Advocating for Consumers in State Medicaid Managed Care Contracting

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Thank you for joining us. We will begin the webinar shortly.

AN ADVOCATE'S TOOLKIT

Medicaid Managed Care and Mental Health Services and Pharmacy Benefits

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Medicaid Refresher

Medicaid: Basic Facts

- Low-income individuals
- ~67 million beneficiaries
- Federal/state partnership
  - Managed separately by each state
  - Federal government matches state dollars, paying ≥50% of costs
  - 2009: $373.9 billion (15% of total US health expenditure)[1]

Medicaid Eligibility

- Federally mandated Medicaid beneficiaries
  - Certain low-income children
  - Certain low-income parents
  - Pregnant women with income ≤133% of federal poverty level (FPL)
  - Elderly
  - Blind and disabled
- Some states opt to serve more people
- 2014: Target date for extended Medicaid eligibility
  - Almost all uninsured individuals
  - Families with income ≤133% of FPL

Medicaid Services

Mandatory	Optional
• Hospital services (ie, inpatient and outpatient) • Physician services • Laboratory and x-ray services • Nursing home and home health services	• Prescription drug benefits • Dental services • Targeted case management • Rehabilitation services • Prosthetic devices and eyeglasses

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Medicaid and Mental Health

Mental Health in the United States

- 1 in 17 adults lives with severe mental illness (SMI)[1]
- 1 in 10 children lives with a serious mental/emotional disorder[1]
- People with SMI at increased risk
  - Additional chronic medical conditions[2]
  - Shortened life expectancy[3]

Medicaid is single largest payer for mental health services in the United States.

[1]National Alliance on Mental Health (NAMI), State mental health cuts: a national crisis, March 15, 2011, www.nami.org/Template.cfm?Section=state_budget_cuts_report. [2]Colton CW, et al. Cited in: NAMI, Mental illness: facts and numbers, [date unknown], available at: http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=5315. [3]Manderscheid R, et al. Cited in: NAMI, Mental illness: facts and numbers, [date unknown], www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=5315.

Medicaid Mental Health Services

All States	Majority of States
• Therapy and counseling • Medication administration and management • Assessments, evaluations, and testing • Treatment planning • Emergency care	• Crisis intervention • Mobile crisis services • Crisis stabilization • Partial hospitalization • Day treatment • Outpatient substance abuse (basic treatment and intensive services) • Ambulatory detoxification • Methadone maintenance therapy

Medicaid Mental Health Prescription Benefits: Open Access

- Although most states have provided largely unrestricted access to pharmacy benefits, they are increasingly looking to contain these costs
- Cost-containment measures are of concern to advocates because mental health medications:
  - Are not clinically interchangeable
  - Work differently—even within the same drug class
- Physicians must have access to a wide range of options to ensure that they can find the appropriate medication and dosage level to treat each patient

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Medicaid Managed Care

Medicaid: Growth of Managed Care

- 2 divergent managed care trends
  - Declining in the commercial market
  - Increasing within state Medicaid programs
    - 71% of current beneficiaries[1]
    - All states except Alaska, New Hampshire, and Wyoming[1]
    - 42 states have ≥50% of beneficiaries in comprehensive managed care (including managed care organizations & primary care case management)[1]
- Possible state goals for Medicaid managed care programs
  - Improved care management and coordination
  - Secure provider networks
  - Lower Medicaid spending
  - Predictable expenditures
  - Improved program accountability

[1] Kaiser Commission on Medicaid and the Uninsured, A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, September 2011, http://www.kff.org/medicaid/8220.cfm.

Medicaid Managed Care and Mental Health

- Budget pressures have prompted states to expand their Medicaid managed care plans to patients with more serious conditions (eg, SMI, physical disability)
- Among disabled Medicaid beneficiaries nationally:
  - 58.4% enrolled in some type of managed care program[1]
  - 28% enrolled in comprehensive, risk-based managed care programs[1]

[1]Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission (MACPAC), Report to the Congress: The Evolution of Managed Care in Medicaid, June 2011, http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw.

Managed Care Plans

- Integrate the medical care and insurance systems
- Take different forms, but most plans:
  - Have a limited network of physicians
  - Require approval from primary care providers (PCP) before patients can see specialists
- Generally pay a set monthly fee per patient to PCPs for patient management services, regardless of amount of care provided
  - However, some plans also incorporate a fee-for-service (FFS) component

Medicaid Managed Care Responsibilities

- For program administrators, there are several areas of managed care responsibilities, including:
  - Quality assurance
  - Setting rates and monitoring claims
  - Customer service
  - Provider network management
  - Usage management
  - Data collection and analysis

Managed care. Fed Regist. 2011;76(108):32816-32838. To be codified at 42 CFR §438, http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.

Managed Care Models

- 3 basic managed care models are recognized by the Centers for Medicare and Medicaid Services
  - Comprehensive risk-based managed care plan
    - Managed care organization (MCOs)
  - Provider-based managed care
    - Primary care case-management (PCCM) plan
  - Limited benefit plan

Comprehensive Risk-based Managed Care Plans/Managed Care Organizations (MCOs)

- Can cover all (full-risk) or some (partial-risk) services
  - Fixed monthly amount (ie, capitation) paid to PCPs for covered services
    - Additional payments for other services on FFS basis
- Often health maintenance organizations (HMOs)
  - Members go to care providers who have contracts with the HMO
  - PCP gives basic care and referrals
- 2010: 35 states and DC contracted with MCOs[1]
- 2009: 22 states and DC had >50% total Medicaid population enrolled in comprehensive risk-based managed care[2]

[1] Kaiser Commission on Medicaid and the Uninsured, A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, September 2011, http://www.kff.org/medicaid/8220.cfm, p. 13.

[2] MACPAC, Report to the Congress: The Evolution of Managed Care in Medicaid, June 2011, http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw.

Risk-based Plans and Organizations by Level of Risk

- Full-risk plan
  - Federal government requires coverage of certain services[1]
  - MCO bears entire risk (ie, cost) of patient services, whether more or less than expected are used
    - Discourages unnecessary procedures—but may also restrict use of some helpful but costly ones
    - Encourages use of preventive care
    - More predictable monthly expenditures for states
- Partial risk plan
  - Mixes capitation model with FFS

[1]Managed care. Fed Regist. 2011;76(108):32816-32838. To be codified at 42 CFR §438, http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.

Primary Care Case Management

- PCP receives small monthly fee to coordinate each patient's care
  - Some services provided on FFS basis
- 2010: PCCM used in 31 states[1]
  - Popular as managed care model in rural areas
- Additional PCCM models
  - Enhanced PCCM – Wider range of services and greater care coordination via use of case managers; specializes in care for patients with chronic conditions
  - Patient-centered medical home – Expanded access and culturally effective care; PCP plus team of providers to customize care

[1] Kaiser Commission on Medicaid and the Uninsured, A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, September 2011, http://www.kff.org/medicaid/8220.cfm, p. 14.

Limited Benefit Plans and Administrative Services Organizations

- Limited benefit plan
  - Non-comprehensive – covers only one type of benefit (eg, behavioral, dental, transportation, inpatient, ambulatory, substance abuse)
    - Used in conjunction with MCOs and FFS models
  - Capitated payments
  - May have more expertise than MCOs in meeting needs of particular beneficiaries (eg, managed behavioral health organizations for people with SMI)

- Administrative services organization (ASO)
  - Manages claims and benefits
  - Optional services: Data reporting, care coordination, and/or customer service
  - Paid fixed fee

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Medicaid Managed Care

Mental Health Services and Pharmacy Benefits

Mental Health Services and Prescription Benefits

- State Medicaid programs (or their MCOs) may separate 1 or both of these components from other healthcare services and/or pharmacy benefits, contracting (or subcontracting) them to:
  - Managed behavioral health organizations (MBHOs) or community mental health centers
  - Pharmacy benefit managers (PBMs)
- Medicaid prescription drug benefits for mental health medications vary widely among states, with some states being less/more restrictive
  - Approximately 20% of states currently "carve out," or exclude, mental health drugs from MCO contracts[1]
  - Drugs not on the state preferred drug list (PDL) often require providers to obtain prior authorization (PA)

[1]National Conference of State Legislatures (NCSL). Recent Medicaid prescription drug laws and strategies, 2001-2010. March 2011. www.ncsl.org/default.aspx?tabid=14456.

Pharmacy Benefit Managers

- PBMs may provide a wide range of services
  - Process claims
  - Discount drug prices by negotiating with manufacturers
  - Mail-order pharmacies
  - Negotiate supplemental rebates from manufacturers
  - Make recommendations to Medicaid Pharmacy & Therapeutics (P&T) Committees
  - Collect data and make recommendations to:
    - Healthcare providers (eg, prescribing practices, dispensing rules)
    - Patients (eg, disease-management tools)
- PBMs are usually paid a management fee rather than a capitation amount

Medicaid Prescription Benefits

- Optional service under federal Medicaid law
  - However, all states (to this point) have chosen to cover medications—at least to some extent
- States can opt to limit access to prescription drugs
- Prescription drug benefits
  - Can be eliminated without a federal waiver
  - Are most vulnerable to budget cuts and other attempts to restrict access

Mental Health Prescription Benefits

- Critical and integral part of medical treatment for people living with SMI
  - Difference between being a productive, fully engaged participant in a community and being institutionalized, incarcerated, or homeless
- Mental health treatment is highly effective
  - 70-90% of people with SMI can experience decreased symptoms and increased quality of life with the right pharmacologic, psychosocial, and supportive services[1]
  - Improves health outcomes
  - Limits future use of expensive medical interventions
- Access to prescription drugs is crucial to:
  - Health and well-being of people living with SMI
  - Reducing overall Medicaid expenditures for this patient population

[1]NAMI, Mental illnesses – What is mental illness: mental illness facts, [date unknown], www.nami.org/template.cfm?section=about_mental_illness.

Cost-containment Strategies

- Drug benefits are extremely vulnerable to cost-containment measures such as:
  - PDLs and restrictive drug formularies
  - PA requirements
  - Cost-sharing arrangements
  - Medication dispensing limits
  - Requiring/incentivizing use of generic equivalents
  - "Fail first," step therapy, or therapeutic substitution policies
  - Supplemental rebates
  - Multi-state purchasing coalitions

PDLs, Restrictive Drug Formularies, and PA Requirements

- States with PDLs in FY2011: 45 + District of Columbia[1]
  - Approximately half of these states carve out whole drug classes for specific (generally costly) medical conditions, such as mental illness[2]
  - Restrict number and range of medications (formulary) for which Medicaid will pay
    - Create PDLs of medications that providers can prescribe without needing to obtain permission
    - HCPs must obtain PA for prescriptions not on the PDL
- Advocacy response
  - Shift costs to more expensive forms of "condition management" that are paid for solely by states
  - Patients with medication coverage gaps are:
    - 3 times more likely to become homeless[3]
    - 2 times as likely to be incarcerated[3]
    - In fact, inpatient mental health spending is nearly 40% higher in states with drug restrictions[4]
  - Consistent mental health medication access = Average monthly savings of $166 per patient[5]

[1] Kaiser Commission on Medicaid and the Uninsured, Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012, http://www.kff.org/medicaid/upload/8248.pdf, Appendix A-7a. [2]NCSL. *Health Cost Cont Effic.* 2010;9:1-6. [3]West JC, et al. *Psychiatr Serv.* 2009;60:601-610. [4]Moore WJ, et al. *J Health Polit Policy Law.* 2000;25(4):653-688. [5]Mental Health America. Talking points: restrictive formularies and preferred drug lists [date unknown]. www.liveyourlifewell.org/farcry/%E2%80%A2/go/action/policy-issues-a-z/access-to-medications/talking-points-restrictive-formularies/talking-points-restrictive-formularies-and-preferred-drug-lists.

Cost-sharing Arrangements

- Implemented by most states
- Shift some cost of medications back onto patients
- Most common form is copayment model (copays)
- Can be ≤20% of cost for beneficiaries with incomes >150% of FPL
- Advocacy response
  - Often a hardship for low-income beneficiaries
    - Save money primarily by discouraging beneficiaries from filling prescriptions at all
      - Can increase emergency room use by 88%[1]
  - Do not generate significant state revenue
    - Patient copays are not federally matched, so copays do not offset a significant percentage of state costs
  - Increase state administrative costs

[1]Cited by: American Psychiatric Association, et al. Joint Statement on Medication Cost Sharing in State Medicaid Programs [date unknown]. www.nmha.org/go/action/policy-issues-a-z/access-to-medications.

Medication Dispensing Limits and Mandated Generic Equivalents

- States with dispensing limits: 16[1]
  - Restrict number of: prescriptions, pills, refills, and/or brand-name prescriptions
- States with generic drug rules: 22[2]
  - Incentivize patients (eg, lower copay amounts) and providers/pharmacists (eg, higher reimbursements) to use generic equivalents because generics often cost 80-85% less than brand-name medications (before drug rebates factored in)[3]
- Advocacy response
  - Numerical prescription limits
    - Pose significant challenges to people with multiple health issues (eg, comorbid SMI)
    - May not save money over long term; beneficiaries more likely to need more expensive medical care in the future as a result of deferred treatment
  - Generic equivalents are not available for newer drugs
  - Restricted access to new drugs can increase long-term costs
  - Interferes with provider-patient relationship

[1]Kaiser Commission on Medicaid and the Uninsured, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, September 2010. www.kff.org/medicaid/upload/8105.pdf. [2]NCSL. *Health Cost Cont Effic.* 2010;8:1-6. [3]US Food and Drug Administration. October 13, 2009. Cited in: NCSL. *Health Cost Cont Effic.* 2010;8:1-6.

"Fail First", Step Therapy, and Therapeutic Substitution Policies

- Require providers (fail first) and pharmacists (step therapy and therapeutic substitution) to prescribe/dispense the oldest and least expensive drug available first
  - Permission to move to a more expensive medication is granted only if the medication fails to help the patient
- Advocacy response
  - Mental health drugs are unique
  - Medication transitions can take 6-12 weeks[1]
    - High risk of emergency department visits and hospitalizations[2]
  - Interferes with provider-patient relationship

[1]Mental Health America, Fact sheet: access to medications [date unknown]. www.nmha.org/farcry/%E2%80%A2/go/action/policy-issues-a-z/access-to-medications/fact-sheet-access-to-medications/fact-sheet-access-to-medications. [2]Cited by: American Psychiatric Association, et al. Joint Statement on Therapeutic Substitution [date unknown]. www.nmha.org/go/action/policy-issues-a-z/access-to-medications.

Supplemental Rebates and Multistate Purchasing Coalitions

- In addition to the federal Medicaid rebate program, pharmaceutical companies cooperate in state-negotiated "supplemental" rebate programs, which include provisions for placing drugs on PDLs
  - States with supplemental rebates: 44[1]
- States join multistate purchasing coalitions for greater bargaining power
  - States in multistate purchasing coalitions: 27[1]
  - Advocacy response
    - Both models assume the use of PDLs and PA requirements, which restrict patient access to certain medications

[1]Kaiser Commission on Medicaid and the Uninsured. Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, September 2010. www.kff.org/medicaid/upload/8105.pdf.

Alternative Cost-containment Approaches

- Provider education and feedback programs
  - Review prescribing practices and pharmacy benefit claims
  - Promote best practices
  - Share data about drug effectiveness and costs
- Prescription case-management programs
  - Include features of provider education and feedback programs
  - Focus on long-term chronic condition management

Alternative Cost-containment Approaches (cont)

- Retrospective drug utilization review
  - Seeks to improve prescribing practices at the point of sale by preventing:
    - Therapeutic duplication
    - Overdosing
    - Drug interactions
- Value-based insurance design
  - Nets savings in health services for chronic conditions
    - Encourages use of “high-value” services (eg, medications) by reducing/eliminating patient cost-sharing arrangements and other obstacles to access

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Transition From Fee-for-Service to Managed Care in Medicaid

Issues to Consider

Advocacy "Opportunity Points"

- During request for proposals (RFP) process when states move to managed care model
- State rule-making public comments
- State Medicaid waiver applications
- Medicaid Pharmacy and Therapeutics Committee meetings (eg, PDL drafting process)
- MCO contract renewals
- Formal MCO member grievance procedures

The best way for mental health advocates to ensure that they have a voice in what happens with Medicaid is to develop and cultivate good working relationships with state Medicaid officials.

Key RFP Issues for Mental Health Advocates

- "Medical necessity"
  - Clear and broad enough definition to cover comprehensive mental health services
  - Experienced licensed clinicians should make necessity decisions using current clinical standards
- Covered services
  - Clear definitions that include: eligibility criteria and amount, duration, and scope of services
  - Prioritizes evidence-based, recovery-focused treatment
  - Consistent coverage decisions based on each patient's needs
- Delivery of care and access to covered services
  - Clear timelines and waiting time standards
  - Meaningful language access for non-English speakers
  - Patients should have at least 2 providers in reasonable proximity

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Key RFP Issues for Mental Health Advocates (cont)

- Network development and maintenance
  - Ensures availability of credentialed, culturally and linguistically competent mental health providers in all geographic areas
- Care management and coordination
  - Provides integration of mental health services with rest of health system
  - Guides patients regarding procedures for selecting PCPs, including how to select a specialist as PCP
  - Encourages care coordination
- Marketing activities, enrollment, and disenrollment
  - Defines permissible vs impermissible marketing activities
  - Specifies enrollment and disenrollment procedures
  - Ensures there is no discrimination regarding health status

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Key RFP Issues for Mental Health Advocates (cont)

- Customer service and member education
  - Lists information members must be given (eg, member handbooks, confidentiality information)
  - Explains standard member inquiry procedures (eg, customer hotlines, ombudsman programs)
- Grievance and appeals processes
  - Includes easy-to-understand definition and explanation of these procedures in writing along with expected response times
- Quality assurance: Data collection and reporting
  - Conforms with federal and state-specified requirements, including publicly available reports

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Key RFP Issues for Mental Health Advocates (cont)

- Payment and cost-sharing arrangements
  - Specifies capitation amounts and payment timelines
  - Ensures limited and clearly defined member cost sharing—especially for prescription drugs
- Utilization review
  - Describes permissible utilization review policies
- Enforcement, corrective action, and sanctions
  - Specifies enforceability mechanisms—including corrective actions and sanctions, which must be significant enough to encourage plan compliance

State and Federal Advocacy Tools

- Fact sheet
  - Reference document that describes the issue and provides relevant statistics and recent research highlights
- Organization sign-on letter
  - Template letter to lawmakers or policymakers to which multiple organizations are asked to add their endorsement
- Action alert
  - Time-sensitive request to contact public officials, etc.
- Constituent letter
  - Personal account sent to public official(s) from registered voter
- Talking points
  - A list of potential arguments and responses
- Op-eds/letters to the editor
  - Short articles or letters conveying a particular opinion about a cause
- Social media
  - Electronic platforms used to share information and mobilize advocates

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