NAMD’s Legislative Priorities for 2017

Over several decades, federal policymakers have incrementally modified the statutory and regulatory parameters for the Medicaid program, while largely maintaining the federal and state governments’ shared financing responsibilities. The resulting dynamic and tensions are compelling states to place ever greater emphasis on refashioning how the program operates in a transformed health care system. In particular, Medicaid Directors are developing and executing a vision for their respective states to transform their delivery and payment structures to improve health outcomes.

As Medicaid continues to evolve, NAMD believes that federal and state goals will remain unified. Specifically, we want to ensure the Medicaid program:

- Engages consumers in their health care and produces good outcomes for them.
- Makes available necessary and appropriate health care services.
- Is cost efficient and is purchasing value.
- Remains a leader and driver in improving the health care system.

There are meaningful opportunities for federal policymakers to support states in working towards these shared goals, including by making targeted reforms to antiquated federal statute and regulations. Too many of the federal policies in place today are legacies from the last century. They do not reflect the current realities for running a Medicaid program nor do they align with the vision for Medicaid and the broader health care system.

NAMD’s “Top Legislative Priorities for 2017” is intended to ensure the federal rules governing Medicaid comport with the realities and expectations for states to run high performing Medicaid programs. We recognize there will be a range of viewpoints on some of these concepts. Some come with significant “cost” to the Medicaid program, while others could pave the way for more efficient use of federal and state resources.

NAMD believes these modernizations can have a meaningful, positive impact for Medicaid enrollees. We look forward to working with federal policymakers and Medicaid stakeholders to tackle these issues.
1. **Implement requirements for advance review of federal regulations and guidance by state Medicaid staff.** The Medicaid program was created as a partnership between the states and federal governments, with joint financing responsibilities, state administration and federal oversight. The lifecycle to conceptualize and develop federal Medicaid regulations fails to recognize the federal-state partnership. This partnership is predicated on states financing and administering the Medicaid program, which differentiates them from all other Medicaid stakeholders. Currently states have no opportunity to provide feasibility input on the rules and guidance prior to submission for final clearance by the federal agencies.

*Require in federal statute a distinct role for state Medicaid leaders to review the conceptual soundness and operational feasibility of federal regulations and guidance prior to finalization, which directly or indirectly impact the Medicaid program.*

2. **Advance value-based reimbursement methodologies for all types of Medicaid providers.** Safety-net providers in Medicaid, such as federally-qualified health centers (FQHCs) and rural health clinics (RHCs), are a major component of the delivery system and ensure access to care for Medicaid beneficiaries. However, federal statute requires that states reimburse FQHCs and RHCs using the prospective payment system (PPS). This distinct reimbursement system limits Medicaid’s ability to use the full range of value-based purchasing strategies in this care delivery setting, including models that incorporate financial risk. It also prevents many states from comprehensively transforming the health care system across all providers.

*Update the tools states may use to allow for aligned value-based purchasing approaches for all Medicaid safety-net providers, including modest down-side risk where consistent with broader statewide reforms.*

3. **Provide long-term certainty for effective state Medicaid program innovations.** For decades, some states have used Section 1115 demonstration authority to operate significant portions of their Medicaid programs, while others have developed more targeted initiatives under this authority. More recently, states are using this authority to increase access to Medicaid or reallocate reimbursement for Medicaid providers or both. These initiatives are intended to transform service delivery and payment to focus on health outcomes. Despite evaluations and other evidence demonstrating the effectiveness of such demonstrations, states are still required to enter into administratively burdensome negotiations every three or five years to secure federal approval.

*Establish a reasonable path for states to make permanent the foundational aspects of their Section 1115 demonstrations programs.*

4. **Make consistent the federal financing options for Medicaid eligibility expansions and ensure state flexibility on coverage strategies.** States continue to examine options to
address the potential coverage gaps for low income individuals and families in their respective states. Many also are exploring strategies to make existing coverage programs more affordable and effective for consumers, but they are limited to doing so through Section 1115 demonstration authority. States need federal partners to take a practical view of what will work in each state.

Provide states more options under the Medicaid state plan to address coverage gaps for low-income populations. An example is to allow a phased approach to coverage for new populations up to 100 percent of the federal poverty level. The existing phase down in federal financing should be consistent for all states, regardless of their starting point.

5. **Provide flexible options for states to streamline waiver authorities and braid funding for Medicaid, overlapping health-related services programs and the social determinants of health.** State Medicaid programs are increasingly responsible for the full spectrum of medical, behavioral and long-term service and support needs of enrollees. Today, states must patch together numerous waiver authorities and coordinate the siloed federal funding streams for these various services and programs. As more states design holistic approaches to address the social determinants of health, the federal and state administrative structures are increasingly seen as barriers to improvement and efficiency.

Establish federal demonstration pilots that allow states to integrate funding from other federal health care funding streams, particularly those for behavioral health services, with the explicit purpose of enhancing states’ ability address the total cost of care for Medicaid enrollees.

6. **Resolve statutory conflicts presented by federal mental health and addiction disorder parity requirements, the federal payment exclusion for Medicaid Institutions for Mental Diseases (IMD) exclusion and federal privacy laws for individuals with a substance use disorder.** Medicaid is obligated to provide for the full continuum of services for individuals with mental health and substance use disorder diagnoses, which may include appropriate stays in a facility-based setting. The Medicaid IMD exclusion, however, prohibits the use of federal Medicaid matching funds for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion remains one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The IMD exclusion also increases costs to states and the federal government by requiring individuals to receive care in more expensive and less specialized settings. Ultimately, this payment exclusion not only creates barriers to appropriate care and increases costs, it is in direct conflict with federal law which requires parity for mental health and substance use disorder services.
In addition, because of the antiquated federal policy at 42 CFR Part 2, persons with substance use disorder miss out on more comprehensive electronic medical records, health information exchanges, prescription drug monitoring and improvement systems, care coordination, and population management. Previous regulatory reforms failed to address states’ concern that the rule unnecessarily complicates and undermines care coordination, and ultimately, this situation produces adverse patient health and safety outcomes.

As applied, the two statutory provisions also present a conflict for state Medicaid programs to comply with federal Mental Health Parity and Addiction Equity Act.

Repeal or make meaningful modifications to the parameters of the Medicaid IMD payment exclusion or authorize defined waiver authority to do so. Revise existing privacy rules to enable access to protected health information (PHI) of individuals with a substance use disorders diagnosis.

7. **Delink Medicaid from Medicare financing.** States finance several aspects of Medicare service costs for low-income Medicare enrollees who are dually eligible for Medicaid, including Part B premiums and Part D prescription drug benefits. In recent years, the state share has increased despite the fact that state Medicaid programs have no control over the management and oversight of these services.

*Congress should develop a mechanism for keeping the impact of Medicare policies on states predictable, reasonable, and sustainable.*

8. **Address the service dichotomy that continues to impede coordinated, high value care for individuals dually eligible for Medicare and Medicaid.** The federal Medicare and Medicaid Coordination Office (MMCO) has made significant progress in its work with states to change the trajectory of spending and consumer experience for individuals dually eligible for Medicare and Medicaid. States are gaining more experience and insights from the demonstration models focused on the dual eligible population. Additionally, in recent years, more states also have pursued or have begun to explore opportunities for integration using the Medicare Advantage Special Needs Plan (SNP) platform. States’ efforts, however, can be hampered by the uncertainty around the long-term federal authority and specific statutory requirements for such plans. It is time to provide more clarity and certainty for the paths available to states to coordinate services for this population.

*Enhance support for the MMCO’s work with states around the dual eligible population, including by authorizing permanent authority for demonstration models which align and coordinate services for the population dually eligible for Medicare and Medicaid. Permanently reauthorize the SNP program, requiring agreements between all types of SNP plans and states, and providing clear expectations for CMS and states to collaborate to maximize the administrative and care coordination opportunities.*
9. **Allow all states to cover complex populations in managed care.** Many states have moved most, if not all, populations into Medicaid managed care. They have built systems to ensure this model delivers coordinated, high quality care. The increasing sophistication has allowed states to improve care for complex and high need beneficiaries through this delivery model.

*Repeal the prohibition on requiring enrollment in Medicaid managed care for the Medicare and Medicaid dual eligible population and children with special health care needs. States have significant experience designing, launching and administering managed care programs for special populations.*

10. **Harmonize federal payment rules across Medicaid delivery system models.** The Upper Payment Limit (UPL) is a federal cap on state Medicaid spending that only applies to fee-for-service reimbursement of Medicaid providers. States may develop supplemental payment programs to increase reimbursement for providers up to the UPL limit. State Medicaid programs cannot claim federal matching dollars for provider payments in excess of the applicable UPL. The shift from fee-for-service to managed care automatically reduces the ability of a state to make supplemental UPL payments to certain providers, including hospitals. CMS confirmed in the recent managed care regulation that a state cannot direct a Medicaid health plan pay particular rates or use a certain methodology. Essentially, different rules apply if states are paying providers under a fee-for-service model as compared to a capitated model.

*Resolve the inconsistency in federal Medicaid policy so that payment rules apply equitably, regardless of the state’s delivery system model.*

11. **Expand the tools states can use to design and manage Medicaid’s optional prescription drug benefit, including flexibility to exclude some FDA-approved drugs from coverage.** While still a fraction of the Medicaid budget, states are increasingly concerned by the statutory limitations they face in addressing the dramatic increase in growth rate for prescription drug expenditures. Namely, state Medicaid programs are required to cover all FDA approved drugs under the Medicaid Drug Rebate Program (MDRP), which limits the levers at states’ disposal to address prescription drug cost growth. While states may use prior authorization of drug therapies under the current MDRP framework, these tools are limited compared to what is available to private payers and Medicare Part D plan sponsors – and ultimately, Medicaid must cover all drugs, regardless of comparative efficacy or efficiency.

The lack of transparency into prescription drug pricing and costs also prevents states from entering into true negotiation with manufacturers. This issue, in combination with the statutory limits on the tools states can employ to manage the drug benefit, exacerbate concerns about Medicaid’s financial sustainability for states.
Expand the factors states may consider in setting their prescription drug benefit, including cost. Also, advance a multi-pronged strategy to address the affordability of prescription drugs, including providing: transparency for drug pricing for public programs; providing authority for new purchasing and reimbursement strategies for Medicaid’s prescription drug benefit, including flexibility to exclude some FDA-approved drugs from coverage; and limiting the states’ exposure to high-cost prescription drugs.

12. **Equalize treatment of the territories of the United States.** Unlike the states, all the territories are subject to the same FMAP matching requirement of 55% federal/45% local. This percentage does not reflect the poverty level in the territories, which in many cases is akin to some of the highest poverty rates in the 50 states. In addition, the statutory cap on the territories’ annual budgets significantly hinders the territories’ abilities to adequately fund their health care system and provide quality care to their populations. Consistently, the territories exhaust their annual Medicaid funding allocations. These two policies – the fixed FMAP and cap on Medicaid – results in many beneficiaries relocating to the U.S. to establish legal residency and enroll in other states’ Medicaid programs. Addressing these policies will allow the territories to realistically provide healthcare services for their low-income populations.

 Apply the same formulary to the territories as for the broader group of states and remove the Medicaid cap.

13. **Facilitate innovation in long-term care, particularly home and community-based services (HCBS).** Long-term care is a major feature and a costly part of the Medicaid program. To manage these costs, states are interested encouraging and supporting more effective use of HCBS. There is considerable interest in using state plan authority to pursue innovations and flexibilities in reimbursement policies to improve HCBS (e.g., tele-health for HCBS populations).

 Allow states to target services to specific populations who will most benefit and for whom the services would be cost-effective.