Medicaid Plan Skirts Key Drug-Access Issues

Changes to Medical Loss Ratio, Network Adequacy Disputed

Stephen Barlas

Mr. Barlas is a freelance writer in Washington, D.C., who covers issues inside the Beltway. Send ideas for topics and your comments to sbarlas@verizon.net.

Despite the worrisome bite that specialty drugs are taking out of state Medicaid budgets, the new federal proposal reforming Medicaid managed care gives states no new tools to address the problem. The proposed rule from the Centers for Medicare and Medicaid Services (CMS)[1] nibbles around a couple of other ascending issues, such as network adequacy and medical loss ratio. But the minimal proposals on formulary, utilization management, and other pharmacy issues leave drug-access standards seemingly below those the CMS has established for the Part D, Medicare Advantage (MA), and marketplace plans.

"Did the CMS give the states the ability to address obscenely high drug costs?" asks Matt Salo, Executive Director of the National Association of Medicaid Directors. "The answer is 'no.'" But he notes that these proposals have been in development for a long time and were probably finalized long before the arrival of Sovaldi and other recently approved hyper-expensive drugs. They weren't published sooner because the White House Office of Management and Budget (OMB) took a very long time to review and approve them.

Medicaid is a joint federal–state program, so the CMS might not have all the authority it does with other federal health insurance programs. Still, given the way the costs of specialty drugs are busting state Medicaid budgets and the swell of new Medicaid patients into those programs thanks to the Patient Protection and Affordable Care Act, it would have been reasonable to expect the CMS to address what some view as out-of-control drug costs, even if the rules had already gone to the OMB prior to the Sovaldi debate.

It might be charitable to give Medicaid credit for putting a little makeup on managed care standards that were last changed in 2002. The Medicaid managed care population has grown substantially in the past two decades. In 1992, 2.4 million Medicaid beneficiaries (8% of the total) accessed part or all of their Medicaid benefits through capitated health plans. In fiscal year 2011, the number was 39 million.

But consumer groups complain that Medicaid patients face long waits to see primary care doctors and other providers, whose numbers are severely diminished because many won't take Medicaid patients due to low payment rates. These physicians refuse to join networks, making it hard for managed care organizations (MCOs) to attract physicians in some areas. Moreover, these MCOs often limit the hospitals in their networks to those that agree to pricing other hospitals might not consider.

The proposed rule makes what can only be considered minor changes to beef up MCO network adequacy requirements. But the proposal essentially soft-pedals the operation of MCO formularies, drug utilization requirements, and P&T committees—pharmaceutical access issues that the CMS *did* address in a final rule affecting Medicare Part D and MA drug programs.[2]

The proposed rule contains a brief section devoted to outpatient drugs. In general, it simply says that the MCO must meet current standards. If an MCO patient needs an off-formulary drug, and that drug happens to be "within the scope of the contract" the MCO signed with the state, the MCO must provide that drug under prior authorization. When the MCO is not obligated by the contract to provide an off-formulary drug, the state must provide the covered outpatient drug on a fee-for-service (FFS) basis "in a manner that is consistent with the standards set forth in its state plan and the requirements in Section 1927 of the [Social Security] Act."

Mary Jo Carden, Senior Director of Regulatory Affairs at the Academy of Managed Care Pharmacy, says the requirement that a state provide an off-formulary drug via FFS is new. She also notes that the CMS wants to change its expedited appeals process, which determines how quickly an MCO must supply services it had previously denied following an individual's successful appeal. The current standard is three working days. The CMS would change that to 72 hours, which would apply to medications as well as medical services. These don't seem to be monumental concessions.

Most of the controversy over the proposed rule has focused on its provisions for the medical loss ratio (MLR) and network adequacy. The MLR covers how much insurers can spend on administrative and operational costs rather than medical services. "We don't believe a nationwide MLR is appropriate," says Jeff Myers, Chief Executive Officer of the Medicaid Health Plans of America, an industry group.

On network adequacy, the CMS would make very minor adjustments moving states toward "time/distance" standards, meaning how long and how far a person should have to drive to see a physician or reach a pharmacy. But the CMS stops short of toughening the standard to match the MA rule for network adequacy. MA health plans must meet both "time/distance" requirements and have a certain number of providers per 1,000 recipients per county.

Some will excuse the CMS for not bringing Medicaid drug-access standards up to MA levels. But the CMS needs to address high drug costs sometime, and if it doesn't have the authority to do so, it should tell Congress what powers it needs.

REFERENCES

1. Centers for Medicare and Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) programs; Medicaid managed care, CHIP delivered in managed care, Medicaid and CHIP comprehensive quality strategies, and revisions related to third party liability; proposed rules. *Fed Regist* 2015:80(104):31098–31297.
2. Centers for Medicare and Medicaid Services. Medicare program; contract year 2016 policy and technical changes to the Medicare Advantage and the Medicare Prescription Drug Benefit programs. *Fed Regist* 2015:80(29):7912–7966. ■