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
Planned Topics

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

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
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 will 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
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

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

**HAO**
- Adults < 65, excludes disabled, LTSS, & SPA Eligibles
- Medical Services Only
- Share 25%-50% Federal Savings
- 5 Year Initial Approval Period; Renewals up to 10 years
- No changes to fraud enforcement; Remains Judicial authority
- Waives some provisions of 42CFR Part 438
- 80% Minimum Spending

**Tennessee**
- Children, low-income parents, & disabled
- Medical and LTSS
- Share 50% Federal Savings
- Requested Permanent Approval
- Grants Medicaid agency authority to punish fraudulent enrollees
- Waives all provisions of 42CFR Part 438
- Minimum spending based on 2019 Program Spending
HAO: Challenges

Legality

- 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

- 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

Does CMS have authority?

Is this what States wanted?

- 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 Fact Sheet: [https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity](https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity)

Tennesseem 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/](https://www.tennessean.com/story/news/health/2020/01/30/tenncare-and-trump-administration-have-very-different-block-grant-plans/4609948002/)
Work Requirements Update
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
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
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

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.

“(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.
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?