



## The First 100 Days: Laying the Groundwork for a Successful Federal-State Medicaid Partnership

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 on a vision for their respective states to reorient their delivery and payment structures to improve health outcomes.

As Medicaid continues to evolve, NAMD believes the 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 through the establishment of ongoing federal-state collaborations in priority areas. In the first 100 days, federal and state agencies can set a course to align the current realities for running a Medicaid program and the vision for high performing Medicaid programs and a high performing health care system more broadly.

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.

## The First 100 Days

**We call upon the new Administration to convene with NAMD's Board of Medicaid Directors to solidify specific areas for ongoing collaboration to be carried out and reflected throughout our respective agencies.**

NAMD and the Centers for Medicare and Medicaid Services (CMS) have dedicated resources to collaborations in priority areas for the state and federal governments, including the move to value-driven models of care. In particular, we have come together to work towards a shared understanding of how Medicare and Medicaid can complement, align, and learn from each other in areas of payment and delivery system redesign. Federal support for state-driven initiatives has been a valuable resource for the on-the-ground work that is underway.

We also have agreed upon a framework for bringing issues around managed care implementation to key Center for Medicaid and CHIP Services (CMCS) staff. We've worked through process, as well as policy issues. While we may not always have been 100 percent satisfied with the outcomes, we believe the opportunity to dialogue about managed care implementation and present state perspectives is critical.

We value open lines of communication with CMS leadership and wish to enhance collaboration around the variety of policy and operational areas important to the federal and state agencies. We have been able to reach out at any point on emergent issues, to talk through concerns, and to serve as a resource to each other in tackling the variety of difficult policy and operational responsibilities of the Medicaid leadership. It is a culture and practice that is mirrored by the expert staff within CMS and NAMD.

**The Administration should make two updates to the process for developing federal Medicaid regulations and guidance. First, build in a step for engaging states during the pre-conceptual phase of work. Second, establish a distinct process whereby state Medicaid leaders can review federal regulations and guidance prior to finalization to ensure policies are operationally sound.**

The Medicaid program was created as a partnership between the states and federal governments, with joint financing responsibilities, state administration and federal oversight. States are operating increasingly more sophisticated Medicaid programs, which are themselves growing in size and scope. Many of these programmatic changes require significant staff and vendor resources just to maintain existing authorities and keep 'waivers' or demonstration projects running. It is through this lens that we collectively believe that the partnership between states and the federal agency has not evolved to reflect the Medicaid program of the 21<sup>st</sup> century. Increasingly, federal regulations and guidance are divorced from the practicalities of operating a Medicaid program. Nor can federal regulators reasonably be expected to conceive of the universe of innovations states may wish to pursue. Meaningful engagement between federal and state Medicaid leaders at key points in the regulatory development process —

mirroring states' robust engagement with stakeholders at the local level – can help to align federal regulations with shared programmatic goals and federal oversight responsibilities.

**We urge the Administration to improve the timeliness and efficiency of the standard business transactions between the federal and state Medicaid agencies.**

The process for state plan amendment (SPAs) and waiver submission, review, and approval should be updated to make more efficient use of limited federal and state resources. Examples of modernization include the following:

- Encourage timely federal consideration and action on SPAs, waivers and other state proposals.
- Limit the questions for states about SPAs to only those necessary and relevant to the matter at hand in the amendment request.
- Allow states to limit the providers of services to those determined by the state as appropriate for a particular service, without need for a 1915(b)4 waiver to restrict services to certain provider types.
- Articulate expedited parameters for approving Section 1115 waivers or waiver elements in states that are substantially similar to waivers approved in other states.

**The Administration should foster federal-state collaboration on the following key issues.**

*Alternative Payment Methodologies (APMs)*

Ensure Medicare payment reforms under the Medicare Access and CHIP Reauthorization Act (MACRA) and other federally-driven models and payment reforms are synthesized with each other and with state-driven initiatives (e.g. Medicare-Medicaid duals initiatives, State Innovation Models, Comprehensive Primary Care Plus, etc.). In particular, we recognize that MACRA implementation will likely continue in the years ahead. A federal-state forum could effectively inform the still-evolving multi-payer provisions under MACRA. In addition, the strong influence of State Innovation Model (SIM) grant funding is an important stream of funds that should continue to support state-led innovation.

The framework and culture of collaboration established in the early days of the new Administration will allow us to enhance collaboration between federal and state leaders on alignment of Medicare and Medicaid APMs and related value-based purchasing initiatives. The future success of any such collaboration hinges on the Administration articulating clear goals and a vision for working with states to include Medicaid in APMs. This vision and practical implications must be conveyed to and understood by federal staff at all levels.

*Medicare and Medicaid Dual Eligible Population*

NAMD proposes that the new Administration prioritize its work with states to drive long-term stability and administrative alignments for the Medicare and Medicaid dual eligible population. Specifically, we ask the Administration to:

- 1) Partner with states to develop a plan for providing continuity and stability to the financial alignment demonstration programs;
- 2) Support permanent authorization of the Medicare Advantage Special Needs Plan (particularly the Dual Eligible SNP) platform, with mandatory MIPAA-like agreements for all SNPs;
- 3) Designate a federal Medicare Advantage SNP expert to serve as a point of contact for each state interested in enhancing its D-SNP contracting and joint oversight initiatives with CMS;
- 4) Finance the testing of state-led initiatives to align enrollment policies for the dual eligible population as between those permitted for Medicare only or Medicaid only enrollees; and
- 5) Allow state Medicaid agencies to apply and be designated as Medicare Part D coverage providers for dual eligible enrollees.

In addition, NAMD supports the Medicare-Medicaid Coordination Office's (MMCO or Duals Office) work with states to improve care coordination. This office 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 welcome continued investment to enhance the various supports the MMCO offers, including webinars on best practices, resources focused on Medicare data analytics and the larger demonstration initiatives.

Additionally, NAMD has a record of supporting ongoing work by CMS to ensure Medicare's payments and quality rating system are appropriate for duals-focused plans, specifically the hierarchical conditions coefficient (HCC) and the STARs rating program.

### *Prescription Drugs*

The Administration should advance proposals to enhance the transparency of prescription drug costs and pricing, and request statutory authority for states to test innovations in prescription drug benefit design, including flexibility to exclude some FDA-approved drugs from coverage. While still a relatively small portion of the Medicaid budget, states are increasingly concerned by the statutory limitations they face in addressing the dramatic increase in prescription drug expenditure growth in recent years. 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.

In addition, the lack of transparency into prescription drug pricing and costs prevents states from entering into true negotiation with manufacturers. This, in combination with the statutory limits on states' ability to manage the drug benefit, exacerbate concerns about Medicaid's financial sustainability for states. As policymakers confront these concerns, state input and experiences into proposals to address prescription drug costs will be essential for realizing the desired impact on Medicaid expenditures and access.

### *Managed Care/Risk-Based Delivery Models*

NAMD proposes the Administration establish a process whereby states can review and provide feedback on sub-regulatory guidance and related documents on Medicaid managed care/risk-based delivery models. This process should take place prior to finalization to ensure policies are operationally sound. The managed care regulation provides a comprehensive framework for managed care programs. States have a vested interest in the operational feasibility of forthcoming sub-regulatory guidance pertaining to the managed care regulation. Particular provisions that will require dedicated federal-state collaboration include quality encounter data, quality rating systems/report cards, medical loss ratio, and *in lieu of* authority, among others. Clear lines between the regional offices and central office on respective roles in the rate reviews would also meaningfully help streamline the process.

Notably, states also are continually evolving the managed care model and will need sub-regulatory parameters that can adapt to federal and state expectations for alternative payment methodologies. States are best-positioned to identify provisions that pose more complex issues for delivery system transformation, and aspects which require more tailored state strategies.

### *Behavioral Health Issues*

The Administration should partner with states on three main issues that impede Medicaid's ability to improve services and outcomes for individuals with behavioral health conditions. These include: the privacy regulations governing substance use disorder (SUD) records, Medicaid's payment exclusion for certain institutions, and implementation timeframes for the parity regulation.

First, existing privacy regulations governing substance use disorder information (42 CFR Part 2) have been interpreted as precluding disclosure to electronic health records and preventing care coordination. 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. The Administration should leverage the extent of its authority – or work with Congress if necessary – to eliminate the extraneous regulatory barriers for meaningful coordination of health care services for individuals with SUD diagnoses.

Next, NAMD supports a federal-state collaboration to develop alternative pathways to shore up the continuum of services available to vulnerable populations with mental health diagnoses and addressing the institutions for mental disease (IMD) exclusion. An example of this is the development of an 1115 template for mental health services similar to the existing template for SUD programs. While Medicaid is obligated to provide for the full continuum of services for individuals with behavioral health diagnoses (including appropriate stays in a facility-based setting), the IMD exclusion 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. This 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.

Finally, we ask the Administration to review the parity regulations and provide flexibility in the effective date for states to comply with the rule issued in March 2016. The importance of parity – and the unique complexities in its application in Medicaid – are widely acknowledged. Technical assistance resources have been delayed from CMCS and state Medicaid programs need additional time to avail themselves of this guidance that will not be available until later in 2017. States will also need to implement outreach and education initiatives, comparative analyses, contract modifications, system updates and other changes after guidance is issued.

### *Access to Services*

CMS should work with states to develop meaningful standards and a process that effectively applies the statutory intent of the access regulation. States are in the early stages of understanding CMS' expectations around the new federal access monitoring plans and SPAs for rate adjustments. However, states' early engagement with CMS point to burdensome standards and unsustainable processes for operationalizing the provisions of the access regulation.

### *Home and Community Based Services (HCBS)*

The Administration should work with states on a process for meeting the goals of CMS' home and community based services (HCBS) settings regulation. States – and our federal partners – have been challenged with the aggressive timeline due to the delay in issuing critical sub-regulatory guidance, the complexity of the issues and the magnitude of work required to reorient an industry to focus on the person-specific needs for living and thriving in integrated community-based settings. State compliance with this regulation has been further impacted by regulatory action from the Department of Labor (discussed below). In particular, NAMD urges the Administration to think about concrete and practical milestones or benchmarks for HCBS that could be developed on a national or state basis or some combination thereof.

### *Department of Labor & the Fair Labor Standards Act*

The Administration should partner with states to address concerns for state Medicaid programs with the Department of Labor regulations implementing the Fair Labor Standards Act (FLSA). Medicaid Directors have longstanding concerns with the regulations implementing FLSA and the unintended consequences they will have on Medicaid home and community-based services (HCBS). The first DOL regulation, which extends the FLSA's minimum wage and overtime requirements to home health workers, is placing significant strain on Medicaid HCBS budgets. The regulation's intent to expand access to home care worker services via increased wages and benefits may have the opposite effect in practice, as states work within limited HCBS budgets to meet this regulatory requirement.

Subsequent rulemaking sought to raise the wage level under which workers receive overtime, which would have significant impact on Medicaid HCBS programs. This policy, as well as an

exception that was subsequently added for certain ID/DD providers, misunderstands the Medicaid program; is discriminatory against some populations that receive HCBS; and may have the effect of limiting the available community providers for Medicaid beneficiaries. A federal judge recently issued a nationwide injunction on this DOL rule in recognition of state concerns and other issues. As a result, we urge the Administration to partner with states to resolve concerns with FSLA implementation.

### *Medicaid Management Information Systems (MMIS)*

State Medicaid agencies seek a partnership with the Administration to advance the vision and implementation for a modular approach to Medicaid management information systems (MMIS) and technology. State Medicaid leaders have never been more vested in the development and acquisition of technology to support complex delivery system and payment initiatives in the Medicaid program. Like the managed care reviews, the role of the regional offices versus the central office could be better defined and clarified in this critical systems work.

With regard to MMIS, the Administration should strike a balance between the need for competition and the merits of existing, experienced vendors, recognizing that states, CMS, and vendors are still defining this new approach. CMS should continue to work with states to distinguish between areas that lend themselves to standardization and areas where states must retain the ability to customize their systems to accommodate their state-specific programs. Finally, CMS should focus on establishing interoperability standards for modules/vendors.

### *Transformed Medicaid Statistical Information Services (T-MSIS)*

CMS should enhance collaboration with states around the functionality and data analytics produced by the transformed Medicaid Statistical Information Services (T-MSIS). The federal and state agencies have a shared interest in more timely and accurate Medicaid data from T-MSIS that can be used to evaluate programs and guide federal and state policymaking.

An applied federal-state T-MSIS forum is necessary to ensure the following: 1) shared federal-state goals for the analytic priorities and program development support provided by T-MSIS; 2) mutual agreement on process(es) for state review and release of T-MSIS analyses and products; and 3) acknowledgement and remediation of challenges with T-MSIS production.

### *Other Existing Regulations*

CMS should collaborate with Medicaid Directors to understand the impact of other regulatory requirements on Medicaid, and provide additional guidance and resources – where necessary – to support state implementation of those rules. States are in the process of implementing an array of other federal regulations that impact the Medicaid program, in addition to those mentioned above. Many of these rules include a short timeline for implementation. States often need additional guidance from CMS to implement the requirements in the allotted timeframe. For example, states point to the need for additional guidance to implement new rules on non-discrimination in health programs, as well as technical assistance resources for the rule

implementing mental health parity in Medicaid. We encourage the Administration to partner with states to identify needed sub-regulatory guidance and resources.