaid MCOs, including those with delegated TPL responsibilities. TRICARE carriers only coordinate benefits with and accept claims from state Medicaid agencies and require a current billing agreement with the state before they will do so (DHA 2015). In the best-case

scenario, states can coordinate benefits for only the subset of Medicaid enrollees remaining in FFS.[6]

The exclusion of Medicaid MCOs from TRICARE TPL activities also complicates states' abilities to accurately set payment rates for Medicaid MCOs. States have several options for complying with federal TPL rules but many have delegated TPL responsibility to MCOs, and set payment rates accordingly. That is, the states' payment rates assume that MCOs will either cost avoid or pay and chase a reasonable proportion of third-party claims. Because TRICARE carriers will not accept claims from Medicaid MCOs without a billing agreement, MCOs cannot pay and chase any TPL claims; their only option is to cost avoid. However, because DoD will not conduct data matches with Medicaid MCOs or give them access to the DEERS database, MCOs must rely on the state agency to provide information from the annual data match to identify which enrollees have TRICARE coverage to determine which claims can be cost avoided. The result is that MCOs are likely paying claims that are the responsibility of the DoD, and the capitation rates paid to the MCOs overestimate the cost of services that are the responsibility of the MCOs (i.e., MCOs pay for services that should be paid by TRICARE as the primary insurer but cannot be proactively cost avoided) and underestimate TPL recoveries (i.e., MCOs cannot recover improperly paid amounts from TRICARE due to DHA policies).

Commission Recommendations

Recommendation 4.1

The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

Rationale

Medicaid is generally the payer of last resort: by law, all other sources of coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual. To put this into practice, Medicaid attempts to coordinate benefits with other insurers as a secondary payer and will deny claims (for resubmission to the primary payer) when a Medicaid enrollee has other health insurance. However, if a Medicaid program is unaware that an enrollee has other coverage at the time a claim is paid, it may pay the full amount, then later seek reimbursement from the primary insurer for the amount that insurer is liable, a practice known as pay and chase. GAO has noted that cost avoidance accounts for most of the savings to Medicaid associated with coordination of benefits and that fewer savings result from pay and chase (GAO 2015). Therefore, it is important from a fiduciary standpoint that state agencies have information in the system about which Medicaid enrollees have other sources of health insurance before claims are paid.

There are two ways that state Medicaid agencies can learn about TRICARE coverage without a data match. First, individual Medicaid enrollees are asked about sources of other coverage at enrollment and may indicate that they have TRICARE coverage. Even so, without the data match process, states are unable to identify many cases (e.g., non-custodial children, mid-year changes) and as a result, they are paying claims that should be the responsibility of DoD. The second method is for states to access the DEERS database and look up whether Medicaid enrollees have TRICARE coverage. However, state staff can research only one case at a time in the DEERS system, a time-consuming task that cannot be scaled up to determine third-party coverage for multiple enrollees at once.

The data match system need not be reinstated under the same terms as previously. From 1987 through 2016, a data sharing agreement between the DoD and CMS allowed state agencies and the DHA to share eligibility records. However, states have noted that the information and frequency

of matches allowed by the previous data sharing agreement supported an inefficient coordination of benefits process (OIG 2013). Alternatives could include: developing a process to share data between the DoD and CMS that CMS could then share with states through an existing, secure portal; facilitating direct data sharing agreements between the DoD and state Medicaid agencies; determining whether other DoD-CMS-state data sharing mechanisms include sufficient data fields and could be adapted to support this activity; or identifying a third party to conduct data sharing and coordination of benefits between DoD and state Medicaid agencies. A working group of DHA, CMS, and state representatives could help identify the approach that best balances the requirements of data security, timeliness, and administrative efficiency.

Without a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the DHA, states cannot identify all of the nearly 1 million Medicaid enrollees who also have TRICARE coverage and are therefore paying claims that should be paid first by TRICARE. Because most of these payments cannot be recouped by Medicaid even if the TRICARE coverage is later identified, the lack of a routine, complete eligibility data match results in a cost shift from DoD to state Medicaid agencies and HHS. Reinstating the data match would help ensure that Medicaid remains the payer of last resort, as intended by Congress.

Implications

Federal spending. This recommendation would increase the integrity of the Medicaid program and reduce cost shifting to Medicaid from TRICARE, which would increase federal spending, because Medicaid is partially paid for by the states and TRICARE is a wholly federal program. However, this does not represent new federal spending, because TRICARE is already responsible for these payments. The Congressional Budget Office (CBO) typically only provides cost estimates for changes to federal spending that result from statutory changes and will not score this type of recommendation. It is worth

noting that CBO looks at expenditures from the perspective of the unified federal budget (meaning that it would not provide an estimate of Medicaid savings and TRICARE costs resulting from this recommendation, only the net effects, if any, on federal spending).

States. This recommendation would change the administrative demands on states; they would have additional administrative activities associated with the data match, but improved coordination of benefits could potentially streamline benefit administration and reduce the need for repayment negotiations. At the same time, some claims costs currently borne by states would be shifted back to the DoD. Generally, improved coordination of benefits is considered a positive return on investment and it is possible that reduced claims costs for the nearly 1 million enrollees with primary TRICARE coverage would outweigh any additional administrative burdens.

Enrollees. Timely data exchange would affect enrollees by helping to support coordination of benefits. For Medicaid enrollees who have primary insurance coverage through TRICARE, improved coordination of benefits should simplify Medicaid payment of patient cost sharing.

Plans and providers. Improved coordination of benefits would also affect providers by helping to ensure that claims will be paid by the appropriate organization at first billing, improving the speed and accuracy of provider payment. Some providers could receive higher payments if TRICARE becomes the primary payer for services provided to enrollees with both Medicaid and TRICARE coverage, because TRICARE physician rates are generally based on the Medicare fee schedule, which is typically higher than the Medicaid fee schedule (MACPAC 2019b).

Recommendation 4.2

To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE,

Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Rationale

The operational limitations in how DHA coordinates benefits contribute to a cost shift to Medicaid. Because it may take states more than one year from the date of service to receive and review a claim within the normal course of business, Congress created the DRA provision requiring insurers to accept TPL requests from states for up to three years after the date of service. By limiting TRICARE TPL claims to one year, it is likely that this timely filing policy results in states improperly paying claims that are the responsibility of the DoD. In addition, the exclusion of Medicaid MCOs from TRICARE TPL activities also complicates states' abilities to accurately set payment rates for Medicaid MCOs. Requiring the TRICARE carriers to implement the same TPL policies as other health insurers (e.g., share coverage information with the states, accept claims for up to three years, and accept the right of recovery from the state and its contractors, including MCOs) should reduce the shifting of costs and improve operational efficiency.

Although statutory changes are not necessary to make some changes to improve the TPL process (e.g., the DHA has the administrative authority to waive the timely filing limit), as of 2020, the Medicaid and TRICARE programs have not been able to coordinate benefits for over three years, despite efforts to improve coordination at the agency level. From the Medicaid perspective, aligning TRICARE's requirements with the requirements of other third-party insurers would be administratively straightforward. However, because Congress has previously exempted TRICARE from state and local laws related to health insurance (10 USC § 1103), it appears that clearer direction from Congress through a statutory change or other directive is needed to apply those requirements to TRICARE. This would also be consistent with prior Commission recommendations to Congress

to change the statute to avoid Medicaid making disproportionate share hospital (DSH) payments to cover costs that are the primary responsibility of other payers (MACPAC 2019c).

Implications

Federal spending. This recommendation would increase the integrity of the Medicaid program and reduce cost shifting to Medicaid from TRICARE, which would increase federal spending, because Medicaid is partially paid for by the states and TRICARE is a federal program. The total effect to both programs from implementing all components of this recommendation would likely be greater than from Recommendation 4.1, which would only reinstate the data match without necessarily changing the timely filing limit or adding managed care coordination of benefits. As with Recommendation 4.1, this does not represent new federal spending, because TRICARE is already responsible for these payments.

States. This recommendation would change the administrative demands on states. They would have additional administrative activities associated with coordination of benefits but would be able to return liability for many claims back to the primary payer, DoD. Over time, states would have more accurate data to set capitation rates. It is likely that the reduced claims costs would outweigh any additional administrative burdens.

Enrollees. As with Recommendation 4.1, timely data exchange would affect enrollees by helping to support coordination of benefits and could simplify Medicaid payment of patient cost sharing for Medicaid beneficiaries who have primary insurance through TRICARE. In addition, these changes would affect Medicaid managed care enrollees by helping to support coordination of benefits and coverage of patient cost sharing.

Plans and providers. Improved coordination of benefits would affect providers by helping to ensure that claims would be paid by the appropriate organization at first billing, improving the speed and accuracy of provider payment. Some providers,

including FFS and managed care providers, could receive higher payments if TRICARE becomes the primary payer for services provided to enrollees with both Medicaid and TRICARE coverage.

Endnotes

[1] Exceptions include a small number of programs that have been statutorily designated as payers of last resort after Medicaid (e.g., the Ryan White HIV/AIDS Program, Title V Maternal and Child Health Block Grant Program, Indian Health Service, Individuals with Disabilities Education Act programs, and World Trade Center Health Program) and programs that are not considered to be legally liable third parties, such as schools, public health programs, and family service and child welfare agencies carrying out their general responsibilities to ensure access to needed health care.

[2] CMS has regulations and guidance addressing coordination of benefits between Medicare and Medicaid, but these interactions are not the focus of this analysis. MACPAC has previously examined several of these policies, including lesser-of payment policies and Medicaid coverage of premiums and cost sharing. Similar detailed policies do not exist for interactions between Medicaid and other third-party payers.

[3] Sharing of third-party liability information between the state, its contractor, and providers or potentially liable third parties is permitted under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) but must comply with the HIPAA business associate requirements, where applicable.

[4] Section 6035 of the DRA created a new section of the Social Security Act (1902(a)(35)) that directs states to pass laws requiring health insurers to provide certain information "in a manner prescribed by the Secretary" and to comply with timely filing requirements.

[5] An important distinction exists between data exchange for purposes of supporting the health insurance exchange federal data hub and data exchange for purposes of supporting Medicaid TPL activities: CMS operates the federal data hub and each state can access the data from the hub, so only one data exchange with TRICARE is needed;

but under the terms of the Medicaid TPL data sharing agreement, CMS acts as an intermediary only and TRICARE conducts data exchanges with each state Medicaid program individually (i.e., 51 separate data exchanges each year).

[6] Depending on state policy, a state may be able to recoup the amount that TRICARE is liable for from the provider if it is unable to recover it directly from TRICARE.

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020. *Medicare-Medicaid Coordination Office FY 2019 report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Medicaid and CHIP frequently asked questions: Identification of Medicaid beneficiaries' third-party resources and coordination of benefits with Medicaid. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-04-2014.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2010. Letter from Cindy Mann to state Medicaid directors regarding "Third Party Liability." June 21, 2010. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10011.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2006. Letter from Dennis Smith to state Medicaid directors regarding "Implementation of the Deficit Reduction Act of 2005." December 15, 2006. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD121506.pdf.

Defense Health Agency (DHA). 2019a. *Evaluation of the TRICARE Program: Fiscal year 2019 report to Congress*. February 2019. Falls Church, VA: DHA. https://www.health.mil/Reference-Center/Congressional-Testimonies/2019/04/08/TRICARE-Program-Effectiveness.

Defense Health Agency (DHA). 2019b. Using other health insurance. Falls Church, VA: DHA. https://tricare.mil/Plans/OHI.

Defense Health Agency (DHA). 2019c. Filing claims. Falls Church, VA: DHA. https://tricare.mil/FormsClaims/Claims.

Defense Health Agency (DHA). 2015. TRICARE reimbursement manual: State agency billing. Falls Church, VA: DHA. https://manuals.health.mil/pages/DisplayManualHtmlFile/TO15/59/AsOf/tr15/c1s20.html#FM16794.

Defense Logistics Agency (DLA), U.S. Department of Defense. 1986. Privacy Act of 1974: Computer Matching Program and System of Records Amendment; Department of Defense/State Medicaid Agencies. Notice. *Federal Register* 51, no. 147 (July 31): 27443–27446.

Division of TennCare (TennCare), State of Tennessee. 2019. TennCare II Demonstration Project, Amendment 42. Draft document for public comment. https://www.tn.gov/content/dam/tn/tenncare/documents2/TennCareAmendment42.pdf.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 1998. Letter from Sally Richardson to state Medicaid directors regarding "Defense Enrollment Eligibility Reporting System (DEERS) related items." February 9, 1998.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 1995. *Medicaid Managed Care enrollment report: Summary statistics as of June 30, 1995*. Baltimore, MD: HCFA.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. Exhibit 29: Percentage of Medicaid enrollees in managed care by state, July 1, 2017. In *MACStats: Medicaid and CHIP data book*. December 2019. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/05/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-July-1-2017.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. Chapter 3: Improving the effectiveness of Medicaid program integrity. In *Report to Congress on Medicaid and CHIP*. June 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/improving-the-effectiveness-of-medicaid-program-integrity/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019c. Chapter 2: Treatment of third-party payments in the definition of Medicaid shortfall. In *Report to Congress on Medicaid and CHIP*. June 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/treatment-of-third-party-payments-in-the-definition-of-medicaid-shortfall/.

Office of Inspector General (OIG), U.S. Department of Health and Human Services. 2013. *Medicaid third-party liability savings increased, but challenges remain*. Washington, DC: OIG. https://oig.hhs.gov/oei/reports/oei-05-11-00130.asp.

Shin, P., S. Rosenbaum, and R. Mauery. 2005. *Medicaid's role in treating children in military families*. Washington, DC: George Washington University SPHHS Center for Health Services Research and Policy. https://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/Medicaid_military_102405.pdf.

Tricare for Kids Coalition (TFK). 2018. *America's military readiness and the essential role of Medicaid*. Washington, DC: TFC. http://www.tricareforkids.org/wp-content/uploads/2018/11/11152018-TFK-Military-Report.pdf.

U.S. Department of Health and Human Services (HHS). 2019. HHS computer matching agreements. Baltimore, MD: HHS. https://www.hhs.gov/foia/privacy/cmas/index.html.

U.S. Government Accountability Office (GAO). 2015. *Medicaid: Additional federal action needed to further improve third-party liability efforts*. Report no. GAO-15-208. Washington, DC: GAO. https://www.gao.gov/assets/670/668134.pdf.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP 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, fulfills 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 on Medicaid and TRICARE third-party liability coordination. 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 Recommendation 4.1 and Recommendation 4.2 on April 2, 2020.

Medicaid and TRICARE Third-Party Liability Coordination

4.1 The Centers for Medicare & Medicaid Services should facilitate state Medicaid agency coordination of benefits with the Department of Defense TRICARE program by working with the Department of Defense to develop a mechanism for routinely sharing eligibility and coverage data between state Medicaid agencies and the Defense Health Agency.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
		1	Not present
Not present:	Barker		

4.2 To protect Medicaid from improper payment of claims that are the responsibility of a third party and improve coordination of benefits for persons who have coverage through both Medicaid and TRICARE, Congress should direct the Department of Defense to require its carriers to implement the same third-party liability policies as other health insurers, as defined in Section 1902(a)(25) of the Social Security Act.

Yes:	Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	16	Yes
		1	Not present
Not present:	Barker		

Medicaid's Role in Maternal Health

Medicaid's Role in Maternal Health

Key Points

- Approximately 700 women die annually as a result of pregnancy or related complications, which can occur during pregnancy, at birth, and in the postpartum period. Potentially life-threatening complications are increasing, as are the rates of preterm and low-birthweight infants. Women of color have significantly higher rates of maternal morbidity and mortality.

- Medicaid plays a key role in providing maternity-related services for pregnant women, financing more than 40 percent of births in 2018. Medicaid paid for a greater share of births in rural areas, among young women, among women with lower levels of educational attainment, and among Hispanic, African American, and American Indian and Alaska Native women.

- Compared to privately insured women, pregnant women covered by Medicaid have higher rates of severe maternal morbidity and mortality and are more likely to have certain pregnancy risk factors, such as obesity and a history of smoking.

- States are required to provide Medicaid coverage for pregnant women with incomes at or below 133 percent of the federal poverty level; such coverage must extend for 60 days postpartum. Although the vast majority of states provide full Medicaid benefits to all pregnant women, five states (Arkansas, Idaho, New Mexico, North Carolina, and South Dakota) cover only pregnancy-related services.

- Medicaid programs are taking steps to improve maternal outcomes. These include adopting policies to expand eligibility and simplify enrollment; offering education and outreach materials to beneficiaries and providers; enhancing covered benefits; implementing alternative models of care and payment arrangements; and building quality improvement and performance measurement into managed care contracting.

- The Centers for Medicare & Medicaid Services (CMS) has also focused efforts on improving outcomes for pregnant women, including two grant opportunities—Strong Start for Mothers and Newborns and the Maternal Opioid Misuse (MOM) model—under the aegis of the Center for Medicare and Medicaid Innovation. CMS has also provided several technical assistance opportunities to states and, more recently, has focused its attention on maternal health in rural areas.

- The Commission will continue to focus on Medicaid mechanisms to address poor maternal and infant health outcomes over the next report cycle. Future work will focus on the use of value-based purchasing, access to maternity providers, family planning services, and postpartum coverage.

CHAPTER 5: Medicaid's Role in Maternal Health

Although most births occur without adverse outcomes, poor maternal and infant outcomes are on the rise. Approximately 700 women die annually as a result of pregnancy or related complications, with such deaths occurring over the course of pregnancy and in the postpartum period (CDC 2019a, Petersen et al. 2019a). At least 50,000 women experience serious complications during birth (Creanga et al. 2014). Additionally, poor infant outcomes, including preterm births and low-birthweight infants, are increasing (Martin et al. 2019). Significant racial and ethnic disparities also exist, with black and American Indian and Alaska Native women having higher pregnancy-related death rates (Petersen et al. 2019b). Women of color are also at greater risk of maternal morbidity and giving birth to a preterm or low-birthweight infant (Martin et al. 2019). Women living in rural areas also face greater maternal health risks than those residing in urban areas (Kozhimannil et al. 2019a). These poor outcomes and disparities may be exacerbated by the current COVID-19 pandemic.

Although these worrisome trends are not limited to Medicaid, poor outcomes for many women and infants could be addressed through Medicaid policy. Medicaid has long played a key role in providing maternity-related services for pregnant women, financing more than two out of every five births in 2018 (MACPAC 2020a). Compared to privately insured women, pregnant women covered by Medicaid are more likely to have certain pregnancy risk factors, such as obesity and a history of smoking, and have higher rates of severe maternal morbidity and mortality (MACPAC 2020a, 2018; Kozhimannil et al. 2019b).

There is widespread interest among state and federal policymakers, providers, and advocates in improving maternal health outcomes. Some of this interest focuses on particular groups, such as women of color or women living in rural communities. Less attention has been paid to the role of Medicaid in

addressing these poor outcomes. Over the last year, the Commission has been gathering information to understand the experience of pregnant women covered by Medicaid and the efforts by states and the federal government to improve maternal and infant health. The Commission has analyzed birth certificate data, commissioned original research, met with stakeholder organizations, and convened multiple panels at public meetings. Our work in this area has been primarily descriptive. Although possible solutions have been raised in the course of our inquiry, the Commission is not making recommendations at this time. Nonetheless, given the importance of this topic to the Medicaid program, the mothers and infants it serves, and the detrimental societal effects of poor maternal and birth outcomes, the Commission plans to spend considerable time over the next year weighing different policy alternatives and highlighting evidence-based solutions.

This chapter begins by describing the maternal and infant health outcomes that are raising alarm. It then explains Medicaid's role in providing maternity care, including the share of births that are paid for by Medicaid, as well as an overview of Medicaid eligibility for pregnant women and the benefits available to them. The chapter then goes on to describe state-led and federal initiatives to improve access to care and the quality of services pregnant women in Medicaid receive. It concludes with a discussion of future areas of work for the Commission, including value-based payment, access to maternity providers, family planning services, and postpartum coverage.

Maternal and Infant Health Outcomes

Pregnant women in the United States are increasingly experiencing adverse maternal and birth outcomes. Pregnancy-related deaths occur during pregnancy, at birth, and up to a year postpartum; potentially life-threatening complications are increasing, as are the rates of

preterm and low-birthweight infants. There are also significant racial and ethnic disparities in outcomes. Research suggests that although a number of factors, such as higher prevalence of comorbidities and pregnancy complications, lower socioeconomic status, and less access to prenatal care, contribute to these disparities, they do not fully explain the differences in outcomes (Howell 2018).

Maternal mortality

Approximately 700 women die annually in the United States from pregnancy or related complications; about 60 percent of these deaths may be preventable (Petersen et al. 2019a).[1] The pregnancy-related mortality ratio (the number of deaths per 100,000 live births) has increased over the last 30 years, from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. However, it is unclear how much the risk of a woman dying as the result of pregnancy-related causes has actually increased, because identification of such deaths has improved over time (CDC 2020a).[2]

Pregnancy-related deaths can result from a number of medical conditions. Cardiovascular conditions are responsible for approximately one-third of pregnancy-related deaths. Other medical conditions, infection, and obstetric hemorrhage are also leading causes of pregnancy-related deaths (Petersen et al. 2019a, 2019b). Pregnancy-related deaths due to hemorrhage, preeclampsia and eclampsia, and anesthesia complications have declined, while those due to cardiovascular conditions, cerebrovascular accidents, and other medical conditions have increased. An increasing number of pregnant women have chronic conditions that put them at higher risk of complications (CDC 2020a).

The leading causes of death vary by the time frame. About one-third of deaths occur during pregnancy, about one-third occur on the day of delivery or within one week, and about one-third occur postpartum. During pregnancy, other medical conditions and cardiovascular medical conditions are the most common cause of death for women. On the day of delivery, hemorrhage and amniotic fluid embolism are the major causes of death; from six weeks postpartum through the end of the first year, cardiomyopathy is the leading cause of death (Petersen et al. 2019a).

There are considerable racial and ethnic disparities in pregnancy-related mortality, with rates two to three times higher among black, non-Hispanic women (40.8 per 100,000); American Indian and Alaska Native women also have higher pregnancy-related mortality (29.7 deaths per 100,000) (Petersen et al. 2019b). The causes and timing of deaths also differ by race. Cardiomyopathy, embolism, and hypertensive disorders contribute to a significantly higher proportion of deaths among black women; hemorrhage and hypertensive disorders contribute to a higher proportion of deaths among American Indian and Alaska Native women. A greater proportion of deaths among black women occurs in the late postpartum period (43–365 days) in comparison to white women (Petersen et al. 2019a).

Drug overdose, suicide, and homicide may also be leading causes of death during or within a year of pregnancy.[3] For example, the Maternal Mortality and Morbidity Task Force of the Texas Department of Health and Human Services examined all maternal deaths occurring within one year of the end of pregnancy and found that between 2012 and 2015, drug overdose (17 percent) was the leading cause of maternal death. Almost 80 percent of these deaths occurred more than 60 days postpartum. Homicides accounted for 11 percent of maternal deaths and suicide was the cause of death in almost 9 percent of cases. Most of these maternal deaths also occurred more than 60 days postpartum (DHHS 2018).

State maternal mortality review committees (MMRCs) conduct comprehensive reviews of women's deaths during or within a year of pregnancy (Box 5-1). These committees are typically convened at the state or local level under the auspices of the state maternal and child health program, which is generally responsible for maternal mortality surveillance (Review to Action 2020b). In 38 jurisdictions, the MMRC is fully or

partially funded using the Maternal and Child Health Services Block Grant Program; additional jurisdictions reported using block grant funds for MMRC planning activities (GAO 2020).[4] These committees have access to both clinical and non-clinical information (such as vital records, medical records, and receipt of social services) to illuminate the factors contributing to deaths during pregnancy, birth, and the postpartum period (Davis et al. 2019).

MMRCs also may make recommendations on ways to prevent deaths and improve outcomes overall (Davis et al. 2019). A 2020 review of MMRC reports found recommendations related to hospital procedures, payment mechanisms, and other preventive services guidelines to reduce

maternal mortality (MACPAC 2020b). For example, in 2015, Maryland's MMRC recommended the state implement universal screening at least once during pregnancy and postpartum for substance use conditions (DHMH 2015). In 2018, the Louisiana MMRC had a set of recommendations to improve the timeliness of emergency room responses and protocols for better coordination between emergency and obstetric providers (Kieltyka et al. 2018). Other states had recommendations around improving both provider and patient education; for example, in Arizona, the committee recommended implementing public awareness campaigns on the importance of healthy behaviors in preventing pregnancy complications in its 2019 report (Cabasag et al. 2019).

BOX 5-1. State Maternal Mortality Review Committees

Maternal mortality review committees (MMRCs) are multidisciplinary teams that conduct reviews of deaths among women during pregnancy and within a year of the end of a pregnancy. The committees typically include representatives from the provider community (e.g., obstetricians and gynecologists, maternal-fetal medicine specialists, midwives, and nurses), public health and behavioral health professionals, forensic pathologists, and advocacy or community-based organizations (CDC 2020b). Although state public health officials may participate in reviews in some states, it does not appear that Medicaid programs have a formal role in MMRCs (MACPAC 2020b). As of February 2019, 46 states and the District of Columbia had a functioning MMRC (Kozhimannil et al. 2019c).

Some committees have limited funding and rely on volunteers to do their work while others are more professional in nature; committees also vary in terms of which data they examine and how frequently they report (Kozhimannil et al. 2019c, Martin 2018). MMRC recommendations for improving data collection include increasing data completeness, implementing a comprehensive database of pregnancy-associated deaths, and identifying techniques to complete the death certificate, particularly as it relates to the pregnancy checkbox (McFarland 2017, DPHHS 2011).

There have been several efforts over the last few years to improve and expand the capabilities of MMRCs. In 2016, the Association of Maternal & Child Health Programs, the U.S. Centers for Disease Control and Prevention (CDC), and the CDC's Division of Reproductive Health collaborated to establish Building U.S. Capacity to Review and Prevent Maternal Deaths, an effort to improve and standardize data collection to identify the number of maternal deaths and improve data sharing (CDC Foundation 2016). The Preventing Maternal Deaths Act (P.L. 115-334), enacted in December 2018, authorizes $12 million per year in new funds for five years to establish and support MMRCs. In 2019, the CDC awarded more than $45 million for five-year grants to support the work of MMRCs through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality program. This funding directly supports MMRC efforts to identify and review maternal deaths and identify prevention opportunities (CDC 2020b).

Maternal morbidity

Each year at least 50,000 women experience potentially life-threatening complications in childbirth; the rate of severe maternal morbidity doubled between 1998 and 2011 (Creanga et al. 2014). One analysis of hospital discharge data showed that the share of deliveries involving severe maternal morbidity and mortality (SMMM) was higher among women whose deliveries were paid for by Medicaid than among women covered by private insurance (Fingar et al. 2018).[5] Furthermore, researchers have also documented racial differences in SMMM, with black non-Hispanic, and American Indian and Alaska Native women having heightened risk of morbidity, compared with white non-Hispanic women (Admon et al. 2018). Rural residents also have worse health outcomes during pregnancy and childbirth than urban residents (Kozhimannil et al. 2019a, 2014; ACOG 2014).

A study commissioned by MACPAC found that Medicaid beneficiaries were almost twice as likely as those with private insurance to experience SMMM (Kozhimannil et al. 2019b). Further, this analysis confirmed prior findings indicating that there are elevated risks for SMMM among people of color and rural residents.[6] There appears to be little variability across payers in racial and geographic disparities in SMMM—the risk for people of color and rural residents was similar when comparing Medicaid beneficiaries with women with private insurance and other payers. Clinical risk factors, including pulmonary hypertension and chronic kidney disease, as well as cesarean delivery, were among the strongest predictors of SMMM for Medicaid beneficiaries (Kozhimannil et al. 2019b).

Infant birth outcomes

Infants born preterm (that is, delivery prior to 37 weeks) or with low birthweight (less than 2,500 grams) are at increased risk for experiencing physical disabilities and developmental impairments (Colicchia and Simhan 2016). Preterm birth rates decreased from 2007 to 2014, but then began increasing; in 2018, the preterm birth rate

was 10 percent (Martin et al. 2019, Ferré et al. 2016). The rate of preterm birth is higher among women of color (Martin et al. 2019).[7] In 2018, 11 percent of infants born to Medicaid-covered mothers were born preterm (MACPAC 2020a). The rate of preterm births in Medicaid varies by state and was highest in Mississippi and lowest in Vermont in 2018 (Table 5A-1).

The percentage of low-birthweight infants has also been on the rise since 2014; in 2018, the rate was about 8 percent. Between 2017 and 2018, the rate of low-birthweight infants declined among white non-Hispanic women but rose for the second consecutive year for black non-Hispanic women, to 14 percent (Martin et al. 2019).[8] In 2018, about 10 percent of infants born to mothers with Medicaid were low birthweight (MACPAC 2020a). The rate of low-birthweight infants in Medicaid was highest in the District of Columbia and lowest in Alaska, California, and Utah (Table 5A-1).[9]

Medicaid's Role in Maternity Care

In 2018, Medicaid paid for 43 percent of all births in the United States (MACPAC 2020a). The share of births covered by Medicaid varies across states, with Medicaid paying for more than half of births in six states: Arizona, Louisiana, Mississippi, New Mexico, Oklahoma, and Tennessee (Table 5A-2). Medicaid paid for a greater share of births in rural areas, among young women (under age 19), and for women with lower levels of educational attainment than other payers did. Medicaid also paid for a greater share of deliveries by Hispanic, African American, and American Indian and Alaska Native women (Table 5A-3). Compared to privately insured women, women covered by Medicaid were more likely to have certain pregnancy risk factors, such as obesity and a history of smoking (MACPAC 2020a, 2018).

All states are required to provide Medicaid coverage for pregnant women with incomes at or below

133 percent of the federal poverty level (FPL).[10] Currently, all but four states extend Medicaid coverage to pregnant women with higher incomes. As of April 2019, the median eligibility threshold was 195 percent FPL (MACPAC 2019a). States must extend coverage to these women for 60 days postpartum.[11] Women who are otherwise eligible for Medicaid (for example, as a low-income parent) and become pregnant can retain their existing coverage and generally are not required to shift to a pregnancy-related eligibility pathway; as such, they do not face an end to their coverage at 60 days postpartum.[12]

Pregnant women are typically entitled to the full Medicaid benefit package; however, for women covered through poverty-level pregnancy pathways (i.e., women with incomes above the state's income threshold for the former Aid to Families with Dependent Children (AFDC) program), states may limit services to those related to pregnancy.[13] As a result, Medicaid benefit packages for pregnant women may differ by eligibility pathway both across and within states. Although the vast majority of states provide the full Medicaid package to all pregnant women, five states (Arkansas, Idaho, New Mexico, North Carolina, and South Dakota) provide only pregnancy-related services (Brooks et al. 2019). Pregnancy-related services are defined as those that are necessary for the health of the pregnant woman and fetus, including prenatal care, delivery, postpartum care, family planning services, and services for other conditions that might complicate the pregnancy, threaten carrying the fetus to full term, or create problems for the safe delivery of the fetus (42 CFR 440.210). If a state proposes not to cover certain services or items for pregnant women that it covers for other adults, the state must describe in its state plan the basis for determining that such services are not pregnancy-related (CMS 2012a).[14]

State Efforts to Improve Maternal Outcomes

Medicaid programs have implemented a number of policies, programs, and initiatives designed to improve maternal outcomes. In many cases, states have adopted these approaches under existing federal guidelines that offer state flexibility in terms of coverage and benefits and gone beyond the standard Medicaid requirements. Under contract with MACPAC, Mathematica compiled an inventory of these Medicaid activities (Mathematica 2020). This inventory is descriptive in nature and was compiled from publicly available information and then confirmed by the states and territories. Mathematica also sought to collect information related to outcomes, but that information was available for only a small subset of policies. As such, the information about the effectiveness of these interventions is not generally included in the inventory.

The inventory includes Medicaid-led initiatives and policies specific to pregnant and postpartum women.[15] However, some of these state efforts are designed to improve the outcomes for both mother and infant. Although Mathematica conducted a thorough document review and had a high response rate from states, it is possible that not all relevant policies were captured.

Mathematica examined state efforts in the following areas: eligibility and enrollment, education and outreach (to providers and beneficiaries), covered benefits, models of care, payment, managed care contracting, performance measurement, and other (Table 5-1). Overall, Mathematica captured almost 400 policies in place over the last 10 years across all states, the District of Columbia, and Puerto Rico.[16]

TABLE 5-1. Overview of Medicaid Policies, Programs, or Initiatives to Improve Maternal Outcomes across States and Territories

Category or initiative	Number of states or territories
Eligibility and enrollment	43
Education and outreach to beneficiaries or providers	44
Covered benefits	47
Models of care delivery	18
Payment models or policies	41
Managed care contracting strategies	40
Performance measurement, performance improvement projects, and quality improvement projects	32
Other	34

Notes: The inventory includes information from all 50 states, the District of Columbia, and Puerto Rico.

Source: Mathematica 2020.

Eligibility and enrollment

As discussed above, states must cover pregnant women with incomes up to 133 percent FPL and extend coverage for 60 days postpartum. States also have options to broaden coverage to pregnant women, including using presumptive eligibility, covering women who are immigrants, and extending the postpartum period through a waiver or by using state-only funds.

Presumptive eligibility. States have the option to allow qualified entities to screen pregnant women for Medicaid eligibility based on their income and temporarily enroll them in Medicaid (§ 1920 of the Social Security Act (the Act), 42 CFR 435.1101). Qualified entities include health care providers, schools, and agencies that administer other assistance, such as the Special Supplemental Nutrition Program for Women, Infants and Children (42 CFR 435.1101). Presumptive eligibility allows women to obtain Medicaid-covered prenatal care immediately and ensures that providers are paid for any services they deliver during the presumptive eligibility period, even if the pregnant woman is not subsequently determined eligible. Currently, 31 states have adopted this option (Mathematica 2020).

Immigrant coverage. To qualify for the full range of benefits offered under Medicaid, individuals must be citizens or nationals of the United States or qualified aliens.[17] Legal permanent residents entering after August 22, 1996, are generally barred from receiving full Medicaid benefits for five years, after which coverage becomes a state option.[18] However, pregnant women who are lawfully residing may be covered during the five-year waiting period at state option (§ 1903(v)(4) of the Act). States can also extend coverage to other immigrants using state-only funds. Twenty-seven states provide coverage to immigrant pregnant women under such policies (Mathematica 2020).

Postpartum coverage. As described above, Medicaid coverage extends 60 days postpartum for women who are eligible for the program by virtue of their pregnancy. At that point, states are required to screen a woman for continued eligibility through other pathways (such as a low-income parent) or transfer her to the federal or state health care exchange if she is no longer eligible for any type of Medicaid. A handful of states have expanded coverage beyond the typical 60-day postpartum period, although they may target a particular population (such as women

with a mental health or substance use disorder) or a particular service (such as family planning). To receive federal matching funds for this coverage, states need approval of a demonstration waiver under Section 1115 of the Act.[19] Some of the states taking such actions are awaiting federal approval for implementation and others are using state-only funds. For example, South Carolina received approval in December 2019 to extend coverage to as many as 500 postpartum women with substance use disorders or serious mental illness under a Section 1115 demonstration waiver (Mathematica 2020, CMS 2019a). As another example, Wyoming extends family planning services to eligible postpartum women (Mathematica 2020).

Education and outreach

Medicaid programs may provide educational resources to beneficiaries to help them understand the benefits to which they are entitled, connect them to care, and instruct them on maternal health issues, such as smoking cessation and healthy eating. Medicaid may also educate providers about issues related to maternal health.

Education and outreach to beneficiaries. Thirty-three states have initiatives to educate pregnant women in Medicaid about a variety of maternal health issues; 34 states have initiatives to contact pregnant women for additional reasons, such as case management. In Idaho, for example, managed care organizations are required to send newly identified pregnant women information from the Idaho Department of Health and Welfare about the importance of obtaining dental care during their pregnancy. Wisconsin provides more comprehensive care coordination for high-risk pregnant women via prenatal care coordination agencies, which offer personal supports, referrals to health care services, nutrition counseling, and help locating other relevant community services. They also conduct outreach, perform assessments, and develop care plans (Mathematica 2020).

Education of providers. Seventeen states have initiatives to educate providers about maternal

health issues, including how to identify high-risk women. In Virginia, for example, providers are trained to know what to do when a patient screens positive on the Behavioral Health Risks Screening Tool, what treatment services are available to these women, and how to bill Medicaid for using the screening tool. Providers also receive continuing medical education credits for their participation in the training (Mathematica 2020).

Covered benefits

Some states offer benefits to pregnant women that are not offered to other Medicaid enrollees. Although these benefits are not mandated pregnancy-related services, states offer them with the goal of improving pregnancy and birth outcomes.

Behavioral health. More than half of states and territories cover postpartum depression screening under the infant's Medicaid identification number (i.e., as a benefit to the child). Postpartum depression is estimated to occur in 5 percent to 25 percent of all pregnant, postpartum, and parenting women; low-income mothers are more likely to experience depression, with rates as high as 40 percent to 60 percent (CMS 2016a). Postpartum depression can lead to adverse effects for both the mother and the child, and screening for maternal depression is recommended by the U.S. Preventive Services Task Force and the American Academy of Pediatrics (Earls et al. 2019; USPSTF 2019a, 2019b; CMS 2016a). In 2016, CMS issued an informational bulletin detailing how Medicaid agencies may cover maternal depression screening as part of a well-child visit (CMS 2016a). Pregnant women may need treatment for behavioral health conditions other than postpartum depression; almost half of states provide treatment services for mental health or substance use disorders (Mathematica 2020). (For more on pregnant women with substance use disorders, see Chapter 6.)

Dental services. Oral health care is also a concern for pregnant and postpartum women. Studies have suggested that maintaining good oral health may

have a positive effect on cardiovascular disease, diabetes, and other disorders. Some studies have shown a possible association between periodontal infections and preterm birth. However, more than half of pregnant women reported that they did not have a dental visit during pregnancy, with the lowest income women least likely to have received care (MACPAC 2015, ACOG 2013). A few states have targeted initiatives to improve access to dental services.[20] For example, Maryland provides pregnant women with dental coverage, including services such as fluoride treatments, root canals, and crowns, until their delivery dates. In Virginia, pregnant women receive dental services through the end of the 60-day postpartum period and are the only adult Medicaid population in the state with access to comprehensive dental coverage through the Smiles for Children program (Mathematica 2020).

Home visiting. Through home visiting programs, trained individuals provide support and evidence-based prevention and health promotion activities to pregnant women or families with young children. Home visiting programs typically include services such as screening, case management, family support, counseling, and skills training. Multiple federal and state funding streams, including

through Medicaid and the Maternal, Infant, and Early Childhood Home Visiting Program, can be combined to finance home visiting for women and their families (CMS and HRSA 2016). (For more on home visiting, see Chapter 6.)

Twenty-six Medicaid programs cover prenatal or postpartum home visits, and some target these services to high-risk mothers (Box 5-2) (Mathematica 2020). In Colorado, home visitors are registered nurses who provide targeted case management services. Since 2009, the Nurse Home Visitor Program has been available for first-time mothers or mothers whose first child is less than one month old who have family incomes at or below 200 percent FPL. Women can receive up to three home visits per month until the child turns two years old, with a lifetime maximum of 75 visits. Michigan's home visiting program, the Maternal Infant Health Program (MIHP), uses community-based providers to conduct at least two home visits (one prenatal and one postpartum) for women and their infants, with additional visits for high-risk women. MIHP services also include risk assessment, care coordination, and referral to services such as parenting education and lactation support (Mathematica 2020).

BOX 5-2. Home Visiting Models

Home visits during pregnancy and early childhood by a nurse, social worker, early childhood educator, or other trained professional have been shown to be effective in preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness (HRSA 2020). Among numerous evidence-based approaches, three home visiting models that are commonly used by state Medicaid agencies are Healthy Families America, Nurse-Family Partnership (NFP), and Parents as Teachers. These models all meet the U.S. Department of Health and Human Services criteria for being evidence-based (CMS and HRSA 2016).

Healthy Families America. The Healthy Families America model includes weekly hour-long home visits as well as screenings and assessments for adverse childhood experiences, maternal depression, child development, and parent-child interactions. Home visits begin during the prenatal period or within the first three months postpartum, and continue until the child reaches six months old, with the possibility of less frequent visits until age five. Local sites select the target population they plan to serve, which could be parents on Medicaid (ACF 2018). Maryland, Michigan, Minnesota,

BOX 5-2. (continued)

and New Jersey all use this model as one option for providing home visiting services (Massey 2020, Mathematica 2020).

Nurse-Family Partnership. NFP serves first-time mothers and low-income women and their children through one-on-one home visits with a registered nurse. Women must receive their first home visit no later than the end of the 28th week of pregnancy and continue to receive visits until the child's second birthday (ACF 2019a). NFP receives some form of Medicaid payment in 24 states (McGee 2020).

Parents as Teachers. This model serves families from pregnancy through kindergarten entry, and families can enroll at any point during this time frame. Parents as Teachers includes one-on-one home visits, monthly group meetings, developmental screenings, and connections to resources. Local sites offer at least 12 one-hour home visits with parent educators annually, and these visits may occur in a family's home or another location (ACF 2019b). Michigan, New Jersey, and New Mexico use this model as an option for home visiting services (Massey 2020, Mathematica 2020).

Doula services. A doula is an individual who provides physical and emotional support during pregnancy, labor and delivery, and postpartum. Only six states (Indiana, Minnesota, New Jersey, New York, Oregon, and Washington) currently provide or are preparing to cover doula services. For example, Minnesota Medicaid covers services including childbirth education and physical and emotional support during pregnancy, labor, birth, and postpartum, provided by a certified doula (Mathematica 2020). A study of doula services used by Medicaid beneficiaries in Minnesota found that women who received doula support had lower preterm and cesarean birth rates than Medicaid beneficiaries regionally (Kozhimannil et al. 2016).

Models of care delivery

Some states have changed how they provide services to pregnant women, for example, by establishing pregnancy medical homes or providing prenatal care in a group setting.

Pregnancy medical homes. Also known as maternity medical homes or maternity care homes, pregnancy medical homes are based on the patient-centered medical home concept. The

pregnancy medical home model is patient-centered and features a single provider who coordinates care, quality improvement measures, and timely access to care (Hill et al. 2018). Four states use this model, with North Carolina being one of the earliest adopters (Mathematica 2020). Under the state's Pregnancy Management Program, all pregnant Medicaid beneficiaries are eligible to participate in the comprehensive maternity care model. A clinical provider, which can be a family physician, obstetrician, or maternal-fetal medicine specialist, is paired with a care coordinator and receives incentive payments for certain services.[21] They then work with a team of care managers to provide in-person interaction and home visits (Dowler 2020, Mathematica 2020). Women participating in the pregnancy medical home model in North Carolina have better outcomes on many measures. For example, such women have a 20 percent lower rate of low-birthweight infants compared to women who are not in the pregnancy medical home. In addition, almost 70 percent of medical home participants receive prenatal care beginning in the first trimester (Dowler 2020).

Group prenatal care. Nine states allow prenatal care to be provided in a group setting, most often

using the CenteringPregnancy model. This model includes a clinical component, in which routine medical exams are completed, and a group visit component. During the group visit, women who have similar due dates participate in a facilitated discussion on topics such as nutrition, stress management, labor and delivery, and infant care (Centering Healthcare Institute 2020). The use of CenteringPregnancy in South Carolina has been successful in improving maternal outcomes such as lowering rates of preterm births, cesarean sections, and gestational diabetes, and increasing rates of breastfeeding (Mathematica 2020, CMS 2019b).

Payment initiatives

States have designed payment policies to encourage use of certain services, such as long-acting reversible contraception (LARC) and prenatal and postpartum visits. States have also established a range of value-based payment arrangements, some of which are designed to discourage use of certain services, such as early elective deliveries, while others are designed to improve quality measures and reduce costs.

Long-acting reversible contraception. LARC, which includes intrauterine devices and contraceptive implants, are highly effective methods of birth control and contribute to improved maternal health by assisting in birth spacing (CDC 2019b). However, LARC is used at lower rates in the U.S. than in other countries due to administrative and payment barriers.[22] For example, LARC placement may require significant upfront costs to providers to obtain the devices. To promote the availability of effective contraception, CMS released an informational bulletin in 2016 describing state approaches to LARC coverage and payment (CMS 2016b). Thirty-one Medicaid programs have policies that make it easier for women to receive LARC immediately postpartum. For example, Alabama covers LARC immediately after delivery, during the delivery hospitalization, or immediately after discharge from inpatient hospital delivery. The cost of the device and insertion are both paid for by Medicaid (Mathematica 2020).

Value-based payment. To reduce the rate of early elective deliveries and unnecessary cesarean deliveries, improve access to prenatal and postpartum care, improve quality, and reduce costs, states are seeking to change financial incentives for providers.[23] In some cases, states have adopted multiple payment approaches (MACPAC 2019b, Mathematica 2020). Approximately one-third of Medicaid programs have implemented reduced-payment or non-payment policies for maternity services. That is, these states do not cover procedures that do not follow clinical guidelines, such as early elective deliveries, elective inductions, and cesarean deliveries that are not medically indicated. Almost one-quarter of states have adopted pay-for-performance programs to provide financial incentives to hospitals or health professionals to meet perinatal care quality metrics. For example, Connecticut provides annual payments to eligible providers, in addition to current fee-for-service payments, for achieving a suite of metrics related to the receipt of prenatal and postpartum care (Mathematica 2020).

Fewer states have implemented bundled-payment or blended-payment arrangements. A bundled payment is a single fixed payment for a group of services provided to treat a condition during a defined episode of care. Implementation of a bundled-payment arrangement is meant to create incentives for providers to manage costs for each episode, because they are not paid more for providing additional or more costly services (MACPAC 2019b). For example, Ohio has instituted perinatal episodes of care for Medicaid beneficiaries, with a bundled payment covering all pregnancy-related care that a beneficiary receives 40 weeks before birth, labor and delivery services, and postpartum care up to 60 days after the birth (Mathematica 2020). However, some states have found that unbundling the postpartum visit from the bundled prenatal and delivery care payment can improve rates of postpartum care visits (CMS 2019c).

A blended payment consists of a single payment for a birth, regardless of mode of delivery. Payment rates for cesarean delivery are generally higher than those for vaginal delivery. By eliminating this discrepancy, a

blended payment may reduce the financial incentive to perform cesarean sections or minimize adoption of practices that lead to cesarean deliveries (such as limits on time in labor or management of fetal heart tracings) (MACPAC 2019b). Minnesota and Tennessee have adopted a blended-payment approach (MACPAC 2019b, Mathematica 2020).

Managed care and performance measurement

Managed care is the predominant Medicaid delivery system in most states and is often the system through which pregnant women receive services. As such, Medicaid programs can use managed care contracting strategies to encourage improvement in maternal health. For example, 32 states require managed care organizations (MCOs) to report on prenatal and postpartum Healthcare Effectiveness Data and Information Set (HEDIS) measures. Almost half of Medicaid programs base decisions about capitation payments, incentive payments,

or penalties on MCO performance on specific maternity measures. For example, Delaware requires MCOs to report on such quality measures; if the managed care plans do not achieve the performance levels set by the state, they face financial penalties of up to 1 percent of their total net revenue (Mathematica 2020).

Medicaid programs may also impose contract requirements for performance improvement projects (PIPs) or quality improvement projects (QIPs) to improve outcomes among pregnant or postpartum women enrolled in managed care.[24] For example, six states have PIPs or QIPs related to the receipt of prenatal care and three have PIPs or QIPs related to postpartum visits. In Michigan, MCOs are required to submit HEDIS data reporting maternal and child health measures by race and ethnicity as part of the state's Medicaid Health Equity Project (Box 5-3). Plans are also required to conduct PIPs to identify and address disparities in the timeliness of prenatal care (Mathematica 2020).

BOX 5-3. Michigan Mother Infant Health and Equity Improvement Plan

In the years 2011 to 2015, 66 women died of pregnancy-related causes in Michigan; 44 percent of these deaths were determined preventable. Women of color face a higher risk of death from pregnancy complications, even when controlling for age, socioeconomic status, and education. Black non-Hispanic women were three times more likely to die from pregnancy-related causes than white non-Hispanic women. In 2017, more than 760 babies in Michigan did not live to their first birthdays and babies born to black non-Hispanic women were more than twice as likely to die before their first birthdays than babies born to white non-Hispanic women (DHHS 2019).

To address these racial disparities, Michigan requires health plans to submit maternal and child Healthcare Effectiveness Data and Information Set (HEDIS) measures by race and ethnicity as part of the state's Medicaid Health Equity Project. These data are used to identify areas for targeted quality improvement; measures that are below the 50th percentile are tied to a performance payment withhold in managed care contracts. The state also works with managed care organizations (MCOs) to develop interventions to address barriers to and gaps in care experienced by women of color; these interventions are developed through literature reviews, data analysis, and member engagement. In addition, the state requires that MCOs pick a measure for a focused performance improvement project. Of the plans that have selected maternal and infant health measures, many are targeting interventions to social determinants of health, such as referring women to food assistance (Mathematica 2020, Massey 2020).

BOX 5-3. (continued)

Michigan has also launched a broader program to address racial disparities in maternal mortality. The Michigan Department of Health and Human Services has partnered with Medicaid and behavioral health agencies, as well as various stakeholders, to introduce the Mother Infant Health and Equity Improvement Plan. The goals of the plan include a reduction in disparities in the infant mortality rate by 15 percent by 2023. The plan also seeks to reduce the rate of low-birthweight infants by 11 percent, reduce the rate of preterm births by 8 percent, decrease the rate of severe maternal morbidity by 23 percent, and decrease the rate of maternal mortality by 37 percent during this time frame. As part of the plan, agencies within the department, including maternal and infant health programs, Medicaid, behavioral health, and human services, are working with external partners, such as the regional perinatal quality collaboratives, home visiting programs, and providers, to align programs and extend their reach (DHHS 2019).

Federal Initiatives

The federal government has also focused efforts on improving outcomes for pregnant women.[25] The Center for Medicare and Medicaid Innovation (CMMI) established two grant opportunities focused on maternal health: the Strong Start for Mothers and Newborns initiative, which ended in 2017, and the Maternal Opioid Misuse (MOM) model, which is ongoing. The MOM model seeks to address the opioid epidemic by supporting coordination of clinical care and other services critical for well-being and recovery (for more on the MOM model, see Chapter 6). In 2014, CMS launched the Maternal and Infant Health Initiative to provide technical assistance to states. The current administration has focused on improving access to maternal health care in rural communities and plans to launch a department-wide initiative in 2020 to address maternal health more broadly.

Strong Start for Mothers and Newborns

Strong Start for Mothers and Newborns (Strong Start) was a four-year (funded from February 2013 to February 2017) initiative to test and evaluate alternative enhanced prenatal care for women enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) who were at risk for having a preterm birth. The goal of the initiative was to reduce the rate of preterm births, improve health outcomes for pregnant women and newborns, and decrease the total cost of medical care during pregnancy, delivery, and the infant's first year of life (CMS 2015a).[26]

In 2013, 27 cooperative agreements were awarded, covering 211 provider sites across 32 states, the District of Columbia, and Puerto Rico. Strong Start funded enhanced services through three evidence-based, prenatal care models which served approximately 46,000 women:[27]

- Birth centers followed the midwifery model of care, a more holistic approach to pregnancy that is typically more time-intensive. This care was supplemented by peer counselors who provided psychosocial support, health education, and referrals to additional resources. This model was implemented by two grantees across 47 sites and served about 20 percent of Strong Start participants.

- Group prenatal care paired comprehensive prenatal care with facilitated discussions covering a broad range of issues in a group setting; topics included nutrition and exercise, stress reduction, family planning, parenting,

domestic violence, and childbirth preparation. Group prenatal care was implemented by 15 awardees in 60 sites, serving approximately 23 percent of participants.

- Maternity care homes supplemented prenatal care with care managers to coordinate and provide psychosocial support, although the intensity level of these interventions varied. Seventeen awardees at 112 sites implemented maternity care homes. This model served the largest proportion of participants, at 57 percent (Hill et al. 2018).

All Strong Start models went beyond the typical medical model of prenatal care and provided educational interventions designed to improve outcomes. These activities addressed nutrition, exercise, stress management, pregnancy, childbirth, breastfeeding, and family planning, among other topics. Additionally, staff in the Strong Start models worked to connect women to non-medical services that could support a healthy pregnancy, such as food support, transportation services, and child care. Finally, all the models emphasized psychosocial support through relationship-based care (Hill et al. 2018).

The five-year national evaluation of Strong Start found that overall, women who received prenatal care in birth centers had dramatically better outcomes at lower cost compared to risk-matched Medicaid enrollees who were not in Strong Start and received more typical prenatal care.[28] Specifically, infants born to women served by Strong Start birth centers were 26 percent less likely to be born preterm and 20 percent less likely to be born with low birthweight than infants born to mothers in the comparison groups. Rates of cesarean deliveries were 40 percent lower for mothers served in Strong Start birth centers than for women in typical care. Furthermore, delivery expenditures were, on average, 21 percent lower and total expenditures from delivery until the infant's first birthday were 16 percent lower for women enrolled in birth centers than for women and infants in the comparison groups. Although prenatal care expenditures for

Strong Start group prenatal care enrollees were lower than for women in typical Medicaid prenatal care, the evaluation found that this model produced few statistically significant improvements in maternal or infant outcomes. Finally, the evaluation found no evidence that Strong Start maternity care homes improved birth outcomes or reduced costs relative to typical Medicaid prenatal care. Improvements in outcomes for birth center enrollees were largely attributed to centers' use of the midwifery model of care, which is more time-intensive and emphasizes prenatal care that focuses on education and psychosocial support (Dubay et al. 2020, Hill et al. 2018).

In November 2018, CMS issued an informational bulletin describing the promising results of the Strong Start initiative. The bulletin suggests that states use these evaluation results in considering how to improve care for pregnant women and that they study the availability of birth centers in their states. The bulletin also explains federal requirements and optional coverage for midwifery and birth center services (CMS 2018a).

Maternal and Infant Health Initiative

In June 2012, CMS convened an expert panel to explore program, policy, and payment opportunities that could result in better care, improved birth outcomes, and reductions in costs of care for mothers and infants in Medicaid and CHIP. Based on the expert panel recommendations, in July 2014, CMS launched the Maternal and Infant Health Initiative (MIHI). The initiative had two primary goals: (1) increase the rate and improve the content of postpartum visits; and (2) increase access and use of effective methods of contraception (CMS 2014a).[29] The key components of the strategy included:

- promoting coverage of women before and after pregnancy;

- strengthening technical assistance on policies that enhance provider service delivery, including contraception and postpartum services;

- expanding beneficiaries' engagement in their care through enhanced outreach; and

- collaborating with other agencies to improve data and coordination (CMS 2014b).

Through the MIHI, CMS has worked to improve maternal and infant health by focusing on quality measurement and state reporting on relevant core set measures.[30] A majority of states are now reporting on these measures, which include the timeliness of prenatal care, the receipt of postpartum care, and the percentage of low-birthweight infants (CMS 2019d, 2019e). CMS also worked with the U.S. Department of Health and Human Services (HHS) Office of Population Affairs and the U.S. Centers for Disease Control and Prevention to develop two measures of contraceptive care. In 2015, 12 states and one territory were awarded grants to test and report these measures. These measures have since been added to the Maternity Core Set and states have used them, for example, to understand the barriers to hospital and provider uptake of LARC (CMS 2019f).

Under MIHI and related activities, CMS has also conducted a number of technical assistance efforts. For example, CMS launched a pilot project with four states (California, Louisiana, Ohio, and Oklahoma) to assess the effectiveness of using mobile technology to engage pregnant and postpartum Medicaid enrollees in their health care. Text4baby, a free service that delivers educational text messages timed to a woman's stage of pregnancy or her infant's age, was customized to address CMS's maternal health priorities, such as reducing early elective deliveries and ensuring appropriate postpartum visits.[31] During the first year, the pilot focused on identifying and engaging outreach partners; states saw an increase in both the number of partnerships and the percentage of pregnant women actively subscribed to Text4baby (CMS 2015c). Another study suggested that Text4baby may be a successful tool for promoting health information and improving knowledge, given that subscribers were more likely to report receiving high-priority health information

during pregnancy and exhibited a higher level of health knowledge (HHS 2015).[32]

Additionally, CMS held a learning collaborative with 10 states to share experiences developing quality improvement plans, engaging stakeholders, implementing interventions, specifying measures, and to consider opportunities to build on lessons learned (CMS 2014c). CMS also convened the Postpartum Care Action Learning Series for 10 states to develop and implement QIPs to improve the rate of postpartum visits (CMS 2019g).

In March 2017, the Medicaid Innovation Accelerator Program launched the MIHI Value-Based Payment (VBP) Technical Support project to assist states in selecting, designing, and testing value-based payment approaches to maternal and infant health. Beginning in June 2017, Colorado, Maine, Mississippi, and Nevada participated for a two-year period (CMS 2018b, 2017).

To mark the fifth anniversary of the original 2014 MIHI expert workgroup recommendations, CMS has reconvened a maternal and infant health expert workgroup to help chart the trajectory of the initiative over the next five years and recommend priority areas of focus. CMS anticipates using these recommendations to develop new technical assistance opportunities and resources for states (CMS 2020b).

Rural health

As part of a larger strategy targeting rural health, CMS has more recently focused its attention on maternal health among women living in rural areas (CMS 2018c). In June 2019, CMS collaborated with other partners to host a forum examining maternal health care in rural communities.[33] The top priorities emerging from the forum were in the areas of payment, workforce, and clinical and quality improvement (CMS 2019h). The agency subsequently published an issue brief to focus attention on the scope of the problem (CMS 2019b). In February 2020, CMS released a request for information to learn more about the barriers that

exist in rural communities and opportunities for improving access, quality, and outcomes for women in rural communities before, during, and after pregnancy (CMS 2020c).[34]

Forthcoming initiatives

HHS held a series of stakeholder roundtables on ways to improve maternal health in the fall of 2019, meeting with states, providers, health plans, advocates, and funders (Marks 2020, Cirruzzo 2019). The department also conducted listening sessions in several states to gain a better understanding of how states are seeking to address poor maternal and infant health outcomes. Based on these meetings, the department is working on an action plan to address the goals laid out in the President's fiscal year (FY) 2021 budget, which include: achieving healthy outcomes for all women of reproductive age by improving prevention and treatment; achieving healthy pregnancies and births by prioritizing quality improvement; achieving healthy futures by optimizing postpartum health; and improving data and bolstering research to inform future interventions. The President's FY 2021 budget would provide $74 million in new resources to address these goals (OMB 2020). The action plan is slated to be released sometime in 2020.

Next Steps

MACPAC'S work over the course of this year was primarily descriptive, seeking to identify factors affecting maternal health, the role Medicaid plays in providing maternity and postpartum services, and how states and the federal government are using Medicaid to address the issues. Going forward, the Commission will focus on a number of areas for analysis and possible recommendations. These areas include VBP, access to maternity providers, family planning services, and postpartum coverage. Given poor maternal and infant health outcomes, as well as Medicaid's critical role in providing such services, the Commission views this topic as a high priority. As it continues to explore these areas, the

Commission will focus on how various policies and evidence-based solutions can be designed to help improve maternal and infant health in Medicaid.

Value-based payment

The Commission is interested in understanding how states are using VBP models to improve the quality of maternity care. Over the years, the Commission has examined state efforts to implement VBP through a variety of projects. Most recently, MACPAC studied five states using managed care to implement VBP strategies. Two of the study states use episode-based models for maternity care. New York State designed a maternity episode-of-care model as an option for managed care plans, although interviewees noted that MCOs had not opted to implement the state-designed model. In Ohio, managed care plans and providers are required to participate in the model. Based on the quality and cost of care provided over the course of the episode, providers may be eligible for a shared savings payment or liable for downside risk payment (Bailit Health 2020). Preliminary results from Ohio's use of a perinatal episode of care show an improvement in screening rates and a three percent increase in medical spending (Ohio Medicaid 2019, Moody 2018).

Future work will more closely examine how states are designing and implementing various payment models to improve maternal health outcomes. These payment approaches could include pay-for-performance, shared savings, and episodes of care. The Commission will examine the drivers and barriers to implementation, review data on their effectiveness, and explore how state models are evolving.

Access to maternity providers

Given the promising results of the Strong Start evaluation in terms of both outcomes and costs, the Commission has expressed interest in examining the barriers to expanding the use of midwives and birth centers in Medicaid. Nurse-midwife services

are a mandatory Medicaid benefit; the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required coverage for care at birth centers in states that license the facilities.[35] There are currently 370 freestanding birth centers in the United States, and the number has been steadily growing for the past decade (Bauer 2019). However, almost all births financed by Medicaid occur in a hospital setting and more than 90 percent of Medicaid-financed births were attended by a doctor (MACPAC 2020a). Barriers such as capacity constraints, scope of practice, and payment policies may make it difficult to increase access to midwives and birth centers.

The Commission is also interested in learning more about the role that doulas can play in supporting healthy birth outcomes and how Medicaid can provide that service. As discussed above, only a few states cover doulas, despite evidence that they can improve outcomes. Further information about how these services are covered and how Medicaid programs can integrate a typically community-based service into medical care may help guide other states as they pursue coverage for doulas.

Finally, the Commission is concerned that access issues may arise, particularly in rural areas, where hospitals and obstetric units have closed. One study found that more than half of all rural counties were without hospital obstetric services in 2014 (Hung et al. 2017). Because almost all births financed by Medicaid occurred in a hospital setting, this low density of obstetric services may leave fewer options for women living in rural areas (MACPAC 2020a, CMS 2019b, Hung et al. 2017). The loss of hospital obstetric services in rural counties not adjacent to urban areas was associated with increases in out-of-hospital and preterm births and births in hospitals without obstetric units (Kozhimannil et al. 2018). The Commission is concerned about hospital closures and rural access more generally, but as the Commission considers the role of all maternity providers (including obstetricians, family physicians, and midwives), it will consider how they might address barriers to access in rural areas.

Family planning

Family planning can help prevent unintended pregnancies and assist in birth spacing. Unintended pregnancy is associated with poorer preconception health, delayed prenatal care, and increased risks of low-birthweight and preterm infants (CMS 2014b). Medicaid provides coverage for more than 70 percent of family planning services for low-income individuals (CMS 2016b). Family planning services are a mandatory benefit under Medicaid and must be provided to individuals of childbearing age without cost sharing. States can also extend eligibility for only family planning services through Section 1115 demonstration waivers or under the state plan. However, states may establish different coverage requirements for family planning services for different eligibility pathways (Walls et al. 2016).

The Commission is interested in learning more about how states are covering family planning services. Medicaid agencies typically pay for multiple types of family planning services and 31 states have a payment policy specifically designed to encourage LARC insertion immediately postpartum (Mathematica 2020, CMS 2016b, Walls et al. 2016). However, there are payment challenges related to LARC. For example, the use of a single payment for labor and delivery services may not address the additional costs associated with purchasing the device or payment to the hospital or provider for the placement (CMS 2016b). There are also issues related to informed consent when LARC insertion is offered immediately postpartum, not only related to the requirement that women have the choice of contraceptive methods but also related to the appropriate timing of that choice (ACOG 2016, ASTHO 2016). The Commission is interested in learning more about these barriers and what states have done to mitigate them. The Commission is also interested in understanding how states have extended family planning benefits to individuals who may not otherwise have coverage for the services, including the interaction between other Medicaid eligibility pathways and coverage under exchange plans.

Postpartum care and continuity of coverage

As discussed above, approximately one-third of pregnancy-related deaths occur postpartum, including almost 12 percent that occur between 43 and 365 days postpartum, highlighting the importance of follow-up care (Petersen et al. 2019a). Postpartum care offers the opportunity to monitor recovery from childbirth as well as to address other health care needs, such as postpartum depression, chronic conditions, and family planning. Not all Medicaid-covered women, however, are accessing services during the postpartum period; only about 60 percent of women in Medicaid had a postpartum visit within eight weeks of delivery (CMS 2019d).

Furthermore, Medicaid coverage for women eligible for the program by virtue of their pregnancy ends at 60 days postpartum, and in states that have chosen not to expand Medicaid under provisions of the ACA, women who become ineligible at the end of the postpartum period may not be eligible under another Medicaid pathway. This disrupts coverage and access to care for postpartum women. Between 2015 and 2017, one-third of women experienced a change in health insurance from preconception to postpartum; in states that expanded Medicaid, a higher proportion of women were continuously insured and the churning rate on and off Medicaid was less pronounced (Daw et al. 2019). There are also racial and ethnic disparities in insurance status and continuity of insurance coverage for women spanning the preconception to postpartum period (Daw et al. 2020).

The 60-day postpartum coverage period has been described as a barrier to ongoing care and has sparked interest in extending coverage for a longer period of time among state and federal lawmakers. For example, in January 2020, Illinois submitted a Section 1115 demonstration application to extend the postpartum coverage period to 12 months and New Jersey submitted an amendment to its existing demonstration to extend the postpartum coverage period to 6 months in March 2020

(HFS 2020, DHS 2020). Furthermore, MMRCs in Georgia, Illinois, Mississippi, and Washington have recommended extending Medicaid postpartum coverage for pregnant women (MACPAC 2020b). In addition, several professional societies, including the American College of Obstetricians and Gynecologists, the American Medical Association, and the Society for Maternal-Fetal Medicine, have endorsed extending the postpartum period to 12 months (ACOG 2020, SMFM 2020, AMA 2019). The President's FY 2021 budget called for allowing states to extend Medicaid coverage for pregnant women with substance use disorder to one year postpartum (OMB 2020). The Commission will explore the issues related to extending coverage, including the interaction with the Medicaid expansion for adults, as well as the provision of limited benefits to certain groups of pregnant women in some states.

Endnotes

[1] Pregnancy-related death is defined as the death of a woman while pregnant or within one year of the end of a pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy (CDC 2019a).

The National Center for Health Statistics (NCHS) also reports data on maternal mortality through the National Vital Statistics System (NVSS). These data rely on the definition of maternal mortality used by the World Health Organization (WHO): deaths of women while pregnant or within 42 days of being pregnant, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Due to implementation of the standard death certificate, NCHS did not publish the maternal mortality rate between 2008 and 2017 (Hoyert and Miniño 2020).

[2] According to the U.S. Centers for Disease Control and Prevention (CDC), the reasons for the overall increase in pregnancy-related mortality are unclear. Due to the use of computerized data linkages by states, changes in the way causes of death are coded, and the addition of a pregnancy

checkbox to the death certificate, the identification of pregnancy-related deaths has improved. However, noted errors in reported pregnancy status on death certificates may be leading to overestimation of the number of pregnancy-related deaths. It is not clear whether the actual risk of a woman dying from pregnancy-related causes has increased, and in recent years the pregnancy-related mortality ratios (the estimate of the number of pregnancy-related deaths for every 100,000 live births) have been relatively stable (CDC 2020a). Currently available data do not report the number of women covered by Medicaid who die from pregnancy-related causes.

[3] These deaths are considered pregnancy-associated deaths, which are defined as the death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause. However, depending upon the particular circumstances of the case and the criteria used in the review, they may or may not be considered pregnancy-related (see also endnote 1) (Review to Action 2020a).

[4] Fifty-nine states or jurisdictions receive grants from the Health Resources and Services Administration (HRSA) under the Maternal and Child Health Services Block Grant Program.

[5] Severe maternal morbidity refers to potentially life-threatening complications or the need to undergo a lifesaving procedure during or immediately following childbirth.

[6] Specifically, the analysis for MACPAC showed 20 percent to 80 percent increased likelihood of severe maternal morbidity and mortality (SMMM) for all people of color (black non-Hispanic, Hispanic, Asian or Pacific Islander, American Indian or Alaska Native, or other or unknown) compared with white non-Hispanic women (Kozhimannil et al. 2019b). National data looking at the time period from pregnancy through the postpartum year show maternal mortality rates are two to three times higher for black and indigenous women than for white non-Hispanic women (Petersen et al. 2019b). The analysis for MACPAC included measures of morbidity as well as mortality, but only focused on the childbirth hospitalization, which may account for some of the differences. The findings with regard to the elevated risks of SMMM among rural residents—Medicaid beneficiaries as well as patients with other payers—were similar to previously-published results (Kozhimannil et al. 2019a).

[7] Rates of preterm births and low-birthweight infants were higher among black non-Hispanic women, as well as among American Indian, Alaska Native, Native Hawaiian or other Pacific Islander women, than among white women. Hispanic women experience preterm births and low-birthweight infants at rates that are more similar to (although still higher than) those of white women (Martin et al. 2019).

[8] See endnote 7.

[9] In a prior MACPAC analysis, women with Medicaid for prenatal care and delivery were more likely than women who were uninsured for prenatal care and delivery to have a low-birthweight baby. Less than 10 percent of women with Medicaid for prenatal care and delivery had a preterm birth and there was no statistically significant difference when compared to women who were uninsured. Demographic characteristics and potentially complicating health factors can influence a woman's likelihood of having a preterm delivery or low-birthweight infant. However, when controlling for these factors, women with Medicaid coverage still were more likely than uninsured women to have a low-birthweight infant. There were no differences in these outcomes when comparing women with Medicaid to those with private insurance (MACPAC 2018).

[10] Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of: (1) 133 percent FPL or (2) the income standard, up to 185 percent FPL, that the state had established as of December 19, 1989, for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so (42 CFR 435.116). As such, there are 19 states that have a mandatory minimum eligibility threshold for pregnant women above 133 percent FPL (MACPAC 2014).

[11] The postpartum period begins on the last day of the pregnancy and extends through the end of the month in which the 60-day period concludes (42 CFR 440.210(a)(3)). This extension for 60 days postpartum also applies to pregnant women who, because of a change in household income, would not otherwise remain eligible (§ 1902(e)(6) of the Act).

[12] Generally, when an individual is eligible for more than one category, she has a choice of which eligibility pathway to enroll in (42 CFR 435.404). States are not required to track the pregnancy status of a current enrollee, so unless she self-identifies, she would remain enrolled in her current

eligibility group. Although pregnant women are not eligible for the new adult group that covers individuals with incomes below 138 percent FPL, the self-identification rule still applies and those already enrolled in the group may remain in the group (CMS 2012a).

[13] Mandatory coverage for pregnant women under Section 1931 and Section 1902(a)(10)(A)(i)(III) of the Act, as well as coverage through the optional pathways of Section 1902(a)(10)(A)(ii)(I) and Section 1902(a)(10)(A)(ii)(IV), must provide full Medicaid coverage. However, for women covered under Section 1902(a)(10)(A)(i)(IV) and Section 1902(a)(10)(A)(ii)(IX), states may limit coverage to pregnancy-related services. As such, states can limit coverage to pregnancy-related services for women with family incomes above the May 1, 1988, AFDC levels; women below the 1988 AFDC levels must receive full Medicaid benefits (MACPAC 2014, 2013).

For additional information on Medicaid and State Children's Health Insurance Program (CHIP) eligibility and coverage of services for pregnant women, see Chapter 1, Maternity Services: Examining Eligibility and Coverage in Medicaid and CHIP, in MACPAC's June 2013 report to Congress (MACPAC 2013).

[14] It is not clear from published data what services are not covered in states offering pregnancy-related services only. MACPAC will conduct additional research to understand these benefit limitations and how they might affect pregnant women.

[15] Initiatives in CHIP, programs that exclusively target newborn outcomes (e.g., hearing, lead screening), and general family planning programs are excluded. Federal, local, and health system programs are also excluded. For example, a smoking cessation program run by a state's department of public health may improve outcomes among pregnant women, but it is not a Medicaid initiative so it would not be captured in the inventory. Additionally, if a managed care plan was providing home visiting services, this would not be included unless it was a state requirement.

Mathematica also captured policies that are not currently in effect, either because they are no longer active (but occurred within the last 10 years) or because they have not yet been implemented. The time frame was expanded to include inactive programs because there may exist evidence of the effectiveness of programs that existed for a longer period of time. Programs that have not yet been implemented (e.g., legislation passed) were also included to capture future plans. However, legislation that had not yet been enacted into law was excluded. Similarly, waivers that had been submitted to, but not yet approved by, CMS were excluded. Note that the summary information includes all programs, regardless of active status.

In addition, policies, programs, and initiatives were placed into subcategories based on available information and may be subject to interpretation. Furthermore, the data collection methodology did not allow the researchers to definitively confirm the absence of activity in a particular state or territory in certain subcategories.

[16] Mathematica did look for policies and initiatives targeted toward maternal health in the other territories, but did not find any. It is possible that this is because the Medicaid programs in the territories differ in many respects from those in the 50 states and the District of Columbia. For more, see MACPAC's issue brief *Medicaid and CHIP in the Territories* (MACPAC 2020c).

[17] The term qualified alien was created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193) and includes legal permanent residents, refugees, and asylees.

[18] States have the option to provide legal permanent residents with Medicaid coverage after five years of residency if they otherwise meet Medicaid eligibility criteria (§ 403 of PRWORA).

[19] States can provide family planning services through the state plan; however, for a state to limit the services to a particular category of individual (such as postpartum women), it needs a Section 1115 demonstration waiver. States also need a waiver to extend coverage beyond the statutorily-mandated 60-day postpartum period, regardless of whether the state is targeting a particular category of women (e.g., those with substance use disorders).

[20] Note that this does not include states that offer dental benefits under the standard Medicaid package.

[21] Providers receive $50 for each standardized risk screening completed, $150 for each postpartum visit conducted, and an increased rate for vaginal deliveries. Providers must also decline to do elective deliveries before 39 weeks, maintain a cesarean delivery rate of less than 16 percent,

complete a high-risk screening for each pregnant beneficiary, offer progesterone therapy for women with a history of preterm birth, and cooperate with open-chart audits (Mathematica 2020).

[22] In 2009, LARC utilization rates were higher for women in Medicaid (11.5 percent) than the national rate (8.5 percent) (CMS 2016b).

[23] Early elective deliveries occur prior to 39 weeks by induction or cesarean section, without medical need.

[24] Quality measure reporting and PIPs or QIPs may overlap. The information reported here represents PIPs and QIPs that are state-initiated, including requirements to measure performance, and excludes PIPs and QIPs initiated by a managed care organization.

[25] As of September 2019, HHS had provided funding for 13 initiatives meant to reduce pregnancy-related deaths, including CDC funding to support maternal mortality review committees, perinatal quality collaboratives, and HRSA programs such as the Maternal and Child Health Services Block Grant and the Alliance for Innovation on Maternal Health initiative (GAO 2020). These, however, are not discussed in this section because they are not directed toward improvements in Medicaid.

[26] Another initiative of Strong Start was a public-private partnership and awareness campaign to reduce the rate of early elective deliveries prior to 39 weeks for all populations (CMS 2015b).

[27] CMS, in partnership with HRSA and the Administration on Children and Families, also evaluated a fourth approach, enhanced prenatal care through home visiting, as part of the evaluation of two Maternal, Infant, and Early Childhood Home Visiting models (CMS 2015a).

[28] The evaluation used linked birth certificate and Medicaid data to compare birth and cost outcomes for women participating in Strong Start to outcomes for comparable, non-participating Medicaid enrolled women.

[29] Specifically, CMS established national goals of increasing the rate of postpartum visits by 10 percentage points in at least 20 states over a three-year period and increasing the use of effective contraception by 15 percentage points in at least 20 states over a three-year period (CMS 2014a, 2014b).

[30] The core sets allow states, the public, and CMS to monitor performance on standardized indicators of the quality of care provided to Medicaid and CHIP beneficiaries. The Maternity Core Set (which includes measures from both the Child and Adult Core Sets) is used by CMS to measure and evaluate progress toward improvement of maternal and perinatal health in Medicaid and CHIP (CMS 2020a).

[31] This is distinct from the broader partnership between CMS and Text4baby to promote enrollment in Medicaid and CHIP (CMS 2012b).

[32] The low enrollment in Text4baby made it challenging to assess the effectiveness of the program and its effect on health behaviors and outcomes (HHS 2015).

[33] The event was hosted in collaboration with HRSA, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the National Birth Equity Collaborative, the National Rural Health Association, CDC, and the HHS Office on Women's Health. A summary of the event was also published (CMS 2019h).

[34] HRSA has separately awarded nearly $9 million to launch the Rural Maternity and Obstetrics Management Strategies (RMOMS) program in September 2019 in three states (Missouri, New Mexico, and Texas). The states will receive planning year funding and up to three years of implementation funding to develop models to improve access to and continuity of maternal obstetrics care in rural communities. The RMOMS program requires the involvement of specific stakeholders, including state Medicaid programs (HHS 2019).

[35] Services by licensed midwives may be covered in the Medicaid program under other licensed practitioner services (42 CFR 440.60). This optional benefit allows coverage of midwives who are not registered professional nurses, but are otherwise licensed by the state to furnish midwifery services (CMS 2018a).

References

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2019a. Implementing Nurse-Family Partnership (NFP). Washington, DC: ACF. https://homvee.acf.hhs.gov/implementation/Nurse-Family%20Partnership%20%28NFP%29%C2%AE/Model%20Overview.

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2019b. Parents as Teachers (PAT). Washington, DC: ACF. https://homvee. acf.hhs.gov/effectiveness/Parents%20as%20Teachers%20 %28PAT%29%C2%AE/In%20Brief.

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2018. Healthy Families America (HFA). Washington, DC: ACF. https:// homvee.acf.hhs.gov/effectiveness/Healthy%20Families%20 America%20%28HFA%29%C2%AE/In%20Brief.

Admon, L., T.N. Winkelman, K. Zivin, et al. 2018. Racial and ethnic disparities in the incidence of severe maternal morbidity in the United States, 2012–2015. *Obstetrics & Gynecology* 132, no. 5: 1158–1166.

American College of Obstetricians and Gynecologists (ACOG). 2020. Policy priorities: Medicaid and Medicare. https://www. acog.org/advocacy/policy-priorities/medicaid-and-medicare.

American College of Obstetricians and Gynecologists (ACOG). 2016. *Immediate postpartum long-acting reversible contraception*. Committee opinion no. 670, August 2016. Washington, DC: ACOG. https://www.acog.org/-/media/ project/acog/acogorg/clinical/files/committee-opinion/ articles/2016/08/immediate-postpartum-long-acting- reversible-contraception.pdf.

American College of Obstetricians and Gynecologists (ACOG). 2014. *Health disparities in rural women*. Committee opinion no. 586, February 2014. Washington, DC: ACOG. https://www.acog.org/-/media/project/acog/acogorg/ clinical/files/committee-opinion/articles/2014/02/health- disparities-in-rural-women.pdf.

American College of Obstetricians and Gynecologists (ACOG). 2013. *Oral health care during pregnancy and through the lifespan*. Committee opinion no. 569, August 2013. Washington, DC: ACOG. https://www.acog.org/-/media/ project/acog/acogorg/clinical/files/committee-opinion/ articles/2013/08/oral-health-care-during-pregnancy-and- through-the-lifespan.pdf.

American Medical Association (AMA). 2019. AMA adopts new policies at 2019 annual meeting. June 12, 2019, press release. Chicago, IL: AMA. https://www.ama-assn.org/ press-center/press-releases/ama-adopts-new-policies-2019- annual-meeting.

Association of State and Territorial Health Officials (ASTHO). 2016. *Informed consent and ethical considerations for immediate postpartum long-acting reversible contraception*. Arlington, VA: ASTHO. https://www.astho.org/Maternal-and- Child-Health/Informed-Consent-and-Ethical-Considerations- for-Immediate-Postpartum-LARC-Factsheet/.

Bailit Health. 2020. *State strategies to promote value-based payment through Medicaid managed care*. March 13, 2020, final report. Washington, DC: Medicaid and CHIP Payment and Access Commission (MACPAC). https://www.macpac. gov/wp-content/uploads/2020/03/Final-Report-on-State- Strategies-to-Promote-Value-Based-Payment-through- Medicaid-Mananged-Care-Final-Report.pdf.

Bauer, K., American Association of Birth Centers. 2019. E-mail to MACPAC, July 9.

Brooks, T., L. Roygardner, and S. Artiga. 2019. *Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2019: Findings from a 50-state survey*. Washington, DC: Kaiser Family Foundation. http://files.kff.org/ attachment/Report-Medicaid-and-CHIP-Eligibility-Enrollment- Renewal-and-Cost-Sharing-Policies-as-of-January-2019.

Cabasag, C., V. Rubio, and D. Williams. 2019. *Arizona Maternal Mortality Review Program: Program report 2012– 2015*. Phoenix, AZ: Arizona Department of Health Services. https://reviewtoaction.org/sites/default/files/portal_ resources/maternal-mortality-review-2012-2015.pdf.

CDC Foundation. 2016. CDC Foundation partnership to help reduce maternal mortality in the United States. April 19, 2016, press release. Atlanta, GA: CDC Foundation. https://www.cdcfoundation.org/pr/2016/cdc-foundation- partnership-help-reduce-maternal-mortality-united-states.

Centering Healthcare Institute. 2020. CenteringPregnancy. Boston, MA: Centering Healthcare Institute, Inc. https://www.centeringhealthcare.org/what-we-do/centering- pregnancy.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS). 2020a. Pregnancy Mortality Surveillance System. Atlanta, GA: CDC. https://www.cdc.gov/reproductivehealth/maternal-mortality/ pregnancy-mortality-surveillance-system.htm.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS). 2020b. Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). Atlanta, GA: CDC. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS). 2019a. Pregnancy-related deaths. Atlanta, GA: CDC. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS). 2019b. Contraception. Atlanta, GA: CDC. https://www.cdc.gov/reproductivehealth/contraception/index.htm.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. 2020 core set of maternal and perinatal health measures for Medicaid and CHIP (maternity core set). Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-maternity-core-set.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. E-mail to MACPAC, April 3.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. Request for information regarding "Maternal and infant health care in rural communities." Baltimore, MD: CMS. https://ruralmaternalrfi.org/wp-content/uploads/2020/02/Rural-Maternal-RFI.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Section 1115 of the Social Security Act demonstration approval: South Carolina Palmetto Pathways to Independence. December 12. Baltimore, MD: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-palmetto-pathways-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. *Improving access to maternal health care in rural communities*. Baltimore, MD: CMS. https://www.cms.gov/About-CMS/Agency-

Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019c. *Lessons learned about payment strategies to improve postpartum care in Medicaid and CHIP*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019d. *Quality of care for adults in Medicaid: Findings from the 2018 adult core set*. September 2019 chart pack. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-chart-pack.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019e. *Quality of care for children in Medicaid and CHIP: Findings from the 2018 child core set*. September 2019 chart pack. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-chart-pack.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019f. *The Maternal and Infant Health Initiative grant to support development and testing of Medicaid contraceptive care measures*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/mihi-contraceptive-measures.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019g. *Improving postpartum care: State projects conducted through the Postpartum Care Action Learning Series and Adult Medicaid Quality Grant Program*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-als-state-projects.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019h. *A conversation on maternal healthcare in rural communities: Charting a path to improved access, quality, and outcomes*. Baltimore, MD: CMS. https://www.cms.gov/files/document/rural-maternal-health-forum-summary.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. Joint informational bulletin regarding "Strong Start for Mothers and Newborns initiative (Strong Start)." November 9, 2018. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib110918.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. *Maternal and infant health care delivery models and value-based payment approaches: Key findings from an environmental scan*. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/iap-maternal-health-factsheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018c. *CMS rural health strategy*. Baltimore, MD: CMS. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Value-based payment & financial simulations. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/value-based-payment/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. CMCS informational bulletin regarding "Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children." May 11, 2016. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051116.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. CMCS informational bulletin regarding "State Medicaid payment approaches to improve access to long-acting reversible contraception." April 8, 2016. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB040816.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015a. Strong Start for Mothers and Newborns Initiative: Enhanced prenatal care models. Baltimore, MD: CMS.

https://innovation.cms.gov/initiatives/Strong-Start-Strategy-2/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015b. Strong Start for Mothers and Newborns Initiative: Effort to reduce early elective deliveries. Baltimore, MD: CMS. https://innovation.cms.gov/initiatives/Strong-Start-Strategy-1/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015c. *Pilot Mobile Health Program: Using mobile technology to reach, educate, and connect pregnant and postpartum Medicaid enrollees*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/pilot-mobile-health-program.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014a. CMCS informational bulletin regarding "CMCS Maternal and Infant Health Initiative." July 17, 2014. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/CIB-07-18-2014.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014b. *CMCS Maternal and Infant Health Initiative: Improving maternal and infant health outcomes in Medicaid and CHIP*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/maternal-and-infant-health-initiative.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014c. *Building state capacity to improve maternal and infant health: Overview of the QI 201 Series*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/qi-201-team-summary-brief.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012a. Medicaid program: Eligibility changes under the Affordable Care Act of 2010. Final rule. *Federal Register* 77, no. 57 (March 23): 17143–17217. https://www.govinfo.gov/content/pkg/FR-2012-03-23/pdf/2012-6560.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012b. Obama administration and Text4baby join forces to connect pregnant women and children to health coverage and information. February 28, 2012, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/obama-administration-and-text4baby-join-forces-connect-pregnant-women-and-children-health-coverage.

Centers for Medicare & Medicaid Services and Health Resources and Services Administration (CMS and HRSA), U.S. Department of Health and Human Services. 2016. Joint informational bulletin regarding "Coverage of maternal, infant, and early childhood home visiting services." March 2, 2016. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/CIB-03-02-16.pdf.

Cirruzzo, C. 2019. Azar holds roundtables with advocates on improving maternal health. *Inside Health Policy*, September 10. https://insidehealthpolicy.com/vitals/azar-holds-roundtables-advocates-improving-maternal-health.

Colicchia, L.C., and H.N. Simhan. 2016. Optimizing subsequent pregnancy outcomes for women with a prior preterm birth. *American Journal of Perinatology* 33, no. 3: 267–275.

Creanga, A., C.J. Berg, J.L. Ko, et al. 2014. Maternal mortality and morbidity in the United States: Where are we now? *Journal of Women's Health* 23, no.1: 39.

Davis, N.L., A.N. Smoots, D.A. Goodman. 2019. *Pregnancy-related deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017*. Atlanta, GA: Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf.

Daw, J.R., G.E. Kolenic, V.K. Dalton, et al. 2020. Racial and ethnic disparities in perinatal insurance coverage. *Obstetrics & Gynecology* 135, no. 4: 917–924. https://journals.lww.com/greenjournal/Fulltext/2020/04000/Racial_and_Ethnic_Disparities_in_Perinatal.20.aspx.

Daw, J.R., K.B. Kozhimannil, and L.K. Admon. 2019. High rates of perinatal insurance churn persist after the ACA. *Health Affairs Blog*, September 16. https://www.healthaffairs.org/do/10.1377/hblog20190913.387157/full/.

Department of Health & Human Services (DHHS), State of Michigan. 2019. *Mother infant health & equity improvement plan, 2020–2023*. Lansing, MI: DHHS. https://www.michigan.gov/documents/infantmortality/FINAL_MIHEIP_665052_7.pdf.

Department of Health and Human Services (DHHS), State of Texas. 2018. *Maternal Mortality and Morbidity Task Force and Department of State Health Services joint biennial report*. Austin, TX: DHHS. https://reviewtoaction.org/sites/default/files/portal_resources/MMMTFJointReport2018.pdf.

Department of Health and Mental Hygiene (DHMH), State of Maryland. 2015. *Maryland maternal mortality review: 2015 Annual report.* Baltimore, MD: DHMH. https://reviewtoaction.org/sites/default/files/portal_resources/2015MMR_FINAL%281%29.pdf.

Department of Healthcare and Family Services (HFS), State of Illinois. 2020. Section 1115 of the Social Security Act Medicaid: Illinois continuity of care & administrative simplification. Research and demonstration waiver request. Springfield, IL: HFS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-continuity-care-admin-simplification-pa.pdf.

Department of Human Services (DHS), State of New Jersey. 2020. Section 1115 of the Social Security Act New Jersey 1115 comprehensive Medicaid demonstration waiver amendment request. Trenton, NJ: DHS. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-request-pa.pdf.

Department of Medicaid, State of Ohio (Ohio Medicaid). 2019. *SIM final report*. Columbus, Ohio: Ohio Medicaid. https://medicaid.ohio.gov/Portals/0/PROVIDERS/PaymentInnovation/SIM-Grant-Final-Report.pdf.

Department of Public Health & Human Services (DPHHS), State of Montana. 2011. *Pregnancy-associated deaths in Montana, 2003–2009*. Helena, MT: DPHHS. https://reviewtoaction.org/sites/default/files/portal_resources/pregnancy-associateddeaths2003-2009.pdf.

Dowler, S. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, February 27, 2020, Washington, DC. https://www.macpac.gov/public_meeting/february-2020-macpac-public-meeting/.

Dubay, L., I. Hill, B. Garrett, et al. 2020. Improving birth outcomes and lowering costs for women on Medicaid: Impacts of Strong Start for Mothers and Newborns. *Health Affairs*. 39, no. 6: 1042–1050. healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01042.

Earls, M., M.W. Yogman, G. Mattson, et al. 2019. Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics* 143, no. 1: 1–9. https://pediatrics.aappublications.org/content/pediatrics/143/1/e20183259.full.pdf.

Ferré, C., W. Callaghan, C. Olson, et al. 2016. Effects of maternal age and age-specific preterm birth rates on overall preterm birth rates — United States, 2007 and 2014. *Morbidity and Mortality Weekly Report* 65, no. 43: 1181–1184. https://www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6543a1.pdf.

Fingar, K.R., M.M. Hambrick, K.C. Heslin, and J.E. Moore. 2018. *Trends and disparities in delivery hospitalizations involving severe maternal morbidity, 2006–2015.* Healthcare Cost and Utilization Project (HCUP) statistical brief no. 243. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ). https://hcup-us.ahrq.gov/reports/statbriefs/sb243-Severe-Maternal-Morbidity-Delivery-Trends-Disparities.jsp.

Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. 2020. *The Maternal, Infant, and Early Childhood Home Visiting program: Partnering with parents to help children succeed.* Rockville, MD: HRSA. https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf.

Hill, I., L. Dubay, B. Courtot, et al. 2018. Strong Start for Mothers and Newborns evaluation: Year 5 project synthesis. Baltimore, MD: Centers for Medicare & Medicaid Services. https://downloads.cms.gov/files/cmmi/strongstart-prenatal-finalevalrpt-v1.pdf.

Howell, E.A. 2018. Reducing disparities in severe maternal morbidity and mortality. *Clinical Obstetrics and Gynecology* 61, no. 2: 387–399. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/.

Hoyert, D.L., and A.M. Miniño. 2020. Maternal mortality in the United States: Changes in coding, publication, and data release, 2018. *National Vital Statistics Reports* 69, no. 2. https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69_02-508.pdf.

Hung, P., C. Henning-Smith, M.M. Casey, and K.B. Kozhimannil. 2017. Access to obstetric services in rural counties still declining, with 9 percent losing services, 2004–14. *Health Affairs* 36, no. 9: 1663–1671. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0338.

Kieltyka, L., C. Lake, P. Mehta, K. Schoellmann. 2018. *Louisiana maternal mortality review report: 2011–2016.* Baton Rouge, LA: Louisiana Department of Health. https://reviewtoaction.org/sites/default/files/portal_resources/2011-2016_MMR_Report_Louisiana.pdf.

Kozhimannil, K.B., J.D. Interrante, C. Henning-Smith, and L.K. Admon. 2019a. Rural-urban differences in severe maternal morbidity and mortality in the U.S., 2007–15. *Health Affairs* 38, no. 12: 2077–2085. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00805.

Kozhimannil, K.B., J.D. Interrante, and M. Tuttle. 2019b. Analysis for MACPAC of 2007–2015 Healthcare Cost and Utilization Project, national inpatient sample.

Kozhimannil, K.B., E. Hernandez, D.D. Mendez, T. Chapple-McGruder. 2019c. Beyond the preventing Maternal Deaths Act: Implementation and further policy change. *Health Affairs Blog*, February 4. https://www.healthaffairs.org/do/10.1377/hblog20190130.914004/full/.

Kozhimannil, K.B., P. Hung, C. Henning-Smith. 2018. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. *Journal of American Medical Association* 319, no. 12: 1239–1247. https://jamanetwork.com/journals/jama/fullarticle/2674780.

Kozhimannil, K.B., R.R. Hardeman, F. Alarid-Escudero, et al. 2016. Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth* 43, no. 1: 20–27.

Kozhimannil, K.B., P. Hung, S. Prasad, M. Casey, I. 2014. Rural-urban differences in obstetric care, 2002–2010, and implications for the future. *Medical Care* 52, no. 1: 4–9.

Marks, C., Office of Intergovernmental and External Affairs, U.S. Department of Health and Human Services. 2020. Conversation with MACPAC, March 13.

Martin, J.A., B.E. Hamilton, M.J.K. Osterman, et al. 2019. Births: Final data for 2018. *National Vital Statistics Reports* 68, no. 13. https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.

Martin, N. 2018. "Landmark" maternal health legislation clears major hurdle. *Pro Publica*, December 12. https://www.propublica.org/article/landmark-maternal-health-legislation-clears-major-hurdle.

Massey, K. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, February 27, 2020, Washington, DC. https://www.macpac.gov/public_meeting/february-2020-macpac-public-meeting/.

Mathematica. 2020. *Inventory of state-level Medicaid policies, programs, and initiatives to improve maternity care and outcomes*. March 2020 contractor report. Washington, DC: Medicaid and CHIP Payment and Access Commission (MACPAC). https://www.macpac.gov/publication/inventory-of-state-level-medicaid-policies-programs-and-initiatives-to-improve-maternity-care-and-outcomes/.

McFarland, C. 2017. *Trends in statewide maternal mortality New Jersey 2009–2013*. Trenton, NJ: Division of Family Health Services Reproductive and Perinatal Health. https://nj.gov/health/fhs/maternalchild/documents/nj_maternal_mortality_trends_2009_2013.pdf.

McGee, S., Nurse-Family Partnership. 2020. E-mail to MACPAC, February 20.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. *Medicaid's role in financing maternity care*. January 2020 fact sheet. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Analysis of state maternal mortality review committee reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020c. *Medicaid and CHIP in the territories*. April 2020 fact sheet. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. Exhibit 35: Medicaid and CHIP income eligibility levels as a percentage of the FPL for children and pregnant women by state. In *MACStats: Medicaid and CHIP Data Book*. December 2019. https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-35.-Medicaid-and-CHIP-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Children-and-Pregnant-Women-by-State-April-2019.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. *Medicaid payment initiatives to improve maternal and birth outcomes*. April 2019 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/04/Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *Access in brief: Pregnant women and Medicaid*. November 2018 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 2: Medicaid coverage of dental benefits for adults. In *Report to Congress on Medicaid and CHIP*. June 2015. https://www.macpac.gov/wp-content/uploads/2015/06/Medicaid-Coverage-of-Dental-Benefits-for-Adults.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Chapter 3: Issues in pregnancy coverage under Medicaid and exchange plans. In *Report to Congress on Medicaid and CHIP*. March 2014. https://www.macpac.gov/wp-content/uploads/2015/01/Issues_in_pregnancy_Coverage_under_Medicaid_and_Exchange_Plans.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. Chapter 1: Maternity services: Examining eligibility and coverage in Medicaid and CHIP. In *Report to the Congress on Medicaid and CHIP*. June 2013. https://www.macpac.gov/wp-content/uploads/2015/01/Maternity_Services_Examining_Eligibility_and_Coverage_in_Medicaid_and_CHIP.pdf.

Moody, G. 2018. Moving Ohio's health care payment system upstream. Presentation before the Health Policy Institute of Ohio, April 18, 2018, Dublin, OH. https://www.healthpolicyohio.org/wp-content/uploads/2018/04/Moody.pdf.

Office of Management and Budget (OMB). 2020. *Fiscal year 2021: A budget for America's future.* https://www.whitehouse.gov/wp-content/uploads/2020/02/budget_fy21.pdf.

Petersen, E.E., N.L. Davis, D. Goodman, et al. 2019a. Vital signs: Pregnancy-related deaths, United States, 2011−2015, and strategies for prevention, 13 states, 2013−2017. *Morbidity and Mortality Weekly Report* 68, no. 18: 423−429. https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6818e1-H.pdf.

Petersen, E.E., N.L. Davis, D. Goodman, et al. 2019b. Racial/ethnic disparities in pregnancy-related deaths: United States, 2017−2016. *Morbidity and Mortality Weekly Report* 68, no. 35: 762−765. https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6835a3-H.pdf.

Review to Action. 2020a. Learn: Definitions. https://reviewtoaction.org/learn/definitions.

Review to Action. 2020b. Getting started. https://reviewtoaction.org/implement/getting-started.

Society for Maternal-Fetal Medicine (SMFM). 2020. *Continuing Medicaid coverage for 12 months postpartum: An official position statement of the Society for Maternal-Fetal Medicine.* Washington, DC: SMFM. https://s3.amazonaws.com/cdn.smfm.org/media/2261/Final_PDF.pdf.

U.S. Department of Health and Human Services (HHS). 2019. HHS awards $9 million to develop new models to improve obstetrics care in rural communities. September 10, 2019, press release. Washington, DC: HHS. https://www.hhs.gov/about/news/2019/09/10/hhs-awards-9-million-new-models-obstetrics-care-rural-communities.html.

U.S. Department of Health and Human Services (HHS). 2015. *Promoting maternal and child health through health text messaging: An evaluation of the Text4baby program.* Washington, DC: HHS. https://www.hrsa.gov/sites/default/files/archive/healthit/txt4tots/text4babyfinalreport.pdf.

U.S. Government Accountability Office (GAO). 2020. *Maternal mortality: Trends in pregnancy-related deaths and federal efforts to reduce them.* Report no. GAO-20-248. Washington, DC: GAO. https://www.gao.gov/assets/710/705331.pdf.

U.S. Preventive Services Task Force (USPSTF). 2019a. Interventions to prevent perinatal depression: U.S. Preventive Services Task Force recommendation statement. *Journal of American Medical Association* 321, no. 6: 580−587. https://jamanetwork.com/journals/jama/fullarticle/2724195.

U.S. Preventive Services Task Force (USPSTF). 2019b. *Perinatal depression: Preventive interventions.* February 12, 2019, final recommendation statement. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/perinatal-depression-preventive-interventions.

Walls, J., K. Gifford, U. Ranji, et al. 2016. *Medicaid coverage of family planning benefits: Results from a state survey.* Washington, DC: Kaiser Family Foundation. http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey.

APPENDIX 5A: Medicaid's Role in Financing Maternity Care

TABLE 5A-1. Prenatal Care and Birth Outcomes among Medicaid Births, by State, 2018

State	Prenatal care began in first trimester	Nine or more prenatal care visits	Cesarean section	Preterm birth	Low-birthweight baby
United States	**68.3%**	**76.3%**	**31.7%**	**11.0%**	**9.7%**
Alabama	60.9	72.6	33.9	12.9	11.3
Alaska	66.5	63.2	19.7	10.3	6.7
Arizona	65.3	73.1	25.6	9.9	7.7
Arkansas	59.5	71.2	33.4	12.0	9.4
California	78.5	83.6	31.4	9.3	6.7
Colorado	69.7	69.7	24.8	9.5	9.0
Connecticut	78.3	81.5	34.0	10.8	8.5
Delaware	68.7	71.7	31.9	11.7	10.6
District of Columbia	52.4	55.1	30.9	13.8	13.1
Florida	65.4	73.1	36.1	11.5	9.7
Georgia	66.7	75.9	33.8	12.8	10.8
Hawaii	65.5	66.2	24.9	10.7	7.1
Idaho	73.3	80.7	24.1	10.0	7.3
Illinois	66.3	74.1	29.5	11.6	9.3
Indiana	60.8	74.2	29.8	11.0	9.0
Iowa	72.2	82.7	30.6	10.5	7.4
Kansas	74.5	79.0	30.5	11.3	8.3
Kentucky	73.6	80.1	35.2	12.5	9.9
Louisiana	70.6	77.6	36.9	13.8	11.8
Maine	79.1	87.3	30.4	9.5	7.7
Maryland	61.6	68.2	33.0	11.6	9.3
Massachusetts	71.6	79.7	31.0	9.6	7.5
Michigan	71.4	80.1	31.8	11.5	9.8
Minnesota	71.5	74.6	26.4	9.8	7.2
Mississippi	72.7	80.8	37.2	14.4	12.8
Missouri	64.2	73.1	29.7	12.0	9.9
Montana	67.6	73.0	28.3	11.4	9.1

TABLE 5A-1. (Continued)

State	Prenatal care began in first trimester	Nine or more prenatal care visits	Cesarean section	Preterm birth	Low-birthweight baby
Nebraska	63.0%	72.7%	29.9%	11.1%	8.0%
Nevada	67.1	77.5	34.4	11.9	9.8
New Hampshire	75.0	81.5	28.8	9.3	7.7
New Jersey	61.8	70.4	33.7	10.1	7.5
New Mexico	66.6	69.8	23.0	10.3	9.0
New York	72.4	76.5	32.1	9.0	7.9
North Carolina	65.3	78.5	28.9	11.7	10.5
North Dakota	61.1	62.1	30.9	10.3	7.5
Ohio	67.1	74.2	30.8	12.3	10.3
Oklahoma	67.9	75.4	32.1	12.0	8.8
Oregon	72.7	81.1	27.9	9.4	7.1
Pennsylvania	68.6	75.1	30.6	11.5	9.8
Rhode Island	78.3	91.5	30.3	9.4	7.8
South Carolina	65.2	77.4	33.0	12.8	10.9
South Dakota	61.1	61.0	25.5	10.6	6.8
Tennessee	68.4	75.7	32.0	12.5	10.3
Texas	59.7	72.7	34.2	11.1	8.3
Utah	72.2	78.7	24.0	10.2	6.7
Vermont	84.8	89.4	26.6	8.7	7.7
Virginia	64.3	79.9	32.5	11.2	9.2
Washington	69.7	74.9	26.9	9.5	6.9
West Virginia	70.7	75.7	35.1	13.4	10.7
Wisconsin	73.0	78.9	26.5	11.3	9.0
Wyoming	66.1	71.2	25.8	9.3	8.1

Notes: Universe is births paid for by Medicaid. Percentage columns are calculated based on number of births. Total number of births may not be consistent across breakdowns due to missing values or suppression. State is mother's legal state of residence recorded on the birth certificate. Low birthweight is defined as less than 2,500 grams.

Source: MACPAC, 2019, analysis of U.S. Centers for Disease Control and Prevention WONDER online database, Natality information: Live births, https://wonder.cdc.gov/natality.html.

TABLE 5A-2. Number of Births, by Payer, by State, 2018

State	Total Number	Medicaid Number	Medicaid Percent	Private insurance Number	Private insurance Percent	Uninsured Number	Uninsured Percent	Other Number	Other Percent
Total	**3,832,168**	**1,647,833**	**43.0%**	**1,881,528**	**49.1%**	**156,604**	**4.1%**	**146,203**	**3.8%**
Alabama	58,908	29,120	49.4	26,348	44.7	1,272	2.2	2,168	3.7
Alaska	10,267	4,026	39.2	3,877	37.8	325	3.2	2,039	19.9
Arizona	81,696	43,517	53.3	33,241	40.7	2,713	3.3	2,225	2.7
Arkansas	37,003	16,921	45.7	18,036	48.7	1,072	2.9	974	2.6
California	471,142	202,943	43.1	229,115	48.6	19,000	4.0	20,084	4.3
Colorado	64,186	25,261	39.4	33,088	51.6	1,642	2.6	4,195	6.5
Connecticut	35,144	13,058	37.2	19,499	55.5	1,836	5.2	751	2.1
Delaware	10,841	4,855	44.8	5,403	49.8	215	2.0	368	3.4
District of Columbia	9,540	4,155	43.6	4,608	48.3	77	0.8	700	7.3
Florida	222,687	109,078	49.0	93,061	41.8	13,701	6.2	6,847	3.1
Georgia	129,008	59,425	46.1	50,350	39.0	8,633	6.7	10,600	8.2
Hawaii	17,491	5,490	31.4	7,382	42.2	573	3.3	4,046	23.1
Idaho	22,156	8,196	37.0	11,890	53.7	1,269	5.7	801	3.6
Illinois	148,709	60,852	40.9	84,181	56.6	2,280	1.5	1,396	0.9
Indiana	81,993	33,693	41.1	42,903	52.3	3,764	4.6	1,633	2.0
Iowa	38,410	15,381	40.0	21,429	55.8	1,230	3.2	370	1.0
Kansas	36,398	11,466	31.5	20,435	56.1	2,487	6.8	2,010	5.5
Kentucky	54,331	26,158	48.2	24,024	44.2	1,914	3.5	2,235	4.1
Louisiana	61,016	38,340	62.8	20,648	33.8	504	0.8	1,524	2.5
Maine	12,260	4,804	39.2	6,703	54.7	478	3.9	275	2.2
Maryland	71,263	28,631	40.2	38,102	53.5	2,232	3.1	2,298	3.2
Massachusetts	70,598	19,652	27.8	47,788	67.7	542	0.8	2,616	3.7
Michigan	111,097	46,989	42.3	61,988	55.8	1,586	1.4	534	0.5
Minnesota	68,454	21,871	32.0	43,378	63.4	1,607	2.4	1,598	2.3
Mississippi	37,307	23,339	62.6	12,358	33.1	1,149	3.1	461	1.2
Missouri	72,008	27,919	38.8	40,071	55.7	2,508	3.5	1,510	2.1
Montana	11,774	4,864	41.3	5,616	47.7	617	5.2	677	5.8
Nebraska	25,501	8,822	34.6	14,905	58.5	980	3.8	794	3.1
Nevada	35,508	16,834	47.4	15,589	43.9	1,746	4.9	1,339	3.8
New Hampshire	12,029	3,091	25.7	8,316	69.1	202	1.7	420	3.5
New Jersey	101,221	31,194	30.8	60,977	60.2	7,966	7.9	1,084	1.1
New Mexico	23,737	13,350	56.2	6,781	28.6	1,546	6.5	2,060	8.7
New York	228,873	110,653	48.4	107,662	47.0	2,784	1.2	7,774	3.4
North Carolina	120,010	51,686	43.1	54,138	45.1	8,327	6.9	5,859	4.9
North Dakota	10,602	2,677	25.3	5,940	56.0	283	2.7	1,702	16.1
Ohio	135,913	57,120	42.0	68,586	50.5	6,407	4.7	3,800	2.8

TABLE 5A-2. (Continued)

State	Total Number	Medicaid Number	Medicaid Percent	Private insurance Number	Private insurance Percent	Uninsured Number	Uninsured Percent	Other Number	Other Percent
Oklahoma	50,095	25,959	51.8%	20,066	40.1%	1,038	2.1%	3,032	6.1%
Oregon	43,518	19,639	45.1	22,409	51.5	886	2.0	584	1.3
Pennsylvania	133,209	45,537	34.2	78,578	59.0	6,146	4.6	2,948	2.2
Rhode Island	10,627	5,146	48.4	5,216	49.1	71	0.7	194	1.8
South Carolina	56,874	28,253	49.7	24,518	43.1	1,626	2.9	2,477	4.4
South Dakota	12,080	3,871	32.0	7,162	59.3	360	3.0	687	5.7
Tennessee	76,755	39,045	50.9	33,041	43.1	1,521	2.0	3,148	4.1
Texas	381,322	180,969	47.5	151,035	39.6	27,959	7.3	21,359	5.6
Utah	47,016	12,222	26.0	30,281	64.4	2,506	5.3	2,007	4.3
Vermont	5,644	2,421	42.9	2,951	52.3	91	1.6	181	3.2
Virginia	100,237	30,247	30.2	62,394	62.3	5,238	5.2	2,358	2.4
Washington	86,174	34,135	39.6	45,417	52.7	962	1.1	5,660	6.6
West Virginia	18,557	9,261	49.9	8,757	47.2	365	2.0	174	0.9
Wisconsin	64,104	23,500	36.7	37,472	58.5	1,832	2.9	1,300	2.0
Wyoming	6,875	2,197	32.0	3,815	55.5	536	7.8	327	4.8

Notes: Percentage columns are calculated based on number of births. State is mother's legal state of residence recorded on the birth certificate.

Source: MACPAC, 2019, analysis of U.S. Centers for Disease Control and Prevention WONDER online database, Natality information: Live births, https://wonder.cdc.gov/natality.html.

TABLE 5A-3. Number and Share of Births, by Payer and Maternal Characteristics, 2018

Characteristic	Total	Medicaid	Private	Uninsured	Other
Total births	**3,832,168**	**43.0%**	**49.1%**	**4.1%**	**3.8%**
Residence					
Rural	516,779	50.0	41.1	4.9	4.0
Urban	3,315,389	41.9	50.3	4.0	3.8
Maternal age					
0–19	194,988	77.5	15.2	3.6	3.8
20–34	2,962,002	44.1	48.0	4.0	4.0
35 and older	675,178	28.2	63.9	4.8	3.1
Maternal Hispanic ethnicity					
Hispanic or Latino	894,418	60.2	28.5	6.7	4.7
Not Hispanic or Latino	2,906,389	37.8	55.3	3.3	3.6
Maternal race					
American Indian or Alaska Native, non-Hispanic	29,699	67.3	19.5	1.8	11.4
White non-Hispanic	1,979,495	30.5	63.1	3.0	3.4
Black non-Hispanic	557,571	65.9	27.7	3.0	3.4
Asian non-Hispanic	248,410	25.0	65.2	6.8	2.9
Native Hawaiian or Pacific Islander, non-Hispanic	9,315	56.2	28.6	6.3	8.9
More than one race, non-Hispanic	81,899	49.3	43.0	2.1	5.6
Maternal years of education					
8th grade or less	123,476	66.7	7.3	21.2	4.8
Some high school	378,566	79.1	10.8	6.0	4.1
High school diploma or GED certificate	967,101	65.8	26.8	3.6	3.8
Some college or associate degree	1,090,106	44.4	48.5	2.6	4.6
College or graduate degree	1,224,980	10.2	83.4	3.5	2.9

Notes: Percentages are calculated based on number of births. Total number of births may be inconsistent across breakdowns due to missing values or suppression. Urban and rural categories are based on the mother's legal county of residence as recorded on the birth certificate and are defined using the 2013 National Center for Health Statistics Urban-Rural Scheme for Counties. Urban includes counties classified as large central metro, large fringe metro, medium metro, and small metro. Rural includes counties classified as micropolitan and non-core. GED is general equivalency diploma.

Source: MACPAC, 2019, analysis of U.S. Centers for Disease Control and Prevention WONDER online database, Natality information: Live births, https://wonder.cdc.gov/natality.html.

Substance Use Disorder and Maternal and Infant Health

Substance Use Disorder and Maternal and Infant Health

Key Points

- Substance use can have serious consequences for maternal and infant health, including preterm labor and complications related to delivery.

- Infants born to women using opioids or other substances may experience neonatal abstinence syndrome (NAS), a postnatal withdrawal syndrome. Infants with NAS are more likely to be delivered preterm, have longer hospital stays and higher readmission rates, and receive care in the neonatal intensive care unit.

- Although pregnant women covered by Medicaid are more likely than pregnant women with other forms of insurance to misuse substances or have substance use disorder (SUD), they are also more likely to have received treatment for their SUD in the past year. Medicaid also covers a disproportionate share (more than 80 percent) of infants with NAS.

- There are many barriers to treatment for pregnant women with SUD. Relatively few pregnant women with SUD seek treatment, in part due to obstacles such as balancing caregiver roles and fear of losing custody of their newborns as a result of their SUD.

- Many specialty SUD treatment facilities do not offer special programming for pregnant women with SUD. Few provide child care services or residential beds for clients' children.

- State Medicaid programs can use multiple authorities, including those under the state plan and waivers, to tailor benefits for pregnant women with SUD and infants with NAS. However, few states are using all of the available authorities to do so.

- Many states are expanding the continuum of services offered to individuals with SUD, including pregnant women; however, states generally do not have a separate SUD benefit for pregnant women. Rather, pregnant women with SUD receive the same benefits as the general Medicaid population.

- State systems are highly fragmented, with no single agency responsible for addressing the range of needs of pregnant and postpartum women with SUD. In addition to health services, these needs include food, housing, and transportation. As such, providing comprehensive services to pregnant women with SUD requires connecting women and their children with multiple state agencies.

- New models of care that seek to improve access to well-coordinated, evidenced-based care for pregnant women and their children are currently being tested. These models include the Maternal Opioid Misuse model and the Integrated Care for Kids model.

CHAPTER 6: Substance Use Disorder and Maternal and Infant Health

High rates of substance use disorder (SUD), including opioid use disorder (OUD), are taking their toll on families and communities across the United States. For the first time in nearly two decades, however, the rate of drug overdose deaths in the United States is beginning to drop, declining by 4.1 percent between 2017 and 2018. The largest declines are related to opioids that are commonly available by prescription, such as oxycodone and hydrocodone, and there are slight declines in overdose deaths due to heroin as well. However, the rate of overdose deaths for synthetic opioids such as fentanyl, psychostimulants, including methamphetamines, and cocaine continue to rise. Specifically, in 2018 the rate of drug overdose deaths involving synthetic opioids other than methadone increased by 10 percent over the previous year.[1] From 2012 to 2018, the rate of drug overdose deaths involving cocaine more than tripled and the rate for deaths involving psychostimulants, such as methamphetamines, increased nearly five-fold. Some drug overdose deaths may involve multiple drugs (Hedegaard et al. 2020).[2]

MACPAC has previously reported on the opioid epidemic and its disproportionate effect on the Medicaid program (MACPAC 2017). Medicaid beneficiaries have a higher rate of SUD than privately insured individuals, and they also receive treatment at higher rates. In 2018, Medicaid beneficiaries were more than twice as likely as individuals with private coverage to report illicit drug dependence or abuse.[3] At the same time, they were nearly three times more likely than individuals with private coverage to be in treatment (SHADAC 2020).[4] Even so, only about 12.1 percent of Medicaid beneficiaries with any SUD indicated that they were currently receiving treatment (SHADAC 2020).

State Medicaid programs are responding to the opioid epidemic by providing clinical services, including residential treatment and medications to treat opioid use disorder (MOUD), and non-clinical recovery supports, such as peer supports, skills training and development, and case management services. Gaps in coverage, however, persist in many states (MACPAC 2019a, 2018a).

In this chapter, the Commission focuses specifically on the effects of SUD on pregnant and postpartum women and their infants. Substance use can have serious consequences for both maternal and infant health. Pregnant and postpartum women who misuse substances are at risk for poor maternal outcomes, including preterm labor and complications related to delivery (CMS 2019a). Although our lens is broad, some of the policy responses discussed in this chapter are specific to misuse of opioids and may not be relevant to the misuse of other substances. Where possible, we note whether the data or program designs are broadly relevant to SUD or targeted to the opioid epidemic.

Although pregnant women covered by Medicaid are more likely than pregnant women with other forms of insurance to misuse substances or have SUD, they are also more likely to have ever received treatment for their SUDs. A small percentage of beneficiaries with SUD, however, are receiving treatment; from 2015 to 2018, only one in five (19.9 percent) pregnant women enrolled in Medicaid with SUD received alcohol or drug treatment in a health care setting in the previous year (SHADAC 2020). Barriers to treatment include stigma both within and outside the health care system, fear of punitive repercussions, and limited access to providers, as few SUD treatment facilities offer specialized programming for this population (SAMHSA 2019, GAO 2017). In some regions, a high percentage of providers do not participate in Medicaid and accept only cash payments (Patrick 2020a).

High rates of SUD have also affected the lives of infants and children covered by Medicaid. Infants born to women using opioids or other substances

may experience neonatal abstinence syndrome (NAS), which is a drug withdrawal syndrome that occurs in infants after they are exposed to certain drugs in utero. Notably, use of medications to treat OUD can also result in NAS; however, such medications can prevent more severe neonatal complications, such as preterm birth. Given that Medicaid pays for 43 percent of all U.S. births, it is not surprising that NAS disproportionately affects the Medicaid program; over 80 percent of infants with NAS are covered by Medicaid (Martin et al. 2018, Winkelman et al. 2018).[5] In addition, emerging evidence suggests that rising rates of overdose deaths have coincided with an increase in the number of children entering foster care (ASPE 2018). Low-income children currently or formerly served by the child welfare system are generally eligible for Medicaid (MACPAC 2015).

This chapter begins by describing the prevalence of SUD among pregnant women enrolled in Medicaid and the rates at which these women seek treatment. Next, we discuss the continuum of care for pregnant and postpartum women with SUD, the extent to which state Medicaid agencies cover SUD treatment services, and the availability of specialty SUD treatment for this population. The chapter then describes the incidence of NAS among Medicaid-covered infants as well as emerging models of care to treat infants with NAS. Then the chapter outlines the various Medicaid authorities that can be used to provide treatment services to pregnant women with SUD and infants with NAS, including summaries of relevant federal guidance and examples from selected states.

State Medicaid programs can use multiple authorities, including those under the state plan and waivers, to tailor benefits for pregnant women with SUD and infants with NAS. However, few states are using all the authorities available to them to do so. Moreover, in many states, additional work is needed to engage providers to treat pregnant women with SUD and ensure adoption of evidence-based care for infants with NAS. New models of care are being piloted that seek to improve access to well-coordinated, evidence-based care for pregnant women and their children.

Although many states are expanding the continuum of services offered to individuals with SUD, including pregnant women, state systems remain highly fragmented. This is especially problematic for pregnant women who face unique obstacles when seeking treatment, including balancing caregiver roles with seeking treatment and fear of losing custody of their newborns, and possibly other children, as a result of their SUD. The chapter concludes by describing the roles of the criminal justice and child welfare systems, as well as other social service agencies, in the lives of pregnant women with SUD. Two new models of care that seek to reduce this fragmentation and improve access to care for pregnant women with SUD and their infants are also discussed.

SUD among Pregnant Women

Women of childbearing age may be more susceptible than the general population to substance use dependence and disorders for several reasons. Opioids are widely prescribed to women of childbearing age, with over one-third of Medicaid-enrolled women filling an opioid prescription annually (Ailes et al. 2015). Of women reporting non-medical use of a prescription opioid, pregnant women are more likely to receive an opioid from a doctor (46 percent) than non-pregnant women (28 percent) (Kozhimannil et al. 2017). Women also develop SUD and health-related problems in less time than do men (SAMHSA 2009).

Below, we describe the prevalence of SUD among pregnant women and the rates at which they receive treatment, comparing, where possible, the experience of pregnant women enrolled in Medicaid to those with other sources of coverage. This analysis is based on the National Survey on Drug Use and Health (NSDUH), a federal survey conducted annually in all 50 states and the District of Columbia.[6] Our analysis, conducted by the State Health Access Data Assistance Center (SHADAC)

under contract to MACPAC, combined data from 2015 to 2018 (SHADAC 2020). Due to issues with sample size, we are unable to report on additional demographic information (e.g., race and ethnicity, age), state-level estimates, or information on the settings in which women receive treatment. We are also unable to look at treatment rates for specific SUDs, such as alcohol, amphetamine, cocaine, or opioids.[7]

From 2015 to 2018, pregnant women enrolled in Medicaid were more likely to abuse or have a

substance use dependency in the previous year than pregnant women with other sources of coverage (Table 6-1). Pregnant women enrolled in Medicaid were more likely to report ever using methamphetamines. They were also more likely to have ever used heroin and misused a prescription pain reliever. However, pregnant women enrolled in Medicaid were less likely to report alcohol use in the previous year than pregnant women with other forms of coverage.

TABLE 6-1. Substance Misuse, Abuse, and Dependence in Pregnant Women Age 12–44, by Insurance Status, 2015–2018

Type of use	Number of pregnant women age 12–44	Percentage of all pregnant women age 12–44	Percentage of pregnant women age 12–44 in each coverage category	
			Medicaid	All other forms of coverage
Illicit drug dependence, past year	63,478	2.7%	4.5%	1.6%*
Illicit drug dependence or abuse, past year	77,560	3.4	5.7	1.9*
Illicit drug or alcohol abuse, past year	61,714	2.7	2.9	2.6
Pain reliever dependence, past year	17,895	0.8	–	–
Misused pain reliever, past 30 days	25,881	1.1	–	–
Ever misused pain reliever	273,161	11.8	12.0	11.8
Misused OxyContin, past year	19,736	0.9	–	–
Ever used heroin	50,137	2.2	3.6	–
Ever used heroin and ever misused pain reliever	43,437	1.9	3.2	–
Ever used methamphetamines	112,727	4.9	7.2	3.5*
Methamphetamine use, past year	22,611	1.0	1.9	–
Alcohol use, past year	1,498,081	64.7	52.9	72.7*
Alcohol dependence or abuse, past year	119,795	5.2	5.7	4.8

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview. All other forms of coverage include Medicare, private insurance (excluding plans that pay for only one type of service, such as accident coverage or dental care), military, or other types of insurance.

* Difference from Medicaid is statistically significant at the 0.05 percent level.

– Dash indicates that the estimate is based on too small a sample or is too unstable to present.

Source: SHADAC 2020.

Obtaining SUD treatment services during pregnancy increases the number of prenatal visits and improves birth outcomes. Delaying prenatal care and SUD treatment, however, can lead to worse outcomes for both mother and baby (Mee-Lee et al. 2013). Women may be reluctant to seek prenatal care or disclose drug use to providers for many reasons, including the fear of severe consequences, such as losing their jobs, social services interventions, possible loss of child custody, and in some instances, criminal charges for abuse and neglect (GAO 2017, Mee-Lee et al. 2013).

Pregnant women with SUD enrolled in Medicaid are more likely to have received treatment for their SUD than pregnant women with SUD with other forms of coverage. Treatment services, however, remain substantially underutilized. From 2015 to 2018, one in five (19.9 percent) pregnant women with SUD enrolled in Medicaid received alcohol or drug treatment in a health care setting in the previous year (Table 6-2).[8]

TABLE 6-2. Treatment for Substance Use Disorder among Pregnant Women, Age 12–44 with Past Year Substance Use Disorder, by Medicaid and Other Insurance Coverage, 2015–2018

Treatment characteristics	Percentage of pregnant women age 12–44 with past year substance use disorder	Percentage in each coverage category	
		Medicaid	**All other forms of coverage**
Ever received alcohol or drug treatment	29.0%	37.0%	21.8%
Received alcohol or drug treatment in a health care setting, past year	11.9	19.9	—*

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview. All other forms of coverage include Medicare, private insurance (excluding plans that pay for only one type of service, such as accident coverage or dental care), military, or other types of insurance. Health care settings include: an inpatient hospital overnight; an outpatient drug or alcohol rehabilitation facility; an outpatient mental health center; an emergency room; a private doctor's office.

* Difference from Medicaid is statistically significant at the 0.05 percent level.

– Dash indicates that the estimate is based on too small a sample or is too unstable to present.

Source: SHADAC 2020.

Medicaid Coverage of SUD Treatment Services

A continuum of care includes early identification of substance use using tools such as screening, brief intervention, and referral to treatment (SBIRT) which may be used during prenatal visits. Use of such tools can ensure women are referred to appropriate treatment services. Because the severity of an individual's SUD influences the type and intensity of services needed, providing access to SUD treatment services along a continuum of care that offers progressive clinical services, ranging from residential treatment to outpatient treatment with

MOUD, and that includes non-clinical supports, such as recovery services and case management services, is important for effective treatment and recovery (Box 6-1) (MACPAC 2019a, 2018a).

Generally, states do not have a separate SUD benefit for pregnant women; rather, pregnant women with SUD receive the same benefits as the general Medicaid population. As discussed later in this chapter, a minority of states have taken additional steps to tailor SUD treatment benefits for pregnant and postpartum beneficiaries. In addition, new models of care are being tested in a few states to improve access to care for these populations.

BOX 6-1. Components of the Substance Use Disorder Continuum of Care

Clinical services. As defined by the American Society of Addiction Medicine, clinical services include early intervention, outpatient services, intensive outpatient services, partial hospitalization, residential and inpatient treatment at varying intensities, and medications to treat opioid use disorder. Substance use disorder (SUD) treatment also should be offered in non-specialty settings such as primary care (Mee-Lee et al. 2013).

Residential treatment may be more common among pregnant women when compared to the general population. For postpartum women who are not in residential treatment, intensive outpatient treatment appears to have higher completion rates than traditional outpatient services. Pregnant women who benefit from outpatient care tend to have some stability in their lives, including housing and employment (SAMHSA 2009).

Recovery support services. These are non-clinical services that address psychosocial factors in an individual's environment and provide emotional and practical support to maintain remission from a behavioral health condition. They include peer support, supportive housing, supported employment, and skills training and development.

Case management. The Substance Abuse and Mental Health Services Administration describes case management for beneficiaries with SUD as a coordinated approach to the delivery of physical health, SUD, mental health, and social services (SAMHSA 2015). With the wide array of services that pregnant women may need, comprehensive case management that involves medical and social case management is an essential component for women in treatment (CMHS National GAINS Center 2007).

Case management may be also be needed to help coordinate transitions from more intensive to less intensive treatment settings (SAMHSA 2015). Such transitions tend to be challenging for all individuals; however, pregnant and postpartum women are more likely to encounter obstacles across the continuum of care as a result of caregiver roles and gender expectations. For example, after pregnancy, women often assume many caregiver roles, and these roles can interfere with treatment engagement and regular attendance at treatment services. Evidence suggests that women will continue services if they stay within the same agency or if an effort is made to connect them to the new service prior to the transition (SAMHSA 2009).

As of 2018, MACPAC found that most states have gaps in SUD coverage, covering on average six of the nine levels of care described by the American Society of Addiction Medicine (ASAM), with the largest gaps in coverage for partial hospitalization and residential treatment. (As discussed later in this chapter, many states are increasingly addressing these gaps in coverage through SUD demonstration waivers under Section 1115 of the Social Security Act (the Act)). Forty-nine states and the District of Columbia covered some form of outpatient treatment for SUD; all states covered some form of buprenorphine (a medication used to address OUD); and the majority of states (41 states and the District of Columbia) also paid for opioid treatment program (OTP) services, which is the only setting in which methadone can be dispensed to treat OUD.[9] Fewer states cover partial hospitalization and residential treatment. In addition to coverage of clinical services, many states cover recovery support services such as peer support (38 states) and comprehensive community supports (29 states).

However, fewer states offer services such as skills training and development (15 states), supported employment (13 states), or supportive housing (4 states) for beneficiaries with SUD (Appendix 6A) (MACPAC 2019a, 2019b, 2018a).

Availability of SUD Treatment for Pregnant Women

Access to treatment for pregnant women depends upon having a sufficient supply of appropriate providers. Generally, maternity providers, including obstetrician-gynecologists and certified nurse-midwives, are not trained in addiction medicine. Similarly, SUD treatment providers are rarely equipped to provide prenatal care. There are a limited number of treatment facilities with programs tailored to pregnant or postpartum women (Moore et al. 2018). In 2018, less than 25 percent of specialty SUD treatment facilities reported offering special treatment programs for these populations (SAMHSA 2018). Access to services is also affected by provider participation in Medicaid, the distribution of providers, state coverage policies, including those related to utilization management (e.g., prior authorization and quantitative treatment limits), and providers' responses to those policies.

Below, we describe the availability of specialized SUD treatment for pregnant or postpartum women in various settings and states, including outpatient, intensive outpatient, partial hospitalization, and residential treatment. We also examine specialty SUD treatment facilities that report offering specialized programming for pregnant or postpartum women, including the extent to which they participate in Medicaid, the degree to which they offer child care for their clients' children or residential beds for clients' children, and whether these facilities offer MOUD.

Provider supply

Few specialty SUD treatment facilities are able to meet the unique needs of pregnant and postpartum women. In 2018, less than one-quarter (23 percent) of specialty SUD treatment programs in the U.S. offered specialized programming for pregnant or postpartum women.[10] Only 20 percent of SUD treatment facilities offered both outpatient treatment and specialized programming for this group. A smaller proportion of facilities offered special programming as well as intensive outpatient treatment (11 percent); partial hospitalization (3 percent); long-term residential treatment (4 percent); or short-term residential treatment (3 percent). In some states, there are no facilities offering partial hospitalization and specialized programming for pregnant or postpartum women (SAMHSA 2019).

For pregnant or postpartum women with SUD, access to providers offering MOUD is also limited. Eight percent of specialty SUD facilities offer both specialized programming for pregnant or postpartum women and at least one of the three medications approved by the U.S. Food and Drug Administration (FDA) for treating OUD (methadone, buprenorphine, or naltrexone). Moreover, as of December 2019, only about 6 percent of all active physicians, nurse practitioners, and physician assistants had obtained a waiver to prescribe these medications (KFF 2020). Of these, 74 percent were certified to prescribe buprenorphine to up to 30 patients, 18 percent were certified to prescribe to up to 100 patients, and 7 percent were certified to prescribe to up to 275 patients. It is worth noting that practitioners generally prescribe well under their patient limits (Varghese et al. 2019, Thomas et al. 2017).

Congress has taken a number of steps to address concerns about limited treatment capacity. First, the Comprehensive Addiction and Recovery Act of 2016 (CARA, P.L. 114-198) expanded prescribing authority for buprenorphine to nurse practitioners and physician assistants. This action helped expand access to buprenorphine for Medicaid beneficiaries
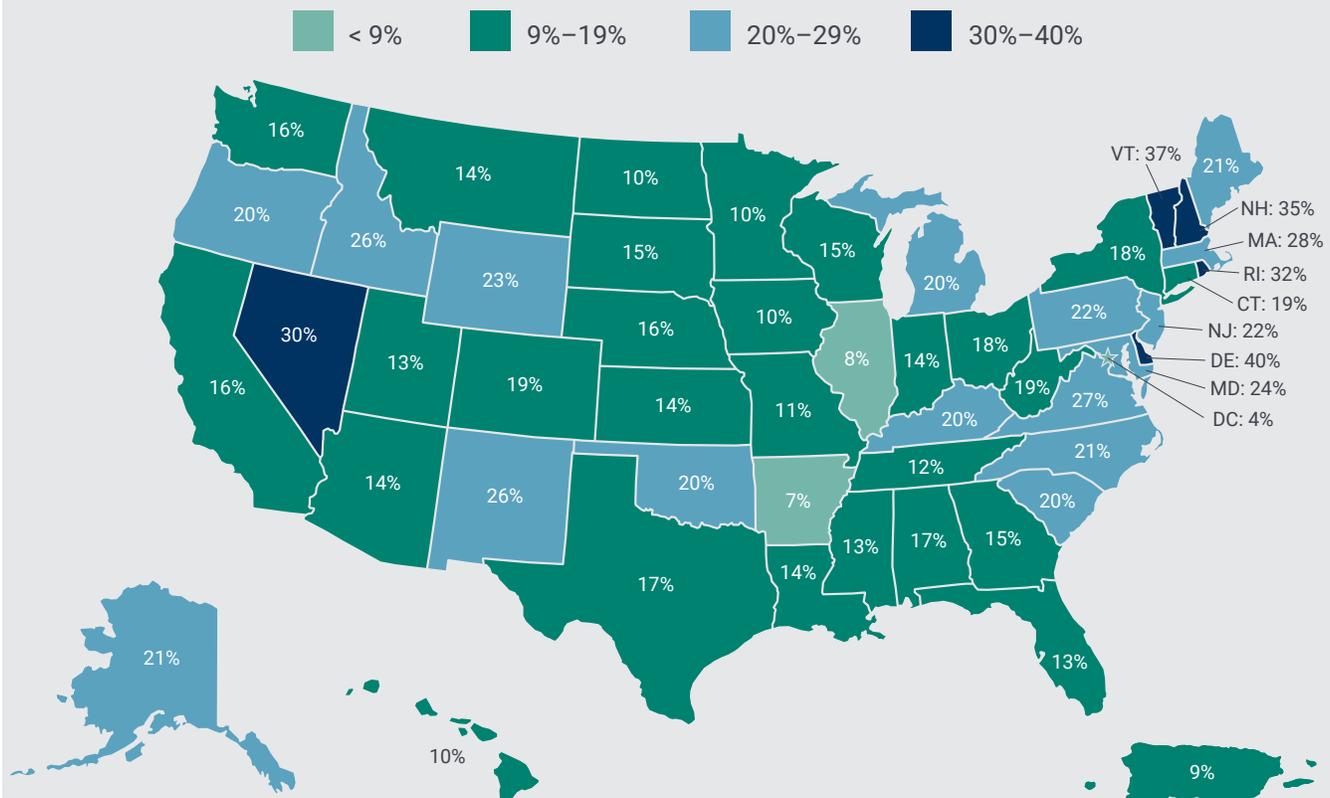
![MACPAC]

(Johnson et al. 2019).[11] In 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) expanded the list of eligible practitioners to include clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists, allowing them to prescribe through October 2023. However, few practitioners have obtained a waiver to prescribe buprenorphine under this SUPPORT Act provision; as of December 2019, waivers had been obtained by a total of 18 clinical nurse specialists, 21 certified nurse-midwives, and 1 certified registered nurse anesthetist (Dugan 2020).

Provider participation in Medicaid

Access to treatment is also affected by low SUD provider participation in Medicaid. In 2018, fewer than one in five (17 percent) specialty SUD facilities that reported accepting Medicaid offered specialized treatment for pregnant or postpartum women. Medicaid participation among such facilities varies greatly by state, ranging from 4 percent in the District of Columbia to 40 percent in Delaware (Figure 6-1).

Pregnant and postpartum beneficiaries have limited access to specialized SUD treatment at certain levels of care. Approximately 15 percent

FIGURE 6-1. Percentage of Substance Use Disorder Treatment Facilities Offering Specialized Programming for Pregnant or Postpartum Women and Accepting Medicaid, 2018
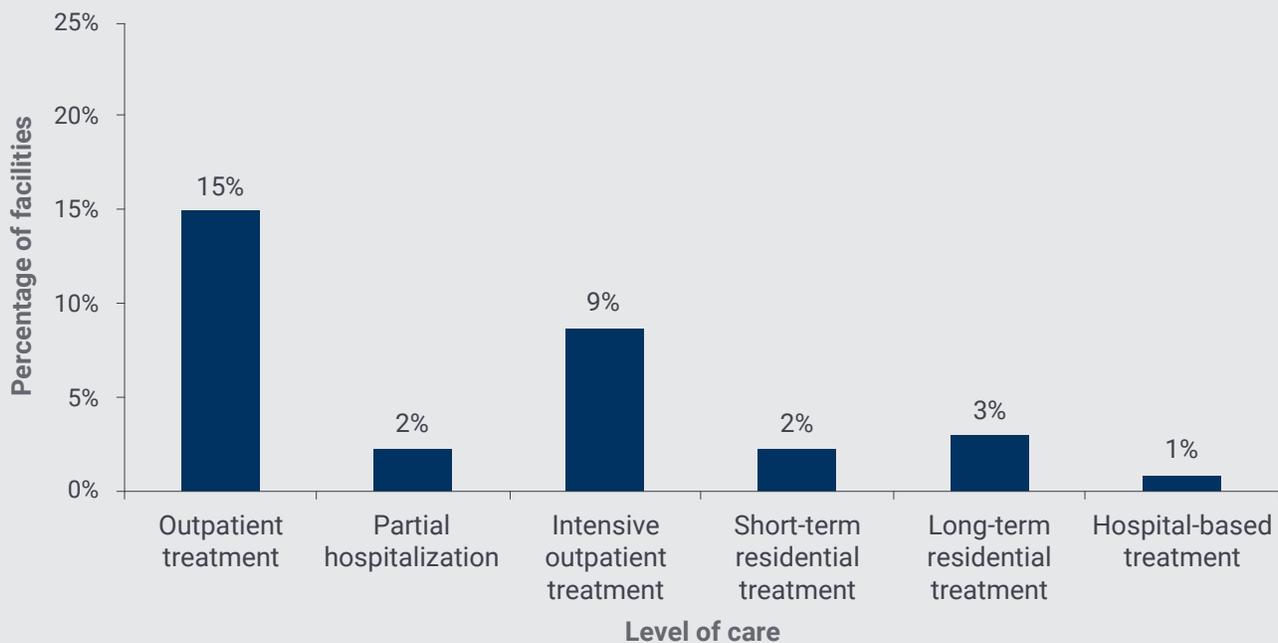

Source: MACPAC, 2019, analysis of SAMHSA 2019.

of specialty SUD treatment facilities offer special programming for pregnant or postpartum women, accept Medicaid, and provide outpatient treatment services. But providers of more intensive services are much less likely to be available to pregnant or

postpartum Medicaid beneficiaries (Figure 6-2).[12] Providers offering special programming for pregnant or postpartum women, as well as partial hospitalization and different intensities of residential services, accept Medicaid at a lower rate overall.

FIGURE 6-2. Percentage of Substance Use Treatment Providers Offering Specialized Services for Pregnant or Postpartum Women and Accepting Medicaid by Level of Care, 2018

Source: MACPAC, 2019, analysis of SAMHSA 2019.

Provision of services for clients' children. Women are more likely to enter, participate in, and stay in SUD treatment, and maintain abstinence, if they can have their children with them (SAMHSA 2016, CMHS National GAINS Center 2007). However, in 2018, 6 percent of SUD treatment facilities both provided child care for patients' children and accepted Medicaid. The rate varies considerably by state; in Delaware and the District of Columbia, no facilities accepted Medicaid and provided child care. In comparison, 19 percent of facilities in Wyoming did both. Moreover, only 2 percent of SUD treatment facilities provided residential beds for patients' children and accepted Medicaid. In six states and the District of Columbia, there are

no specialty SUD treatment facilities that did both (SAMHSA 2019).[13]

Regulatory requirements may affect the ability of SUD treatment facilities to accommodate their patients' children. For example, these facilities may need to be separately licensed to provide child care services (Mee-Lee et al. 2013).

Access to SUD treatment in other settings. Pregnant women with OUD may receive medication as a part of outpatient treatment for their SUD by an office-based provider, such as a primary care physician or obstetrician-gynecologist; this is the standard of care and is recommended over medically supervised withdrawal (ACOG 2017,

Mee-Lee et al. 2013). Such treatment can stabilize the pregnant woman and protect the fetus from episodes of withdrawal. When initiating treatment with MOUD, providers must counsel the woman regarding NAS and ensure connections to prenatal care (MACPAC 2017).[14]

Obstetric providers may provide opioid treatment during pregnancy, but the current number of these physicians currently prescribing buprenorphine to pregnant women enrolled in Medicaid is unknown. A study from 2015 found that 1 percent of obstetrician-gynecologists had obtained the required certification to prescribe buprenorphine (Rosenblatt et al. 2015). Another study using Medicaid claims data from Pennsylvania found that 5 percent of pregnant women with OUD who received MOUD obtained their buprenorphine prescriptions from an obstetrician-gynecologist; in contrast, 63 percent received prescriptions from primary care physicians and 18 percent received prescriptions from psychiatrists or behavioral health providers (Hollander et al. 2019).

Other providers, including community health centers, play an important role in the provision of SUD treatment to Medicaid beneficiaries. In 2018, community health centers served one in five Medicaid beneficiaries. While these facilities generally provide primary care, a growing number of community health centers are providing behavioral health services. For example, in 2018 these health centers performed SBIRT services for more than 1 million patients; and nearly 5,000 prescribers employed by community health centers are authorized to prescribe MOUD (NACHC 2020).

Neonatal Abstinence Syndrome

NAS is a postnatal withdrawal syndrome that most commonly occurs after exposure to an opioid. NAS typically manifests in the first few days of life with symptoms such as difficulty with mobility and flexing; inability to control heart rate, temperature,

and other autonomic functions; irritability; poor sucking reflex; impaired weight gain; and, in some cases, seizures. NAS is also an expected outcome of MOUD, but the use of MOUD improves other neonatal outcomes, such as reducing the risk of preterm birth (Patrick et al. 2015, Tolia et al. 2015). Nationally, approximately one infant is born every 15 minutes with opioid withdrawal (Patrick 2020a).

Not much is known about the long-term effects of NAS (Kocherlakota 2014). In one study of mothers and their infants in the Pennsylvania Medicaid program, infants diagnosed with NAS had a probability of a diagnosis of a pediatric complex chronic condition (e.g., cardiovascular, neurologic or neuromuscular condition) of 24.2 percent (Jarlenski et al. 2020).[15] A few observational studies have not found substantial differences in cognitive development between children (up to age five) exposed to methadone in utero and control groups. It has been suggested, however, that preventive interventions during early developmental years are likely to be beneficial for the infant and mother as well as other caregivers (ACOG 2017).

Infants with NAS are more likely to be delivered preterm, have longer hospital stays, higher readmission rates, and receive care in the neonatal intensive care unit (NICU) (Winkelman et al. 2018, Patrick et al. 2015). As such, the average hospital costs for infants with NAS is higher than for infants without NAS: between 2011 and 2014, the mean hospital cost for an infant with NAS was $19,340, compared to $3,700 for infants without NAS. In 2014, Medicaid hospital costs associated with NAS were estimated at $462 million, accounting for 6.7 percent of all birth-related hospital costs paid for by Medicaid. Between 2004 and 2014, NAS resulted in approximately $2.0 billion in additional costs to Medicaid (Winkelman et al. 2018).
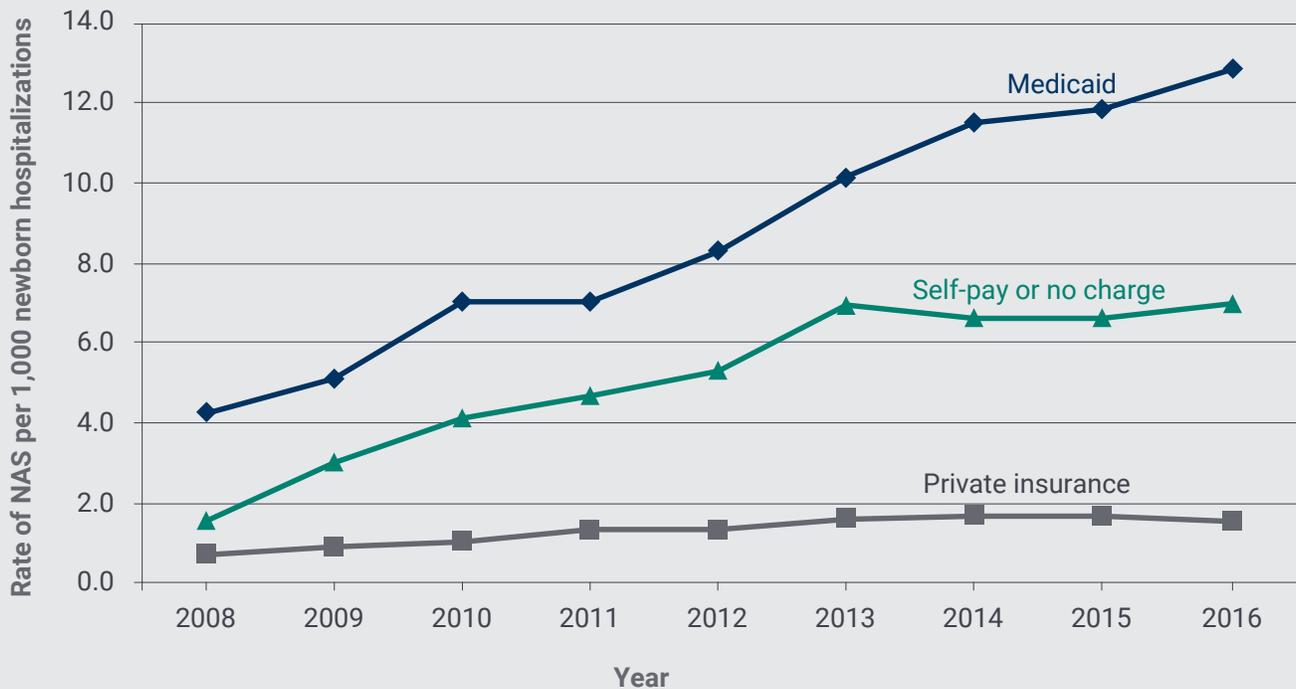
Rates of NAS in Medicaid

Since 2004, the incidence of NAS, the share of NAS births covered by Medicaid, and associated hospital costs have all increased. The incidence of NAS has quadrupled since 2004. In 2016, 83 percent

of NAS-related births were paid for by Medicaid, an increase from 2004 when Medicaid covered 74 percent (Strahan et al. 2019, Winkelman et al. 2018). Compared to private insurance or those who pay cash, Medicaid pays for NAS at a much higher rate—13 per 1,000 newborn hospitalizations in 2016 (AHRQ 2019) (Figure 6-3).

FIGURE 6-3. Rate of Neonatal Abstinence Syndrome per 1,000 Newborn Hospitalizations by Expected Payer, 2008−2016

Notes: NAS is neonatal abstinence syndrome.

Source: AHRQ 2019.

Rates of NAS and the number of NAS births paid for by state Medicaid programs vary by state. In 2017, 3 babies were born with NAS per 1,000 hospital births in Nebraska, while 88 babies were born with NAS per 1,000 hospital births in West Virginia (Figure 6-4). Medicaid agencies, however, may not receive complete information on the incidence of NAS because the condition is not always reflected in hospital billing and coding (Becker 2020a, Patrick 2020a). Some states, such as Florida, Georgia, Kentucky, and Tennessee, have sought to increase data accuracy and timeliness by making NAS a reportable condition; West Virginia

is also considering doing so (Becker 2020a, Ko et al. 2016). Other states have not done so due to concerns that reporting would foster distrust and harm the provider-patient relationship (ACOG 2011). Such fears are well founded. In 2018, 44 states prosecuted women for drug use during pregnancy (Moore et al. 2018). Twenty-three states and the District of Columbia categorize prenatal drug use as child abuse or neglect, and three states cite substance use during pregnancy as grounds for civil commitment. In addition, 25 states and the District of Columbia require providers to report suspected prenatal drug use, and 8 states require testing for

prenatal drug exposure if providers suspect drug use (Guttmacher Institute 2020). In one study of births in eight states, policies that criminalized substance use during pregnancy, or considered it grounds for civil commitment or child abuse or neglect, were associated with greater rates of NAS in the year after enactment and afterwards. Policies requiring reporting of suspected prenatal substance use, however, were not associated with rates of NAS (Faherty et al. 2019).

FIGURE 6-4. Rate of Neonatal Abstinence Syndrome per 1,000 Newborn Hospitalizations, Medicaid, 2017
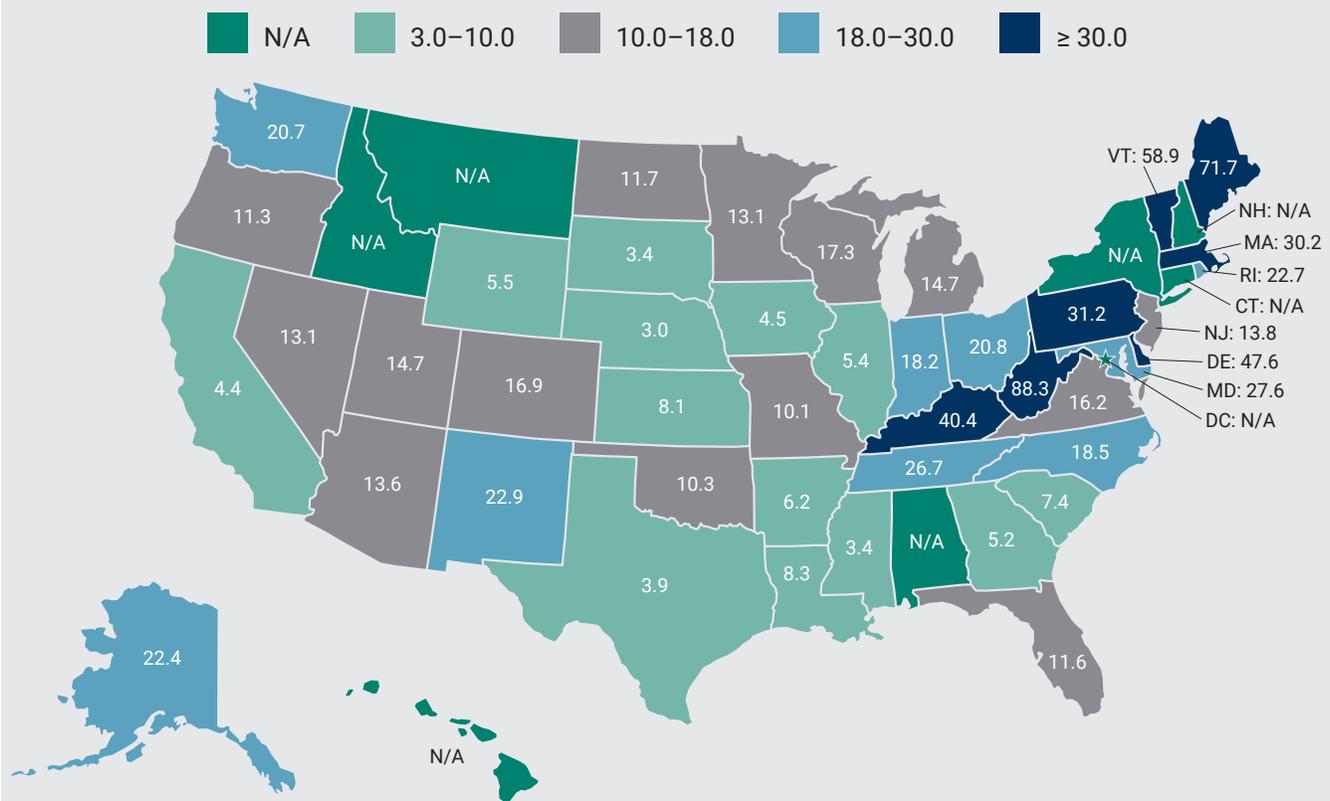
Notes: N/A indicates no state-level data are available for Alabama, Connecticut, District of Columbia, Hawaii, Idaho, Montana, New Hampshire, and New York.

Source: AHRQ 2019.

Treatment of neonatal abstinence syndrome

There is no national standard of care for infants with NAS. Many of the tools used for screening and diagnosis were developed in the 1970s for full-term, heroin-exposed infants and have not been updated recently. In addition, these tools may not be well suited for infants exposed to other substances.

As such, there is a lack of agreement on how to use screening tools in various settings and on the threshold for diagnosis (Patrick 2020a).

Emerging models of care for infants with NAS. The traditional model of care for infants with NAS is to separate the mother and child and place the infant in the NICU. Emerging models of care keep the mother and infant together outside of the NICU, with treatment being more inclusive of the

mother (Patrick 2020a). Although care protocols are not standardized, non-pharmacological care is recommended as the first option for mild and moderate signs of NAS, managing the condition by rooming-in (keeping the mother and infant together in a low-stimulus setting, such as a private hospital room) and monitoring with a standardized protocol for more severe symptoms (SAMHSA 2018). Rooming-in allows for a quieter, less disruptive environment; it may decrease length of treatment and length of hospital stay (Sanlorenzo et al. 2018). Other types of non-pharmacological care include demand feeding, avoidance of waking a sleeping infant, swaddling, continuous minimal stimulation, skin-to-skin contact, gentle rocking, and therapies such as music or massage therapy (Kocherlakota 2014). Breastfeeding is also encouraged, if appropriate, because evidence suggests that breastfeeding decreases NAS severity and length of hospital stay (Patrick 2020a).

Treatment with medications may be necessary for infants with severe NAS; there are no clinically agreed upon standards for pharmacological care, but treating with an opioid is generally recommended (Kocherlakota 2014). Morphine is the most commonly used medication, but evidence is emerging that buprenorphine may be a better option for infants (Kraft et al. 2017). Delays in the administration of necessary pharmacological treatment have been associated with higher morbidity and longer hospital stays (Kocherlakota 2014).

Limited adoption of emerging models of care for NAS. Research suggests that many hospitals have not adopted recommended approaches, such as reducing separation of mother and infant, as part of routine care (Patrick 2020a, Moore et al. 2018). The precise reason for slow adoption, however, is unclear and may be due in part to limited physical capacity to care for infants with NAS, who require frequent, personalized attention. It can be difficult to find spaces with low levels of stimulation where the mother and infant can stay together within a hospital setting (GAO 2017). Lack of funding may also be a contributing factor (GAO 2017, 2015).

Case management is also necessary to ensure effective care for infants with NAS and their mothers (CMS 2018a). However, there may be limited coordination of care for mothers and babies throughout the entire continuum of care, including follow-up care after discharge (GAO 2017). For example, in one study of Medicaid-enrolled children in Pennsylvania, children with in utero opioid exposure were less likely to attend the recommended number of well-child visits from birth through 15 months, at 42 percent, compared to 56 percent for children with neither in utero opioid nor tobacco exposure (Jarlenski et al. 2020).

Medicaid Authorities for SUD Services and Treatment of NAS

Numerous Medicaid authorities, including the state plan, waivers, and other demonstration programs, can be used to provide SUD treatment and recovery support services to pregnant women with SUD as well as specialized services for infants with NAS. The Centers for Medicare & Medicaid Services (CMS) has issued guidance related to the treatment of NAS in newborns and the role of the early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Below we describe these and other Medicaid authorities and, where relevant, provide examples of how states are using these authorities to tailor benefits for pregnant women with SUD and infants with NAS.

State plan

States that pay for clinical SUD treatment or recovery support services using Medicaid state plan authority have several options to tailor services: the state plan rehabilitative services option, the health home state plan option, the Section 1915(i) state plan option, and a new state plan option, established by the SUPPORT Act, to pay for residential pediatric recovery centers.

State plan rehabilitative services option. Authorized under Section 1905(a)(13) of the

Act, this option allows states to pay for discrete rehabilitative services for beneficiaries with SUD, such as intensive outpatient treatment, residential treatment, supported employment, and skills training and development. Most states use this option to provide clinical SUD treatment and certain recovery support services, such as peer support.

A few states offer additional benefits to pregnant women with SUD that they do not offer to other Medicaid beneficiaries with SUD. For example, prior to implementing a Section 1115 SUD demonstration, California covered only outpatient SUD services, OTP services, and naltrexone services; however, additional services, including intensive outpatient care and perinatal residential services, were available under the Medicaid state plan for pregnant and postpartum women (CMS 2016a). Prior to July 1, 2018, South Dakota only offered SUD treatment to pregnant women (DSS 2018). Various SUD treatment services, including intensive outpatient and residential treatment, are now available to

the general Medicaid population in South Dakota (CMS 2019b).

Some states are using state plan authority to specifically address the needs of infants with NAS. For example, West Virginia received approval of its state plan amendment (SPA) in 2018, making it possible for Lily's Place, a 12-bed, community-based residential treatment facility for infants with NAS, to be recognized as its own model of care and receive Medicaid funds through a prospective bundled payment (Box 6-2). As the only non-hospital based NAS treatment center in the state, Lily's Place provides medication management for withdrawal as well as a comprehensive focus on the mother and child and family supports (Becker 2020a). The payment bundle includes NAS treatment services provided by registered nurses, licensed counselors, and social workers (Normile and Hanlon 2018).

BOX 6-2. West Virginia's State Plan Amendment on Neonatal Abstinence Syndrome Treatment Services

West Virginia received approval for a state plan amendment (SPA) that defined both the services and rate methodology for neonatal abstinence syndrome (NAS) treatment services. Approved early in 2018, the SPA was retroactive to October 1, 2017.

NAS services are paid for via an all-inclusive prospective bundled payment based on the daily treatment of Medicaid beneficiaries. Direct services include payments to providers of:

- nursing services;

- targeted case management;

- evaluation and assessment;

- service planning;

- supportive counseling; and

- all non-physician early and periodic screening, diagnostic, and treatment services.

Additional indirect services for other salaries, administration, and supplies are also included. Room and board costs and physician treatment services are not included in payment rates (CMS 2018b).

Health home state plan option. States may choose to establish health homes as a state plan option under Section 2703 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended, Section 1945 of the Act). Health homes integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. States use this approach to pay for clinical, as well as recovery support services via bundled payments to health homes that coordinate care for beneficiaries with chronic conditions, including SUD. As of September 2018, 22 states had active health homes, of which 13 targeted beneficiaries with SUD (CMS 2018c). As discussed later in this chapter, some states are further tailoring their health homes to address the needs of pregnant women with SUD.

Section 1915(i). Section 1915(i) of the Act allows states to provide home- and community-based services (HCBS) under the state plan without obtaining a waiver, including for pregnant women.[16] Like the Section 1915(c) waiver, Section 1915(i) allows states to design service packages targeted to people with specific needs, including special services for those who have developmental disabilities, physical disabilities, mental illness, or SUD. States may offer benefits to a specific age group without regard to comparability of services for those who do not receive the Section 1915(i) services, although they must abide by the statewideness rule dictating that state Medicaid programs cannot exclude enrollees or providers because of where they live or work in the state. Unlike Section 1915(c) waivers, the Section 1915(i) SPA allows states to set the qualifying level for HCBS at an institutional level of care or lower (MACPAC 2016).

Under Section 1915(i) authority, states may offer a variety of HCBS services, such as case management or rehabilitative services, to beneficiaries. However, few states use this authority to pay for recovery support services for beneficiaries with SUD, including pregnant women. As of 2015, 16 states and the District of Columbia had a total of 23 approved Section 1915(i) SPAs,

but only 7 targeted adults with behavioral health conditions (ASPE 2016).

Residential pediatric recovery centers. Section 1007 of the SUPPORT Act established a new state plan option to make Medicaid inpatient or outpatient services available to infants with NAS at a residential pediatric recovery center. Infants with NAS are most often treated in inpatient hospital settings, but other facilities that meet current Medicaid requirements can also receive payment for room and board (CMS 2018a). In July 2019, CMS issued guidance summarizing how residential pediatric recovery centers can be used to treat less severe cases of NAS or cases where the infant is not medically stable and ready to go home, but can be safely discharged to this lower level of care (CMS 2019c). As of April 2020, no state has submitted a SPA to pay for residential pediatric recovery centers.

Waivers

States may use several waiver authorities to pay for SUD treatment and supportive services, including those for pregnant women: Section 1115 demonstration waivers, Section 1915(c) waivers, and Section 1915(b) managed care waivers.

Section 1115 demonstration waivers. Beginning in 2016, more states began to pay for SUD treatment services through Section 1115 SUD demonstrations, using these waivers to reduce gaps in the clinical continuum of care, particularly for residential and inpatient treatment, and to pay for both recovery support services and SUD case management (MACPAC 2018a). As of January 2020, 26 states and the District of Columbia have approved demonstrations and another 5 states have waiver applications pending CMS review (MACPAC 2020).

Under these demonstrations, Medicaid beneficiaries, including pregnant women with SUD, have access to the full continuum of SUD treatment. However, few states are targeting pregnant women with SUD under these demonstrations. Massachusetts is an exception in that it provides

pregnant women specialized services to ensure coordination between acute SUD services, clinical supports, and obstetrical care (Mathematica 2020).

A few states also use Section 1115 authority to extend postpartum coverage, some specifically for women with SUD. (Extending postpartum coverage is discussed further in Chapter 5.) Illinois submitted a Section 1115 waiver on December 31, 2019 to extend coverage for all pregnant women enrolled in Medicaid from 60 days postpartum to one year (HFS 2020). South Carolina received partial approval of its Section 1115 demonstration waiver in December 2019. Although the state requested extending postpartum coverage for all eligible women, CMS only approved an additional 500 slots within the targeted adult group under the Palmetto Pathways to Independence demonstration, which will allow the state to extend postpartum coverage for women in need of SUD treatment (CMS 2019d). Missouri submitted an application to CMS for a new Section 1115 demonstration on February 13, 2020 that proposes to extend SUD and mental health treatment for an additional 12 months after the standard 60-days postpartum period that is currently covered by Medicaid pregnancy-related state plan coverage (MO Healthnet 2020). At the time of writing, Illinois and Missouri's applications were still pending approval with CMS.

Section 1915(c) waivers. Waivers under Section 1915(c) of the Act can be used to provide services that are not available through the state plan to certain beneficiaries who are at risk for institutionalization. Generally, states can use this authority to pay for discrete rehabilitative services such as supported employment and skills training and development for beneficiaries with SUD. However, states can limit HCBS to a specific number of individuals or limit services to a certain region of the state. Nearly all states and the District of Columbia offer services through HCBS waivers; however, few use this authority to provide recovery support services to beneficiaries with SUD.

Section 1915(b) waivers. States use 1915(b) waivers to create a specialized or targeted program

that provides a limited set of benefits or services to beneficiaries. For example, Colorado contracts with behavioral health organizations to provide behavioral health services, including recovery support services, to beneficiaries across the state. Colorado's Special Connections program provides a comprehensive range of SUD treatment services for pregnant women and covers treatment services up to 12 months postpartum. Services include case management, group health education with other pregnant women, group substance use counseling with other pregnant women, in-depth risk screening, individual substance use counseling, referral to appropriate aftercare and ongoing support, urine screening and monitoring, and residential services (Mathematica 2020).[17]

North Carolina uses Section 1915(b) authority to provide intensive recovery supports to women with children returning home from SUD treatment programs. These include skills training, social skills training, pre-employment readiness, recovery education, and change readiness (RTI 2019). Virginia also operates a Section 1915(b) waiver, Virginia Medicaid MEDALLION 4.0, which has a high-risk maternity program that includes comprehensive care management and family planning services for women. The fully capitated program is available statewide to pregnant women, infants and children, and provides acute and primary health care services, prescription drug coverage, and behavioral health services for its members (Caminiti and Harrell 2019).

Early and periodic screening, diagnostic, and treatment services

All children under age 21 enrolled in Medicaid are entitled to EPSDT services, which requires states to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether it is covered in the state plan. EPSDT benefits are intended to discover and treat childhood health conditions before they become serious or disabling. States must inform all Medicaid-eligible families about the benefit, screen

children at reasonable intervals, diagnose and treat any health problems found, and report certain data regarding EPSDT participation annually to CMS. In 2018, CMS issued guidance on identification and treatment of NAS that, among other things, discussed how EPSDT may be used to provide medically necessary services to infants with NAS (Box 6-3) (CMS 2018c).

Under certain circumstances, mothers who are ineligible for Medicaid may receive certain services via EPSDT that are directed at treating and promoting the health of a Medicaid-covered infant

with NAS. Services such as counseling a parent on how to care for and interact with their infants, including how to breastfeed an infant with NAS, may be covered if the infant is present and the therapeutic intervention directly benefits the infant. For NAS treatment services to directly benefit the infant, the services must actively involve the infant, be directly related to the infant's individualized needs, and be delivered to the infant and mother jointly. Screening for maternal depression can also be done as part of a well-child visit (CMS 2018a). (Additional discussion of postpartum depression screening can be found in Chapter 5.)

BOX 6-3. Centers for Medicare & Medicaid Services Guidance on Neonatal Abstinence Syndrome, 2018

Guidance issued by the Centers for Medicare & Medicaid Services (CMS) offers possible strategies states may consider in designing Medicaid benefits to diagnose and treat infants with neonatal abstinence syndrome (NAS):

- **Treatment of NAS.** NAS services provided under the state plan must be available statewide and cannot be limited to certain geographic regions in a state. Children under the age of 21 enrolled in Medicaid are entitled to all medically necessary services under the early and periodic screening, diagnostic, and treatment benefit, which provides comprehensive and preventive health services.

- **Coverage for infants in hospital settings.** Potential covered services for infants with NAS include assessments, care planning, swaddling, feeding, and other specialized care. Services can be covered under a variety of Medicaid state plan benefits. Benefit categories can include, but are not limited to, physician and other licensed practitioner services, physical and occupational therapy, speech, hearing and language disorder services, respiratory care services, diagnostic and rehabilitative services, drugs, non-emergency medical transportation, and case management. States can pay for individual services or via bundled payments.

- **Coverage for infants in non-institutional settings.** Room and board is not reimbursed in facilities that do not meet the Medicaid standards for facility-based inpatient settings; however, services delivered in such facilities can be covered and paid for under Section 1905(a) of the Social Security Act as described in the state plan. The potential covered services are the same as those delivered in hospital settings, as described above.

BOX 6-3. (continued)

- **Case management.** Case management is a potential covered service for infants with NAS and their mothers. Case management predelivery, during treatment, and postdischarge can be critical services for providing and maintaining effective care and treatment for infants with NAS. Mothers may also benefit from an assessment of their behavioral health needs and case management services. Such services assist both the infant and the caregiver in gaining access to needed medical, social, educational, and other services.

- **Continued monitoring.** There is currently little data on the long-term effects of in utero exposure to opioids and other substances. While research progresses, home visiting and well-child visits are important monitoring tools for infants with NAS diagnoses (CMS 2018a).

Other Medicaid authorities

Two Medicaid authorities allow states to pay for residential and inpatient SUD treatment for pregnant women: a limited exception to the institutions for mental diseases (IMD) exclusion for services provided to pregnant women outside of an IMD and a time-limited state plan option to pay for residential and inpatient SUD treatment in an IMD.[18] The State Children's Health Insurance Program (CHIP) also requires behavioral health coverage to be provided to all individuals in the program. States can also cover pregnant women and unborn children in CHIP. As of January 2017, 5 states provided CHIP-funded coverage to pregnant women and 16 states provided coverage for unborn children (MACPAC 2018b).

Limited exception to the IMD exclusion for pregnant women. Section 1012 of the SUPPORT Act created a new limited exception to the IMD exclusion for certain pregnant and postpartum women who are eligible for Medicaid on the basis of pregnancy. Specifically, it allows states to claim federal financial participation (FFP) for non-IMD services delivered to women during pregnancy and up to 60 days postpartum who are patients in an IMD for the treatment of SUD. It is important to note that this provision only makes FFP available for items and services provided outside of an IMD.[19] CMS guidance issued in July 2019

encouraged states to implement this provision as quickly as possible to ensure that pregnant and postpartum women with SUD could receive services (CMS 2019e). States must be in compliance by October 1, 2020, with possible exceptions based on state legislative time frames.

State plan option for SUD treatment in an IMD. The SUPPORT Act created a new state plan option to allow states to pay for care for Medicaid beneficiaries age 21–64 with at least one SUD in certain IMD settings. Under this option, FFP is available to pay for services provided in IMD settings for a maximum of 30 days per 12-month period per eligible beneficiary, including pregnant women. States may use this option from October 1, 2019 through September 30, 2023 if they meet certain requirements.[20]

Behavioral health coverage under CHIP. Section 5022 of the SUPPORT Act amends Section 2103(c)(5) of the Act to make behavioral health coverage a required CHIP benefit, effective October 24, 2019. The statute specifically requires states to provide child health and pregnancy-related assistance that includes coverage of mental health services and SUD (CMS 2020a). Guidance from CMS published on March 2, 2020 indicates that states are now required to do the following:

- provide coverage of all the developmental and behavioral health-related screenings and preventive services recommended by the American Academy of Pediatrics Bright Futures periodicity schedule, as well as those with a grade A or B by the U.S. Preventive Services Task Force;

- use age-appropriate, validated screening tools;

- demonstrate that the CHIP benefits are sufficient to treat a broad range of behavioral health symptoms and disorders;

- cover MOUD and tobacco cessation benefits;

- identify a strategy for the use of validated assessment tools and specify tools in use; and

- deliver behavioral health services in a culturally and linguistically appropriate manner regardless of the delivery system (CMS 2020a).

States must submit a CHIP state plan amendment to demonstrate compliance with these new provisions. To obtain an effective date of October 24, 2019, as required under the SUPPORT Act, states must submit their SPAs no later than the end of the state fiscal year that includes this date (CMS 2020a).

The Role of the Criminal Justice System and Child Welfare Agencies in SUD Treatment for Medicaid Beneficiaries

SUD is widely stigmatized, and depending on the substance being used, may involve criminal behavior. For the general population, disclosure of SUD-related information can have serious consequences, including arrest, prosecution, and incarceration (MACPAC 2018c). Like many people with SUD, pregnant women often fear facing stigma from health care providers and the public if they seek care. Pregnant women may also fear

that disclosing their SUD to a health care provider, testing positive for SUD, or giving birth to a child with NAS will result in loss of custody of their newborns and possibly other children. Depending on state law or health care provider policy, this may happen even if a woman is undergoing treatment with MOUD, which is considered the standard of care for treating OUD (Guttmacher Institute 2020, CMHS National GAINS Center 2007). In addition, rising rates of overdose deaths have increased the number of children entering foster care (ASPE 2018).

The criminal justice and child welfare systems are often involved when pregnant and postpartum women are initiating SUD treatment. In part, the involvement of these systems occurs because SUD treatment may be court-ordered. However, collaboration between child welfare agencies, the courts, and SUD treatment programs may be limited due to systemic barriers, including those related to data sharing; conflicting agency missions and priorities, including differing views on the perceived value of MOUD; and engaging parents in treatment given potential mistrust of child welfare agencies (ASPE 2018). MACPAC has previously noted poor interagency coordination and data sharing between child welfare and Medicaid agencies, with a lack of knowledge among program staff about each other's benefit programs (MACPAC 2015).

This section describes how pregnant and postpartum Medicaid beneficiaries with SUD may interact with the criminal justice system and child welfare agencies. We also examine the roles of Medicaid, the criminal justice system, and state agencies that oversee the child welfare system.

Criminal justice system

Women make up a small proportion of individuals who are incarcerated; however, three-quarters of them are of childbearing age. Two-thirds of these women are mothers and the primary caregivers to young children, and up to 84 percent have been pregnant at some point (Sufrin et al. 2019). Incarcerated pregnant women are more likely to have risk factors, including a history of SUD, limited

access to health care, and a history of trauma and abuse, that may lead to poorer perinatal outcomes when compared to pregnant women who are not incarcerated (Kozhimannil and Shlafer 2014). In a study of 22 state prison systems and federal prisons, 3.8 percent of newly admitted women were pregnant and 0.6 percent of all incarcerated women were pregnant in December 2016 (Sufrin et al. 2019).

Payment for services while individuals are incarcerated. Medicaid and the criminal justice system share responsibility for providing health care to justice-involved populations, including pregnant women. With a few exceptions, Medicaid is the payer of health care services for eligible and enrolled individuals who are subject to parole and probation, while correctional institutions, including federal and state prisons and local jails, must pay for health care costs while individuals are confined to their facilities.[21] SUDs, including OUD, are prevalent among criminal justice populations (MACPAC 2018c). However, in national surveys, utilization of MOUD is often low in criminal justice settings (e.g., drug courts, jails, and prisons). Thus, OUD goes largely untreated during periods of incarceration, and use of opioids and other drugs often resumes after release (NIDA 2018). As such, former inmates are at high risk for opioid overdose following prison release.

Federal law prohibits the use of federal Medicaid funds for most health care services for inmates of public institutions, except in cases of inpatient care lasting 24 hours or more (42 USC § 1393d(a)(29)(A)).[22] As such, states have an incentive to enroll individuals in Medicaid to claim federal funds for hospital stays longer than 24 hours, including those associated with pregnancy. However, the extent to which Medicaid is the payer of eligible hospital services varies by state—some states do not have written policies regarding Medicaid enrollment for incarcerated individuals; in other states, policies are inconsistent (MACPAC 2018c, McKee et al. 2015).

Prerelease services. Historically, most justice-involved adults were uninsured. In Medicaid expansion states, many are now eligible for

Medicaid coverage upon release. For example, 80 percent and 90 percent of state prison inmates in New York and Colorado, respectively, are likely eligible for Medicaid. In North Carolina, which has not expanded Medicaid, only 2 percent of state prison inmates are eligible for Medicaid at any given time (MACPAC 2018c, GAO 2014). Pregnant inmates released before giving birth, or postpartum women leaving prison or jail, may benefit from being connected with Medicaid upon release. Among other things, this may improve access to family planning and preconception care, as well as SUD treatment following release from jail or prison (Kozhimannil and Shlafer 2014).

In Colorado, regional accountable entities, which are responsible for administering the state's Medicaid benefit, are required to provide care coordination for Medicaid-eligible individuals, including pregnant women with SUD, who are transitioning out of the criminal justice system. Care coordination services are meant to ensure continuity of care. The state Medicaid agency also shares data with the Colorado Department of Corrections to streamline Medicaid enrollment for criminal justice-involved populations in the prison system (Normile et al. 2018).

More states may begin to provide care coordination services to individuals leaving jail or prison under a new demonstration opportunity. Among other things, Section 5031 of the SUPPORT Act requires CMS to issue guidance based on best practices to improve care transitions for Medicaid-eligible individuals leaving jail or prison. Care transition services can be provided up to 30 days prerelease and may include providing education about and assistance with Medicaid enrollment, as well as providing health care services. Such guidance was due to states in October 2019; however as of March 2020, it had yet to be released.

Drug courts. Depending on the state, Medicaid agencies and managed care organizations may be required to pay for court-ordered SUD treatment (Regenstein and Nolan 2014).[23] However, in some states, general funds or local government dollars may be used to fund such services. Jail diversion

programs, including drug courts, have been developed with the goal of reducing or eliminating time individuals with behavioral health conditions spend in jail by redirecting them from the criminal justice system to community-based treatment (CMHS National GAINS Center 2007). Participation in drug court often occurs over months or years. Frequent urine drug screens, clinical treatment for SUD, case management, and appearances in court are required (NDCRC 2020).[24]

There are more than 4,100 drug court programs in the U.S.; this number includes family drug courts, which emphasize treatment for parents with SUD (NDCRC 2020). Family drug courts seek to reunify and stabilize families affected by parental drug use. Program goals include helping the parent to become emotionally, financially, and personally self-sufficient; promoting the development of parenting and coping skills adequate for serving as an effective parent on a day-to-day basis; and providing services to their children (DOJ 2020).

Child welfare agencies

Child welfare agencies are tasked with promoting the safety, permanency planning and placement, and well-being of children. They provide services to prevent the abuse and neglect of children and to ensure a child's safety within the home.[25] They also investigate allegations of abuse and neglect and, when necessary for a child's safety, remove the child from the home for placement in foster care (MACPAC 2015).

After declining for many years, the total number of children in foster care began increasing in 2012; 36 states experienced caseload increases from 2012 to 2016 (ASPE 2018). These increases are correlated with the increase in overdose deaths (Figure 6-5).

FIGURE 6-5. Number of Foster Care Entries and Drug Overdose Deaths in the United States, 2002–2018
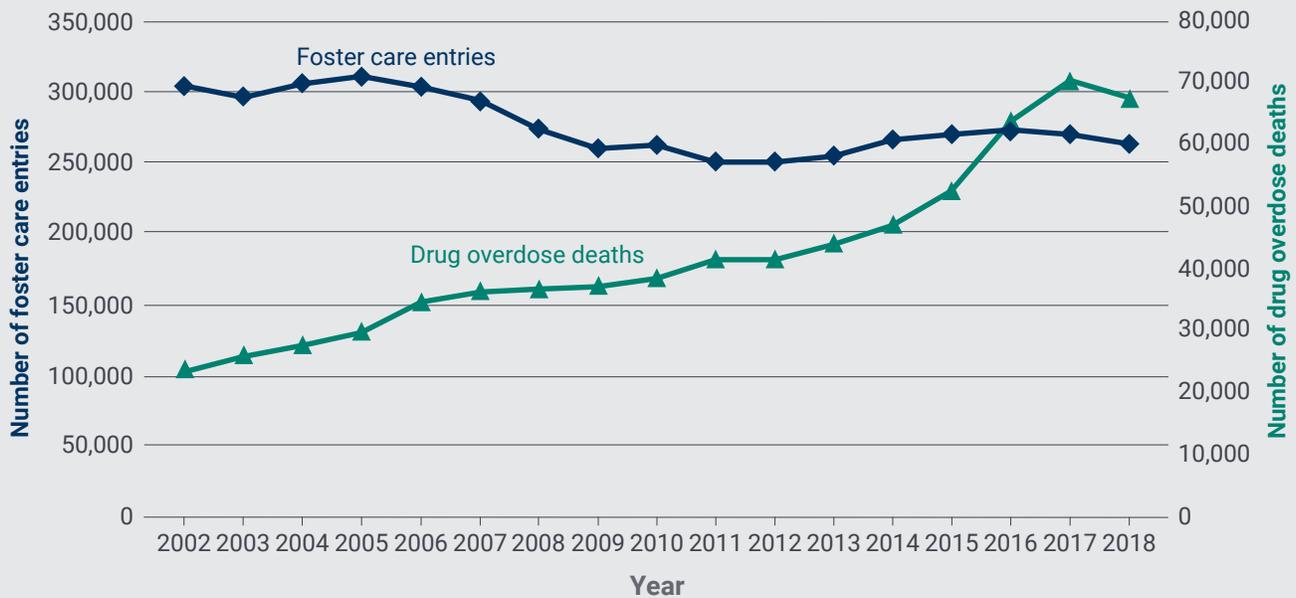
Notes: Deaths are classified using the *International Classification of Diseases, 10th Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.

Sources: Hedegaard et al. 2020; ACF 2019.

One study estimated that in the average U.S. county, a 10 percent increase in the overdose death rate corresponded to a 4 percent increase in the foster care entry rate. Similarly, a 10 percent increase in the average county's drug-related hospitalization rate corresponded to a 3 percent increase in its foster care entry rate (ASPE 2018).

Medicaid's role for child welfare-involved infants and children.
Low-income children currently or formerly served by the child welfare system are generally eligible for Medicaid.[26] These children and youths have either been removed from their homes due to abuse or neglect or are receiving in-home child welfare services as the result of allegation of maltreatment.[27] These children often have substantial health, behavioral, social, and other needs for which a range of Medicaid-covered services, including mental health and SUD treatment, may be necessary and appropriate (MACPAC 2015).[28]

Generally, Medicaid is the payer of last resort and can only pay when third parties—including other public programs, private insurers, and certain other entities—do not have a legal obligation to do so (CMS 2014a, 2014b).[29] As a result, states may claim federal Medicaid funding only for services that are not the specific responsibility of a child welfare or other agency.

Role of Medicaid for parents with child welfare agency contact.
Unlike their children, who are eligible for Medicaid if they receive services under Title IV-E of the Act, parents do not automatically become eligible for Medicaid when their children come in contact with the child welfare system.[30] Because eligibility for Medicaid as a parent requires the adult to be living with a dependent child, a parent would not be eligible if the child were removed from the home. However, the expansion of Medicaid to low-income adults may allow many parents in families whose children are in the custody of child welfare agencies to gain coverage and access to behavioral health or other Medicaid-covered services. Even if family members are not eligible for Medicaid, services such as family

therapy or parenting education may be covered by the program if they are medically necessary for a Medicaid-enrolled child and are directed exclusively to the treatment of the child (MACPAC 2015).

Guidance on family-focused residential treatment.
Section 8081 of the SUPPORT Act requires the Secretary of the U.S. Department of Health and Human Services (the Secretary) to develop and issue guidance to states identifying opportunities to support family-focused residential treatment for the provision of SUD treatment. This guidance may provide states with additional opportunities to further coordinate funding provided under Medicaid and Title IV-E. Before issuing the guidance, the Secretary must solicit input from states, various health care providers, health plans, and other relevant stakeholders. Among other things, the guidance must discuss:

- flexibilities under Sections 1115 or 1915 of the Act to provide family-focused residential treatment;

- how states can employ and coordinate funding from the state Medicaid program, Title IV-E, and other programs administered by the Secretary to support treatment and services provided by family-focused residential treatment facilities, including MOUD, family, group, or individual therapy, coordination of care for children, and transitional services and support for families leaving treatment; and

- how states can employ and coordinate funding from the state Medicaid program and Title IV-E to provide foster care payments for a child placed with a parent who is receiving treatment in a licensed residential family-based residential treatment program.

Guidance on opportunities to finance family-focused residential treatment was due 180 days after enactment of the SUPPORT Act; however as of April 2020, this guidance had not been issued.

Systems Fragmentation

No single agency is charged with addressing all the needs of pregnant and postpartum women with SUD, including food, housing, and transportation. The majority of public funding for these programs flows through state government, but state systems are generally fragmented (SAMHSA 2016, CMHS National GAINS Center 2007). As such, providing comprehensive services to pregnant women with SUD requires connecting women and their children with multiple agencies (CMHS National GAINS Center 2007). Below we describe the various programs that support pregnant and postpartum women with SUD and their infants, including:

- services provided by the state behavioral health authority;

- early intervention services, including those provided by the Program for Infants and Toddlers with Disabilities (Part C of the Individuals with Disabilities Education Act (IDEA)), and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); and

- other supports, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Supplemental Nutrition Assistance Program (SNAP), housing, and transportation assistance.

Behavioral health authority

Historically, services for physical health and behavioral health (which includes both mental health and SUD) have been financed and delivered under separate systems (Sundararaman 2009). That means Medicaid beneficiaries with behavioral health conditions, including pregnant women, often find themselves interacting with multiple public and private agencies and receiving care from providers funded by different sources.

Behavioral health efforts are increasingly led by the state Medicaid agency through collaboration with other state and federal agencies, including SAMHSA and the state behavioral health authority. In most states, one behavioral health agency administers both mental health and SUD services, but in other states the two are separated. In most cases, the state behavioral health agency is its own entity, although some states include it in the state Medicaid agency because Medicaid is a major payer of behavioral health services (Sundararaman 2009).

When Medicaid does not pay for certain SUD treatment services, they are typically available through the state behavioral health authority.[31] The Substance Abuse Prevention and Treatment (SAPT) block grant is a noncompetitive formula grant awarded to all states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the six Pacific territories, and one tribal entity to plan, implement, and evaluate activities that prevent and treat SUD and promote public health. The SAPT block grant affords certain protections for statutorily identified vulnerable populations, including pregnant women. Specifically, pregnant women receiving services under the SAPT block grant must be given priority in treatment admissions, and individuals referred to the state for treatment must be placed in a program or have interim arrangements made within 48 hours (42 USC § 300x-27). States are also required to allocate a dedicated portion of the SAPT block grant award to support pregnant and parenting women (NASADAD 2019).

In addition to the SAPT block grant, since 2004, SAMHSA has provided grants to treatment facilities under its Residential Women and Children and Pregnant and Postpartum Women programs (SAMHSA 2009). It also provides funding for various drug court programs, including family drug courts.

Early intervention services

The Program for Infants and Toddlers with Disabilities and MIECHV offer early intervention services to families of infants with NAS. (Additional discussion of home visiting programs is included in Chapter 5.) Both programs are federally funded and administered by state agencies and are

required to interact with state Medicaid programs to varying degrees.

Program for Infants and Toddlers with Disabilities. Part C of IDEA provides grants to states for early intervention services for infants and toddlers with disabilities or developmental delays, from birth through age two.[32] The program was created to minimize potential developmental delays, reduce educational costs, minimize the need for institutionalization, and improve the capacity of families to meet the needs of children with disabilities.[33] All states and territories participate in the Part C program and are required to designate a lead agency to administer the program and to ensure early intervention services are available to all eligible children, among other requirements.[34] Early intervention services may not be denied to a child based on the family's ability to pay, and Part C requires certain services to be provided at no cost. Other services may be covered by the parent's health insurance, by the Indian Health Service, or by Medicaid (Dragoo 2019).

Because exposure to substances in utero can affect newborn, infant, and childhood developmental outcomes, infants and toddlers born with NAS may require Part C services. As such, models of care that incorporate referrals for infants with NAS to lead agencies for screening and evaluation are necessary to identify potential developmental delays and improve outcomes (Patrick 2020a). Primary referral sources include hospitals, physicians, public health facilities, social service agencies, clinics or health care providers, and child welfare agencies (Dragoo 2019).

Maternal, Infant, and Early Childhood Home Visiting Program. Coordination between Medicaid and Title V agencies—states and non-profit organizations that promote maternal and child health—is required by law (§ 505(a)(5)(F)(ii) of the Act, 42 CFR 431.615). Medicaid and state Title V agencies and grantees care for many of the same populations and contract with many of the same providers. State Title V agencies have pursued coordination in various ways, such as assisting in

the development of EPSDT provisions in managed care contracts, monitoring network adequacy, helping to develop EPSDT standards of care, and coordinating with Medicaid agencies to provide home visiting programs (CMS 2016b).

Home visiting can be instrumental in post-discharge care of pregnant women with SUD and infants with NAS. Under MIECHV, created under the ACA, federal grants are available to states, tribal organizations, and non-profit organizations to support evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. Federal funding can be added to state and local funds to support a full array of services for pregnant women, families, infants, and young children. States may implement home visiting models that include services eligible for Medicaid coverage including the following: case management, preventive services, rehabilitative services, home health services, EPSDT, health homes, other licensed practitioner services, and extended services to pregnant women (CMS 2018c, CMS 2016b).

Every state has its own system for determining MIECHV eligibility, and Medicaid may pay for certain components if the infant or mother is Medicaid-eligible and the proposed services are coverable. Authorities that can be used to pay for home visiting services include state plan authority and Sections 1903(m), 1932, 1915(b), 1915(c), and 1115 of the Act (CMS 2016b).

Other social supports

Many social determinants of health, including nutrition, housing, and transportation, are critical for pregnant women with SUD. For example, proper maternal nutrition is critical for fetal development; use of illicit drugs, including opioids and methamphetamines, can contribute to nutritional deficiencies (Sebastiani et al. 2018). Housing is also a critical component in recovery, and experts view it as part of the continuum of care (CMHS National GAINS Center 2007). The various federal programs

that address these social determinants of health are described in greater detail below.

Special Supplemental Nutrition Program for Women, Infants, and Children.
WIC is a federal grant program that provides supplemental nutritious foods, nutrition education and counseling, and screening and referrals to other health and social services to low-income pregnant and postpartum women, infants, and children up to the age of five. WIC emphasizes the importance of breastfeeding; breastfeeding women can receive benefits up to the infant's first birthday, while non-breastfeeding postpartum women can receive benefits for up to six months after giving birth (FNS 2013). In 2016, WIC served more than 7.5 million participants. Of this, more than 1.85 million were infants, representing 85.9 percent of all eligible infants (FNS 2019a).

WIC has multiple eligibility qualifications, including categorical, financial, and nutritional risk. Financial eligibility is met if a household has income that is 185 percent of the federal poverty level or less, or if the applicant receives benefits from Temporary Assistance for Needy Families, SNAP, Medicaid, or certain other state programs. Medicaid eligibility is frequently used to establish WIC eligibility. In 2014, 68.8 percent of WIC participants were also enrolled in Medicaid, and 25.7 percent of WIC participants were enrolled in both Medicaid and SNAP. WIC requires states to give information about Medicaid to participants who are income-eligible but not currently enrolled in Medicaid (42 USC § 1786(e)(4)) (Aussenberg 2017).

Supplemental Nutrition Assistance Program.
SNAP is the largest federal nutrition assistance program, helping low-income individuals and families purchase groceries at authorized food retail outlets.[35] Beneficiaries of SNAP and Medicaid often overlap; in 2014, about three-quarters of SNAP households included one or more members enrolled in Medicaid or CHIP. Households with young children and households with children headed by single women experience food insecurity at 16.6 percent and 31.6 percent respectively (Coleman-

Jensen et al. 2017). In 2017, more than one in five SNAP households included a child age zero to four (Schanzenbach and Alexander 2019).

Some states are aligning their SNAP and Medicaid eligibility systems in an effort to coordinate services and reduce churn. Strategies to coordinate renewals include: using SNAP income data for Medicaid renewals; aligning renewal processes so SNAP and Medicaid renewal dates, notices, and procedures coincide; using streamlined enrollment; and using express lane eligibility (Wagner and Huguelet 2016). Thirty-two states have combined online applications for Medicaid and SNAP (Code for America 2019).

Housing assistance.
The relationship between housing and health is well-established. Poor housing conditions can worsen health outcomes related to infectious and chronic disease, injury, and mental health, and may also affect childhood development through exposure to harmful toxins such as lead. Individuals experiencing homelessness or housing instability (for example, difficulty paying rent or frequent moves) also have difficulty obtaining health care and managing complex health conditions (MACPAC 2018d). Pregnancy can increase a woman's risk of being homeless, and pregnant women face greater health risks when they do not have stable housing. Homelessness or housing instability during pregnancy is associated with low birthweight and preterm delivery (Clark et al. 2019).

Historically, programs addressing homelessness and housing instability have been financed through the U.S. Department of Housing and Urban Development (HUD) and administered by state and local governments.[36] Generally, families are eligible for HUD assistance if their incomes are below certain HUD-defined income thresholds.[37] But given that housing assistance programs are not structured as entitlements, they only serve roughly one in four eligible households. Families wishing to receive housing assistance are often placed on waiting lists (Perl and McCarthy 2017).

Pregnant and postpartum Medicaid beneficiaries with SUD may face additional challenges accessing safe and affordable housing. Federal statute imposes a time-limited ban against living in HUD-assisted housing for individuals evicted for drug-related activities. In addition, federal policies allow housing agencies to prohibit or limit housing assistance to individuals who have a past history of drug use or are considered at risk for engaging in illegal drug use (CBPP 2019).

Although Medicaid programs and HUD-funded entities serve many of the same individuals, federal, state, and local housing programs have not traditionally collaborated. Although Medicaid dollars cannot be used to cover room and board, states can cover some housing-related activities. This includes supportive housing services, which combine affordable housing (financed through non-Medicaid funds) with intensive coordinated services such as tenancy sustaining services to help individuals with chronic physical and behavioral health issues maintain stable housing and receive appropriate supports (MACPAC 2018d).

Transportation assistance. Pregnant and postpartum women with SUD enrolled in Medicaid may have trouble accessing care due to inadequate transportation. Federal Medicaid regulations require that states ensure transportation to and from medical appointments for Medicaid beneficiaries with no other means of accessing services; this benefit is known as non-emergency medical transportation (NEMT) (42 CFR 440.170). States must ensure necessary transportation and use of the most appropriate form of transportation for the beneficiary (42 CFR 431.53, CMS 2016c). States are also required to provide assistance with transportation for children and their families under the EPSDT benefit (42 CFR 441.62).

Although the scope of this benefit varies by state, NEMT generally covers a broad range of transportation services, including trips in taxis, vans, and personal vehicles belonging to the beneficiaries and their families or friends. Some states rely on public transportation to provide NEMT; however, this approach varies considerably both within and across states given that public transportation is not available in all areas. States may also use ride-sharing companies like Uber and Lyft to provide NEMT (MACPAC 2019c).

New Models of Care

In February 2019, CMS announced two new models of care: the Maternal Opioid Misuse (MOM) model, which aims to improve the coordination of care for pregnant women with an OUD and infants with NAS, and the Integrated Care for Kids (InCK) model, which aims to reduce expenditures and improve child health outcomes, including those related to the opioid crisis. Both aim to address fragmentation among systems and improve quality of care and access to services while creating sustainable coverage and payment strategies. These models began January 1, 2020, and will run for five and seven years respectively; thus, any findings from these models will not be available for some time.

Maternal Opioid Misuse model. The MOM model provides funding to state Medicaid agencies to target pregnant and postpartum beneficiaries with an OUD and their infants, addressing barriers to care, including:

- lack of access to comprehensive services during pregnancy and the postpartum period;

- fragmented systems of care; and

- shortage of maternity care and SUD treatment providers for pregnant and postpartum Medicaid beneficiaries (CMS 2019a).

The MOM model requires that pregnant and postpartum women with OUD receive a comprehensive set of services (e.g., maternity care, MOUD, mental health screening). Awardees can define a specific set of services within the model that satisfy five components: comprehensive care management, care coordination, health promotion, individual and family support, and referral to community and social services (CMS 2019a).

In December 2019, CMS issued cooperative agreements to 10 states, with awards totaling approximately $50 million for a five-year period.[38] In the first year of the model, awardees will receive implementation funding to address structural barriers to care.[39] In the second year, states will receive transition funding to cover wrap-around coordination, engagement, and referral activities. During full implementation of the model in the last three years of the agreement, state Medicaid agencies will access milestone funding to sustain care transformation based on their performance on a number of quality metrics (see Box 6-4 for state examples) (CMS 2019a).

BOX 6-4. Examples of State Implementation Plans under the Maternal Opioid Misuse (MOM) Model

Maine. Maine is seeking to establish a more integrated system of care that brings together all of a pregnant woman's providers, services, and supports. This could include providers such as obstetrician-gynecologists, prescribers of medications used to treat opioid use disorder, and substance use counselors; services such as contraceptive counseling and offering long-acting reversible contraceptives; and supports such as child protective services and the creation of plans of safe care, among many others. In particular, the state plans to build off its existing opioid health home program to establish a maternity opioid health home. Using bundled payments, this model will meet the specialized needs of pregnant women with opioid use disorder through a team-based approach to care.

Maine is also using its CradleME line, which is a specialized referral system for families to be connected to resources. The state plans on promoting the line and doing outreach to encourage access to treatment for pregnant women with substance use disorder (SUD) (Alford 2020).

Tennessee. Tennessee is focusing on providing evidence-based care and making connections to public resources (Patrick 2020a). The state is providing a targeted set of services for mothers and infants during the prenatal period, at the hospital, and in the postdischarge period:

- **Prenatal.** Provide evidence-based mental health, infectious disease, and addiction treatment for the pregnant woman, as well as well-woman care, and other pediatric, childlife, and lactation services.

- **Hospital.** Ensure rooming-in of mother and baby and provide consultations with addiction medicine and lactation specialists for the mother. For infants, use risk-appropriate care, minimize the use of morphine, and provide developmental screenings and preventive services.

- **Discharge.** Provide relapse prevention, home nurse visiting, contraceptive counseling, and addiction treatment for the mother. For infants, refer to early intervention services, monitor development, and do hepatitis C follow-up (Patrick 2020b).

Using patient navigators to coordinate care, developing plans of safe care, and ensuring that mothers are engaged with maternal addiction recovery programs will be essential throughout the three time periods (Patrick 2020b).

BOX 6-4. (continued)

West Virginia. West Virginia is using the MOM grant to build on its Drug Free Moms and Babies program, to increase the number of programs in the state from 12 to 16. The state plans to build services around its health home care coordination model and plans to fully integrate the model into West Virginia's maternity care system. The state will also extend postpartum coverage up to one year and transition to well-woman care (Becker 2020a). Ultimately, West Virginia hopes to increase access to treatment and expand accessibility to services by:

- developing comprehensive care for the mother and baby;

- increasing care coordination;

- recognizing specialized community resources in the treatment and recovery of SUD, healthy pregnancy, childbirth, lactation, infant bonding, and child development;

- continuing support to rural counties by health worker engagement in local communities; and

- addressing social determinants of health that cannot be as effectively addressed in a health care setting (Becker 2020b).

Integrated Care for Kids model. The InCK model targets all Medicaid and CHIP beneficiaries from birth to age 21, across multiple service systems. The model's goals are to improve child health, reduce avoidable inpatient stays and out-of-home placement, and create alternative payment models. By bringing together medical, behavioral, and community-based services, InCK expects to reduce fragmentation in service delivery and expand access to care. Lead organizations, which are state Medicaid agencies or HIPAA-covered entities (e.g., hospitals), will coordinate and integrate the following core child services, some of which may or may not be covered by Medicaid: clinical care (physical and behavioral health), schools, food, early care and education, housing, Title V agencies, child welfare, and mobile crisis response services (CMS 2019f).

InCK model participants can design interventions for their local communities that align health care delivery with child welfare support, educational systems, housing and nutrition services, mobile crisis response services, maternal and child health

systems, and other relevant service systems; participants must integrate these services via care coordination and case management.[40] This model uses a tiered service-delivery model to provide increased services to children who may have multisector needs, functional impairments, and who are at risk or currently placed outside of their homes (CMS 2019f).

In December 2019, CMS announced that nearly $126 million would be awarded through eight cooperative agreements to states and lead organizations in seven states for a seven-year period.[41] The first two years cover the preimplementation period in which CMS will work with participants to provide technical assistance and establish or modify any needed Medicaid and CHIP authorities. The model will be fully implemented for the following five years (CMS 2019f).

Endnotes

[1] Opioids can be natural, synthetic, or semisynthetic. Morphine and codeine are examples of natural opioids. Synthetic opioids are designed to have a chemical structure that is similar to opioids naturally derived from the opium poppy. These include drugs such as fentanyl, fentanyl analogs, and tramadol. Semisynthetic opioids include prescription drugs such as morphine, hydrocodone, and oxycodone, as well as illicit drugs, such as heroin (CAMH 2020).

[2] Marijuana use is also increasing among pregnant women; however, use of marijuana during pregnancy is beyond the scope of this chapter.

[3] In 2018, 6.9 percent of Medicaid beneficiaries self-reported illicit drug dependence or abuse, compared to 2.7 percent of individuals with private coverage (SHADAC 2020).

[4] In 2018, 12.1 percent of Medicaid beneficiaries with SUD were currently receiving treatment, compared to 4.3 percent of individuals with private coverage (SHADAC 2020)

[5] Federal statute requires that all states provide Medicaid coverage for pregnant women with incomes at or below 138 percent of the federal poverty level (§ 1902(a)(10)(A)(i)(IV) of the Social Security Act). Most states provide coverage at levels above this (CMS 2019g).

[6] The NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

[7] MACPAC did not develop estimates on marijuana use during pregnancy because it was outside the scope of this chapter.

[8] Health care settings include: an overnight stay in an inpatient hospital; an outpatient drug or alcohol rehabilitation facility; an outpatient mental health center; an emergency room; or a private doctor's office.

[9] Under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-217), states must explicitly include MOUD as a Medicaid-covered service for a five-year period beginning October 1, 2020. States can be exempted from this requirement if before October 1, 2020, they can satisfactorily certify that covering all eligible individuals in the state is not feasible due to a shortage of qualified MOUD providers or treatment facilities willing to provide services under contract either with the state or with a managed care organization working with the state under Section 1903(m) or Section 1905(t)(3) of the Act (MACPAC 2019b).

[10] The National Survey on Substance Abuse Treatment Services does not further define what special programming for pregnant and postpartum women includes.

[11] Specifically, MACPAC found that buprenorphine prescriptions for Medicaid beneficiaries increased by 12 percent between July 2017 and June 2018, twice the rate of increase for all patients. In addition, nurse practitioners and physician assistants accounted for an increasing proportion of all buprenorphine prescribers during this period (MACPAC 2019b).

[12] Facilities may offer services across multiple ASAM levels of care; therefore, the percentage of facilities accepting Medicaid is not necessarily indicative of the percentage of facilities that accept Medicaid payment for a specific level of service. For example, a provider offering two services—partial hospitalization (ASAM level 2.5) and outpatient treatment (ASAM level 1.0)—may report accepting Medicaid, but the state Medicaid program may only cover one of the services. Facilities offering partial hospitalization and different intensities of residential services (ASAM level 3.0) accept Medicaid at a lower rate overall (MACPAC 2018a).

[13] Colorado, Delaware, Idaho, Indiana, Nevada, and Wisconsin do not have any SUD treatment facilities that also accept Medicaid with beds for the children of clients.

[14] There are currently no FDA-approved medications to treat marijuana, amphetamine, or cocaine use disorders (MACPAC 2019b).

[15] A pediatric complex chronic condition is a medical condition that is expected to last at least 12 months and involve either one organ system or several organ systems severely enough that it requires specialty pediatric care. Condition categories include cardiovascular, other congenital or genetic defect, hematologic or immunologic, metabolic, neurologic and neuromuscular, respiratory, premature and neonatal, gastrointestinal, malignancy, renal and urologic, technology dependence, and transplantation (Jarlenski et al. 2020).

[16] The Section 1915(i) state plan option was created in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and updated by the ACA.

[17] Approval for Special Connections was granted under a SPA that allowed the state Medicaid program to provide extended services to pregnant women up to 60 days postpartum, and a Section 1915(b) waiver that allowed the state to continue to cover SUD treatment for 2 to 12 months postpartum. Historically, for women to be eligible to receive services postpartum, they had to be enrolled in Special Connections prior to delivery. Legislation passed in July 2019 allows postpartum enrollment. This is currently covered through non-Medicaid funds but will be covered through Medicaid by July 1, 2021 (Mathematica 2020).

[18] Since its inception in 1965, Medicaid has largely prohibited payments for services provided to beneficiaries in IMDs. This restriction is one of the few instances in the Medicaid program in which federal financial participation is not available for medically necessary and otherwise covered services based on the setting in which they are provided. Federal law broadly defines an IMD as a "hospital, nursing facility, or institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (§ 1905(i) of the Act). States may make Medicaid payments for services provided in IMDs under other authorities (e.g., Section 1115 demonstration waivers and time-limited state plan options) (MACPAC 2019d).

[19] This applies only to women who are enrolled under the state plan immediately before becoming a patient in the IMD or who become eligible to enroll while a patient in an IMD.

[20] For a state to be eligible for FFP, the following requirements must be met:

- States must cover services consistent with at least six levels of care; four of these services must be outpatient levels of care. The state must also cover at least two inpatient or residential levels of care.

- IMDs must follow reliable, evidence-based practices and offer at least two forms of MOUD on-site. For opioid use disorder, this must include one antagonist (e.g., naltrexone) and one partial agonist (e.g., buprenorphine). IMDs must also be able to provide care at a lower level of clinical intensity or have

an established relationship with another facility or provider that can deliver a lower level of care and accepts Medicaid.

- States must maintain non-federal, non-Medicaid spending levels for services furnished to Medicaid beneficiaries age 21–64 with at least one SUD in IMDs that would qualify under this state plan option and for outpatient and community-based settings. Outpatient and community-based service spending includes all outpatient treatment as well as spending on drugs used to treat SUD, drug testing, monitoring for medication adherence, evidenced-based recovery support services, and other services designated by the Secretary of Health and Human Services (the Secretary). States must submit a report to the Secretary prior to state plan approval.

- Prior to approval of a state plan amendment, the state must notify the Secretary how the state will ensure that individuals receive appropriate evidenced-based clinical screenings before they receive services in an IMD, including the initial screening and periodic assessments to determine if care is appropriate.

- States must ensure appropriate transitions of care for individuals leaving IMDs and ensure that placement in an IMD will allow an individual to successfully transition to the community, considering factors such as proximity to an individual's support network.

[21] Criminal justice-involved individuals include adults serving sentences in prisons and jails, awaiting trial or sentencing, and fulfilling obligations under community supervision, such as in parole or on probation. They also include youths who may be served in a separate system; most youths are under community supervision through orders of probation and parole. Compared to the general population, those involved in the criminal justice system tend to have more complex and unmet health care needs. An estimated 65 percent of incarcerated individuals have SUD (MACPAC 2018c).

[22] To be considered an inmate of a public institution, an individual must be held involuntarily by law enforcement authorities. In 2015, CMS issued guidance further clarifying when an individual is considered an inmate of a public institution. Specifically, federal matching funds are available for individuals who are: on parole, probation, or released to the community pending trial; living in a halfway house where

individuals can exercise personal freedom; voluntarily living in a public institution; or on home confinement. Federal financial participation is not available for individuals living in: state or federal prisons, local jails, or detention facilities; federal residential reentry centers; residential mental health and substance use disorder treatment facilities for incarcerated individuals; or hospitals or nursing facilities that exclusively serve incarcerated individuals (MACPAC 2018c).

[23] Medicaid payment for services that are mandated by drug courts is affected by a number of factors, including whether Medicaid covers mandated services and if the person is eligible for Medicaid.

[24] Drug courts receive funding through a variety of federal and state funding mechanisms. In the past, some drug courts have resisted the use of MOUD. In 2015, the Office of National Drug Control Policy announced that state drug courts receiving federal grants must not: (1) deny any appropriate and eligible client for drug court access because of their use of FDA-approved medications that is in accordance with an appropriately authorized prescription; or (2) mandate that a drug court client no longer use medications as part of the conditions of the drug court if such a mandate is inconsistent with a medical practitioner's recommendation or prescription (DOJ 2015).

[25] Among other things, child welfare agencies are responsible for monitoring the work of local entities to determine whether and how plans of safe care are adopted for substance-exposed infants. A plan of safe care is a document, developed by a health care professional, that directs services and supports to ensure the safety and well-being of infants exposed to substances in utero, including opioids. The passage of CARA included amendments that changed the requirements for plans of safe care to be inclusive of the needs of the family or caregiver in instances when an infant experiences withdrawal symptoms or fetal alcohol disorder or is identified as being affected by substance use (Heisler and Duff 2018).

[26] For children eligible for Medicaid on the basis of child welfare assistance, Medicaid agencies accept child welfare determinations of eligibility (MACPAC 2015).

[27] Children who have been removed from their homes may be placed in temporary foster care but may also be permanently placed with an adoptive or kinship guardian family. Others may age out of foster care without having secured permanent placement but remain eligible for Medicaid until age 26 (MACPAC 2015).

[28] Among children eligible for Medicaid based on child welfare assistance, 49 percent had diagnoses of mental health disorders and 3 percent had diagnoses of SUD; for other children in Medicaid, the figures were 11 percent and less than 1 percent, respectively. Child maltreatment has also been associated with increased risk of other longer-term health and social problems. Specifically, childhood trauma can increase alcoholism, illicit drug use, risky sexual behavior, and mental health issues, including depression and attempted suicide, as well as cancer and heart, lung, and liver disease (MACPAC 2015).

[29] The Bipartisan Budget Act of 2018 (P.L. 115-123) allows states to use funding under Title IV-E to support certain SUD and mental health treatment services as well as skills-based programs for in-home parents. Such services may be provided to children at risk of entering foster care, youths in foster care who are pregnant and parenting, and parents or kin caregivers of these children. Prior to this action, Title IV-E funding was not available for these services to families involved in the child welfare system. Other federal funding may also be used to provide SUD and mental health treatment, including Medicaid funds (Heisler and Duff 2018). The SUPPORT Act (§§ 106(b)(2)(B)(ii)—(iii)) clarifies Medicaid's role in paying for Title IV-E prevention services when a child or adult may be eligible for services under more than one program. Specifically, it stipulates that Title IV-E prevention services are not intended to reduce Medicaid payment for services that would otherwise be available to a beneficiary.

[30] Title IV-E of the Act provides federal funding for child welfare assistance for low-income children who have been removed from their homes. Title IV-E is an entitlement program through which states are entitled to reimbursement for some of the costs of providing foster care, adoption assistance, or kinship guardianship assistance for eligible children. State child welfare agencies are responsible for the safety and well-being of children under their care and for connecting them to a permanent and safe home if they cannot be reunited with their biological parents. Agencies must also ensure that the health needs of these children are met but may not use federal funds under Title IV-E to do so (MACPAC 2015).

31 SAMHSA has made funding available for SUD treatment services through other programs including Access to Recovery grants, the State Targeted Response to Opioid Crisis grant, and Bringing Recovery Supports to Scale Technical Assistance Center Strategy funding (MACPAC 2019a).

32 In 2018, approximately 389,000 infants and toddlers received early intervention services, and in FY 2019, approximately $470 million was appropriated for Part C programs (Dragoo 2019).

33 Part C of the IDEA uses a definition of disability in determining eligibility for early intervention services that hinges on a child experiencing a developmental delay or having a high probability of experiencing a developmental delay. This may include delays in physical, cognitive, communication, social, emotional, or adaptive development (Dragoo 2019). Eligibility for Part C services differs by state, and is determined based on each state's definition of developmental delay (ECTA 2020). This definition can include disorders secondary to exposure to toxic substances, such as neonatal abstinence syndrome (34 CFR 303.21).

34 Under the Part C program, the governor is responsible for appointing members to an interagency coordinating council (ICC), including parents of infants and toddlers with disabilities, service providers, and employees of relevant state agencies, one of which must be from the state Medicaid agency (Dragoo 2019).

35 SNAP benefits are loaded each month onto an electronic benefits transfer card which can be used to purchase eligible items. The SNAP benefits that a household receives are based on the U.S. Department of Agriculture's Thrifty Food Plan, which is an estimate of the cost to buy food for nutritious, low-cost meals (FNS 2019b).

36 HUD administers five main rental assistance programs that subsidize rents for low-income families. These are: the Public Housing program, the Section 8 Housing Choice Voucher program, the Section 8 Project-Based Rental Assistance program, the Section 202 Supportive Housing for the Elderly program, and the Section 811 Supportive Housing for Persons with Disabilities program. In addition to these five main rental assistance programs, HUD also operates several grant programs including Homeless Assistance Grants, the Housing Opportunities for Persons with AIDS

(HOPWA) grant, and the HOME Investment Partnerships Program (Perl and McCarthy 2017).

37 HUD programs vary in some important ways (e.g., how assistance is provided, who administers the assistance, which populations may receive assistance), but they use similar standards when establishing tenants' income eligibility and minimum contributions toward rent. Unlike the poverty measurement used by some other federal benefits programs, income eligibility for HUD-assisted housing varies by locality and is tied to the median income of the area (Perl and McCarthy 2017).

38 Ten states have been awarded MOM Model funding: Colorado, Indiana, Louisiana, Maine, Maryland, Missouri, New Hampshire, Tennessee, Texas, and West Virginia. These funds may not be used to supplant or duplicate Medicaid-funded services (e.g., well-woman care, OUD treatment, prenatal and postpartum care, or labor and delivery) (CMS 2019a).

39 On April 16, 2020, as a result of the COVID-19 public health emergency, CMS announced a six-month postponement of the requirement that MOM model recipients begin to screen and enroll beneficiaries by January 2021, pushing the enrollment date to July 1, 2021. In addition to the enrollment delay, CMS is reviewing all requirements currently in place for years one and two of the MOM model (CMS 2020b).

40 Each InCK model awardee must also incorporate six key service integration design characteristics into its model:

- population-wide approach;
- information sharing across provider and families and caregivers;
- mobile crisis response services;
- person- and family-centered service delivery;
- streamlined and coordinated eligibility and enrollment processes; and
- service accessibility (CMS 2019f).

41 The InCK model is funding states and organizations in Connecticut, Illinois (two awards), New Jersey, New York, North Carolina, Ohio, and Oregon (CMS 2019f).

References

Administration for Children & Families (ACF), U.S. Department of Health and Human Services (HHS). 2019. Adoption & Foster Care Statistics. Washington, DC: HHS. https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/afcars.

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. 2019. Healthcare Cost and Utilization Project (HCUP) fast stats: Neonatal abstinence syndrome (NAS) among newborn hospitalizations. Rockville, MD: AHRQ. https://www.hcup-us.ahrq.gov/faststats/NASMap.

Ailes, E.C., A.L. Dawson, J.N. Lind, et al. 2015. Opioid prescription claims among women of reproductive age — United States, 2008–2012. *Mortality and Morbidity Weekly Report* 64, no. 2: 37–41. https://www.cdc.gov/mmwr/pdf/wk/mm6402.pdf.

Alford, O. 2020. Access to treatment for pregnant women with a substance use disorder and infants with neonatal abstinence syndrome. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2020, Washington, DC. https://www.macpac.gov/public_meeting/january-2020-macpac-public-meeting/.

American College of Obstetricians and Gynecologists (ACOG). 2017. *Opioid use and opioid use disorder in pregnancy*. August 2017 ACOG Committee Opinion no. 711. Washington, DC: ACOG. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy.

American College of Obstetricians and Gynecologists (ACOG). 2011. *Substance abuse reporting and pregnancy: The role of the obstetrician-gynecologist*. January 2011 ACOG Committee Opinion no. 473 (reaffirmed 2014). Washington, DC: ACOG. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2018. *Substance use, the opioid epidemic, and the child welfare system: Key findings from a mixed methods study*. Washington, DC: ASPE. https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2016. *The use of 1915(i) Medicaid plan option for individuals with mental health and substance use disorders*. Washington, DC: ASPE. https://aspe.hhs.gov/system/files/pdf/255716/1915iSPA.pdf.

Aussenberg, R.A. 2017. *A primer on WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children*. Report no. R44115. April 7. Washington, DC: Congressional Research Service. https://crsreports.congress.gov/product/details?prodcode=R44115.

Becker, J. 2020a. Access to treatment for pregnant women with a substance use disorder and infants with neonatal abstinence syndrome. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2020, Washington, DC. https://www.macpac.gov/public_meeting/january-2020-macpac-public-meeting/.

Becker, J. 2020b. West Virginia Department of Health and Human Resources Bureau for Medical Services: Substance Use Disorder (SUD) Programs. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2020, Washington, DC. https://www.macpac.gov/publication/access-to-treatment-for-pregnant-women-with-a-substance-use-disorder-and-infants-with-neonatal-abstinence-syndrome/.

Caminiti, M., and A. Harrell. 2019. Virginia advances integrated care for pregnant and parenting women with substance use disorder. *National Academy for State Health Policy Blog*, December 16. https://nashp.org/virginia-advances-integrated-care-for-pregnant-and-parenting-women-with-substance-use-disorder/.

Center on Budget and Policy Priorities (CBPP). 2019. *Meeting the housing needs of people with substance use disorders*. Washington, DC: CBPP. https://www.cbpp.org/sites/default/files/atoms/files/5-1-19hous.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. CMS state health official letter regarding "Access to mental health and substance use disorder services for children and pregnant women in the Children's Health Insurance Program." March 2, 2020. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho20001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Maternal Opioid Misuse (MOM) model. Baltimore, MD: CMS. https://innovation.cms.gov/innovation-models/maternal-opioid-misuse-model.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Maternal Opioid Misuse (MOM) model. December 2019 updated fact sheet. Baltimore, MD: CMS. https://innovation.cms.gov/Files/fact-sheet/mom-model-fs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. South Dakota state plan amendment. April 4, 2019. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SD/SD-18-004.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019c. CMCS informational bulletin regarding "State guidance for implementation of the treatment for infants with neonatal abstinence syndrome in residential pediatric recovery centers provisions of Section 1007 of Pub. L. 115-271, *the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.*" July 26, 2019. https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1007.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019d. Section 1115 of the Social Security Act Medicaid demonstration: South Carolina Health Connections Works. December 12, 2019. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=51634.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019e. CMCS informational bulletin regarding "State guidance for the new limited exception to the IMD exclusion for certain pregnant and postpartum women included in Section 1012 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Help for Moms and Babies." July 26, 2019. https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019f. *Integrated Care for Kids (InCK) model*. December 2019 updated fact sheet. Baltimore, MD: CMS. https://innovation.cms.gov/Files/fact-sheet/inck-model-fs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019g. Medicaid, Children's Health Insurance Program, & Basic Health Program eligibility levels. April 1, 2019. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. CMCS informational bulletin regarding "Neonatal abstinence syndrome: A critical role for Medicaid in the care of infants." June 11, 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/cib060818.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. West Virginia state plan amendment: Neonatal abstinence syndrome treatment services. February 8, 2018. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WV/WV-17-004.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018c. *Conditions targeted by Medicaid health homes*. Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/targeted-conditions-matrix.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Section 1115(a) of the Social Security Act Medicaid demonstration: Evaluation design for the Drug Medi-Cal Organized Delivery System component of California Medi-Cal 2020 Demonstration. June 20, 2016. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/medi-cal-2020/ca-medi-cal-2020-organized-delivery-system-eval-design-06202016.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. Joint informational bulletin regarding "Coverage of maternal, infant, and early childhood home visiting services." March 2, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016c. *Let Medicaid give you a ride: Medicaid non-emergency medical transportation fact sheet*. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-factsheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014a. Letter from Cindy Mann to state Medicaid directors regarding "Medicaid payment for services provided without charge (free care)." December 15, 2014. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2014b. Medicaid and CHIP FAQs: Identification of Medicaid beneficiaries' third party resources and coordination of benefits with Medicaid. September 11, 2014. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/FAQ-09-04-2014.pdf.

Centre for Addiction and Mental Health (CAMH). 2020. Heroin. Toronto, ON: CAMH. https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/heroin.

Clark, R.E., L. Weinreb, J. Flahive, and R.W. Seifert. 2019. Homelessness contributes to pregnancy complications. *Health Affairs* 38, no. 1: 139–146. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05156.

Center for Mental Health Services (CMHS) National GAINS Center, 2007. *Practical advice on jail diversion: Ten years of learnings on jail diversion from the Center for Mental Health Services National GAINS Center*. Delmar, NY: CMHS National GAINS Center. http://www.pacenterofexcellence.pitt.edu/documents/PracticalAdviceOnJailDiversion.pdf.

Code for America. 2019. *Bringing social safety net benefits online: Examining online platforms for all 50 states*. San Francisco, CA: Code for America. https://www.codeforamerica.org/features/bringing-social-safety-net-benefits-online/.

Coleman-Jensen, A., M.P. Rabbitt, C.A. Gregory, A. Singh. 2017. *Household food security in the United States in 2016*. Economic Research Report no. 237. Washington, DC: U.S. Department of Agriculture, Economic Research Service. https://www.ers.usda.gov/webdocs/publications/84973/err-237.pdf.

Department of Healthcare and Family Services (HFS), State of Illinois. 2020. Section 1115 of the Social Security Act Medicaid: Illinois continuity of care & administrative simplification. Research and demonstration waiver request. Springfield, IL: HFS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-continuity-care-admin-simplification-pa.pdf.

Department of Social Services (DSS), State of South Dakota. 2018. Substance use disorder services. Presentation before the South Dakota Medicaid Advisory Committee, May 16, 2018. Pierre, SD: DSS. https://dss.sd.gov/docs/medicaid/advisorycommittee/Substance%20Use%20Disorder%20(SUD)%20Services.pdf.

Dragoo, K.E. 2019. *The Individuals with Disabilities Education Act (IDEA), part C: early intervention for infants and toddlers with disabilities*. Report no. R43631. August 9. Washington, DC: Congressional Research Service. https://crsreports.congress.gov/product/pdf/R/R43631.

Dugan, S. Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2020. E-mail to MACPAC, January 6.

Early Childhood Technical Assistance Center (ECTA), Frank Porter Graham Child Development Institute of the University of North Carolina at Chapel Hill. 2020. Part C eligibility. Chapel Hill, NC: ECTA. https://ectacenter.org/topics/earlyid/partcelig.asp.

Faherty, L.J., A.M. Kranz, J. Russell-Fritch, et al. 2019. Association of punitive and reporting state policies related to substance use in pregnancy with rates of neonatal abstinence syndrome. *JAMA Network Open* 2, no. 11: e1914078. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2755304.

Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA). 2019a. WIC 2016 eligibility and coverage rates. Washington, DC: USDA. https://www.fns.usda.gov/wic/wic-2016-eligibility-and-coverage-rates#Chart1.

Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA). 2019b. Facts about SNAP. Washington, DC: USDA. https://www.fns.usda.gov/snap/facts.

Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA). 2013. About WIC–WIC at a glance. Washington, DC: USDA. https://www.fns.usda.gov/wic/about-wic-wic-glance.

Guttmacher Institute. 2020. Substance use during pregnancy. https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy.

Hedegaard, H., A.M. Miniño, and M. Warner. 2020. *Drug overdose deaths in the United States, 1999–2018*. National Center for Health Statistics (NCHS) data brief no. 356. Hyattsville, MD: NCHS. https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf.

Heisler, E.J. and J.H. Duff. 2018. *Public health and other related provisions in P.L. 115-271, the SUPPORT for Patients and Communities Act*. Washington, DC: Congressional Research Service. https://crsreports.congress.gov/product/pdf/R/R45423.

Hollander, M.A.G., M.P. Jarlenski, J.M. Donohue, et al. 2019. Medical specialty of buprenorphine prescribers for pregnant women with opioid use disorder. *American Journal of Obstetrics & Gynecology* 220, no. 5: 502–503. https://doi.org/10.1016/j.ajog.2019.01.226.

Jarlenski, M.P., E.E. Krans, J.Y. Kim, et al. 2020. Five-year outcomes among Medicaid-enrolled children with in utero opioid exposure. *Health Affairs* 39, no. 2: 247–255. https://doi.org/10.1377/hlthaff.2019.00740.

Johnson, K.E., R. Varghese, B. Feng, et al. 2019. The effects of the Comprehensive Addiction And Recovery Act of 2016 on nurse practitioner and physician assistant buprenorphine prescribing in Medicaid. *Health Affairs Blog*, November 6. https://www.healthaffairs.org/do/10.1377/hblog20191105.242580/full/.

Kaiser Family Foundation (KFF). 2020. Providers and service use. Washington, DC: KFF. https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Ko, J.Y., S.W. Patrick, V.T. Tong, et al. 2016. Incidence of neonatal abstinence syndrome – 28 states, 1999–2013. *Morbidity and Mortality Weekly Report* 65, no. 31: 799–802. https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm.

Kocherlakota, P. 2014. Neonatal abstinence syndrome. *Pediatrics* 134, no. 2: e547–e561. https://pediatrics.aappublications.org/content/134/2/e547.

Kozhimannil, K.B., A.J. Graves, M. Jarlenski, et al. 2017. Non-medical opioid use and sources of opioids among pregnant and non-pregnant reproductive-aged women. *Drug and Alcohol Dependence* 174: 201–208. https://www.sciencedirect.com/science/article/abs/pii/S0376871617300728.

Kozhimannil, K.B., and R. Shlafer. 2014. What the Affordable Care Act means for pregnant inmates. *Health Affairs Blog*, April 4. https://www.healthaffairs.org/do/10.1377/hblog20140404.038266/full/.

Kraft, W., S.C. Adeniyi-Jones, I. Chervoneva, et al. 2017. Buprenorphine for the treatment of the neonatal abstinence syndrome. *New England Journal of Medicine* 376, no. 24: 2341–2348.

Martin, J.A., B.E. Hamilton, M.J.K. Osterman, et al. 2018. Births: Final data for 2017. *National Vital Statistics Reports* 67, no. 8. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf.

Mathematica. 2020. *Inventory of state-level Medicaid policies, programs and initiatives to improve maternity care and outcomes*. Washington, DC: Mathematica. https://www.macpac.gov/publication/inventory-of-state-level-medicaid-policies-programs-and-initiatives-to-improve-maternity-care-and-outcomes/.

McKee, C., S. Somers, S. Artiga, and A. Gates. 2015. *State Medicaid eligibility policies for individuals moving into and out of incarceration*. Washington, DC: Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. Section 1115 waivers for substance use disorder treatment. Washington, DC: MACPAC. https://www.macpac.gov/subtopic/section-1115-waivers-for-substance-use-disorder-treatment.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. *Recovery support services for Medicaid beneficiaries with a substance use disorder*. July 2019 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/07/Recovery-Support-Services-for-Medicaid-Beneficiaries-with-a-Substance-Use-Disorder.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. *Report to Congress: Utilization management of medication-assisted treatment in Medicaid*. October 2019. Washington, DC: MACPAC. https://www.macpac.gov/publication/report-to-congress-utilization-management-of-medication-assisted-treatment-in-medicaid/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019c. *Medicaid coverage of non-emergency medical transportation*. May 2019 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-coverage-of-non-emergency-medical-transportation/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019d. *Report to Congress on oversight of institutions for mental diseases*. December 2019. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/Report-to-Congress-on-Oversight-of-Institutions-for-Mental-Diseases-December-2019.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018a. Chapter 4: Access to substance use disorder treatment in Medicaid. In *Report to Congress on Medicaid and CHIP*. June 2018. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018b. *State Children's Health Insurance Program (CHIP)*. February 2018 fact sheet. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-childrens-health-insurance-program-chip-fact-sheet/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018c. *Medicaid and the criminal justice system*. July 2018 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018d. *Medicaid's role in housing*. October 2018 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Chapter 2: Medicaid and the opioid epidemic. In *Report to Congress on Medicaid and CHIP*. June 2017. Washington, DC: MACPAC. https://macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 4: Integration of behavioral and physical health services in Medicaid. In *Report to Congress on Medicaid and CHIP*. March 2016. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.

Medicaid and the CHIP Payment and Access Commission (MACPAC). 2015. Chapter 3: The intersection of Medicaid and child welfare. In *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf.

Mee-Lee, D., G.D. Shulman, M.J. Fishman, et al., eds. 2013. *The ASAM Criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions*. Third edition. Carson City, NV: The Change Companies. https://www.asam.org/resources/the-ASAM-criteria/text.

MO Healthnet Division (MO Healthnet), Department of Social Services (DSS), State of Missouri. 2020. Section 1115 of the Social Security Act Medicaid: Missouri targeted benefits for pregnant women. Demonstration waiver request. Jefferson City, MO: DSS. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=53959.

Moore, J.E., B.T. Bateman, and S.W. Patrick. 2018. Opioid crisis in Medicaid: Saving mothers and babies. *Health Affairs Blog*, May 1. https://www.healthaffairs.org/do/10.1377/hblog20180426.63403/full/.

National Association of Community Health Centers (NACHC). 2020. *Community health center chartbook 2020*. Washington, DC: NACHC. https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf.

National Association of State Alcohol and Drug Abuse Directors (NASADAD). 2019. *Substance abuse prevention and treatment (SAPT) block grant*. Washington, DC: NASADAD. https://nasadad.org/wp-content/uploads/2019/03/SAPT-Block-Grant-Fact-Sheet-March-2019.pdf.

National Drug Court Resource Center (NDCRC), University of North Carolina Wilmington (UNC-W). 2020. What are drug courts? Wilmington, NC: UNC-W. https://ndcrc.org/what-are-drug-courts-2/.

National Institute on Drug Abuse (NIDA). 2018. How is opioid use disorder treated in the criminal justice system? In *Medications to treat opioid use disorder*. Bethesda, MD: NIDA. https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/how-opioid-use-disorder-treated-in-criminal-justice-system.

Normile, B., and C. Hanlon. 2018. WV Medicaid covers an innovative and less costly treatment model for opioid-affected infants. *National Academy for State Health Policy Blog*, February 27. https://nashp.org/wv-medicaid-covers-an-innovative-and-less-costly-treatment-model-for-opioid-affected-infants/.

Normile, B., C. Hanlon, and H. Eichner. 2018. *State options for promoting recovery among pregnant and parenting women with opioid or substance use disorder*. Washington, DC: National Academy for State Health Policy. https://nashp.org/wp-content/uploads/2018/10/NOSLO-Opioids-and-Women-Final.pdf.

Patrick, S.W. 2020a. Access to treatment for pregnant women with a substance use disorder and infants with neonatal abstinence syndrome. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2020, Washington, DC. https://www.macpac.gov/public_meeting/january-2020-macpac-public-meeting/.

Patrick, S.W. 2020b. Improving outcomes for families affected by the opioid crisis. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2020, Washington, DC. https://www.macpac.gov/publication/access-to-treatment-for-pregnant-women-with-a-substance-use-disorder-and-infants-with-neonatal-abstinence-syndrome/.

Patrick, S.W., J.F. Burke, T.J. Biel, et al. 2015. Risk of hospital readmission among infants with neonatal abstinence syndrome. *Hospital Pediatrics* 5, no. 10: 513–519. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5110214/.

Perl, L., and M. McCarthy. 2017. *Income eligibility and rent in HUD rental assistance programs: Frequently asked questions*. Washington, DC: Congressional Research Services. https://crsreports.congress.gov/product/pdf/R/R42734.

Regenstein, M., and L. Nolan. 2014. *Implications of the Affordable Care Act's Medicaid expansion on low-income individuals on probation*. Washington, DC: Department of Health Policy, School of Public Health and Health Services, George Washington University. https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1296&context=sphhs_policy_facpubs.

Rosenblatt, R.A., C.H.A Andrilla, M. Catlin, and E.H. Larson. 2015. Geographic and specialty distribution of Us physicians trained to treat opioid use disorder. *Annals of Family Medicine* 13, no. 1: 23–26. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4291261/.

RTI International (RTI). 2019. Analysis for MACPAC of recovery support services.

Sanlorenzo, L.A., A.R. Stark, and S.W. Patrick. 2018. Neonatal abstinence syndrome: An update. *Current Opinion in Pediatrics* 30, no. 2: 182–186.

Schanzenbach, D.W., and M.W. Alexander. 2019. *Food support programs and their impacts on very young children.* March 2019 *Health Affairs* health policy brief. Bethesda, MD: Project Hope. https://www.healthaffairs.org/do/10.1377/hpb20190301.863688/full/.

Sebastiani, G., C. Borrás-Novell, M.A. Casanova, et al. 2018. The effects of alcohol and drugs of abuse on maternal nutritional profile during pregnancy. *Nutrients* 10, no. 1008: 1–17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6116049/pdf/nutrients-10-01008.pdf.

Strahan, A.E., G.P. Guy Jr., M. Bohm, et al. 2019. Neonatal abstinence syndrome incidence and health care costs in the United States, 2016. *JAMA Pediatrics* 174, no. 2: 200–202.

State Health Access Data Assistance Center (SHADAC), University of Minnesota. 2020. Analysis for MACPAC of the National Survey on Drug Use and Health.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2019. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2018, Data on substance abuse treatment facilities.* September 2019. Rockville, MD: SAMHSA. https://wwwdasis.samhsa.gov/dasis2/nssats/NSSATS-2018-R.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2018. *Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants.* January 2018. Rockville, MD: SAMHSA. https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). 2016. *A collaborative approach to the treatment of pregnant women with opioid use disorders.* HHS publication no. (SMA) 16-4978. Rockville, MD: SAMHSA. https://ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA). U.S. Department of Health and Human Services (HHS). 2015. *Comprehensive case management for substance abuse treatment.* Treatment improvement protocol (TIP) Series no. 27. HHS publication no. (SMA) 15-4215. Rockville, MD: SAMHSA. https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2009. *Substance abuse treatment: addressing the specific needs of women.* Treatment improvement protocol (TIP) no. 51. HHS publication no. (SMA) 13-4426. Rockville, MD: SAMHSA. https://store.samhsa.gov/system/files/sma15-4426.pdf.

Sufrin, C., L. Beal, J. Clarke, et al. 2019. Pregnancy outcomes in U.S. prisons, 2016–2017. *American Journal of Public Health* 109, no. 5: 799–805. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2019.305006.

Sundararaman, R. 2009. *The U.S. mental health delivery system infrastructure: A primer.* Washington, DC: Congressional Research Services. https://fas.org/sgp/crs/misc/R40536.pdf.

Thomas, C.P., E. Doyle, P.W. Kreiner, et al. 2017. Prescribing patterns of buprenorphine waivered physicians. *Drug and Alcohol Dependence* 181: 213–218. https://www.ncbi.nlm.nih.gov/pubmed/29096292.

Tolia, V.N., S.W. Patrick, M.M. Bennett, et al. 2015. Increasing incidence of the neonatal abstinence syndrome in U.S. neonatal ICUs. *New England Journal of Medicine* 372, no. 22: 2118–2126. http://www.nejm.org/doi/full/10.1056/NEJMsa1500439#t=article.

U.S. Department of Justice (DOJ). 2020. *Drug courts.* Washington, DC: DOJ. https://www.ncjrs.gov/pdffiles1/nij/238527.pdf.

U.S. Government Accountability Office (GAO). 2017. *Newborn health: Federal action needed to address neonatal abstinence syndrome.* Report no. GAO-18-32. Washington, DC: GAO. https://www.gao.gov/assets/690/687580.pdf.

U.S. Government Accountability Office (GAO). 2014. Letter from Carolyn L. Yocum to the Honorable Fred Upton and the Honorable Joseph Pitts regarding "Medicaid: Information on inmate eligibility and federal costs for allowable services." September 5, 2014. http://gao.gov/assets/670/665552.pdf.

Varghese, R., K. Johnson, B. Feng, et al. 2019. *Buprenorphine prescribing by nurse practitioners, physician assistants, and physicians after CARA 2016*. MACPAC Contractor report no. MACP18409T3. Washington, DC: MACPAC. https://www.macpac.gov/publication/buprenorphine-prescribing-by-nurse-practitioners-physician-assistants-and-physicians-after-cara-2016/.

Wagner, J., and A. Huguelet. 2016. *Opportunities for states to coordinate Medicaid and SNAP renewals*. Washington, DC: Center on Budget and Policy Priorities. https://www.cbpp.org/research/health/opportunities-for-states-to-coordinate-medicaid-and-snap-renewals.

Winkelman, T.N.A., N. Villapiano, K.B. Kozhimannil, et al. 2018. Incidence and costs of neonatal abstinence syndrome among infants with Medicaid: 2004–2014. *Pediatrics* 141, no. 4: e20173520. https://pediatrics.aappublications.org/content/141/4/e20173520.

APPENDIX 6A: Medicaid Coverage of Services for Substance Use Disorder

TABLE 6A-1. Number of States Offering Medicaid Coverage of Substance Use Disorder Treatment, Recovery Support Services, and Case Management, 2018

Service description	States with Medicaid coverage
Clinical services	
Early intervention services. Assessment and education for at-risk individuals who do not meet diagnostic criteria for SUD.	44
Outpatient services. Fewer than nine hours of service per week for recovery or motivational enhancement therapies or strategies.	50
Intensive outpatient services. Nine or more hours of service per week to treat multidimensional instability.	44
Partial hospitalization. Twenty or more hours of service per week for multidimensional instability not requiring 24-hour care.	33
Clinically managed low-intensity residential services. Twenty-four-hour structure with available trained personnel; at least five hours of clinical service per week or as step-down from more intensive care.	27
Clinically managed population-specific high-intensity residential services. Twenty-four-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community.	22
Clinically managed high-intensity residential services. Twenty-four-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.	34
Medically monitored intensive inpatient services. Twenty-four-hour nursing care with physician availability for significant problems in acute intoxication, withdrawal potential, or both; biomedical conditions and complications; above symptoms may or may not be accompanied by emotional, behavioral, or cognitive conditions and complications. Counselor availability 16 hours per day.	29
Medically managed intensive inpatient services. Twenty-four-hour nursing care and daily physician care for severe, unstable problems in acute intoxication, withdrawal potential, or both; biomedical conditions and complications; above symptoms may or may not be accompanied by emotional, behavioral, or cognitive conditions and complications. Counseling available to engage patient in treatment.	44

TABLE 6A-1. (continued)

Service description	States with Medicaid coverage
Medications to treat opioid use disorder	
Methadone, oral formulation. An opioid agonist that binds to and activates the brain's opioid receptors to treat opioid use disorder. It suppresses withdrawal symptoms, controls opioid cravings, and blunts or blocks euphoric effects of opioids. Methadone may only be dispensed in oral form, in accordance with federal opioid treatment program standards.	42
Buprenorphine. A partial opioid agonist that binds to and activates the brain's opioid receptors. It reduces withdrawal symptoms and cravings and blunts or blocks euphoric effects of other opioids. It comes in oral, injectable, and implantable formulations. Oral formulations commonly include naloxone, a drug that is used to reverse opioid overdose.	
Oral formulations of buprenorphine, including buprenorphine-naloxone	50
Implantable buprenorphine	37
Injectable buprenorphine	33
Naltrexone, oral and injectable formulations. An opioid antagonist that binds to opioid receptors but does not activate them. It is used to prevent relapses and comes in an oral formulation and an extended-release injectable formulation.	51
Recovery support services	
Comprehensive community supports. Services that address barriers that impede the development of skills necessary for independent functioning in the community.	29
Peer support services. Supportive services delivered by a person in recovery from SUD.	38
Skills training and development. Services that help a beneficiary with SUD acquire new skills, ranging from life skills to employment readiness and restoration to the community.	15
Supported employment. Helps individuals achieve competitive employment in community settings.	13
Supportive housing. Evidenced-based intervention that combines housing assistance with wrap-around support services for people experiencing homelessness, as well as other people with disabilities.	4
Case management services	
Recovery management. Case management or checkups to assess where an individual is in the recovery cycle and what additional recovery support services may be necessary.	10
Transitional case management. Care management services for a patient following a discharge from a hospital, or facility-based care.	17
Targeted case management. Case management services that assist individuals in gaining access to needed medical, social, educational, and other services.	41

Notes: SUD is substance use disorder. For the purposes of this table, the District of Columbia is counted as a state, for a maximum total of 51.

Sources: MACPAC 2019a, 2019b, 2018a.

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 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. Previously, she 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.

Charles Milligan, JD, MPH (Vice Chair), is an independent consultant. Previously, he was the national dual eligible special needs plans executive director for UnitedHealthcare Community & State and, prior to that, chief executive officer (CEO) of UnitedHealthcare's Community Plan in New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories. Mr. Milligan is a former state Medicaid and CHIP director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland at Baltimore County, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley, and his law degree from Harvard Law School.

Thomas Barker, JD, is a partner at Foley Hoag, LLP, where he specializes in Medicaid and Medicare regulatory, coverage, and reimbursement issues and is a member of the executive committee. He also has a pro bono law practice focusing on health care issues facing immigrants. Previously, he held numerous positions within the U.S. Department of Health and Human Services (HHS), including acting general counsel, counselor to the Secretary of HHS, chief legal officer for CMS, and senior health policy counselor to the administrator of CMS. Mr. Barker received his law degree from Suffolk University 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 the policy, program administration, and quality of Medicaid and CHIP coverage for children and families. Prior to 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.

Brian Burwell is vice president, healthcare policy and research, at Ventech Solutions, where his work includes research, consulting services, policy analysis, and technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. Previously, Mr. Burwell was a senior executive in the government health and human services unit at Watson Health in Cambridge, Massachusetts. He received his bachelor of arts degree from Dartmouth College.

Martha Carter, DHSc, MBA, APRN, CNM, is an independent consultant. She is the founder and former CEO of FamilyCare Health Centers, a community health center that serves four counties in south-central West Virginia. Dr. Carter practiced as a certified nurse-midwife in Kentucky, Ohio, and West Virginia for 20 years and is a member of the West Virginia Alliance for Creative Health Solutions, a practice-led research and advocacy network.

Dr. Carter was a Robert Wood Johnson Foundation Executive Nurse Fellow in 2005–2008 and received the Robert Wood Johnson Foundation Community Health Leader award in 1999. She holds a doctorate of health sciences from A.T. Still University in Mesa, Arizona, and a master of business administration from West Virginia University in Morgantown, West Virginia.

Frederick Cerise, MD, MPH, is president and CEO of Parkland Health and Hospital System, a large public safety-net health system in Dallas, Texas. Previously, he oversaw Medicaid and other programs for the state of Louisiana as secretary of the Department of Health and Hospitals. Dr. Cerise also held the position of medical director and other leadership roles at various health care facilities operated by Louisiana State University. He began his career as an internal medicine physician and spent 13 years treating patients and teaching medical students in Louisiana's public hospital system. Dr. Cerise received his degree in medicine from Louisiana State University and his master of public health from Harvard University.

Kisha Davis, MD, MPH, is regional medical director for Aledade. Previously, Dr. Davis was Maryland medical director for VaxCare Corporation; worked as a family physician at CHI Health Care in Rockville, Maryland; and served as program manager at CFAR in Philadelphia, Pennsylvania, where she supported projects for family physicians focused on payment reform and practice transformation to promote health system change. Dr. Davis has also served as the medical director and director of community health at CHI and as a family physician at a federally qualified health center (FQHC) in Maryland. As a White House Fellow at the U.S. Department of Agriculture, she established relationships among leaders of FQHCs and the Women, Infants, and Children nutrition program. Dr. Davis received her degree in medicine from the University of Connecticut and her master of public health from Johns Hopkins University.

Toby Douglas, MPP, MPH, is senior vice president, national Medicaid, at Kaiser Permanente. Previously,

Mr. Douglas was senior vice president for Medicaid solutions at Centene Corporation, and prior to that, a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He served as director of the California Department of Health Care Services and was director of California Medicaid for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a CHIP director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

Leanna George is the parent of a teenager with a disability who is covered under Medicaid and a child covered under CHIP. A resident of Benson, North Carolina, Ms. George is the chair of the North Carolina Council on Educational Services for Exceptional Children, a special education advisory council for the state board of education. She also serves as the secretary of the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

Darin Gordon is president and CEO of Gordon & Associates in Nashville, Tennessee, where he provides health care-related consulting services to a wide range of public- and private-sector clients. Previously, he was director of Medicaid and CHIP in Tennessee for 10 years, where he oversaw various program improvements, including the implementation of a statewide value-based purchasing program. During this time, he served as president and vice president of the National Association of Medicaid Directors for a total of four years. Before becoming director of Medicaid and CHIP, he was the chief financial officer and director of managed care programs for Tennessee's Medicaid program. Mr. Gordon received his bachelor of science degree from Middle Tennessee State University.

Christopher Gorton, MD, MHSA, was formerly president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire, as well as CEO of a regional health plan that was acquired by the Inova Health System of Falls Church, Virginia. Other positions held include vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver Spring, Maryland. After beginning his career as a practicing pediatrician in FQHCs in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

Stacey Lampkin, FSA, MAAA, MPA, is an actuary and principal with Mercer Government Human Services Consulting, where she has led actuarial work for several state Medicaid programs. She previously served as an actuary and assistant deputy secretary for Medicaid finance and analytics at Florida's Agency for Health Care Administration and as an actuary at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's uninsured work group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow of the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

Sheldon Retchin, MD, MSPH, is professor of medicine and public health at The Ohio State University in Columbus, Ohio. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2015 until 2017, he was executive vice president for health sciences and CEO of the Wexner Medical Center. From 2003 until 2015, he

served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization, Virginia Premier, with approximately 200,000 covered lives. Dr. Retchin received his medical and public health degrees from The University of North Carolina at Chapel Hill, where he was also a Robert Wood Johnson Clinical Scholar.

William Scanlon, PhD, is an independent consultant, working with West Health among others. He began conducting health services research on the Medicaid and Medicare programs in 1975, with a focus on such issues as the provision and financing of long-term care services and provider payment policies. He previously held positions at Georgetown University and the Urban Institute, was managing director of health care issues at the U.S. Government Accountability Office, and served on the Medicare Payment Advisory Commission. Dr. Scanlon received his doctorate in economics from the University of Wisconsin, Madison.

Peter Szilagyi, MD, MPH, is professor of pediatrics, executive vice chair, and vice chair for research in the Department of Pediatrics at the Mattel Children's Hospital at the University of California, Los Angeles (UCLA). Prior to joining UCLA, he served as chief of the division of general pediatrics and professor of pediatrics at the University of Rochester and as associate director of the Center for Community Health within the University of Rochester's Clinical Translational Research Institute. His research has addressed CHIP and child health insurance, access to care, quality of care, and health outcomes, including the delivery of primary care with a focus on immunization delivery, health care financing, and children with chronic disease. From 1986 to 2014, he served as chairman of the board of the Monroe Plan for Medical Care, a large Medicaid and CHIP managed care plan in upstate New York. He is editor-in-chief of *Academic Pediatrics* and has served as the president of the Academic Pediatric Association. Dr. Szilagyi received his medical and public health degrees from the University of Rochester.

Katherine Weno, DDS, JD, is an independent public health consultant. Previously, she held positions at the Centers for Disease Control and Prevention, including senior advisor 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 Shoenebaum 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

Kirstin Blom, MIPA, is the contracting officer and a principal analyst. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service. Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison.

James Boissonnault, MA, is the chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

Kacey Buderi, MPA, is a senior analyst. Prior to joining MACPAC, she worked in the Center for Congressional and Presidential Studies at American University and completed internships in the office of U.S. Senator Ed Markey and at the U.S. Department of Health and Human Services (HHS). Ms. Buderi holds a master of public administration and a bachelor of arts in political science, both from American University.

Kathryn Ceja is the director of communications. Previously, she served as lead spokesperson for Medicare issues in the Centers for Medicare & Medicaid Services (CMS) press office. Prior to her tenure in the press office, Ms. Ceja was a speechwriter for the Secretary of HHS as well as the speechwriter for a series of CMS administrators.

Ms. Ceja holds a bachelor of arts in international studies from American University.

Moira Forbes, MBA, is a policy director focusing on payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and the State Children's Health Insurance Program (CHIP). Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes was elected to the National Academy of Social Insurance in 2019. She has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

Martha Heberlein, MA, is a principal analyst. Prior to joining MACPAC, she was the research manager at the Georgetown University Center for Children and Families, where she oversaw a national survey on Medicaid and CHIP eligibility, enrollment, and renewal procedures. Ms. Heberlein holds a master of arts in public policy with a concentration in philosophy and social policy from The George Washington University and a bachelor of science in psychology from James Madison University.

Kayla Holgash, MPH, is an analyst focusing on payment policy. Prior to joining MACPAC, Ms. Holgash worked as a senior research assistant in the Department of Health Policy and Management at The George Washington University and as a health policy legislative intern for U.S. Senator Charles Grassley. Before that, she served as the executive manager of the Health and Wellness Network for the Homewood Children's Village, a non-profit organization in Pittsburgh, Pennsylvania. Ms. Holgash holds a master of public health from The George Washington University and a bachelor of science in public and community health from the University of Maryland.

Tamara Huson, MSPH, is an analyst. Prior to joining MACPAC, she worked as a research assistant in the Department of Health Policy and Management at The University of North Carolina. She also worked for the American Cancer Society and completed internships with the North Carolina General Assembly and the Foundation for Health Leadership and Innovation. Ms. Huson holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of arts in biology and global studies from Lehigh University.

Joanne Jee, MPH, is the congressional liaison and a principal analyst focusing on CHIP and children's coverage. Prior to joining MACPAC, she was a program director at the National Academy for State Health Policy, where she focused on children's coverage issues. Ms. Jee also has been a senior analyst at GAO, a program manager at The Lewin Group, and a legislative analyst in the HHS Office of Legislation. Ms. Jee has a master of public health from the University of California, Los Angeles, and a bachelor of science in human development from the University of California, Davis.

Allissa Jones, MTA, is the executive assistant. Prior to joining MACPAC, Ms. Jones worked as an intern for Kaiser Permanente, where she helped coordinate health and wellness events in the Washington, DC area. Ms. Jones holds a master of tourism administration from The George Washington University and a bachelor of science with a concentration in health management from Howard University.

Kate Kirchgraber, MA, is a policy director. Prior to joining MACPAC, she led the private health insurance and Medicaid and CHIP teams at the CMS Office of Legislation. She has held health policy and budget analysis positions on the federal and state levels, including with the U.S. Senate Committee on Finance, the federal Office of Management and Budget (OMB), and the New York State Assembly Ways and Means Committee. She also has worked as a private consultant on Medicaid, health coverage, and financing issues. Ms. Kirchgraber has a master of arts in teaching

from the State University of New York at Albany and a bachelor of arts in economics and history from Fordham University.

Erin McMullen, MPP, is a principal analyst. Prior to joining MACPAC, she served as the chief of staff in the Office of Health Care Financing at the Maryland Department of Health. Ms. McMullen also has been a senior policy advisor in the Office of Behavioral Health and Disabilities at the Maryland Department of Health and a legislative policy analyst for the Maryland General Assembly's Department of Legislative Services. Ms. McMullen holds a master of public policy from American University and a bachelor's degree in economics and social sciences from Towson University.

Jerry Mi is a research assistant. Prior to joining MACPAC, Mr. Mi interned for the U.S. House of Representatives Committee on Energy and Commerce, the Health Resources and Services Administration, the Food and Drug Administration, and the National Institutes of Health. Mr. Mi recently graduated from the University of Maryland with an undergraduate degree in biological sciences.

Breshay Moore is the communications specialist. Prior to joining MACPAC, Ms. Moore worked as a communications intern for Better Markets, a non-profit organization in Washington, DC, where she supported press engagement and updated media databases. She also was a junior transcriber at Verb8tm Captioning & Transcription Software and Services, Inc., where she translated audio for company partners and clients. Ms. Moore graduated from Towson University with a bachelor of science in mass communications.

Robert Nelb, MPH, is a principal analyst focusing on issues related to Medicaid payment and delivery system reform. Prior to joining MACPAC, he served as a health insurance specialist at CMS, leading projects related to CHIP and Medicaid Section 1115 demonstrations. Mr. Nelb has a master of public health and a bachelor's degree in ethics, politics, and economics from Yale University.

MACPAC

Kevin Ochieng is an IT specialist. Before joining MACPAC, Mr. Ochieng was a systems analyst and desk-side support specialist at American Institutes for Research, and prior to that, an IT consultant at Robert Half Technology, where he focused on IT system administration, user support, network support, and PC deployment. Previously, he served as an academic program specialist at the University of Maryland University College. Mr. Ochieng has a bachelor of science in computer science and mathematics from Washington Adventist University.

Chris Park, MS, is a principal analyst. He focuses on issues related to managed care payment and Medicaid drug policy and has lead responsibility for MACStats. Prior to joining MACPAC, he was a senior consultant at The Lewin Group, where he provided quantitative analysis and technical assistance on Medicaid policy issues, including managed care capitation rate setting, pharmacy reimbursement, and cost-containment initiatives. Mr. Park holds a master of science in health policy and management from the Harvard School of Public Health and a bachelor of science in chemistry from the University of Virginia.

Aaron Pervin, MPH, is a senior analyst. Prior to joining MACPAC, Mr. Pervin worked for Results for Development, an international consulting firm that advises foreign governments on health finance and provider payment issues related to insurance coverage for low-income and vulnerable populations. Earlier, Mr. Pervin worked for the Commonwealth of Massachusetts at the Health Policy Commission, where his work focused on alternative payment arrangements and delivery system reform. Mr. Pervin holds a master of public health from Harvard University and a bachelor of arts in political science from Reed College.

Ken Pezzella, CGFM, is the chief financial officer. He has more than 20 years of federal financial management and accounting experience in both the public and private sectors. Mr. Pezzella also has broad operations and business experience, and is a proud veteran of the U.S. Coast Guard. He holds a bachelor of science in accounting from

Strayer University and is a certified government financial manager.

Kimberley Pringle is the administrative assistant. Prior to joining MACPAC, she was the executive assistant to the executive director of the NOVA Foundation for Northern Virginia Community College in Annandale, Virginia. Ms. Pringle attended Atlantic Community College where she received a certificate in computer technology.

Brian Robinson is a financial analyst. Prior to joining MACPAC, he worked as a business intern at the Joint Global Climate Change Research Institute, a partnership between the University of Maryland and Pacific Northwest National Laboratory. Mr. Robinson holds a bachelor of science in accounting from the University of Maryland.

Anne L. Schwartz, PhD, is the executive director. She previously served as deputy editor at *Health Affairs*; vice president at Grantmakers In Health, a national organization providing strategic advice and educational programs for foundations and corporate giving programs working on health issues; and special assistant to the executive director and senior analyst at the Physician Payment Review Commission, a precursor to the Medicare Payment Advisory Commission. Earlier, she held positions on committee and personal staff for the U.S. House of Representatives. Dr. Schwartz earned a doctorate in health policy from the School of Hygiene and Public Health at Johns Hopkins University.

Kristal Vardaman, PhD, MSPH, is a principal analyst focusing on long-term services and supports and on high-cost, high-need populations. Previously, she was a senior analyst at GAO and a consultant at Avalere Health. Dr. Vardaman earned a doctorate in public policy and administration from The George Washington University. She also holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of science from the University of Michigan.

Ricardo Villeta, MBA, is the deputy director of operations, finance, and management with overall responsibility for operations related to financial management and budget, procurement, human resources, and IT. Previously, he was the senior vice president and chief management officer for the Academy for Educational Development, a private non-profit educational organization that provides training, education, and technical assistance throughout the United States and in more than 50 countries. Mr. Villeta holds a master of business administration from The George Washington University and a bachelor of science from Georgetown University.

John Wedeles, DrPH, is a principal analyst. Prior to joining MACPAC, Dr. Wedeles served as associate director of the division of analytics and policy research for the District of Columbia Department of Health Care Finance (DHCF), where he directed research activities to support policy and budget development for the District of Columbia's Medicaid agency. Previously, Dr. Wedeles served as a data analyst for DHCF, a researcher for Westat, and program manager for the Manhattan Tobacco Cessation Program at New York University. Dr. Wedeles holds a doctor of public health in health behavior from the Milken Institute School of Public Health at The George Washington University and a master of public health policy from the Mailman School of Public Health at Columbia University.

Eileen Wilkie is the administrative officer and is responsible for coordinating human resources, office maintenance, travel, and Commission meetings. Previously, she held similar roles at National Public Radio and the National Endowment for Democracy. Ms. Wilkie has a bachelor's degree in political science from the University of Notre Dame.

Anna Williams, MPP, is an analyst. A presidential management fellow on rotation at MACPAC, Ms. Williams is based at the CMS Medicare-Medicaid Coordination Office where her work focuses on Financial Alignment Initiative demonstration programs. Ms. Williams holds a master of public policy from American University and a bachelor of arts in economics and Hispanic studies from the College of St. Benedict.

Amy Zettle, MPP, is a senior analyst. Prior to joining MACPAC, Ms. Zettle served as the legislative director for the Health and Human Services Committee at the National Governors Association. Ms. Zettle has been a federal affairs director at Cigna and a health care analyst at the Potomac Research Group. Ms. Zettle holds a master of public policy from the University of Maryland and a bachelor of arts in economics from John Carroll University.