2020 SOA Health Meeting
Medicaid Hot Topics

Tuesday, 6/9/2020, 10:45 am – 12:00 pm eastern

Presenters:
- Taylor Pruisner, FSA, MAAA
- Daniel Schnur, FSA, MAAA
- Jaredd Simons, ASA, MAAA
- David Wierz

Moderator: Sabrina Gibson, FSA, MAAA

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Planned Topics

- COVID-19
- Block Grants
- Funding of High Cost Drugs
- Updates on CMS Guidance and Proposed Regulations

Panel Bios

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Daniel Schnur, FSA, MAAA

- Senior Director for Centene Corporation.
- 25 years health care experience
- 14 years Medicaid experience at MCO in 10 states – Most recently Missouri and South Carolina
- Current focus Medicaid market support and reinsurance
- 7 years consulting experience including Medicare, Commercial and Dental
- Active in SOA subgroups
- First time presenter at SOA

Taylor Pruisner, FSA, MAAA

- Director and Senior Consulting Actuary with Wakely
- 18 years of health care consulting experience
  - Last 10 focused on Medicaid
  - Work primarily with state Medicaid associations
- Experience with over 20 state Medicaid programs

Jaredd Simons, ASA MAAA

- Vice President of Actuarial Services - Magellan Complete Care, Magellan Health
- Healthcare career spans 14 years
- Medicaid focused for 8 years
  - 5 years consulting as state actuary (2 State programs)
  - 3 years at MCO (11 State programs)
- Active member of the AAA and SOA Medicaid Subgroups

David J Wierz, MA

- Lead – Applied Solutions – ECRI
- Training in Health Economics – LDI & University Fellow - UPenn
- Focus on developing payment systems for new technologies and clinical services under Medicaid & Medicare thru CMS
- Design, implementation and management of Rx benefit for multiple Medicaid managed care plans across 8 states
- US & Global lead for value, access, pricing & payment with new technologies in biopharma, devices and diagnostics
- Active in SOA Medicaid and Pharmacy subgroups

Sabrina Gibson, FSA, MAAA

- Vice President for Centene Corporation.
- Health care for 20+ years.
- Medicaid for 14 years - mostly with a health plan but also as a consulting actuary.
- Experience with 27 Medicaid and CHIP programs in 17 states.
- Active member of the American Academy of Actuaries Medicaid workgroup and on the committee that developed the Actuarial Standard of Practice on Medicaid Managed Care Rate Setting – ASOP 49.
- Active with the Medicaid SOA committee as a presenter of current Medicaid topics at SOA meetings and webinars.

COVID-19

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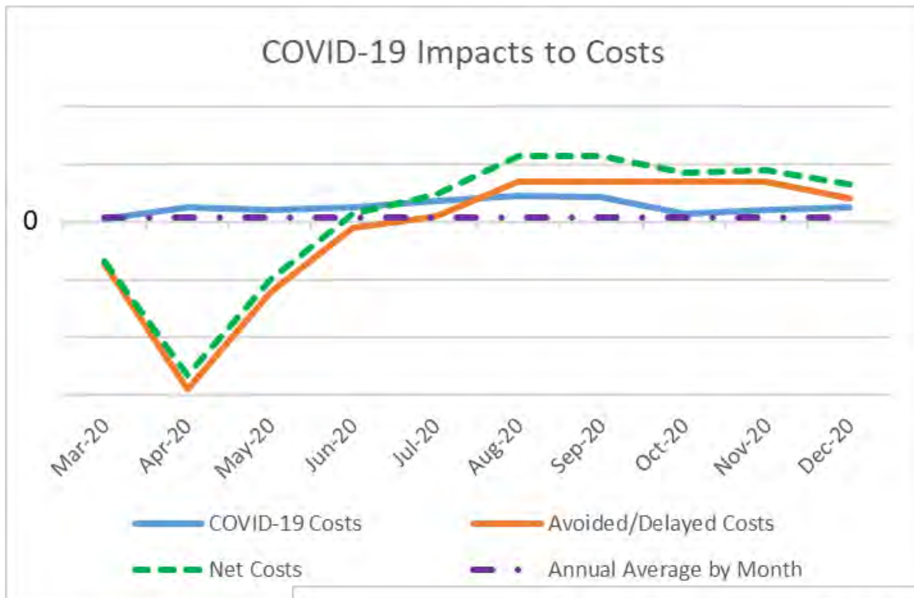
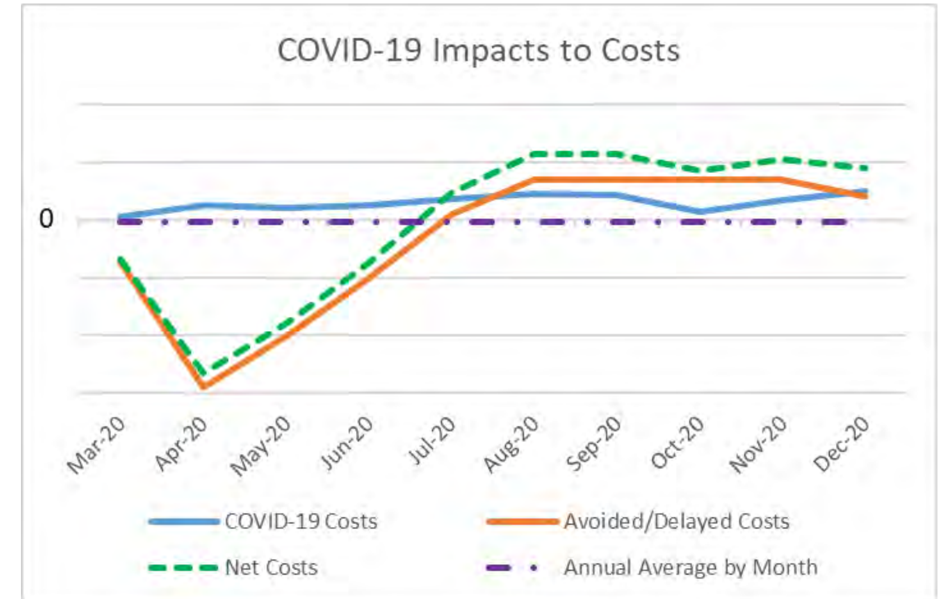
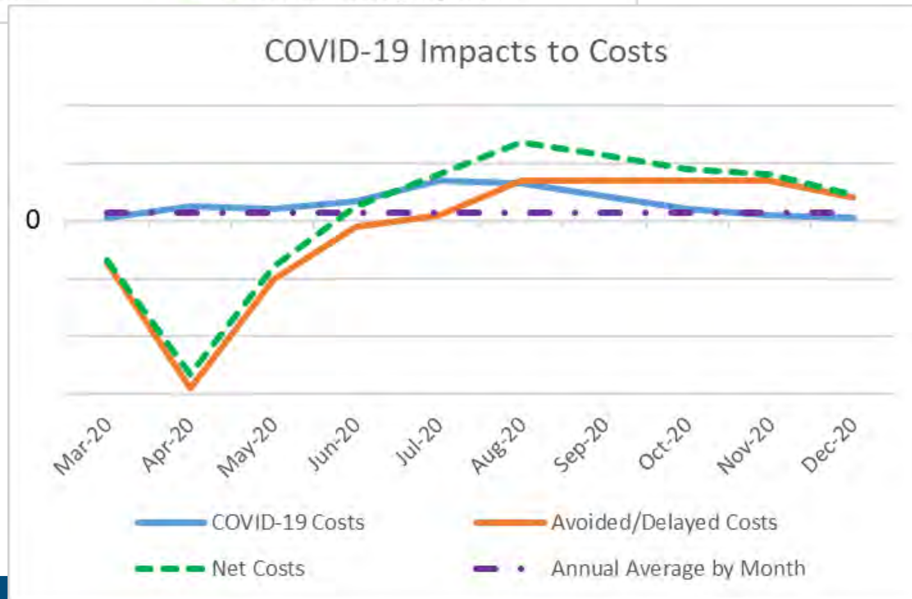
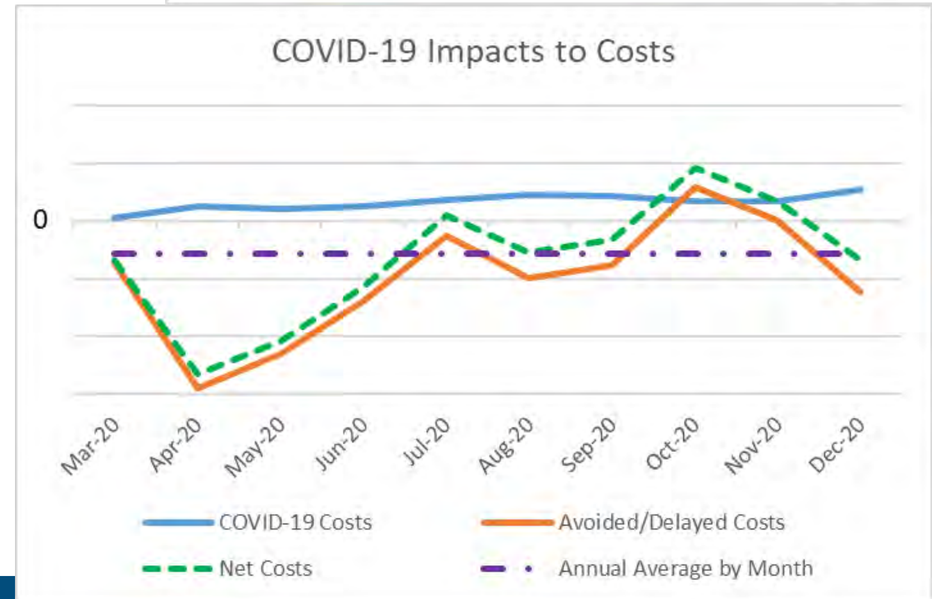
COVID Costs/Suppressed Utilization/Pent Up Demand



Possible Scenarios

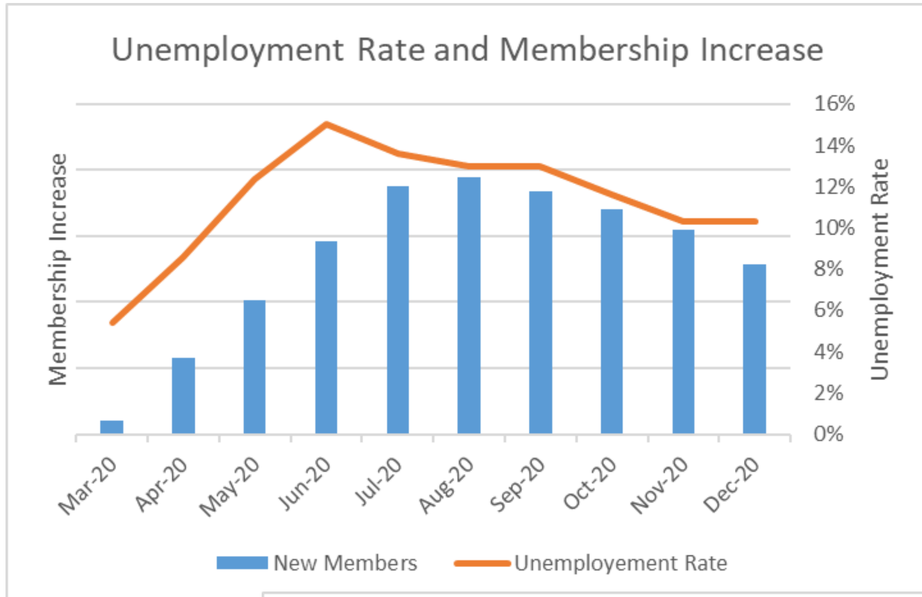


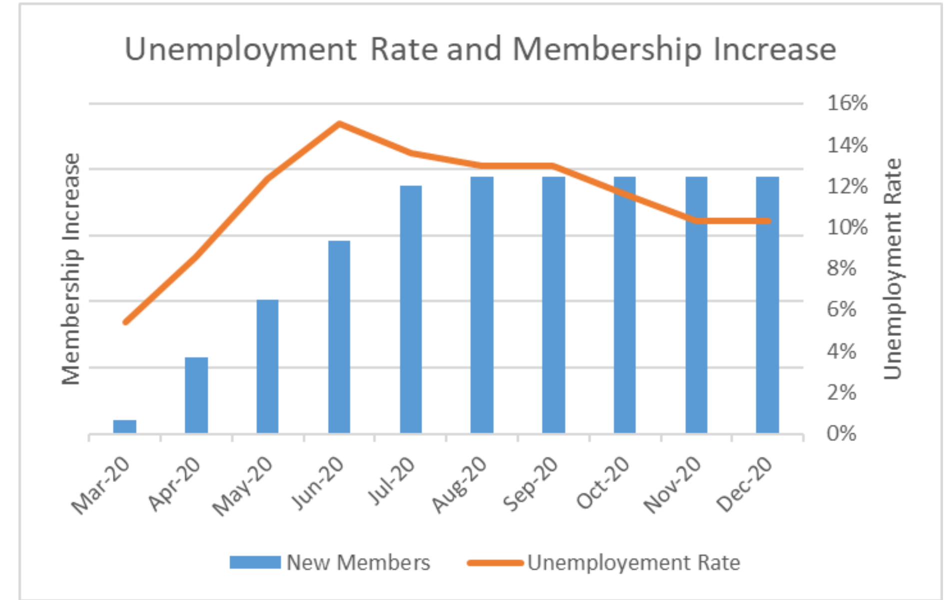


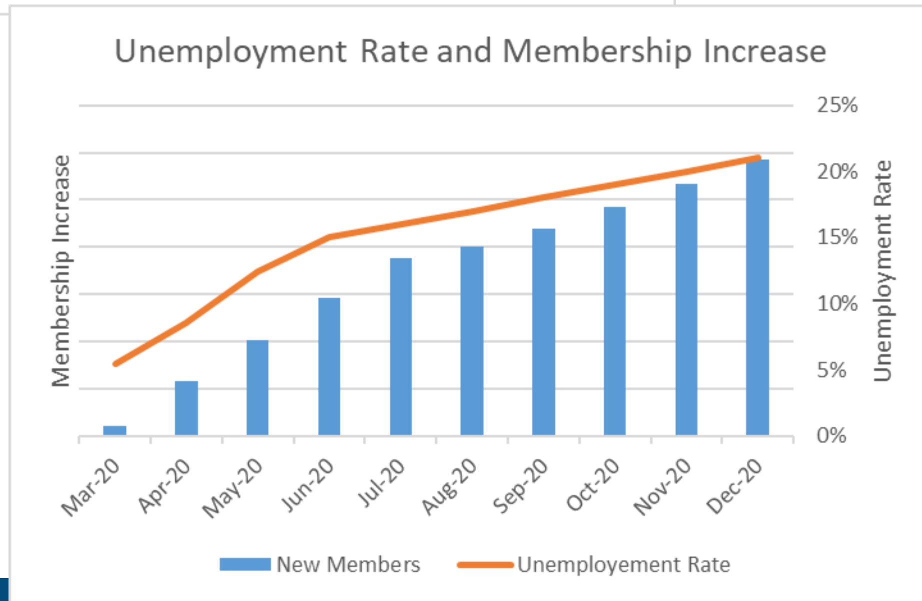


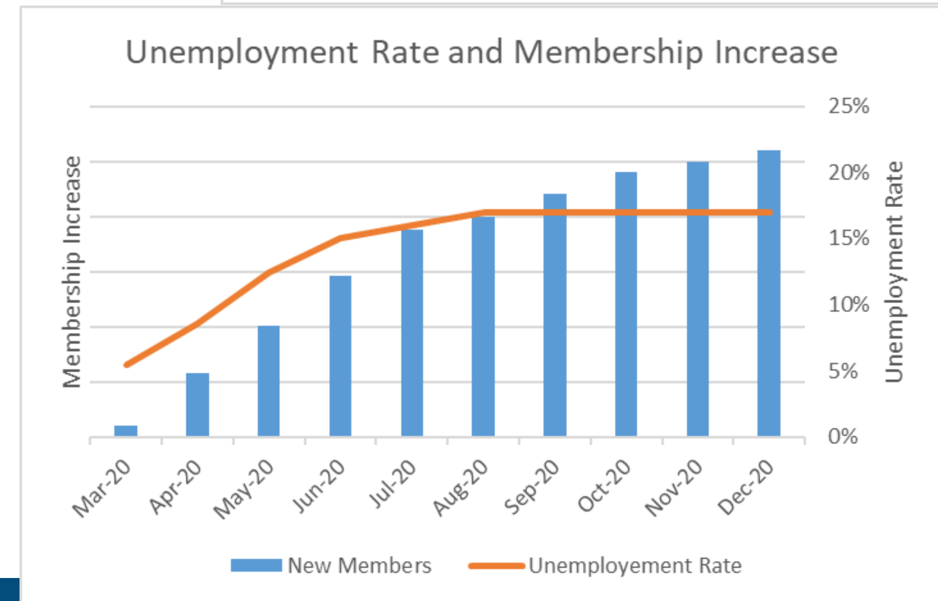
COVID-19 – Unemployment and Medicaid Enrollment

Possible Scenarios









COVID-19 Waivers - Background

- Outbreak constitutes a national emergency. DHHS waived or modified certain requirements of Section 1135 of the Social Security Act. Most states filed 1135 Waiver to accommodate needed flexibility.*

Common Requests:

- Prior Authorization
- Pre-Admission Screening
- Alternative Service Settings
  - Emergency Medical Treatment
  - Telehealth
- State Hearing Requests and Appeals
- State Plan Amendments

Some Requests Not Approved:

- Waiver actuarial soundness requirements in rates (IL, NY, WA)
- Waive client signatures on documents.
- Suspension of HIPAA business associate agreements
- Suspension of CHIP member premiums.

** - 1135 Waiver Tracker: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/federal-disaster-resources/index.html*

COVID-19 Waivers – Risk Mitigation and Rates

- CMS and Office of Actuary to help provide guidance to states and actuaries regarding Medicaid Managed care cates and flexibilities.
- Different approaches:
  - Risk corridor – should be symmetric; combine for both low cost and high cost periods; partial year could be considered, but could be complex; would consider for retro period in such an emergency
  - COVID costs covered non-risk – MCO reimbursement for COVID costs; need consistent definition for COVID services; transparent; continuity of care; w/ risk corridor
  - Prospective rate adjustment – difficult to predict so unlikely to be accurate
  - Retrospective rate adjustment – could strain cash flow; time for claim runout to get experience
  - COVID costs to FFS – admin burden; continuity of care concerns; w/ risk corridor.

* - *link to OACT call: https://www.cms.gov/files/audio/covid19cmcsallstatecall04102020.mp3*

COVID-19 - Other Important Rate Setting Concerns

- Treatment of Provider required payments and/or pass-throughs
  - How will these costs be handled in rates and risk sharing
- Disruption to quality metrics
- Withhold attainability
- Impacts to costs from state mandates:
  - Delayed/unattainable recoveries
  - Waiving of prior authorizations
  - Inability to care manage
- How to use the 2020 (and maybe beyond) data

COVID-19: Population Acuity, Enrollment, and State Budget Considerations

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COVID-19: Enhanced FMAP, Member Redetermination, and Population Acuity

- Families First Coronavirus Response Act (March 18, 2020)
  - States eligible for 6.2% FMAP increase for traditional populations during public health emergency (retroactive to January 1, 2020)
    - States are required to suspend member terminations during the emergency period
- Member Redetermination
  - Process through which the State recertifies that a Medicaid member still meets eligibility requirements
  - Population acuity changes are likely to occur when these processes and implemented, paused, or modified.
    - If suspended, lower acuity members that would have otherwise been disenrolled may remain active
    - When reactivating redetermination processes, members who are found ineligible may be lower cost than those who are eligible

COVID-19: Enhanced FMAP & Economic Impact on Enrollment

- Enhanced FMAP
  - Impact varies by state depending on pre-emergency FMAP and ACA expansion status
  - Timing differences are likely to exist between the public health emergency and increased programmatic enrollment
- Economic Impact on Medicaid Enrollment
  - Changes in economic conditions can have a significant impact on programmatic enrollment. Using 2008 financial crisis as an example:
    - Average annual increase in Medicaid enrollment
      - 2005-2008: +1.4% (+2.5M total enrollees)
      - 2009-2012: +5.4% (+11.2M total enrollees)

COVID-19 and State Budgets

- Medicaid represents nearly 30% of state budget expenditures. Will the 6.2% Enhanced FMAP Cover States' Budget Shortfalls?
- The answer depends on several key questions
  - What is the duration of the national emergency (e.g., how long with the enhanced FMAP apply)?
  - How significantly will state tax revenues be impacted? For how long?
  - Magnitude of the ultimate increase in unemployment/Medicaid enrollment
  - How long will elevated enrollment last?
  - How will enrollee costs compare to pre-COVID-19 levels?
    - How will COVID-19 costs compare to baseline Medicaid spending levels?
    - Impact of eliminating redetermination activities
    - Pent up demand for new enrollees
  - Expansion state versus non-expansion state
  - What period is the question referring to?
    - CY 2020? CY 2021? Beyond?

Block Grants

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Healthy Adult Option

Process

- CMS Issuing Authority cited as 1115(a)(2)
- Comprehensive Pre-packaged waiver authorities in an application template
- Demonstration: 5 year Initial Approval

Rules & Regulation

- Benefits must at minimum meet Essential Health Benefits (EHB) standards
- Ensure access for HIV/AIDS and BH medications
- Limit cost sharing and premiums to no more than 5% of family income
- Report 25 quality & access measures from CMS Adult Core Set
- Follow all federal disability and civil rights laws, many other applicable protections

Healthy Adult Option

State Flexibility

- State may choose either Aggregate Total or PMPM Methodology
- Adjust cost sharing requirements
- Align benefits with Exchange plans
- Ability to close prescription formulary (noted exceptions)
- Make program changes without federal approval
- Waive retroactive coverage and hospital presumptive eligibility
- Change FQHC payment to Value Based Purchasing model
- May use a combination of FFS and Managed Care
- May alter delivery system over course of demonstration period

A Tale of Two Block Grants

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Financing

- Tennessee proposed similar PMPM methodology to HAO option
- Spending in excess of target will not receive additional federal funding
- CMS notified, but approval not required for many changes under the Block Grant

Benefits

- Closed pharmacy formulary
  - HAO excludes HIV/AIDS, BH, and Opioid MAT (Must maintain open formulary)
- Waiver of Network Adequacy Rules – Flexibility to define network adequacy

A Tale of Two Block Grants

DIFFERENCE

HAO	Tennessee
Adults < 65, excludes disabled, LTSS, & SPA Eligibles	Children, low-income parents, & disabled
Medical Services Only	Medical and LTSS
Share 25%-50% Federal Savings	Share 50% Federal Savings
5 Year Initial Approval Period; Renewals up to 10 years	Requested Permanent Approval
No changes to fraud enforcement; Remains Judicial authority	Grants Medicaid agency authority to punish fraudulent enrollees
Waives some provisions of 42CFR Part 438	Waives all provisions of 42CFR Part 438
80% Minimum Spending	Minimum spending based on 2019 Program Spending

HAO: Challenges

Legality Does CMS have authority?

- 1115 Section (a)(2) grants HHS authority to spend federal Medicaid funds on projects that are not otherwise permissible under the state plan (SPA).
- HAO is defined for populations outside the SPA.
- All 1115 waivers must be deemed to promote Medicaid's core purpose – providing medical assistance to eligible enrollees.
- May be seen as waiving federal obligation to pay FMAP, Section 1903. Section 1115 does not include this authority
- Courts will likely have to decide. (Or Congress)

Uptake Is this what States wanted?

- Scope of the HAO is limited to essentially expansion programs
- States that have expanded may not see value in the program
- States that have not adopted expansion may not see this as fiscally viable

Block Grant References

HAO

- CMS Press Release: https://www.cms.gov/newsroom/press-releases/trump-administration-announces-transformative-medicaid-healthy-adult-opportunity
- CMS Letter to State Medicaid Directors: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf
- CMS Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity
- CMS Medicaid Facts & Figures: https://www.cms.gov/newsroom/fact-sheets/medicaid-facts-and-figures
- *The Medicaid Block Grant (Experiment) Cometh*, Health Affairs Blog: https://www.healthaffairs.org/do/10.1377/hblog20200207.495036/full/

Tennesee Block Grant

- *TennCare and the Trump administration have drastically different block grant plans,* The Tennessean, https://www.tennessean.com/story/news/health/2020/01/30/tenncare-and-trump-administration-have-very-different-block-grant-plans/4609948002/
- Why it Matters: Tennessee's Medicaid Block Grant Waiver Proposal, https://www.kff.org/medicaid/issue-brief/why-it-matters-tennessees-medicaid-block-grant-waiver-proposal/

Work Requirements Update

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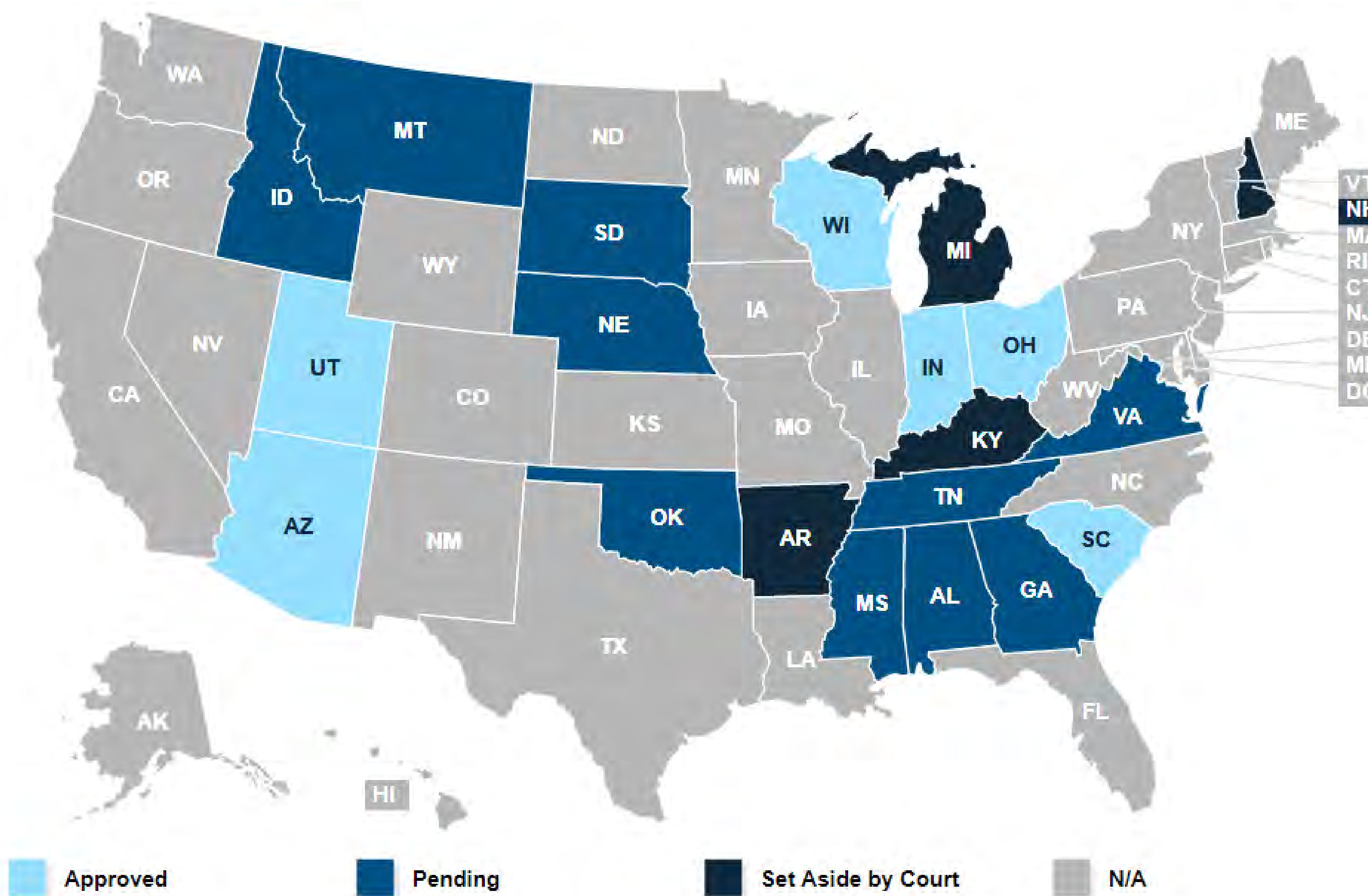
HAO and Work Requirements

- Healthy Adult Option provides states flexibility to pursue work requirements:
  - Work requirements outlined in January 2018 1115 Community Engagement Initiative
  - HAO specifically references:

"States will still have the flexibilities to propose additional conditions of eligibility, such as community engagement requirements, that are consistent with the objectives of the Medicaid program."

https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity-fact-sheet

Work Requirements Update



Submitted and Pending – 10 states : AL, GA, ID, MS, MT, NE, OK, SD, TN, VA

Approved and In Process – 4 states : OH, SC, WI, UT

Approved and Work Halted – 2 states : AZ, IN

Set Aside by Court – 4 states : AR, KY, MI, NH

Sources – Kaiser Family Foundation, updated as of April 24, 2020; Commonwealth Fund , updated as of March 17, 2020

Work Requirements Update

- Arkansas (Feb 14, 2020)
  - U.S. Court of Appeals D.C. Circuit ruled that Arkansas Works approval was "arbitrary and capricious" in failing to consider whether project would result in coverage loss and "not consistent with Medicaid."
  - First time that an appellate court has weighed in. (Sets precedence)
  - Prior to ruling ~18,000 enrollees had been dropped from program.
- Michigan (and Arizona and Indiana) (Mar 4, 2020)
  - U.S. District Court D.C. issued order blocking state from enforcing work requirements among Healthy Michigan enrollees.
  - Same judge in MI case had previously blocked the requirements in KY, AR, and NH.
  - Arkansas decision cited as basis for MI ruling.
  - Would have impacted ~100,000 enrollees in MI
  - AZ and IN blocked enforcement or implementation citing Appellate court rendering.

Source – Washington Post, "Appeals court unanimously strikes down Medicaid work requirements", Feb 14, 2020, Amy Goldstein

Work Requirements Update - Trends

- States with approved programs may delay or hold off implementation in the short term:
  - Likely that Legal challenges will arise prior to implementation and Appellate decision may be difficult to overcome.
  - Economic uncertainty around COVID 19:
    - Politically risky as unemployment skyrockets
    - Less opportunity to find employment may make requirements infeasible
    - Uncertainty of whether non-work options (i.e., community service) will be available
    - Uncertainty on how Medicaid enrollment will change as cases grow.
  - Federal stimulus has not prevented unemployment from increasing
  - However some states may still attempt as tool to control Medicaid budgets.

High Cost Drugs

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High Cost Drugs

- Background
  - Pharmacy costs represent a significant share of Medicaid expenditures, and generally exhibit much higher trend than medical services
- Issues
  - Increasing number of very high cost drugs, many are gene therapies
    - Zolgensma: $2.1M cost for course of treatment
    - CAR-T therapies
    - Trikafta ($311k/year)
    - Palforzia ($11k/year)
    - Etc.
  - Some drug approvals cannot be anticipated at the time rates are set
    - Even when they are, utilization levels can be a significant wild card
  - Expansion of Hep-C criteria
    - Louisiana subscription model

High Cost Drugs

- Rate Setting Challenges
  - Accelerating volume of high cost drug approvals
  - Potential for significant variation by plan
  - Risk adjustment cannot fully address the associated risk
  - One blanket solution may not exist for all high-impact drugs
- Potential programmatic arrangements
  - Carve-out
  - Risk pool
  - Corridor
  - Case rate payments
  - Reinsurance arrangements

Updates on CMS Guidance and Proposed Regulations

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Medicaid Fiscal Accountability Rule (MFAR)

- Issued by CMS in November 2019 as part of Medicaid Program Integrity Initiative
- Issue – States have relied increasingly on the use of supplemental payments (SP) as a source of provider reimbursement.
- Intent of rule – Increase transparency around supplement payments to providers used in rate development by:
  - Improving reporting on supplemental payments
  - Clarifying Medicaid financing definitions
  - Assessing financing of provider payments
- Public comments closed Feb 1, 2020 – General responses are not in favor of rule as written

Medicaid Program; Medicaid Fiscal Accountability Regulation, Federal Register / Vol. 84, No. 222, p 63722; https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf

MFAR - Feedback from stakeholders - MACPAC

"(MACPAC) urges CMS not to implement new limits for supplemental payments and financing arrangements at this time because CMS has not fully assessed the effects of these changes."

- Access to Care would be hindered if providers are less willing to accept Medicaid patients under new payment rules.
  - Proposed rule provides no details on how access to specialty care will be impacted.
  - Medicaid members with complex medical conditions may lose access to important sources of treatment such as academic medical centers.
  - More clarity needed about CMS's review criteria to for guidance on how best to comply
- Expand data collection to include managed care data for providers that receive supplemental payments, not just FFS data
- Make provider-level payment and UPL data publicly-available to promote transparency.
- Estimates of incremental administrative burden may be understated.

https://www.macpac.gov/wp-content/uploads/2020/01/Comments-on-Proposed-Medicaid-Fiscal-Accountability-Regulation.pdf

MFAR - Feedback from stakeholders - AHIP

"(AHIP has) very serious concerns about the proposed rule….we urge CMS to consider a more limited initial step, focusing on the collection of data necessary to fully assess the current landscape of state Medicaid funding and payment mechanisms."

- Restrictions on funding mechanisms (health-related taxes, provider donations, IGTs) could reduce the resources needed to meet the beneficiary healthcare needs.
- CMS should consider a significantly longer implementation timeframe to ensure states have sufficient time to develop permissible financing alternatives.
- Proposed standard is based on unclearly defined criteria (i.e., "considering the totality of circumstances," "results in a reasonable expectation."). Concern that such criteria are too subjective to rely on for setting state tax policy and passing related legislation.
- Request that CMS confirm that value-based purchasing or performance payments made by MCOs to providers and payments under Section 1115 demonstrations are outside the scope of this rule.

https://www.ahip.org/wp-content/uploads/AHIP-Letter-on-Medicaid-Program-Medicaid-Fiscal-Accountability-Regulation-1-31-2020.pdf

MFAR - Feedback from stakeholders - Others

- National Governors Association – Preempting states’ authority and reducing states’ flexibility within their Medicaid program will result in decreased access to care for many vulnerable Americans.
- National Association of Medicaid Directors – This work should take place over multiple rulemaking cycles, in strong partnership with states to ensure regulatory approaches are both feasible and effective.
- U.S. Chamber of Commerce – This could have an adverse impact on overall economic growth…. With 41% of rural hospitals already operating at a negative profit margin and 120 rural hospitals closing in the last nine years, additional closures are likely if this proposal is implemented.
- American Hospital Association – Hospitals specifically could see reductions in Medicaid payments of $23 billion to $31 billion annually, representing 12.8% to 16.9% of total hospital program payments.

https://ccf.georgetown.edu/2020/02/06/strong-opposition-to-damaging-medicaid-state-financing-and-supplemental-rule/

MFAR Other Ramifications

- Limit physician supplemental payments to 50% of base payments (75% of base payments for rural or service shortage areas)
- The 3 year approval limitation could create uncertainty for state and provide budget planning. (and impact the actuarial rate development cycle)
- What is the administrative burden of managing and reporting? Regulation provides a rough cost impact to states, but how does that cost impact other stakeholders such as providers and cost to certify rates?
- How will CMS measure whether supplemental payments meet their objectives? Will this be calculation-driven, or will other impacts and outcomes be considered?

Federal Register - https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf