

JANUARY 2018

Manatt on Medicaid: 10 Trends to Watch in 2018



Introduction

Medicaid has entered a period of volatile change, unprecedented in its 51-year history.

With 74 million members nationwide,¹ Medicaid provides health coverage to more than one in four Americans, ensuring access to healthcare not only for children, pregnant women, the elderly and people with disabilities, but also for an increasing number of low-income working adults.

2017 saw repeated attempts to fundamentally restructure the Medicaid program, and although Congress is likely to turn its attention to other priorities in 2018, federal legislative efforts to revamp Medicaid remain in play. Short of congressional action, vigorous efforts by federal officials to use administrative authority to reshape the program is a certainty. And perhaps more than ever before, states will test the limits of their purchasing power and federal flexibility to make changes to their programs—driven by the desire to improve value, reduce the rate of expenditure growth, and shape the program to meet their policy and political objectives. At the boundaries of these federal and state efforts, expect the courts to weigh in.

Given the sheer size of Medicaid—the \$565 billion program constitutes 17% of health expenditures nationally—significant changes that we’re almost sure to see in 2018 will reverberate in states across the country. These changes will impact millions, including consumers, hospitals, health centers and other providers, health plans, life sciences companies, state governments, and local economies. The following are 10 trends to watch within this dynamic environment.

Trend 1
An End to the Federal-State Partnership as We Know It?

Expect the shared federal-state responsibility for funding and operating Medicaid to be tested in new ways, with potentially profound ramifications for the program.

Trend 2
Medicaid: Welfare Program or Health Insurer?

The debate will continue, even as federal officials advance policies consistent with a welfare framework.

Trend 3
Medicaid Work Requirements: Highway to Employment or Coverage Off-ramp?

More states will seek “community engagement” waivers and grapple with their implementation, while consumers and other stakeholders will feel the impact of coverage losses.

Trend 4
Opioid Crisis: No End in Sight.

New resources and strategies will be brought to bear to stem the tsunami of opioid-related deaths, while pressure mounts for greater accountability.

Trend 5
Raising the Bar for Medicaid Managed Care.

States will bring increased rigor to their managed care procurement, payment, and contracting to get more value from their plans.

Trend 6
The Market Gets Smarter About Value-Based Purchasing.

With mixed early results, expect increasing pressure to leverage multipayer strategies and a recalibration of expectations on both VBP outcomes and the investments necessary to achieve them.

Trend 7
New Tools for Behavioral Health Reform.

States will push the boundaries of federal flexibility to secure support for improving access to and the quality of behavioral healthcare.

Trend 8
Attacking the Root Causes: Addressing Social Determinants of Health.

Strategies to address social determinants of health will take hold in 2018 but will stick only if stakeholders can craft sustainable funding solutions.

Trend 9
States Advance LTSS Reform Through Integration.

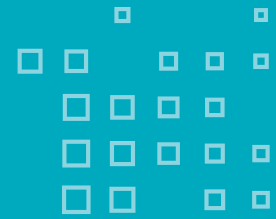
More states will tackle long-term services and supports reform through integration with physical and behavioral health services.

Trend 10
A New Prescription for Drug Spending.

Look for attempts to make Medicaid drug coverage look more like commercial benefits, and a push for value-based initiatives for high-cost therapies.

Trend 1

An End to the Federal-State Partnership as We Know It?



Expect the shared federal-state responsibility for funding and operating Medicaid to be tested in new ways, with potentially profound ramifications for the program.

Medicaid is governed by a unique partnership in which states and the federal government share responsibility for program costs as well as design and operation. The partnership has always been dynamic and sometimes contentious: states routinely seek more rulemaking flexibility and more federal funding; the federal government often promises more flexibility, and, at different times and for different reasons, it loosens or tightens federal purse strings. Despite the ebbs and flows—or perhaps because of the dynamism of the relationship—the basic contours of the partnership have endured.

2018 is likely to be a year in which the boundaries of this partnership are tested in unprecedented ways. The central issue relates to Medicaid’s financing. Since the program began, state and federal financial obligations

have been driven by the cost of services provided to beneficiaries, with the federal share set by a “matching rate” that is more favorable to poorer states and never below 50%. While the 2017 proposals to cap federal Medicaid funding may not be revisited before the mid-term elections, congressional interest in imposing a cap—either through another effort to “repeal and replace” the Affordable Care Act (ACA) or under the rubric of “entitlement reform”—persists.

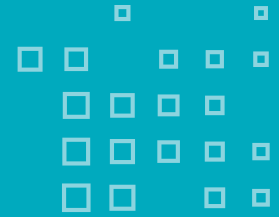
The implications of capped funding would be profound, cutting federal support to states (repeal and replace proposals in 2017 would have reduced federal Medicaid spending by \$750 billion to \$1 trillion over ten years)² and shifting to states full risk for costs that exceed the cap, whether due to the opioid crisis, cancer therapy breakthroughs, an aging population or higher drug costs. Additionally, under the block grant feature of the 2017 Graham-Cassidy proposal, funding would not adjust based on enrollment.

Given tight budgets and state constitutions that don’t permit deficit spending, states cannot be expected to fill the gap—leaving the risks, ultimately, with beneficiaries, localities, and those that provide healthcare services and long-term care.

The Department of Health and Human Services (HHS) also promises sweeping program changes through Medicaid waivers. Other trends in this report focus on the specifics of these waivers; from a federalism perspective, they are potential game changers that raise basic questions as to whether and which federal minimum standards will remain in place. The impact of the new era of waivers will depend on many factors, including whether waivers that carry a federal price tag will be approved as readily as those that cut federal spending. Healthcare providers and other stakeholders are beginning to engage more in waiver debates given the impact on the delivery system, but the final arbiter of this aspect of the federal-state partnership may be the courts.

Trend 2

Medicaid: Welfare Program or Health Insurer?



The debate will continue, even as federal officials advance policies consistent with a welfare framework.

Since its inception in 1966, Medicaid has evolved from a small adjunct to state welfare programs to the nation’s largest health insurer. When Congress ended the entitlement to cash assistance in 1996, imposing new time limits and work requirements, it simultaneously delinked Medicaid, walling off government-sponsored health insurance coverage from these new requirements and signaling that the Medicaid program was different. Passage of the ACA in 2010 solidified Medicaid’s role as health coverage, enabling states to expand Medicaid to all adults with incomes below 138% of the federal poverty level, integrating Medicaid and Marketplace coverage, and streamlining eligibility and enrollment in the new coverage continuum.

The Trump Administration has articulated a different view of Medicaid, describing it, consistent with traditional welfare programs, as intended for “society’s most vulnerable

citizens,” helping them “rise out of poverty and attain independence.” Throughout 2017, the Administration actively promoted ACA repeal and replace bills that would have ended or defunded Medicaid expansion. Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma characterized the Administration’s position in this way: “The thought that a program designed for our most vulnerable citizens should be used as a vehicle to serve working age, able-bodied adults ... does not make sense.”³

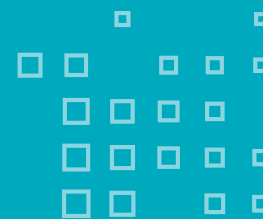
Given this position, it remains to be seen how federal officials will respond to states seeking to expand Medicaid in the future, be it Maine, Virginia, Kansas, North Carolina or a state not now on the radar screen. As a practical matter, federal discretion is limited: Medicaid expansions can be accomplished through a State Plan Amendment and do not require a Section 1115 waiver.

Beyond Medicaid expansion, expect CMS to use waivers and federal guidance to drive its vision of Medicaid, starting with

authorizing states to impose new conditions on Medicaid eligibility. As discussed in more detail in the next trend, the Administration, on January 11, 2018, issued new guidance describing the conditions under which it would permit states to deny coverage to adults who do not meet work or community engagement requirements; a day later it approved the Kentucky waiver, which added four new conditions to Medicaid coverage, including a work requirement. At least ten other states have submitted similar waivers. Also pending are waivers seeking to carry over from cash assistance to Medicaid coverage restrictions such as “lock-out” penalties for failure to meet certain program requirements and lifetime limits on eligibility. Expect the Administration to use the waiver process to explore the boundaries of state flexibility under current law, with an eye toward returning Medicaid to its welfare roots.

Trend 3

Medicaid Work Requirements: Highway to Employment or Coverage Off-ramp?



More states will seek “community engagement” waivers and grapple with their implementation, while consumers and other stakeholders will feel the impact of coverage losses.

Federal officials started the new year with state guidance that makes good on the Administration’s promises to support work as a condition of Medicaid coverage and, soon thereafter, its first two approvals of “community engagement” waivers for Kentucky and Indiana. The move reverses long-standing Medicaid policy and will reverberate nationally in 2018, with implications for consumers, states and providers:

- **Steady Stream of Waiver Approvals from CMS.** Kentucky and Indiana are among 11 states to date that have proposed work requirements as part of 1115 waivers. With its guidance out to states and the terms and conditions for two work waivers approved, CMS is on a glide path to additional approvals in the year ahead. Arkansas’s approval will likely come next.

- **More States Seeking Waiver Approvals.** States have been closely following the Kentucky and Indiana waivers, and some view them as templates for state-based Medicaid reform. Expect additional states to follow their lead in 2018. While states generally like to put their own “imprint” on waivers—and some nuanced variations are sure to emerge—the fundamentals will likely be the same.

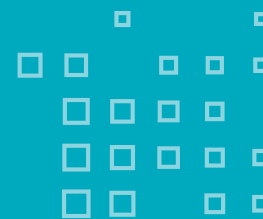
- **State Implementation Challenges.** The operational and IT infrastructure for states to administer community engagement requirements is another area to watch. In true “be careful what you wish for” fashion, states with waiver approvals will be grappling with costly and complex implementation realities in 2018. Kentucky’s Governor Bevin has requested \$23.5 million in state funds from his legislature to implement the Kentucky waiver.⁴ Of concern for states as they consider making this level of investment is recently filed litigation to block Kentucky’s waiver;

states may be reluctant to proceed until the courts decide the matter.

- **Coverage Losses.** When states begin to implement work requirements—likely in mid-2018 at the earliest—expect potentially dramatic drops in Medicaid enrollment. While studies show a majority of nondisabled enrollees are already employed,⁵ significant loss of coverage can be expected for administrative reasons—like enrollees failing to timely report compliance. This has been states’ experience implementing work requirements in Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP).⁶ The implications of coverage losses are obviously most impactful for individuals losing access to healthcare, including some high-needs individuals who are least likely able to “run the traps” on new administrative requirements, but also will be felt by providers, plans and other stakeholders.

Trend 4

Opioid Crisis: No End in Sight.



New resources and strategies will be brought to bear to stem the tsunami of opioid-related deaths, while pressure mounts for greater accountability.

With the opioid crisis now claiming more lives in the United States each year than the HIV/AIDS epidemic at its peak, driving a national decline in lifespan and overwhelming state social services and social justice systems, there is no doubt that it will continue to be a major focus of Medicaid policymakers in 2018.

- **Deploying Data Analytics.** With many of the key drivers of the epidemic well-documented—including overprescribing of opioids and the lack of alternative types of pain management—states and plans will increasingly look to big data to better understand and tackle these trends—for example, analyzing prescribing patterns and sharing prescribing data with physicians so they can see how they stack up against their peers. Watch for state investments in “unleashing the data” within their Medicaid programs (and by all payers) and in crafting

strategies to share data with key stakeholders.

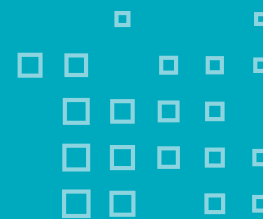
- **Bringing on the Treatment.** With increasing attention being paid to making sure the “right” care is available to individuals with addiction, look for states to press for greater use of medication-assisted treatment (MAT), and to take advantage of new waivers allowing Medicaid funds to pay for substance use disorder (SUD) care provided in institutions of mental disease (IMDs). Most importantly, expect an emphasis on making available the full continuum of care—because what works for one beneficiary may not work for another.
- **Litigation Heats Up.** As the epidemic continues, more states and localities are litigating, arguing producers and distributors are responsible and should be made to pay. Medicaid plans could find themselves caught up in questions of whether they did enough to monitor prescribing patterns and to offer alternatives to opioid-based pain relief. The litigation trend will continue in 2018; every

party will need to figure out where they stand and their plan of action for responding.

- **Bad Actors Smell Opportunity.** To date, people with commercial coverage have been the targets of dangerous “treatment houses” and exploited for insurance money. As Medicaid continues to expand its role, expect states, plans and others to become more vigilant against a tidal wave of fraud.
- **Naloxone Everywhere, but at What Price?** States are distributing naloxone broadly, to first responders, family members, schools, community centers, and over the counter. For now, as the country still struggles to reduce new users and provide effective treatment, naloxone remains a key way to prevent death. But with its cost rising sharply, look for a growing clash over the price of the lifesaving product.

Trend 5

Raising the Bar for Medicaid Managed Care.



States will bring increased rigor to their managed care procurement, payment, and contracting to get more value from their plans.

Over the past decade, states have looked to managed care organizations (MCOs) to bring budget predictability, accountability and improved outcomes to their Medicaid programs across an ever-broadening range of services and populations. In 2014, three out of four Medicaid recipients were enrolled in some form of managed care, and nearly 60% of Medicaid recipients were enrolled in comprehensive managed care products.⁷ As the number and diversity of enrollees in Medicaid managed care has expanded, so too have state expectations of plans. The result? States are bringing more rigor to their procurement and contracting processes, with a focus on advancing quality goals, improving the consumer experience, enhancing provider access, and directing provider payments to care delivery transformation priorities.

On the rate-setting front, expect states in 2018 to look beyond

standard approaches to require more creative quality and accountability metrics (not just Healthcare Effectiveness Data and Information Set (HEDIS)), and to embed funding in plan premiums for specific delivery system reform efforts—like care management capacity building and preparing providers to offer new types of services (such as Home and Community-Based Services (HCBS))—allowing states to get medical matching funds while delivering on transformation goals.

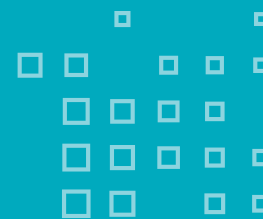
States are also raising the bar on plan contract requirements, going beyond the federal regulatory baseline to include a broad array of state-specific expectations. The most notable requirements link to the larger trends discussed elsewhere in this report—including setting targets for value-based payment arrangements between plans and providers (OH, PA, VA, WA), requirements related to behavioral health integration (NY, OR) and increasing expectations on plans to address social determinants of health (AZ, MN, NJ, NM, WA).⁸ States also are demanding

more in terms of how and where care management is delivered, including mandating coordination with health homes (MN, MO, NY), demanding that care management be provided locally (OH, PA) and integrating requirements related to Medicaid Accountable Care Organizations (ACOs) (MN, NJ). And when it comes time to enforce these requirements, states are increasing relying on liquidated damages—ranging from \$100 to \$5,000 per violation.

Finally, while federal officials are reviewing the federal Medicaid managed care “megarule” issued in 2016⁹ with a pledge for more state flexibility, any rollback of the rule is unlikely to impact this larger trend. While states will welcome relief from some of the more controversial provisions in the rule—like the detailed network adequacy standards—states were raising the bar before the rule was promulgated and are highly motivated to continue.

Trend 6

The Market Gets Smarter About Value-Based Purchasing.



With mixed early results, expect increasing pressure to leverage multipayer strategies and a recalibration of expectations on both VBP outcomes and the investments necessary to achieve them.

2017 saw some of the country's most prominent value-based payment (VBP) efforts suffer setbacks, with mixed performance among Medicare Shared Savings Program (MSSP) participants and payers and providers in New York hard-pressed to meet Medicaid VBP targets under the state's Delivery System Reform Incentive Payment (DSRIP) program.

Despite increasing focus and investment among state and federal policymakers, challenges to VBP adoption in Medicaid abound. Payment rates under the program remain generally insufficient to fund upfront investments needed for providers to succeed in VBP or to fund the shared savings opportunities to incent their participation. The lack of alignment of VBP programs, both within and among payer markets, further hinders provider participation. States on the front lines are discovering that

achieving meaningful VBP will require time and substantial financial investment—a notion that may fall flat for states looking to VBP to quickly reduce program costs at a time of ever-tightening Medicaid budgets.

Still, state interest in increasing provider accountability for cost and quality remains strong. States are contractually requiring Medicaid managed care plans to expand deployment of meaningful VBP arrangements in their provider networks and are demanding more in terms of the proportion of plan payments that are value-based and the level of risk assumed by providers. With this in mind, states—and the plans charged with meeting these contractual requirements—are looking at new strategies to overcome barriers to VBP adoption in Medicaid.

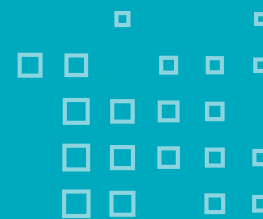
In 2018, expect to see states, plans and providers capitalizing on new alignment opportunities provided through the Medicare and CHIP Reauthorization Act (MACRA), which creates new links between Medicare bonuses and participation in payment models outside Medicare—including Medicaid

VBP arrangements. Under MACRA's "All Payer Combination Option," providers can "count" participation in other payer VBP contracts toward their MACRA targets. As 2019 approaches (the year in which providers can begin counting their non-Medicare VBP contracts under this option), look for Medicaid programs setting VBP standards to align with CMS criteria for the All Payer Combination Option. Doing so will provide a glide path to MACRA bonuses for providers and, in the process, an indirect but powerful incentive for providers to enter into Medicaid VBP contracts.

As VBP implementation progresses, a more realistic restatement of goals is likely to emerge, along with a new definition of what constitutes success. It may be that short- and mid-term success in VBP will be redefined as attaining meaningful quality improvement, breaking through the long-standing fee-for-service mentality, and enabling providers to survive despite these changes, with state savings and efficiency coming further down the road.

Trend 7

New Tools for Behavioral Health Reform.



States will push the boundaries of federal flexibility to secure support for improving access to and quality of behavioral healthcare.

With Medicaid funding up to 25% of mental health and SUD treatment, and with mounting data showing that those with behavioral health comorbidities are among the most costly and vulnerable Medicaid beneficiaries, states are under intense pressure to improve the quality, efficiency and cost of care for individuals with behavioral health conditions.¹⁰ In recent years, states have undertaken considerable efforts to integrate physical and behavioral health services at the clinical, payer and administrative levels—and have used Section 1115 waivers, including DSRIP waivers, to drive and fund these efforts. Responding to the new Administration’s enthusiasm for state flexibility in Medicaid, look for states to ramp up use of 1115 waivers in 2018 as a tool to address behavioral health.

In November 2017, CMS released guidance encouraging states to pursue waivers targeting

opioid use disorders and other SUDs. This guidance sent a clear signal that federal officials view waivers as a crucial mechanism for tackling the opioid epidemic. Under SUD waivers, states can obtain federal matching funds for residential SUD services delivered in IMDs, provided that they offer a full continuum of SUD services, strengthen care coordination for populations with SUDs, and achieve minimum standards for the quality of SUD providers and services. This represented a major departure in federal policy—welcomed by states that have long chafed under the financial burden of the IMD exclusion. To date, the Trump Administration has approved four SUD waivers. With at least nine SUD waivers under review at CMS, expect many more approvals in 2018.

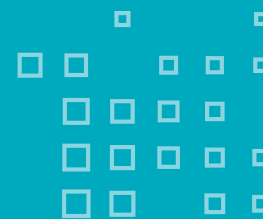
Notably, none of these approved waivers permit states to obtain federal matching funds for residential *mental health* services delivered in IMDs, despite requests from some states to do so. This issue is likely to be revisited in the year

ahead, with states pressuring CMS to expand IMD funding flexibility to cover a broader range of behavioral health services and to support states as they seek to treat patients across the full continuum of care. Whether CMS will be amenable to these pleas is unclear.

Beyond IMD, look for a small number of states to explore waivers to expand coverage to targeted populations with behavioral health needs. At least two nonexpansion states—Virginia and Utah—have used waivers to expand coverage to a small subset of very-low-income adults facing serious mental illness (VA), as well as SUDs and chronic homelessness (UT). While these waivers provide Medicaid coverage for high-need, high-cost populations, they do not offer the enhanced federal financing available for expansion populations. Nevertheless, for states resistant to expansion, the opportunity to bring in federal matching funds may be welcomed relief.

Trend 8

Attacking the Root Causes: Addressing Social Determinants of Health.



Strategies to address social determinants of health will take hold in 2018 but will stick only if stakeholders can craft sustainable funding solutions.

With a mounting evidence base for the influence of nonclinical and social factors—such as unstable housing, food insecurity and interpersonal violence—on health outcomes and healthcare costs, social determinants of health (SDOH) have edged into the mainstream. In 2018, expect to see adoption of SDOH strategies for the most vulnerable, high-need individuals to move at an accelerated pace—taking these interventions from theory into practice. But a key challenge will underlie the implementation and sustainability of these strategies: securing the funds to underwrite the cost of social interventions.

State Medicaid agencies are blazing a path with innovative Section 1115 waivers—like California’s “Whole Person

Care Pilots” and Washington’s “Foundational Community Supports”—securing federal funding to build stronger connections between networks of medical and health-related service providers to address enrollees’ physical, behavioral and social needs. Expect to see states taking action outside of waivers in 2018, including pushing the limits of state plan benefits to cover services that address SDOH, building SDOH-related requirements into managed care contracts (as Michigan has done), and enhancing plan payment, including through incentive arrangements, to compel plans to build network capacity to address these issues. Perhaps the most innovative solutions will come from new players like the startup “Cityblock Health,” which aims to transform healthcare for low-income urbanites, and companies with new technologies like “NowPow,” a community

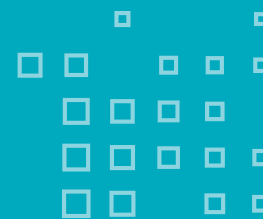
resource database providing “closed loop referrals” between a patient’s care management team and social service organizations.

As addressing SDOH initiatives for the most vulnerable flourishes this year, expect to see a few forward-thinking players turn their attention to the needs of a wider range of individuals, including children and families experiencing toxic stress, for whom the evidence base for SDOH, including “return on investment,” is growing.

At the end of the day, continued innovation in and expansion of SDOH initiatives will be possible only if stakeholders—CMS, states, plans and providers—can come together to craft sustainable funding solutions that support and reward investment.¹¹ Perhaps the most important issue around this trend in 2018 is whether this type of collaboration takes off and takes hold.

Trend 9

States Advance LTSS Reform Through Integration.



More states will tackle LTSS reform in 2018 through integration with physical and behavioral health services.

Medicaid is the nation's largest payer for long-term services and supports (LTSS), covering over 40% of LTSS expenditures at a cost approaching \$145 billion in 2013.¹² Between 2020 and 2030, one of the largest and the last cohort of the baby boom population will turn 65, adding 18 million people to the aging population and increasing pressure on state Medicaid programs to plan for rising LTSS costs.¹³ For these reasons, LTSS is a major Medicaid reform priority in 2018.

The primary LTSS trend in 2018 will be acceleration of initiatives to integrate LTSS with physical and behavioral health services through "managed LTSS programs." While the majority of Medicaid beneficiaries are now enrolled in managed care, the same does not hold true for Medicaid beneficiaries who use LTSS, including those who are dually eligible for Medicaid and

Medicare and individuals with intellectual and developmental disabilities. Following the lead of Virginia, Texas and Tennessee, states will increasingly look to "fully integrated" models to reduce care fragmentation, deliver person-centered and community-based care, improve health outcomes, and reduce overall program costs by placing accountability for coordinating and delivering comprehensive services in a single entity or aligned entities.¹⁴

Not every state is ready to launch or interested in launching a fully integrated model for all populations in 2018. As a glide path to full integration, states will look to phase in integration, leveraging lessons learned from the 22 states that currently operate some form of managed LTSS program. This includes ten states that participate in the federal Financial Alignment Initiative (FAI), focusing on integrating LTSS and providing comprehensive services for dually eligible beneficiaries. Leveraging lessons learned from

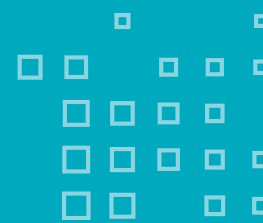
these states will be especially critical with FAI authority expiring in 2018.

States will also explore "next generation" models of integrating Medicaid and Medicare benefits for dually eligible beneficiaries using Medicaid managed care and Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) authorities. States can also be expected to develop new or expand enrollment in existing Programs of All-Inclusive Care for the Elderly (PACE). Finally, a small number of states will explore provider-driven models of care, like ACOs, that integrate LTSS, physical health and behavioral health services, for which the provider organization assumes total cost of care responsibility.

As these models flourish in 2018, states need to tackle development of quality and performance measures that strengthen the LTSS system and are meaningful to LTSS consumers.

Trend 10

A New Prescription for Drug Spending.



Look for attempts to make Medicaid drug coverage look more like commercial benefits, and a push for value-based initiatives for high-cost therapies.

Prescription drug spending is a relatively small share of costs compared with other Medicaid services (4% of Medicaid spending after rebates), but it is an area of rapid growth and sometimes unpredictable spending. Gross spending increased nearly 25% from 2013 to 2014 and another 14% in 2015.¹⁵ This growth is partially the result of emerging high-cost drugs; in 2015, 5% of drug spending was related to two high-cost therapies.¹⁶ Against this backdrop, state efforts to control drug spending in Medicaid is a trend to watch in 2018.

- **Increased Reliance on Managed Care.** Growth in Medicaid managed care generally and an ACA policy change giving state Medicaid programs the federal rebates for drugs covered by Medicaid managed care companies¹⁷ are resulting in an increasing number of states handing the

reins over to their MCOs to control drug spend. States will be watching closely to see if MCOs can render savings from these arrangements in the year ahead.

- **Proposed Waivers to Establish Formularies.** States are looking for ways beyond utilization management to tamp down the growth rate and unpredictability of prescription drug spending. Massachusetts submitted a Section 1115 waiver¹⁸ to establish a Medicaid formulary more akin to the commercial market, limiting covered drugs by waiving federal 1927 requirements that states cover all drugs eligible for rebate. Arizona submitted a letter¹⁹ to CMS indicating its interest in excluding certain treatments from coverage “until market prices are consistent with reasonable fiscal administration.” Stakeholders are waiting to see whether CMS will waive the 1927 requirements—a precedent-setting decision that would trigger a wave of similar state waiver requests. Look for states to press the

Administration for more flexibility in managing drug costs and utilization in 2018.

- **Value-Based Pricing.** Interest in value-based contracting for drugs continues to grow. While there are some legal and regulatory barriers, the Administration is signaling interest in exploring its waiver authority to advance these approaches. In the fall, Novartis hinted at an innovative pricing arrangement for a new gene therapy drug; soon thereafter, Spark Therapeutics announced a similar request to CMS. Though these arrangements have not been approved, CMS noted in a press release²⁰ the agency’s commitment to use the Center for Medicaid and Medicare Innovation (CMMI) to “identify and alleviate regulatory barriers in Medicare and Medicaid as may be necessary to test payment and service delivery models that involve value-based payment arrangements.” Expect CMS to actively encourage states to think more about proposing these types of initiatives in Medicaid.

About Manatt

Manatt Health is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice composed of professionals from [Manatt, Phelps & Phillips, LLP](#), and its wholly owned subsidiary, Manatt Health Strategies, LLC. Manatt Health's extensive experience spans the major issues reinventing healthcare, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid redesign and innovation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With more than 160 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health serves its clients from nine offices across the country on projects in more than 30 states. For more information, visit <https://www.manatt.com/Health>.

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¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/total-enrollment/index.html>

² Range based on Congressional Budget Office (CBO) estimates of reductions to federal funding to states under repeal-and-replace legislative proposals in 2017: the American Health Care Act (\$834 billion), the Better Care Reconciliation Act (\$772 billion) and Graham-Cassidy (\$1 trillion).

³ Remarks by Administrator Seema Verma at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html>

⁴ <https://www.politicopro.com/health-care/article/2018/01/new-medicaid-work-rules-pose-administrative-challenge-for-states-299339>

⁵ <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>

⁶ After implementation of SNAP work requirements in Kansas, enrollment among those subject to the requirements fell 70%. Maine experienced an 80% enrollment decline under SNAP work requirements. Source: Foundation for Government Accountability, Aug. 2015, [https://thefga.org/download/2015_policy_solutions/RestoringWorkRequirements-ResearchPaperFinal\(3\).pdf](https://thefga.org/download/2015_policy_solutions/RestoringWorkRequirements-ResearchPaperFinal(3).pdf)

⁷ 2014 Medicaid Managed Care Enrollment Report, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Spring 2016. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf>

⁸ States listed are illustrative and not an exhaustive list.

⁹ <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201710&RIN=0938-AT40>

¹⁰ Substance Abuse and Mental Health Services Administration. Behavioral Health Spending and Use Accounts, 1986–2014. HHS Publication No. SMA-16-4975. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016. Available at <https://store.samhsa.gov/shin/content/SMA16-4975/SMA16-4975.pdf>

¹¹ https://www.ahip.org/wp-content/uploads/2017/07/SocialDeterminants_IssueBrief_7.21.17.pdf

¹² “Who Pays for Long-Term Services and Supports? A Fact Sheet.” Congressional Research Service. July 2015. Available at: <https://fas.org/sgp/crs/misc/R43483.pdf>

¹³ <http://www.prb.org/pdf16/aging-us-population-bulletin.pdf>

¹⁴ Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States. Center for Healthcare Strategies. December 2017. Available at <https://www.chcs.org/resource/strengthening-medicaid-long-term-services-supports-evolving-policy-environment-toolkit-states/>

¹⁵ Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. (2016). National Health Expenditures: Historical. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

¹⁶ <https://www.macpac.gov/wp-content/uploads/2017/03/High-Cost-HCV-Drugs-in-Medicaid-Final-Report.pdf>. This percentage does not include federal or state rebates.

¹⁷ Prior to ACA, the federal rebates required under Section 1927 were only for prescription drugs through fee for service (FFS). The ACA applied federal rebates to drugs provided under Medicaid managed care as well.

¹⁸ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-pa3.pdf>

¹⁹ https://www.azahcccs.gov/shared/Downloads/News/FlexibilitiesLetterFinal_11172017.pdf

²⁰ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-30-2.html>

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