Medicaid Priorities in a Post-Election Environment

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NAMD
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Disclosures

- Disclosure for Jack Rollins
- I have no actual or potential conflict of interest in relation to this presentation.

National Association of Medicaid Directors (NAMD): Who are we?

- Created in 2011 to support the 56 state and territorial Medicaid Directors
- Standalone, bipartisan, & nonprofit
- Core functions include:
  - Developing consensus on critical issues and leverage Directors' influence with respect to national policy debates;
  - Facilitating dialogue and peer to peer learning amongst the members; and
  - Providing effective practices and technical assistance tailored to individual members and the challenges they face.

The Agenda

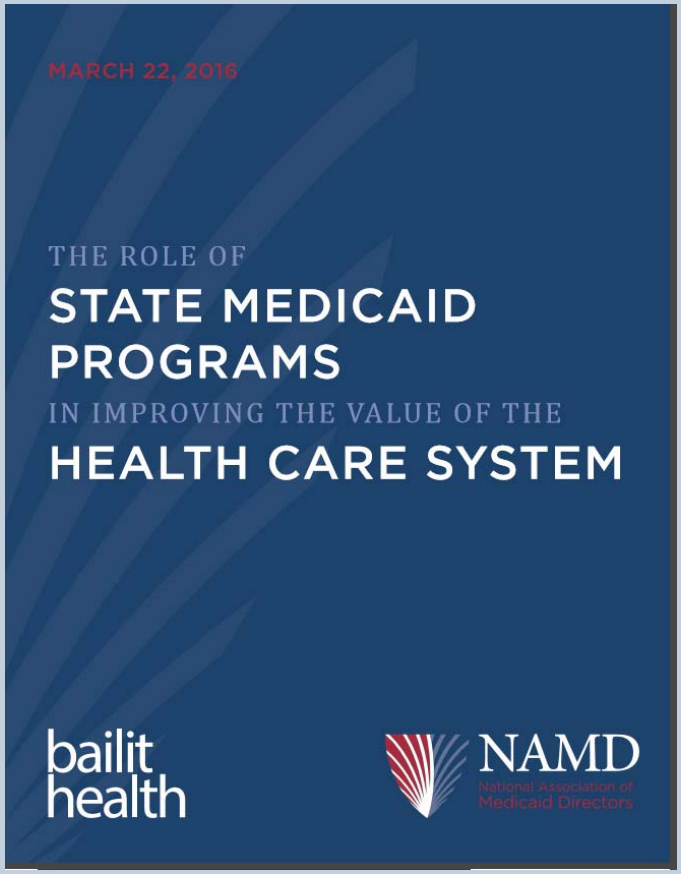
- Key Medicaid Director Priorities
  - Delivery system reform and value-based purchasing (VBP)
  - MACRA and federal VBP vision
  - Managed care
  - Access monitoring
  - Opioids
- Priorities for Congress
  - Medical innovation
  - Drug pricing
  - MDRP oversight and manufacturers “gaming the system”
  - Opioids

The Focus on Reform

- NAMD's latest Operations Survey data shows Medicaid Directors reorienting agency focuses towards:
  - Delivery system and payment reform
  - Behavioral health/SUD
    - Including a focus on the opioid epidemic
  - Systems/IT
- Delivery system reform is an enduring priority across the years

Landscape of Value-Based Purchasing: NAMD Report

- NAMD/Bailit Health report conducted with support from Commonwealth Fund
- Examines Medicaid value-based purchasing through alternative payment models
  - Looks “under the hood” at provider payment
  - Mixed methods approach
  - Findings from 34 states and 5 MCOs
  - Considers behavioral health in these alternative payment models
- Find the report on NAMD’s website



Landscape of Value-Based Purchasing

Findings:

- Broad payment reform happening nationally
- How models are being implemented varies by state
- Being implemented through MCOs in a variety of ways and through direct contracting with providers
- Initial focus typically in acute care; some states beginning to focus on long term care
- SIM, DSRIP states generally farther down path of payment reform

Most Common Alternative Payment Models

- **Additional Payments to Providers in Support of Delivery System Reform**
  - PMPMs on top of FFS payments for care management or to fund practice transformation
  - Typically used to support PCMH and/or Health Homes
- **Episode-based Payments**
  - Provider accountability for a defined and discrete set of services over limited time
  - Focused on identifying and improving clinical pathways
- **Population-based Payments**
  - Providers take on responsibility for a comprehensive set of services for a patient population and have potential to share in savings/risk based on actual costs and quality performance

Most Common Alternative Payment Models

Additional Payment in Support of Delivery System Reform

12

Currently Implemented

We expect many more states to have implemented this model but did not report it in our survey

Episode-Based Payment

3

Currently Implemented

4 more states are in the process of or considering implementation

Population-Based Payment

9

Currently Implemented

2 states are making significant changes or expanding their population-based payment model

Behavioral Healthcare in Alternative Payment Models

Additional Payments in Support of Delivery System Reform

- PCMH for those with SPMI or SUD
- *Examples:* Maine and Vermont

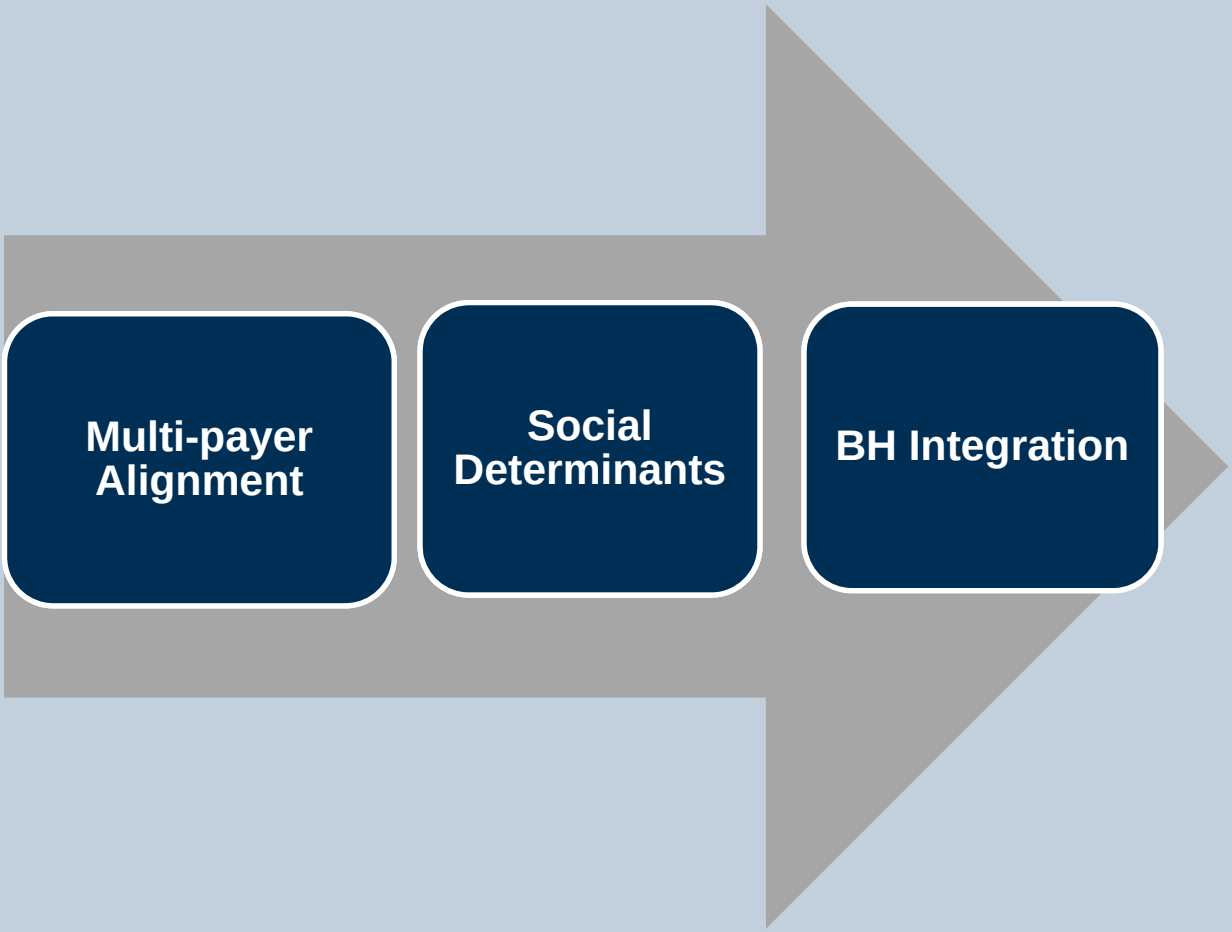
Episode-based Payment

- Specific episodes focused on BH conditions
- *Examples:* Arkansas, Tennessee and New York

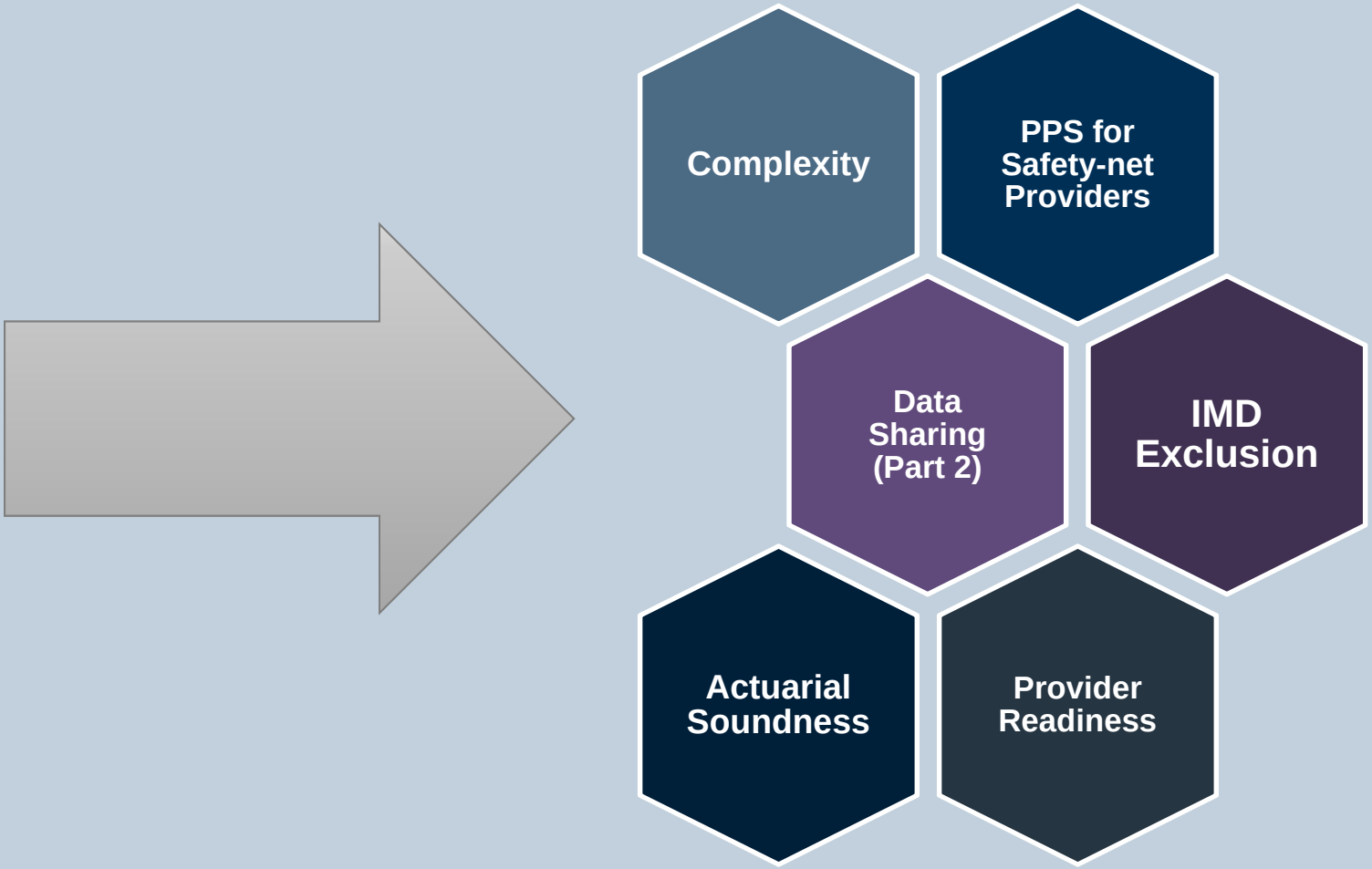
Population-based Payments

- Spending targets may include costs for certain BH services
- Payment may be focused on level of BH integration
- Models often include quality measures focused on BH
- *Examples:* Vermont, Minnesota, and Massachusetts

Path Forward in VBP: Opportunities



Path Forward in VBP: Challenges



What About MACRA?

- MACRA Final Rule impacts Medicare physician reimbursements
- Steering towards value with:
  - Merit-based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)
- Multi-payer APMs have implications for Medicaid delivery system reform and VBP efforts
- Key question: will there be alignment?

Medicaid Advanced APMs

- In order to qualify, providers must:
  - Use certified EHR technology (CEHRT);
  - Base payment for covered services on quality measures comparable to those under MIPS. This comparability requirement is met by having quality measures that are evidence-based, reliable, and valid; and
  - Bear more than nominal financial risk or is a Medicaid medical home model comparable to Medical Home Models expanded by CMMI.

Feeling of Medicaid Directors toward these changes…

- Concern that the rule's multi-payer component could set new definitions or frameworks for Medicaid APMs, which could impact efforts that are well underway in state Medicaid programs
- Need for more clarity regarding how MACRA's Advanced APM program intersects with other multi-payer innovations that are being led by CMMI, such as CPC+ and SIM
- Concern that risk requirement might be problematic, given the statutory limitations on applying risk to certain safety-net providers under the prospective payment system
- Concern that the proposed definition of a Medicaid medical homes conflates a delivery model (medical homes) with a payment model

The Managed Care Rule

- Sweeping overhaul of federal Medicaid managed care regulations
- Advances a federal vision of enhanced accountability, improved quality of care, and a positive beneficiary experience

Implications for Medicaid Program

- **Supplemental Payments**
  - Strengthens existing policy that prohibit states from directing managed care plans' expenditures under the contract. The regulations also provide exceptions ("safe harbors") to this general rule:
    - Participation in a value-based purchasing initiative;
    - Participation in a Medicaid-specific or multi-payer delivery system reform or performance improvement initiative; and/or
    - Adoption of a minimum and/or maximum fee schedule, or a uniform dollar or percentage rate increase, for providers providing a particular service under the contract.
  - Provides a 10-year transition period for hospitals, subject to certain limitations on the maximum amount of pass-through payments permitted; and
  - Provides a 5-year transition period for pass-through payments to physicians and nursing facilities.

Implications for Medicaid Program (cont'd)

- **Institutions of Mental Disease (IMDs)**
  - Permits the state to make a monthly capitation payment to the managed care plan for an enrollee, aged 21-64, that has a short term stay in an Institution of Mental Disease (IMD)
    - No more than 15 days within the month
  - Before the rule, CMS prohibited federal Medicaid reimbursement in IMDs, prompting some states to cover care in IMDs as an **"in lieu of service,"** medically appropriate and cost effective alternatives to state plan services or settings. These states will now face administrative and financial challenges to meeting the new regulation.
- **Rate changes**
  - Establishes standards for the documentation and transparency of the rate setting process;
  - Permits rate increases/decreases by 1.5% (overall 3% range);
  - Requires that differences among capitation rates for covered populations be based on valid rate development standards.

Implications for Medicaid Program (cont'd)

- **Quality**
  - Requires that states implement a **quality rating system (QRS)** for Medicaid and CHIP managed care plans for MCOs, PIHPs, and PAHPs over the next 5 years;
  - Extends managed care quality strategy, QAPI, and **external quality review (EQR)** to PAHPs and to PCCM entities whose contracts include financial incentives; and
  - Adds new mandatory EQR activity to validate network adequacy.
- **Program integrity**
  - Requires managed care plans to implement and maintain administrative and managerial procedures to prevent fraud, waste and abuse; and
  - Requires managed care contracts to address treatment of recovered **overpayments** by managed care plans and to take these amounts into account in the rate setting process.

Implications for Medicaid Program (cont'd)

- **Outpatient drugs**
  - Allows same coverage and criteria as **FFS** for the following:
    - Prescription drug coverage under Medicaid MCOs should demonstrate coverage consistent with the amount, duration, and scope as described by Medicaid Fee-For-Service (FFS).
    - MCOs cannot have medically necessary criteria for prescription drugs that are more stringent than Medicaid FFS.
  - Allows plans the flexibility to maintain their own **preferred drug lists (PDLs)** or formularies and apply their own utilization management practices.
    - BUT if the managed care plan's formulary or PDL does not include a covered outpatient drug that is otherwise covered by the state plan, access to the off-formulary covered outpatient drug must be aligned with the prior authorization requirements.
  - Requires that plans ensure that enrollees have **access to pharmacy services;**
  - Requires that plans submit **utilization data** under section 1927(b)(2) of the Act within 45 calendar days after the end of each quarterly rebate period; and
  - Requires that plans provide a response to a **prior authorization** request for a covered outpatient drug by telephone or other telecommunication device within 24 hours of the request.

Access Monitoring Rule

- Published in November 2015, effective January 1, 2016 – applicable to FFS only
- Requires states to develop Access Monitoring Review Plans (AMRPs) for the following service categories:
  - Primary care
  - Specialists
  - Behavioral health
  - Pre- and post-natal obstetrics
  - Home health
- For rate reduction or restructuring SPAs, states must:
  - Conduct access impact analysis
  - Conduct public engagement process and respond to stakeholder concerns
  - Create AMRP to monitor access to impacted provider type for three years

Access Monitoring and Pharmacy

- The outpatient drug rule's AAC provisions trigger access monitoring review if the AAC methodology SPA yields state savings
- In essence, states will need to create AMRPs for pharmacy services
- Develop monitoring mechanisms to track pharmacy utilization post-AAC implementation

The Opioid Epidemic and Medicaid

- Curbing opioid abuse, educating prescribers, improving access to treatment are all key priorities for Medicaid Directors
- Improving oversight and management of the pharmacy benefit a key component of this effort
- States have:
  - Modified PDLs
  - Adjusted quantity limits
  - Ramped up PDMPs
  - And more…

Congressional Outlook

- The lame duck session can still have impact on Medicaid
- 21st Century Cures and other medical innovation legislation is a key priority for Congressional leaders
- Drug pricing conversations remain relevant
- Increased spotlight on MDRP oversight
- Federal responses to opioid epidemic

Spurring Innovation…

- Both the Speaker of the House and the Senate Majority Leader have publicly listed 21st Century Cures as a priority for the remainder of the year
- Legislation aimed at speeding the pace of drug development and approval
- House legislation, in development since 2014, passed 377 – 44 in July 2016
  - Enhances NIH funding
  - Requires new or streamlined FDA approval pathways for breakthrough drugs and devices
- Senate still considering companion legislation

…and Cognizant of Costs

- The pace of drug price increases commands more attention in Congress this year
- Hepatitis C experience prompted Senate Finance Committee investigation
  - Report condemned pricing strategies designed to maximize revenue over access
- Generic drug price inflation dominated headlines and Congressional hearings
- EpiPen pricing controversy the most recent example

A New Wrinkle: MDRP Oversight

- EpiPen pricing controversy also alerted Congress to potential gaps in CMS oversight of MDRP; manufacturer compliance with MDRP
- EpiPen misclassification as generic drug in MDRP, and CMS's inability to force reclassification, spurred Congressional interest
- Focus on identifying limits of current CMS authority to force manufacturer compliance with MDRP
  - Possibility of legislative remedies in this area

The Opioid Epidemic

- **Comprehensive Addiction and Recovery Act (CARA):** Passed into law on July 22, 2016
  - Authorizes/reauthorizes a number of grant programs for states to build infrastructure and provider capacity to address opioid abuse;
  - Exempts abuse deterrent formulations of opioid drugs (ADFs) from the definition of “line extension” for the purpose of calculating Medicaid rebates; and
  - Makes significant changes to federal policies that will increase states’ capacity to provide medication-assisted treatment.
- **Opioid Use Disorder Treatment Expansion and Modernization Act (HR 4981):** Expand the qualifying practitioners to treat opioid addiction with buprenorphine to include NP’s and/or PA’s; raise the maximum number of patients a qualifying practitioner can treat from 100 to 250; allow the HHS Secretary to recommend revoking or suspending Drug Enforcement Administration registration for practitioners who fail to comply; and require reports to Congress on treatment services.

Questions?