Medicaid Changes & Implications For People Living With HIV: Introduction

Manatt Health
November 15, 2017
1:00 – 2:00 PM ET

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Manatt Health Speakers

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Webinar Series
Medicaid Changes & Implications For PLWH

Webinar 1:
Medicaid Changes & Implications for People Living with HIV: Introduction
Wednesday – November 15, 2017 / 1 PM ET
Guest Panelist from Center for Health Law and Policy Innovation

Webinar 2:
Medicaid Changes & Implications for People Living with HIV: Deep Dive
Wednesday – December 13, 2017 / 1 PM ET
Guest Panelist from AIDS Foundation of Chicago

Webinar 3:
Medicaid Changes & Implications for People Living with HIV: Horizon for 2018 and Beyond
Tuesday – February 13, 2018 / 1 PM ET
Guest Panelist from Southern AIDS Coalition

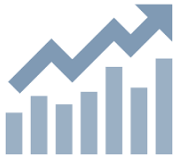
Today's Agenda

- Medicaid Background
- Access to Drugs in Medicaid
- Proposed Medicaid Reform
- Guest Panelist
- Panelist Roundtable/Questions

Medicaid Background

About Medicaid: Eligibility and Benefits

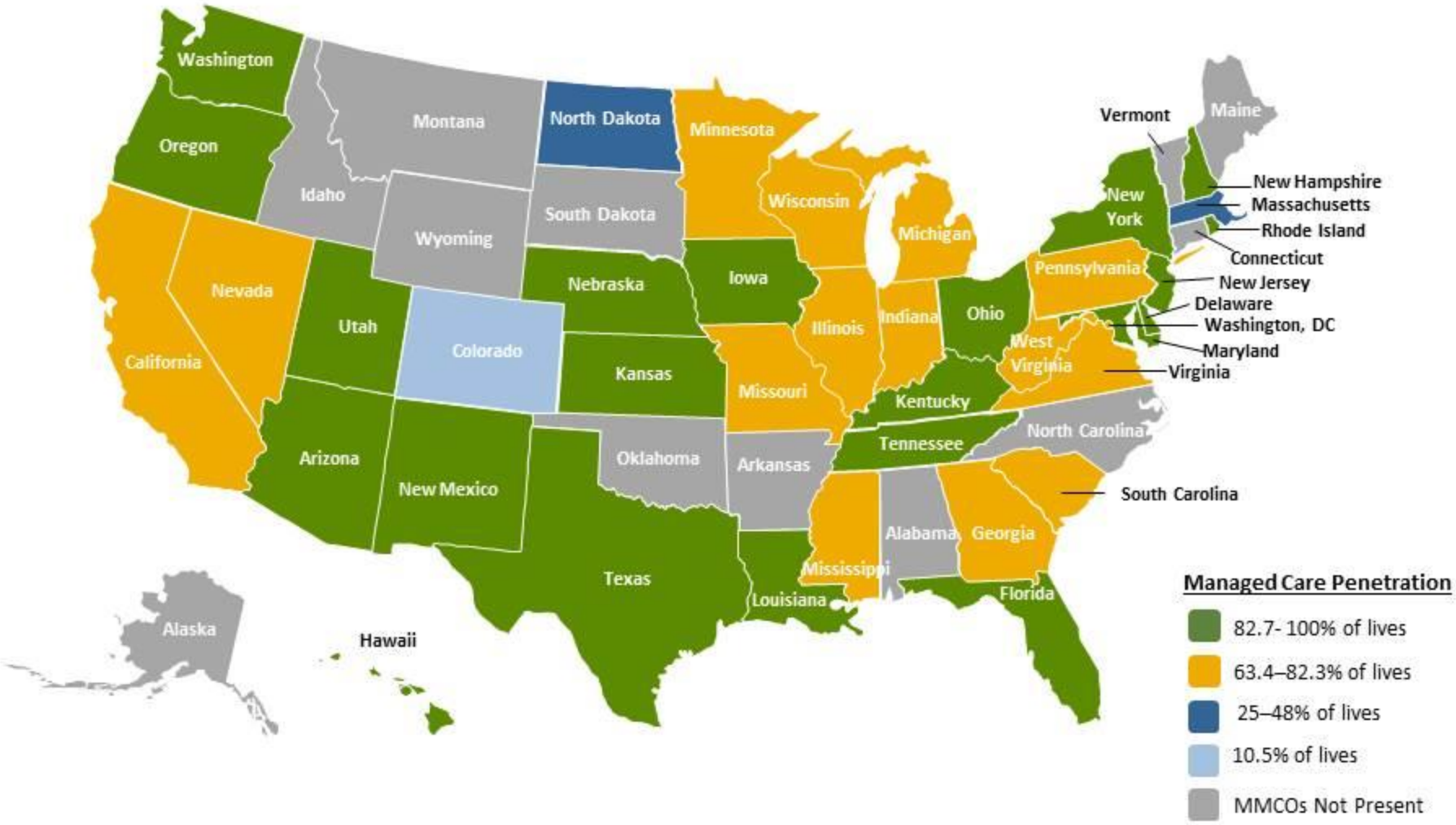
Medicaid is a federal and state entitlement program that continues to grow in enrollment and evolve in its benefits and delivery system.



- Historically, Medicaid provided health coverage for low-income children, pregnant women, parents, elderly people, and people with disabilities – the ACA gave states the option to cover childless adults and parents at higher income levels
- As of August 2017, Medicaid served approximately **68.4 million people nationwide**, or more than one in five Americans
- Medicaid is jointly funded by states and the federal government, with variable state-federal matching rates across the country
- Federal laws and rules set minimum standards and states act as program administrators, leading to wide variation among the states with respect to:
  - Covered populations
  - Eligibility levels
  - Benefits
  - Delivery model
- States cover beneficiaries in Medicaid through traditional fee-for-service and Medicaid managed care organizations

Source: CMS, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

Medicaid Managed Care Penetration for the Total Population as of July 2017



Source: Kaiser Family Foundation, Medicaid Managed Care Penetration Rates by Eligibility Group, July 2017, Available here - https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0&sortModel=%7b%22colId%22:%22Location%22,%22sort%22:%22asc%22%7d

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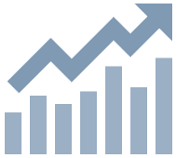
About Medicaid: Eligibility and Benefits

Medicaid has evolved with the Affordable Care Act (ACA), and states still have significant flexibility with respect to eligibility and benefits.

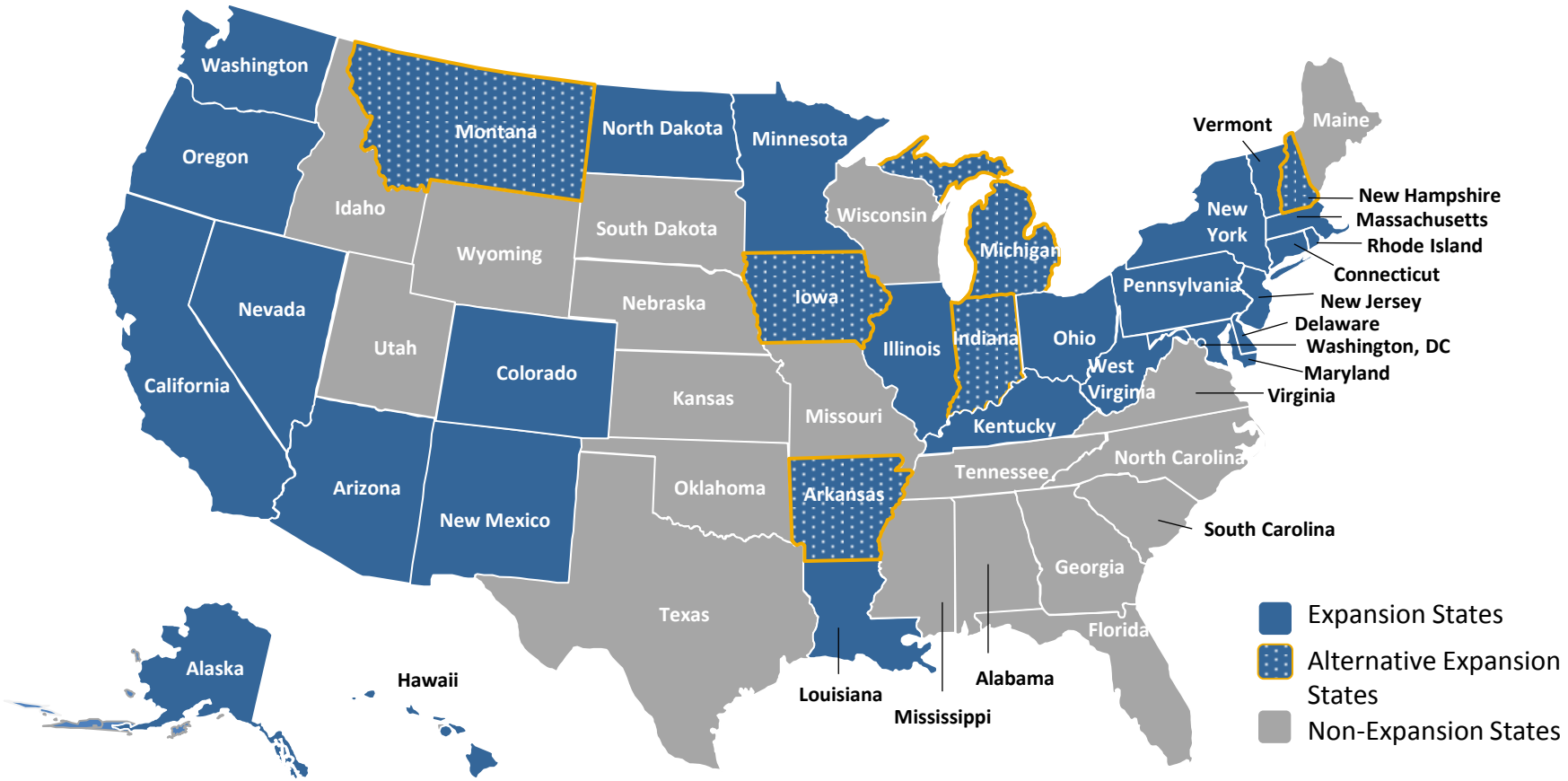


- Traditionally, eligibility in Medicaid has been limited to low-income children, parents, pregnant women, elderly and disabled
- The ACA gave states the option to expand eligibility to adults up to 138% of the federal poverty level (FPL)
  - 138% FPL for a single individual is $16,643, or $28,180 for a family of three
- States must provide beneficiaries with mandatory benefits and many states also provide a range of optional benefits
- For example, **all states currently cover prescription drugs** even though it is an optional benefit for traditional, pre-ACA Medicaid populations
  - Both Medicaid FFS and Medicaid Managed Care use mechanisms to control drug utilization (e.g., step therapy and prior authorization)
- The ACA also required that newly eligible individuals must receive an "alternative benefit package" (ABP) that must include the ten "Essential Health Benefits," including prescription drugs
  - In most states this ABP coverage mirrors standard Medicaid benefits, but there are sometimes differences (e.g., habilitative or substance use services)

Source: State eligibility levels can be found at: https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
2017 Poverty Guidelines: https://aspe.hhs.gov/poverty-guidelines

Medicaid Expansion And Non-Expansion States, 2017

As of August 2017, Medicaid served ~68.4 million people nationwide. Over 16.4 million enrollees have been added as a result of Medicaid expansion under the ACA.



Source: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

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Medicaid and People Living With HIV (PLWH)

Medicaid beneficiaries with HIV have historically gained eligibility through the disability pathway (sometimes through co-morbidities); this excluded many individuals in the early-stages of the disease.

- **Medicaid has played a vital role since the epidemic began and it is the largest source of coverage for people with HIV**
- **Post-Medicaid Expansion:**
  - In states that have adopted it, Medicaid expansion streamlined entry into the program for PLWH
  - "Medically frail" individuals who are "newly eligible" as a result of the Medicaid expansion are exempt from the alternative benefit package and must receive the standard Medicaid benefit package
  - "Medically frail" populations must include individuals with certain minimum criteria, including, for example:
    - Serious and complex medical conditions
    - A disability determination based on Social Security criteria
  - States have discretion to "add to" or expand the definition

Source: Kaiser Family Foundation, Medicaid and HIV Fact Sheet, 2016, available at: http://kff.org/hivaids/fact-sheet/medicaid-and-hiv/; Insurance Coverage Changes for People with HIV Under the ACA, 2017, available at http://kff.org/hivaids/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/
PLWH: people living with HIV/AIDS; ADAPs: AIDS Drug Assistance Programs

Medicaid and People Living With HIV (PLWH)

The Medicaid expansion has facilitated coverage for some PLWH, but many adults still access Medicaid through the disability pathway.

- The disability pathway remains important despite enhanced access for childless adults (precise data not available)
- Non-disabled, low-income adults with HIV can now access Medicaid in the 31 states, plus DC, that have expanded Medicaid
  - **Medicaid coverage of people with HIV increased from 36% in 2012 to 42% in 2014, mostly in expansion states**
  - **In sampled Medicaid expansion states, Medicaid coverage for PLWH rose from 39% in 2012 to 51% in 2014**
- Still, nearly 40% of all PLWH (irrespective of income) live in the 19 states that have not expanded
- The Ryan White program remains important for PLWH; it fills gaps for those with insurance – including Medicaid – and remains a critical safety net for individuals in states that did not expand Medicaid under the ACA

Source: Kaiser Family Foundation, Medicaid and HIV Fact Sheet, 2016, available at: http://kff.org/hivaids/fact-sheet/medicaid-and-hiv/; Insurance Coverage Changes for People with HIV Under the ACA, 2017, available at http://kff.org/hivaids/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/
PLWH: people living with HIV/AIDS; ADAPs: AIDS Drug Assistance Programs

Access to Drugs In Medicaid

Medicaid Drug Coverage

Drug coverage in Medicaid is optional; but all states provide drug coverage, subject to federal rules that dictate pricing and access.

- Section 1927 of the Social Security Act created the drug rebate program in 1990 - a legislative bargain that requires drug manufacturers to give Medicaid their best price (in the form of rebates) in exchange for inclusion of drug on Medicaid formulary
  - Some manufacturers also offer voluntary supplemental rebates to states or to managed care entities, which can translate into preferred status on formularies or preferred drug lists
- The ACA modified 1990 legislation, referred to as OBRA '90, to extend Section 1927 rebates to outpatient drugs delivered through Medicaid managed care organizations
- State Medicaid programs use multiple strategies to manage drug utilization
  - Utilization management (prior authorization, step therapy)
  - Formularies/preferred drug lists (PDLs)
  - Generic drug requirements
- Prior authorization process is allowed, but cannot prevent access to medically necessary drugs
  - States must respond to requests within 24 hours, and must provide a 72-hour emergency supply

Medicaid Beneficiaries Access Drugs through FFS or Managed Care

Traditional Medicaid FFS uses PDLs while Medicaid MCOs use formularies to manage drug utilization.

Traditional Medicaid FFS	Medicaid Managed Care

▪ States are required to cover drugs from any manufacturer participating in the Medicaid Drug Rebate Program
▪ State develops and sets its Preferred Drug List (PDL):
  ▪ States use P&T Committees, Drug Utilization Review Boards, and other mechanisms to review new drugs and set the PDL
	▪ State must assure that beneficiaries receive access to Medicaid Drug Rebate Program drugs – section 1927 applies
	▪ Plan sets formulary subject to state requirements:
	  ▪ Some states require MCOs to adhere to the state's PDL
	  ▪ Others give MCOs more flexibility to manage the formulary for all drugs or to carve out some classes of drugs from contracts, requiring beneficiaries to access those products through FFS

Most States Require MCOs To Take on the Risk of Covering Drugs Within Their Benefits Package

At least 75% of Medicaid beneficiaries are enrolled in managed care[1] - most states now carve drugs into managed care contracts and Section 1927 rules apply.

Carve-In	States include prescription drug benefit in managed care contracts
	Requires the MCO to take on the financial risk of coverage
Carve-Out	States carve out the prescription drug benefit from managed care contract and require coverage through the state's FFS program
	Requires the state to take on the financial risk of coverage
Unified Formulary	Several states have executed a more unified approach, requiring MCOs to take on the financial risk of prescription drug coverage, while requiring those MCOs to use the state's preferred drug list (PDL)
Condition-Specific Policies	**Some states have carved out specific classes of drugs for conditions such as HIV/AIDS**, substance abuse, hemophilia, mental health, and hepatitis C

1. http://www.kff.org/medicaid/issue-brief/data-note-medicaid-managed-care-growth-and-implications-of-the-medicaid-expansion/

Proposed Medicaid Reform

Pathways to Medicaid Change

Medicaid can be changed by the federal government through legislation, regulations and guidance. States seek authorization from the federal government to implement their Medicaid programs and policy through state plan amendments and waivers.

Federal Legislation

Congress can enact legislation to make fundamental changes to Medicaid eligibility and financing

State Plan Amendments

Used by states to make routine changes to eligibility, benefits, provider rates, etc.

Regulations & Guidance

HHS can use existing regulatory authority to make policy changes to Medicaid or issue guidance to clarify existing policy

State Waivers

Section 1115 and 1915 waivers are used by states seeking greater flexibility to manage their Medicaid populations and costs

Proposals To Cap Federal Funding In Medicaid Are Long-Standing, And Likely To Persist

FY 1982 - 1990:
President Reagan's Medicaid proposals were primarily aimed at capping federal contributions to the program

FY 1992 - 1993
Medicaid proposals during President George H.W. Bush's Administration would have capped year-over-year increases in the federal contribution or – later proposed – replaced components with capped block grants

FY 1996 - 1998
Congress proposed a block grant; President Clinton's counter proposal included a per-person cap on Medicaid spending

FY 2009-2013
Various congressional proposals to cap Medicaid funding

2017
Block grant and per capita cap proposals

Sources: MACPAC Key Medicaid Proposals. Retrieved from: http://www.medicaidplans.org/_docs/Key_Medicaid_Reform_Proposals.pdf; Manatt review of proposals

With Capped Funding, Significant Changes In State Spending Are Likely

Beneficiaries are likely to face reduced access to coverage and care as well as increased financial burdens as states make tough decisions on how to spend within budget.

- States may or may not have obligation to match federal funds and match rate may change from today in either a per capita cap or block grant scenario
- States are unlikely to provide state funding above what is required to secure maximum federal funds; cuts in federal funds likely to result in additional state funding cuts
  - A $1 trillion cut in federal funding equates to an additional cut of $754 billion in state funding
- Ending the match requirement or changing the rules for how states raise their share, could result in even deeper cuts
- States will be responsible for all costs above the caps; some states may not choose or be able to pay those costs

1115 Waiver Flexibility

- According to federal statute, waivers must:
  - "Further the objectives" of the Medicaid program
  - Be authorized for a demonstration purpose, subject to evaluation
  - Affect a section of the federal Medicaid law subject to waiver
- By longstanding practice, waivers must be budget neutral to the federal government
- Most states have 1115 waivers that can be extended or amended, and new waivers can be created

Selected New or Amended Waiver Proposals

	New or Amended Waiver Proposals										
	AR	AZ	IA	IN	KY	MA	ME	NH	NM	UT	WI
Premiums	●	●	●	●	●	●	●		●		●
Cost Sharing	●	●	●	●	●	●	●	●	●	●	●
Healthy Behavior Incentives	●	●	●	●	●			●	●		●
Non-Emergency Transportation Waiver			●	●	●	●					
Institutions of Mental Diseases Exclusion Waiver		●		●	●	●			●	●	●
Essential Health Benefits Waiver									●		
Retroactive Eligibility Waiver	●		●	●	●	●	●	●	●	●	
Prompt Enrollment Waiver				●	●						
Elimination of Presumptive Eligibility							●			●	
Drug Testing											●
Partial Expansion	●					●					
Work-Related Provisions	●	●		●	●		●	●		●	●

● = Waiver obtained ● = Waiver continuation requested ● = Waiver requested ● = No waiver required

Notes:

- To date, New Mexico has released a concept paper describing potential changes to its existing 1115 demonstration. It is planning to release a full extension application in the fall of 2017.
- Massachusetts only imposes premiums for individuals with incomes >150% FPL.
- Arkansas received a conditional waiver of retroactive eligibility.
- New Hampshire received a conditional waiver of retroactive eligibility.
- CMS has only approved voluntary work referrals to date. Arizona, Arkansas, Indiana, Kentucky, Maine, and Wisconsin have proposed work-related requirements as a condition of Medicaid eligibility.

1115 Waiver Request Overview: Kentucky

Kentucky, a traditional expansion state, had one of the most successful ACA implementation experiences. The state is now seeking a 1115 waiver to require premium contributions and work requirements to promote personal responsibility in its Medicaid program.

- **Premium Contributions**
  - Imposes sliding scale **premium contribution**
    - From $1 to $15 per month determined by family income level ranging from 0% to 138% FPL (increases to >2% of income for enrollees above 100% FPL, beginning in a beneficiary's third year of enrollment)
  - Requires **premium contributions before coverage is effective** for enrollees between 100-138% FPL
    - Coverage will be effective after 60 days for enrollees below 100% FPL who do not pay a premium
    - Enrollees who pay premiums will be exempt from co-payments
  - Six-month **lock-out period** for delayed renewal and failure to pay premiums
- **Work Requirements**
  - Imposes work requirements for most adults (up to 20 hours per month after one year of enrollment); beneficiaries can be dis-enrolled for failure to comply; can re-enroll once work requirement is met

Waiver was submitted in August 2016 and is pending at CMS

Medically frail individuals – including people diagnosed with HIV/AIDS – will be exempt from copayments, enforceable premiums, and work requirements

Sources: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf; http://www.kff.org/medicaid/fact-sheet/proposed-changes-to-medicaid-expansion-in-kentucky/

1115 Waiver Request Overview: Massachusetts

Building on its landmark 2006 health reform, the state is now seeking precedent-setting federal flexibility to support MassHealth's long-term financial sustainability – PLWH will be affected by some but not all of these provisions.

Requests that exempt PLWH

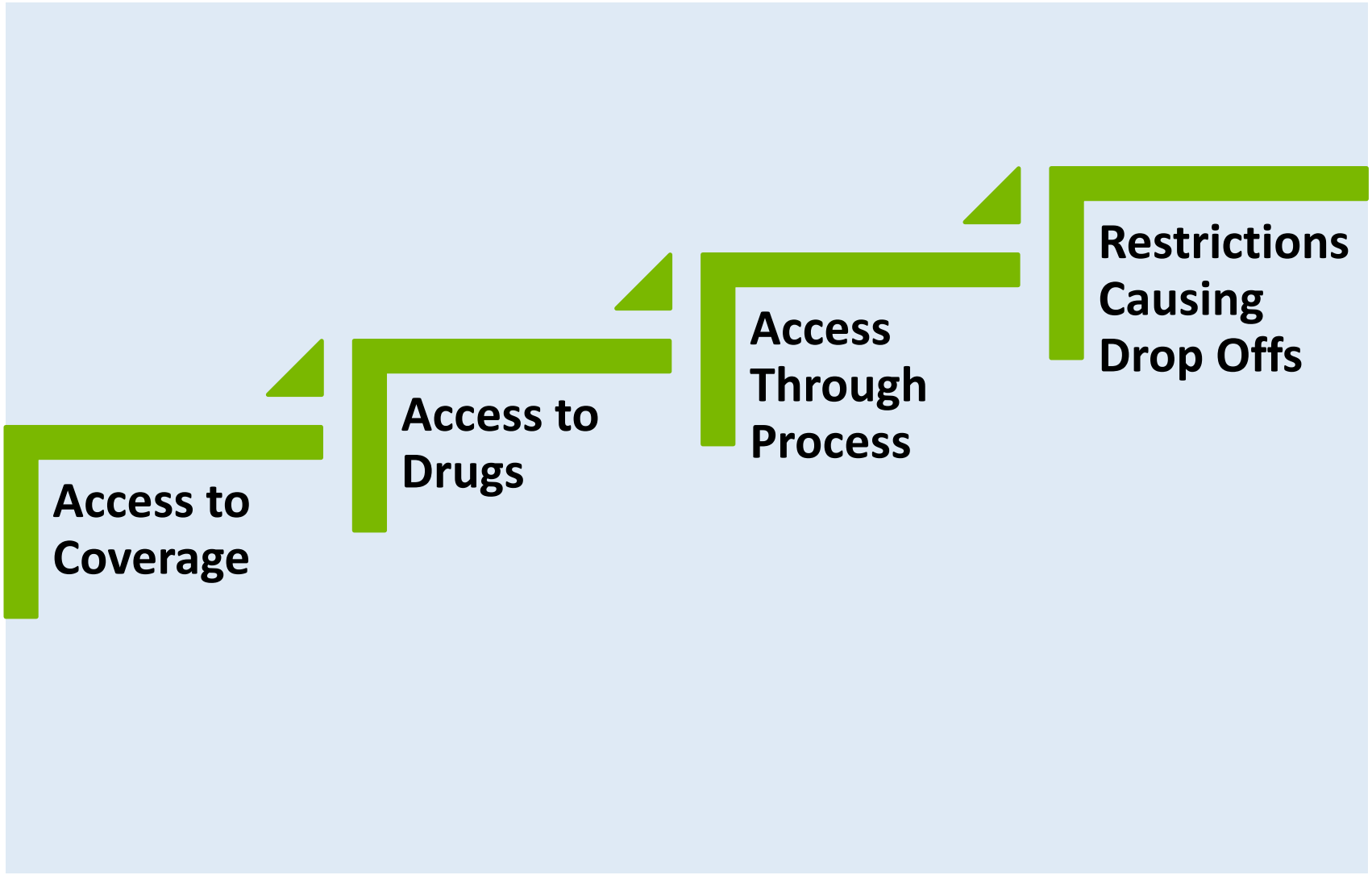
- **Partial Expansion:** Lower eligibility for non-disabled childless adults, parents, and caretakers ages 21 to 64 to 100% FPL (beginning January 2019) while keeping the enhanced expansion matching rate. ~140,000 adults, parents, and caretakers above 100% FPL would be transitioned to qualified health plans offered by the Massachusetts Health Connector, with much higher cost sharing
- **Benefit Changes:** Transition non-disabled parents and caretaker relatives ages 21-64 with incomes ≤100% FPL to MassHealth CarePlus – the state's Alternative Benefit Plan
- **Retroactive Eligibility:** Eliminate 90-day provisional eligibility when income cannot be verified for adults ages 21+

Selected requests that impact PLWH

- **Closed Formularies:** Waiver of Section 1927 to expand the state's authority to exclude drugs from its formulary through a "closed formulary"
- **Selective Specialty Pharmacy Network:** Limit choice of pharmacy to specialty pharmacy for members receiving care through FFS or primary care physician (PCC) plan
- **Narrower PCC Networks:** Establish narrower networks in the PCC plan to encourage enrollment in ACOs and MCOs
- **Premium Assistance Changes:** Eliminate cost-sharing wrap for individuals enrolled in employer-sponsored insurance who receive care from a non-Medicaid participating provider, exposing them to high costs
- **Cost Sharing:** Implement cost sharing greater than 5% of income for members over 300% FPL

Source: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf

Medicaid Reform Proposals Raise Concerns About Patient Access



Today's Guest Panelist

Robert Greenwald
Clinical Professor of Law
Faculty Director, Center for Health Law and Policy Innovation
Harvard Law School

CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

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Panel Roundtable

Questions

Thank You From The Manatt Team

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