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Medicaid News Curator: Volume 2

Reading and highlighting the Medicaid interwebs to save you time

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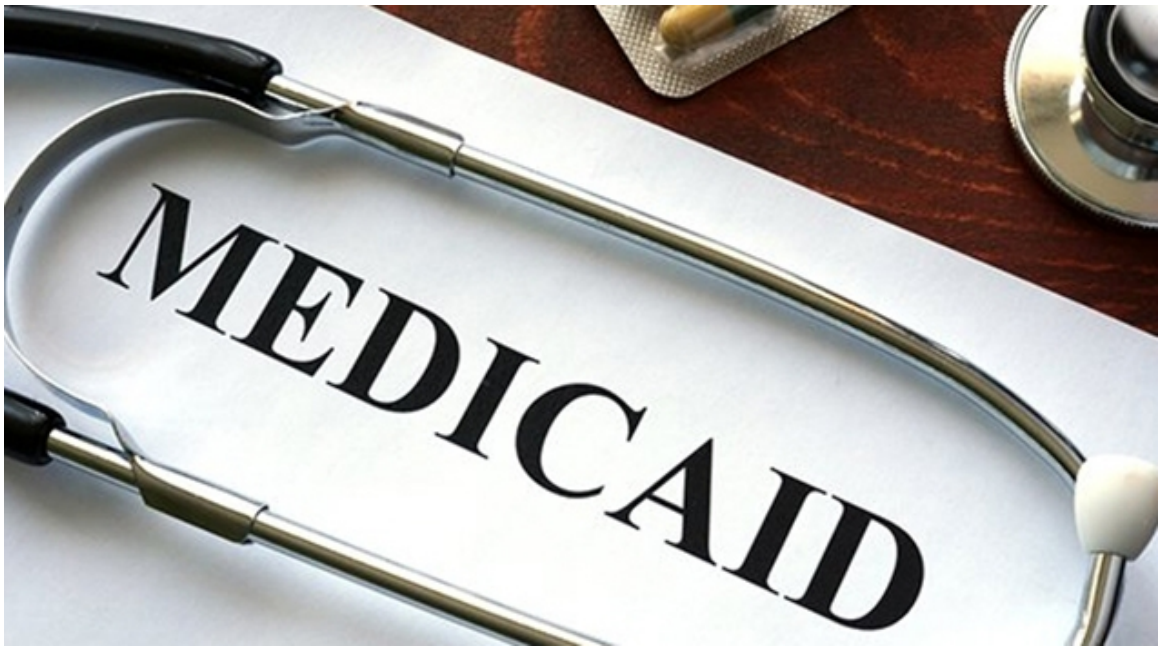
CMS proposes changes to streamline managed Medicaid

Proposed changes include rate range flexibility and adding new delivery models such as telehealth.



The Centers for Medicare and Medicaid Services has proposed regulatory revisions to Medicaid managed care to streamline the program, relieve regulatory burden, support state flexibility and promote transparency, flexibility, and innovation.

The proposed changes address stakeholder concerns from a 2016 final rule. CMS is accepting comment for 60 days.

One issue the agency is not modifying in the rule is a limitation of 15 days length of stay for managed care beneficiaries in an institution for mental health treatment. States said this created administrative challenges.

Instead, the agency is asking states to submit data that could support revisions to this policy.

The key proposed revisions to the 2016 final rule include giving states: greater flexibility on a rate range; a three-year transition period to come into compliance with requirements related to pass-through payments; more flexibility to set meaningful network adequacy standards that take into account new service delivery models such as telehealth; removing outdated administrative requirements; and enabling the use of modern electronic communication.

The rule requires CMS to move more quickly through the federal rate review process and to allow for less documentation.

It maintains the requirement for states to develop a quality rating system for health plans, but gives a greater ability to tailor alternatives.

The rule ensures that differences in reimbursement rates are not linked to enhanced federal match.

WHY THIS MATTERS

Managed care, in which states contract with private health plans to administer Medicaid benefits, is replacing the traditional fee-for-service Medicaid.

THE TREND

In 2016, over two thirds, or 68.1 percent of all Medicaid beneficiaries were enrolled in comprehensive managed care, up from 65.5 percent in 2015. Enrollment reached 54.6 million beneficiaries in 2016.

WHAT ELSE YOU NEED TO KNOW

CMS said it continues to support state flexibility, having approved a total of 15 waivers for states to treat patients with substance use disorder and to expand access to treatment.

ON THE RECORD

"Today's action fulfills one of my earliest commitments to reset and restore the federal-state relationship, while at the same time modernizing the program to deliver better outcomes for the people we serve," said CMS Administrator Seema Verma.

"Targeted improvements to the managed care rule have been a top priority for Medicaid Directors," said Mohr Peterson, board president of the National Association of Medicaid Directors. "NAMD appreciates the partnership shown by CMS to explore these issues and dialogue with the states, providing an opportunity to share perspectives on how the managed care regulatory framework could be improved."

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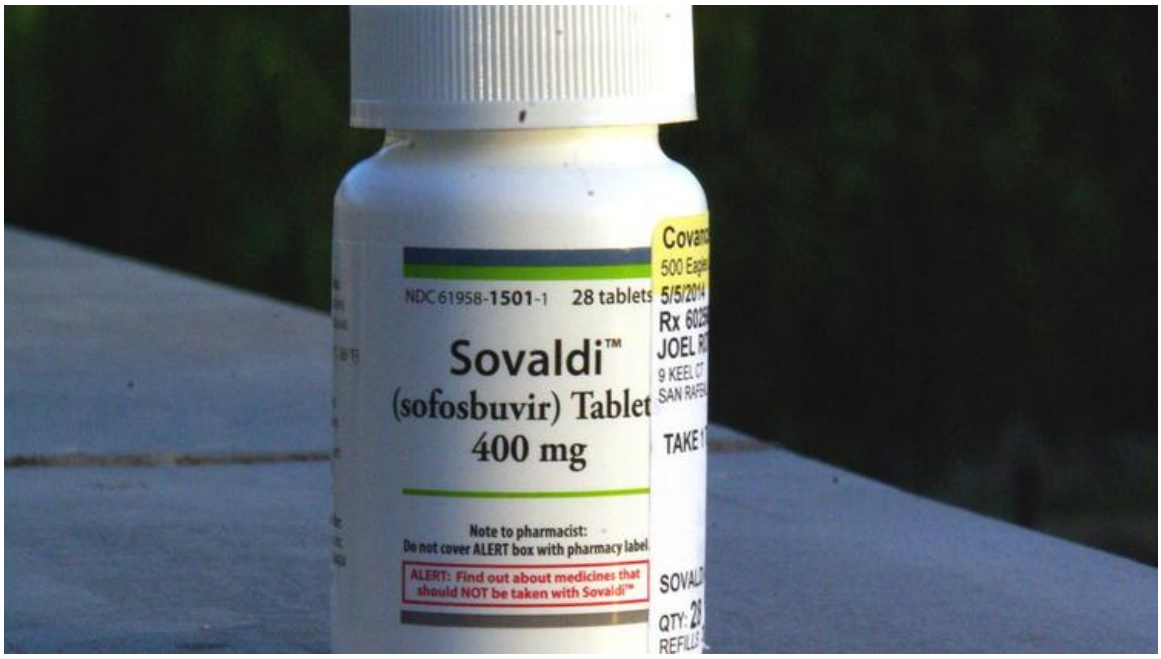
Illinois backs off limits on which Medicaid patients can get costly but lifesaving hepatitis C drugs



Bob Ecker / TNS

Illinois will now allow as many as 7,000 more people on Medicaid with hepatitis C to get medications like Sovaldi that can cure the disease.

Illinois will now allow as many as 7,000 more people on Medicaid with hepatitis C to get medications like Sovaldi that can cure the disease. (Bob Ecker / TNS)

After years of having one of the most restrictive policies in the nation, Illinois will now allow as many as 7,000 more people on Medicaid with hepatitis C to get medications that can cure the disease.

Previously, only the sickest people, who had later stages of liver scarring and could prove their sobriety, got Medicaid coverage for the medications. Medicaid is a state and federally funded health insurance program for the poor, disabled and many elderly people. If left untreated hepatitis C can lead to liver failure, cancer and even death.

Now the state will allow people to get Medicaid coverage for the medications earlier in the disease, before they experience liver damage, and they don't have to prove sobriety, under a recent rule change by the Illinois Department of Healthcare and Family Services.

Activitists had sought to expand Medicaid coverage for the drug for years.

"This is an important change," said Ruth Edwards, director of the HIV program at the Legal Council for Health Justice in Chicago. "Making (the medication) accessible to everybody is a good step on the way to eliminating hepatitis C."

The number of Illinois residents with hepatitis C is on the rise, amid the state's epidemic of opioid addiction, with many of the cases in younger people linked to the use of injectable drugs, according to the Illinois Department of Public Health. The number of new reported cases of hepatitis C in Illinois was 9,838 in 2017 — an increase of 43 percent from 2006.

Hepatitis C can be spread when blood from an infected person enters the body of someone who's not infected, and through sexual contact. It's an especially prominent disease among baby boomers. About three-fourths of those who have it were born between 1945 and 1965. People can have it for years without experiencing symptoms, and about half of people who have it don't know it, according to the state.

The Legal Council group spent more than a year negotiating with the state over expanding coverage of the medications, Edwards said. Last month, the group sent a letter to the head of the Illinois Department of Healthcare and Family Services saying that it planned to sue the department on behalf of Medicaid participants who had been denied access to the medications. Similar lawsuits have resulted in expanded coverage of the drugs in other states.

Department spokesman John Hoffman declined to comment on whether the threat of a lawsuit spurred the state to act. The "policy change offers the potential to contain costs that can occur when hepatitis C is not treated, such as for liver transplants," he said in an email.

In the past, the department resisted expanding coverage to all hepatitis C patients on Medicaid, citing the "state's fiscal restraints."

When the medications, such as Sovaldi and Harvoni, came out several years ago, they had hefty price tags. One medication cost as much as $94,500 for one 12-week treatment regimen. The medications cure the vast majority of those with hepatitis C, without the debilitating side effects of earlier drugs.

But those prices have dropped significantly as more competition has come on the market, and states often get discounts on list prices. Drug company Gilead plans to launch generic versions of two of its hepatitis C medications in January, at a list price of $24,000 for the most common course of therapy.

"The cost barriers that the state had been citing for having such treatment restrictions in place really didn't make sense anymore," said John Peller, president and CEO of the AIDS Foundation of Chicago, which also pushed for the policy change. "Illinois had probably one of the most restrictive policies in place that was denying people, who were still incredibly sick, access to treatment that is really lifesaving and, ultimately, cost-saving."

As of last year, Illinois was among about a dozen states that still restricted coverage of the medications to people with a later stage of liver scarring within their traditional Medicaid programs, according to the National Viral Hepatitis Roundtable and the Center for Health Law and Policy Innovation at Harvard Law School. Insurance companies within the state's Medicaid managed care program have had varying requirements for covering the medications. Most people on Medicaid in Illinois are part of the managed care program, in which private insurers administer Medicaid benefits.

The groups gave the state a grade of D-minus last year for Medicaid access to hepatitis C drugs.

Now, however, Illinois joins a growing number of states that cover the medications within their traditional Medicaid programs regardless of the stage of liver damage. Because of the policy change, all of the state's Medicaid managed

care plans should also now have to cover the medications regardless of the stage of liver damage, Edwards said.

Peter McLoyd, who was cured of hepatitis C in 2016 after taking one of the newer medications, said the changes are long overdue.

While he was living with the disease, McLoyd sustained liver damage and felt weighed down by fatigue. Once he was cured, his energy returned and his quality of life improved dramatically, said McLoyd, who helped advocate for the changes.

McLoyd's medication was covered by health insurance he got through his employer. He works at the Ruth M. Rothstein CORE Center in Chicago, which treats HIV, hepatitis C and other infectious diseases. But he said a person's insurance status shouldn't make a difference when it comes to getting the medications.

"It shouldn't matter whether (someone is) on Medicaid or Medicare or private insurance," McLoyd said. "We should all have the right to the same quality of life and the same cures regardless of our financial situation."

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Medicaid OKs Michigan waiver to negotiate drug prices based on outcomes

By Susannah Luthi | November 14, 2018

Michigan has secured federal approval to negotiate Medicaid drug prices based on how well the medications work for patients, CMS Administrator Seema Verma announced on Wednesday.

This is the agency's second approval of a value-based drug-purchasing proposal by a state Medicaid program. Oklahoma had the first-of-its-kind approval in late June, although the state isn't forecasting that the waiver will save money yet.

The Michigan amendment will give the state authority to leverage additional rebate agreements for "outcomes-based" contracts with manufacturers.

Verma used a speech before the Biopharma Congress in Washington to tie Michigan's effort into the Trump administration's broader strategy to curb drug prices across the board and especially in Medicare Parts B and D.

"I applaud Michigan's proposal," the administrator said, even as she cautioned that value-based payment measures are just a step in the right direction. "As we see innovation in biomedicine, it is incumbent on us to also modernize payment policies."

A congressional advisory panel on Medicaid noted in 2016 that drug spending increases have been higher for Medicaid than for other payers: On average prescription drug spending grew by 12% in 2014 but for Medicaid it was more than 24% as new high-cost specialty drugs to treat hepatitis C and other chronic conditions entered the market.

In total that year, the program spent about $42 billion for medications, for a net expense of $22 billion after collecting approximately $20 billion in rebates according to Medicaid and CHIP Payment and Access Commission analysis.

It's still too early to forecast savings for Oklahoma's parallel state plan amendment, said Nancy Nesser, director of pharmacy for the state's Medicaid program at the Oklahoma Health Care Authority.

So far the state has entered into alternative payment contracts for four drugs: two expensive, long-acting antipsychotics, including Aristada; Orbactiv, a one-time injectible antibiotic for skin infections; and the epilepsy drug Fycompa.

At this time, the program isn't working on additional contracts.

"We're in a holding pattern with it right now to work out how these four contracts work," Nesser said. "They tend to be data-heavy, and it's going to be a big load."

Friso van Reesema, who came from the pharmaceutical industry to work on payer strategies at the healthcare tech company CipherHealth, said in the past decade he has watched manufacturers change from "heavy sales organizations to health economics."

"Pharma is going this way with payers—going into the value of their programs and products," van Reesema said.

For now, Nesser said, it's wait-and-see on how the value ultimately works and in Oklahoma at least they are not projecting savings yet.

"It's too new to even have a valid projection," she said.

In her Wednesday speech, Verma outlined a number of different forms that new payment arrangements—a priority for the administration—could take.

She said they could include "drug payments over time only if the patient achieves certain clinical outcomes; drug payments through a shared-savings approach based on the drug's impact on a patient's total cost of care; and drug payments under a subscription approach, with an upfront fee in exchange for as many doses as clinically necessary."

Earlier in June, the CMS denied a Massachusetts waiver request to give the Medicaid program control over its drug formulary.

Recommended for You

Susannah Luthi

Susannah Luthi

Susannah Luthi covers health policy and politics in Congress for Modern Healthcare. Most recently, Luthi covered health reform and the Affordable Care Act exchanges for Inside Health Policy. She returned to journalism from a stint abroad exporting vanilla in Polynesia. She has a bachelor's degree in Classics and journalism from Hillsdale College in Michigan and a master's in professional writing from the University of Southern California.

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In Michigan, Medicaid can now pay for drugs based on how well they work

CMS Administrator Seema Verma Mandel Ngan/AFP/Getty

WASHINGTON — The Trump administration gave Michigan's Medicaid program permission to pay for drugs based in part on how well the drugs work, Centers for Medicare and Medicaid Services Administrator Seema Verma announced Wednesday.

"Michigan's waiver will empower it to demand results from drug manufacturers in exchange for paying for medicines," Verma said in a speech at an industry conference.

CMS Demonstrations Target Mental Health Services Under Medicaid

CMS recently detailed opportunities for states to design innovative health service delivery systems for individuals with mental health conditions.

Source: CMS

By Chuck Green

November 14, 2018 - Medicaid beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED) are the targets of recent CMS efforts to

improve health outcomes.

In a letter to Medicaid directors across the country, the federal agency highlighted a new opportunity under Section 1115(a) of the Social Security Act authorizing states to pay for treatment services extended to beneficiaries who are short-term residents of psychiatric hospitals or qualified residential treatment settings. States must commit to guaranteeing good quality of care in those settings and upgrading access to community-based services.

In 2016, around 10.4 million adults in the United States has serious mental illness SMI, yet only 65 percent received mental health services. Notably, between 2008 and 2015, this treatment rate remained relatively unchanged.

According to the letter, The Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes "adults with a serious mental illness" as individuals at least 18 years of age currently — or at any time during the past year — who had a diagnosable mental, behavioral, or emotional disorder long enough to meet diagnostic criteria, leading to impaired functions that significantly interfere with or limit at least one major life activity.

Usually, mental health disorders surface during childhood, adolescence, or early in adulthood. Half of those with these disorders experience them by 14 years of age, three-quarters by the age of 24. Furthermore, around 13 percent to 20 percent of children and adolescents living in the US have a mental disorder, while almost half less than 21 who qualify for Medicaid because of a disability experience a behavioral health condition.

Unaddressed treatment needs are high among children and adolescents, with roughly half obtaining mental health services. Meantime, just 41 percent of the 3.1 million adolescents with depression obtained treatment over the past year in 2016.

There was a gap of at least then years between the initial onset of symptoms and start of treatment, previous research yielded. Adults with SMI make up around half of those less than 65 dually eligible for Medicare and Medicaid.

Among younger dual eligibles, individuals with SMI are the most expensive subgroup. On top of that, SMIs are common among incarcerated and homeless adults. Additionally, those with SMI often have co-morbid physical health conditions as well as substance use disorders (SUDs). On average, these individuals pass away eight years younger than the general population. Suicide

— which can be linked with mental disorders — has been on the rise in almost every state. Since 1999, there have been spikes of more than 30 percent in half the states.

Today, CMS grants states the chance to go after similar demonstration projects that hone in on treatment upgrades for SUDs. That includes opioid use disorder. Through these SUD-focused demonstrations, CMS is focused on covering treatment in institutions for mental disease (IMDs) as it improves access across the continuum of care. That includes community-based outpatient services on top of delivering the quality of SUD treatment beneficiaries residing in IMDs receive. As of now, these SUD-focused demonstrations in 17 states have been greenlighted by the CMS. In fact, already there are signs of better beneficiary outcomes.

This SMI-SED demonstration opportunity comes with a host of milestones states are expected to reach as a component of the demonstrations. The goal is to advance on several overarching objectives such as ensuring good quality of care in psychiatric hospitals and residential treatment settings, improving care coordination and transitions to community-based care following stays in acute care settings, and increasing access to a continuum of care including crisis stabilization services and community-based services to address chronic, on-going mental health care needs.

As progress mounts in a state's SMI/SED demonstrations, they are expected to include in their monitoring reports details of their progress toward achieving milestones and when specific actions are expected to be accomplished. Furthermore, information and data will be incorporated into the report to allow CMS to monitor the effectiveness of the demonstrations and the march toward meeting these goals and delivering neutral budgets.

Meantime, CMS will closely assist states as they implement and evaluate demonstrations. The federal agency intends this policy guidance to culminate in new opportunities to partner with states intent on implementing innovative service delivery reforms to drive up the level of care extended to beneficiaries with SMI.

Maine governor says he'd run again if incoming governor doesn't expand Medicaid sustainably

By Megan Keller - 11/14/18 09:02 PM EST 119

© Getty Images

Outgoing Maine Gov. Paul LePage (R) said Tuesday that he would consider running against Janet Mills (D), the governor elect, if she does not implement Medicaid expansion in a financially "sustainable" way.

LePage defined sustainability as Mills leaving the state's budget stabilization fund untouched, The Press Herald reported he told WVOM hosts Ric Tyler and George Hale.

The fund contains about $276 million, while the expansion would likely cost around $200 million, according to LePage.

Instead, the governor suggested Maine should increase its taxes on hospitals, as he suggested earlier this year.

“Listen, I wish her all the success in the world because if she succeeds, Maine succeeds,” LePage said. “And I want her to succeed. I love this state and I want her to be very successful.”

“If she expands Medicaid on Jan. 2, 100 percent of the cost will be borne by the state of Maine," Le Page said, noting that the federal government hasn't approved the state's expansion application.

"If she doesn’t do it sustainably, in four years we will be where we were in 2010 and I will be back to run against her," said LePage, who is 70. "We’re the same age, so we could have a good time."

The paper reports that the governor did not explain his reference to 2010.

He had said previously that he planned to move to Florida for tax purposes if he lost re-election.

Mills' spokesman, Scott Ogden, responded in a statement to the paper Tuesday night.

"Janet won the election with more votes than any governor in Maine history, and she is the first governor since 1966 to be elected to her first term with a majority of the vote,” Ogden said. “The people of Maine have spoken. The campaign is over."

"It is now time to govern, and the Governor-elect is focused solely on leading Maine in a new, better direction, including implementing voter-approved Medicaid expansion in a financially sustainable manner and in accordance with state law and federal guidelines.”