STATE-FEDERAL MEDICAID UPDATE

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STATE-FEDERAL AFFAIRS
MEDICAID OVERVIEW:

- CMS and HHS Updates on Payment Reform
- CMS and HHS Updates on Prescription Drug Pricing Reform and Practices
- Congressional Movement
CMS AND HHS UPDATES ON PAYMENT REFORM:
The Center for Medicare and Medicaid Innovation (CMMI) and HHS released new CMS Primary Care Initiatives

- Includes five new, voluntary payment models looking at value-based care, designed to update current Comprehensive Primary and Next Generation Accountable Care Organization (ACO) programs
PRIMARY CARE INITIATIVE:

- New set of payment models used to deliver care for patients while looking at ways to reduce administrative burdens and encourage providers to spend more time with patients

- Five Payment Models:

  - Primary Care First (PCF) and Primary Care First-High Need Populations: will test whether financial risk and performance-based payments that reward primary care practitioners and other clinicians are easy to understand and have actionable outcomes that will reduce Medicare expenditures

  - Will provide payment to practices through simplified total monthly payment as well as an option with higher payments to practices that specialize in care for high need patients including those with chronic conditions
Direct Contracting- Global, Professional and Geographic: These options are focused on primary care allowing providers managing care for Medicare fee-for-service (FFS) beneficiaries.

This model looks to engage primary care practice sites and a wider variety of organizations that have worked with financial risk and serving larger patient populations.

The type of payment models an organization participates in will receive a fixed monthly payment ranging from a portion of expected primary care costs up to the total cost of care.

CMS is aiming to better align care for Medicare and Medicaid dual eligible patients in a Fee-For-Service, offer new participation and payment options to primary care and other related providers.
WHAT IS THE MEDICARE SHARED SAVINGS PROGRAM?

- Office of Inspector General HHS did a study on the Medicare Shared Savings Program, focusing on ACOs and going from fee-for-service to value-based care.

- Offers providers and suppliers like physicians, hospitals and other stakeholders, an opportunity to create an ACO.

- ACO agrees to be held accountable for quality, cost and experience of care of an assigned Medicare fee-for-service (FFS) population.

- The Medicare Shared Savings Program is part of this transition into new payment models and is one of the largest.
OUTCOMES AND STRATEGIES?

- Working to increase cost awareness among ACO physicians
- Engaging patients to improve their own health
- Managing beneficiaries with costly or complex care needs
- Reducing avoidable hospitalizations
- Controlling costs and improving quality in skilled nursing and home healthcare
- Addressing behavioral health needs and social determinants of health
- Using technology to increase information sharing among providers
RECOMMENDATIONS FROM THE REPORT?

- Review the impact of programmatic changes on ACOs’ ability to promote value-based care

- Expand efforts to share information about strategies that reduce spending and improve quality for ACOs and the public

- Adopt outcome-based measures and better align measures across programs

- Assess and share information about ACO’s and their use of the skilled nursing facility 3-day rule waiver and apply to the Share Savings Program and others
RECOMMENDATIONS FROM THE REPORT?

- Identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health

- Identify and share information on strategies that encourage patients to share behavioral health data

- Prioritize ACO referrals of potential fraud, waste and abuse
MEDICAL LOSS RATIO (MLR):

- Issued guidance for Medicaid and Children’s Health Insurance Plan (CHIP) managed care plans in regard to the calculation of a plan’s Medical Loss Ratio (MLR)
- Concern some managed care plans are not accurately reporting pharmacy benefit spread pricing when calculating and reporting MLRs
- Under current MLR regulations for Medicaid and CHIP, managed care plans require them to exclude prescription drug rebates from the amount of claims costs that are used to calculate an MLR
PRESCRIPTION DRUG REFORM:
Approval of Washington State Plan Amendment (SPA)

Fourth SPA approved, also in Oklahoma, Michigan and Colorado, that will allow states to negotiate a supplemental rebate agreement with value-based purchasing arrangements with drug manufacturers

Under this model, states link payment for prescription drugs to the value delivered and are exempt from the Medicaid “Best Price” rule
CMS approval of Louisiana SPA for modified subscription model for Hepatitis C Therapies in Medicaid

One of the more widely known models in the “subscription” “Netflix model” space

Louisiana will be allowed to cap gross expenditures at a fixed amount for hepatitis C drugs, while the state is provided with unlimited access to clinically needed doses for Medicaid beneficiaries
PRESCRIPTION DRUG PRICING & REFORM:

- Earlier this spring CMS approved final changes to Medicare Advantage and Medicare Part D that will increase transparency on the cost of prescription drugs for enrollees.

- HHS finalized a rule that would have required prescription drug ads to disclose list prices if the cost was more than $35 a month, but recently a U.S. District Judge blocked the rule right before it was supposed to go into effect.

- The administration introduced a drug rebate proposal that would have barred PBMs and insurers from accepting rebates from drug companies participating in Medicare and Medicaid, recently pulled proposal due to potential impact to premiums.

- Continued push for international pricing index demonstration for prescription drug costs as well.
CONGRESSIONAL PAYMENT LEGISLATION:
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- H.R. 1354, the Territories Health Equity Act of 2019- Legislation proposes to change territories financing from a block grant to as needed basis

- Medicaid Disproportionate Share Hospital (DSH) Payments and Reductions: ongoing conversations about the ACA’s reduction of these payments that were supposed to happen in FY2014-FY2019 to account for fewer people being uninsured, and back to what states originally received prior to the implementation of the ACA

- There have been several laws amending ACA’s requirement including: eliminating DSH reductions, changing their amounts and extending the reductions through FY2025
The Senate Finance Committee kicked off their year with a marathon of hearings on prescription drug pricing practices and transparency.

Senator Chuck Grassley (R-Iowa) was working with Senate Finance ranking member Ron Wyden (D-Ore.) on prescription drug pricing and transparency legislation, and held several conversations with the Senate leadership, and administration staff.

Senate HELP Committee Chairman Lamar Alexander (R-Tenn.) and ranking member Patty Murray (D-Wash.) held hearings on drug pricing as it relates to overall rising healthcare costs

- Introduced “Lower Health Care Costs Act of 2019”
- Bill has proposed ban on PBMs from charging more for a drug than what they paid for it, and requires PBMs to pass 100 percent of rebates or discounts to the health insurers or employers that hire them
- Also addresses current competition practices prescription drug makers use when introducing new drugs to market
RESOURCES:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
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