Developments and Opportunities in Medicare and Medicaid

Sector/Topic	Recent/Pending Development	Impact
Medicare and Medicaid Providers, Suppliers, Managed Care Entities, and Downstream Vendors	Trump administration's emphasis on deregulation and reduction of burden on these entities	▪ Decreased cost of regulatory compliance efforts ▪ Potential growth in compliance risk as entities shift resources to other areas
Medicare Post-Acute Care (including skilled nursing facilities (SNFs), home health care providers, inpatient rehabilitation facilities, and long-term care hospitals (LTCHs))	▪ Proposals to move Medicare's various post-acute care (PAC) payment systems to a unified prospective payment system (PPS) ▪ MedPAC March 2018 Report recommends statutory change to create a PAC PPS that is based on a blend of each sector's current setting / specific relative weights and the unified PAC PPS's relative weights ▪ The Center for Medicare & Medicaid Innovation's (CMMI's) bundling demonstration initiatives allow for the participation of PAC providers, and CMMI may seek to implement additional episode payment models for PAC services in the future ▪ Recent proposed rules from the Centers for Medicare & Medicaid Services (CMS) include proposed payment increases for SNFs, home health care providers, and inpatient rehabilitation facilities, as well as a small decrease in payments for LTCHs	▪ Bundling would likely decrease payments for some of the affected provider types ▪ Increase in need for care coordination across affected provider types ▪ Increased opportunities for e-tools and systems to facilitate care coordination

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Medicare and Medicaid Long-Term Care	▪ Increased Medicaid funding for long-term services and supports under Medicaid states moving the affected populations to managed care
	▪ New flexibility under Medicare Advantage to offer supplemental benefits to chronically ill enrollees who are reasonably expected to maintain or improve function though are not necessarily health-related
	  ▪ Medicare Advantage Special Needs Plans (SNPs) were permanently authorized and the Federal Coordinated Health Care Office has been tasked with promulgating regulations governing integration requirements for dual-eligible SNPs; this will lead to improvements in the process for the development of fully integrated Medicare-Medicaid programs that include capitated Medicaid long-term care
	  ▪ More evaluation reports for the Medicare-Medicaid dual-eligible demonstration programs will be released in the coming months and will provide additional support for the
		▪ Provides opportunities for home care vendors and other entities that support the independence of the aged, disabled, and chronically ill
		▪ New opportunities for vendors and non-Medicare covered provider types to provide benefits for coverage under Medicare Advantage
		▪ New opportunities to develop SNPs targeting high-need populations, such as long-stay nursing facility residents, individuals with chronic conditions, and dual-eligible beneficiaries; there may be additional pressure on states to implement Medicaid managed long-term care programs to control Medicaid long-term care spending growth and improve care integration

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	implementation of integrated Medicare-Medicaid SNP products	
Value-Based Payments	▪ Administration continues to focus on value-based care initiatives, including bundled payment and accountable care-style programs, in an effort to seek more cost-efficient and effective care strategies ▪ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provides for payment of bonuses to clinicians who participate in value-based payment arrangements designated as advanced alternative payment arrangements • CMS is encouraging development of new models that would be considered advanced alternative payment models (APMs) through the use of the Physician-Focused Payment Technical Advisory Committee (PTAC) ▪ CMS has developed "ACO Track 1+" to provide an easier path for accountable care organizations (ACOs) to move towards taking on downside risk	▪ Efforts will create varying financial pressures on participating provider types and drive them toward alternative payment and contracting structures ▪ Administration is backing away from mandating participation, which will temper the pressure on entities to develop value-based arrangements ▪ Current ACOs continue to express concern over taking on downside risk

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Care Management for Chronic Illness	Growing CMS acknowledgement of the importance of care coordination or management to improve quality and cost-effectiveness of care for individuals with chronic diseases, e.g., diabetes, depression, a substance use disorder (SUD), chronic obstructive pulmonary disease, congestive heart failure ▪ Fee-for-service payments now allowed for care coordination activities under the Medicare Physician Fee Schedule ▪ Permanent reauthorization of Medicare Advantage SNPs ▪ Medicare now pays for the Diabetes Prevention Program offered by entities certified by the Centers for Disease Control and Prevention	▪ Opens opportunities for technological mechanisms and specialty vendors to support contracted health plans and primary care providers in the provision of care management services ▪ Non-clinical entities can be certified as Diabetes Prevention Program providers
Substance Use Disorder Treatment	Increased focus on and funding for SUD/opioid use disorder treatment needs under both Medicare and Medicaid ▪ Part D prescribers and plans required to monitor enrollees for abusive behavior ▪ CMS approval of waiver requests and Congressional momentum towards allowing Medicaid coverage of residential addiction	▪ Increased opportunities for providers and facilities in this space, in addition to systems to support medication therapy management, prescription drug monitoring, and other technological and care support mechanisms ▪ Challenges raised by the Trump administration's budget cuts in SUD-related programs

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	treatment in facilities with 16+ beds (i.e., institutions for mental disease or "IMDs")
	▪ Renewed focus on confidentiality of SUD patient treatment records; legislation in process to reform 42 CFR Part 2 to allow more effective coordination of care and stronger enforcement of protections for unlawful disclosure
	  ▪ Increased attention on the enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA)
	  ▪ A number of private entities are developing quality assessment programs for SUD providers; this includes a private version of the hospital / nursing home compare programs administered by Medicare and a certification program from the American Society of Addiction Medicine (ASAM)
	▪ There are a number of new devices and medications on the market that will help transition opioid use disorder patients through withdrawal, from detox to long-term medication assisted treatment (MAT)
		▪ Challenges raised by the Trump administration's support of state efforts to impose work requirements on Medicaid beneficiaries, removing likely patients from coverage pool
		▪ Ongoing challenges in patient coordination due to confidentiality rules
		▪ Increased focus on MHPAEA enforcement and improved initiatives to assess and enforce quality among SUD treatment providers will allow for increased opportunities for professional, evidence-based programs that are community-based
		▪ Continued developments in the continuum of MAT along with new devices/medications to bridge, from acute detox to long-term MAT, will present new opportunities for the effective treatment of individuals with opioid use disorders

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Drug Pricing Reform (Administration Blueprint)	▪ Trump Administration recently released a Blueprint with proposals to further the discussion of drug pricing reform. ▪ Blueprint sets forth reforms broadly categorized into four areas: improved competition, better negotiation, incentives for lowering list prices, and lowering patient out-of-pocket-costs. ▪ Major proposals are discussed in greater detail below.	▪ Certain reforms directly address drug pricing, such as relying on Value Based Pricing (outcomes based pricing) in Medicare and Medicaid and incentivizing the development of cures (which are typically higher-priced). ▪ Several of the reforms with indirect impact on pricing create opportunities for market entry for certain types of drugs, by facilitating approval of biosimilars, generic drugs and OTC drugs to boost competition and intensify market pressure on drug prices. ▪ Blueprint lacks a proposal for CMS to directly negotiate with Part D sponsors, but focuses on design changes that could provide Part D sponsors with more leverage to negotiate drug prices, e.g., by reducing the required number of drugs per category.
Drug Pricing Reform (Manufacturer Rebate Pass-Through Requirements)	▪ Blueprint reflects a goal of reshaping the treatment of drug manufacturer rebates, the demand for which may be contributing to drug price inflation. ▪ CMS plans to issue a proposal requiring Part D sponsors and their PBMs to pass-through a portion of rebates obtained from manufacturers to beneficiaries at point of sale, reducing beneficiary cost-share.	▪ Proposal would impact high drug list prices, targeting the increasing "gross-to-net" spread between list price for a drug and the price paid by a plan/PBM after rebates. ▪ Several insurers and PBMs (e.g., United, Aetna) already have announced plans to pass-through rebates in their commercial group plans.

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		▪ Insurance premiums may increase, while patient cost-share at the point of sale may decrease.
Drug Pricing Reform (Transparency)	Increasing requirements and pressure for price and other transparency for both medical procedures and prescription drugs ▪ However, CMS is looking to loosen Medicare/Medicaid drug price reporting rules ▪ CMS's BlueButton initiative to enable beneficiary access to health care claims data and ability to share that data ▪ VA and DoD also participate in BlueButton	▪ Uncertainty in level of transparency that will apply to prescription drugs ▪ Increased transparency requirements regarding medical procedures will pressure providers to use appropriate software to support data reporting
Drug Pricing Reform (Shift from Part B to Part D)	▪ The Administration suggested shifting some drugs to Part D benefit. ▪ Under Part B, physicians obtain higher reimbursement amount for more expensive drugs based on ASP+6%. ▪ Under Part D, plan sponsors and PBMs negotiate discounts with manufacturers.	▪ Reduces the percentage of drug payments reimbursed under Part B's ASP+6%. ▪ Beneficiary cost-sharing under Part D benefit structure is often below Part B's 20% coinsurance. ▪ Drugs shifted to Part D may yield price concessions due to ability to negotiate. ▪ Reduces the direct financial incentive for physicians to select more expensive drugs and the greater reimbursement that results.

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Telehealth	Increased recognition by Medicare and Medicaid of telehealth as a reimbursable service, demonstrated by recent telehealth-focused initiatives in the CMMI pipeline (e.g., Next Generation ACO Telehealth Expansion Waiver eliminating certain Medicare coverage limitations) to drive growth in telehealth technology and dedicated providers ▪ The Bipartisan Budget Act of 2018 expanded the coverage of telehealth services under the Medicare Physician Fee Schedule ▪ CMS now allows separate payment for remote monitoring under CPT code 99091 (used to be bundled with chronic care management, 99490)	▪ Expanding Medicare coverage for certain chronic care telehealth services (e.g., end-stage renal disease) ▪ Expanding Medicare coverage of telehealth services in urban areas (e.g., telestroke) ▪ Increasing state Medicaid coverage of telehealth services to allow patients' homes, workplaces, and schools as originating sites
Managed Care	▪ States continue to rely on managed care for the delivery of some or all Medicaid benefits to most Medicaid populations ▪ States are increasingly moving remaining populations into managed care ▪ Recent Medicare Advantage rate increase is above the expected level ▪ Continued growth in beneficiary enrollment in Medicare Advantage versus original Medicare, including growth in employer plan enrollment	▪ Increased opportunities for managed care entities, downstream providers, and vendors

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	▪ CMS is slowing the move to risk adjustment based on encounter data ▪ New flexibility with respect to supplemental benefits in Medicare Advantage	
Personalized Medicine	Medicare is beginning to cover personalized medicine ▪ Medicare has focused attention on the coverage of next-generation sequencing (NGS) testing for cancer diagnosis and treatment ▪ National coverage analysis was recently initiated for chimeric antigen receptor (CAR) T-cell therapy for cancer	▪ Medicare coverage decisions often impact private commercial payor decisions on coverage of such treatments ▪ Other advances in personalized medicine may raise new coverage opportunities
Clinical Lab Services	▪ Statutory change in methodology for calculating Medicare's Clinical Lab Fee Schedule payment rates, to result in a yearly decrease of 10 percent for most high-volume test services over multiple years ▪ Increased focus by investigators from the U.S. Department of Health and Human Services' Office of Inspector General (OIG) and the U.S. Department of Justice (DOJ)	▪ Increased pressure on clinical labs due to decreased Medicare payments for high-volume test services ▪ Changes to Medicare clinical lab payment rates will also affect Medicaid and commercial rates, which are often based on Medicare rates ▪ Opportunity for innovation in lab testing arrangements to make tests more accessible and cost effective

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	on clinical labs and the medical necessity of test services	▪ OIG/DOJ focus to increase downward pressure on expansion and outreach by clinical lab services providers
Technology/Data Opportunities and Pressures (Systems Interoperability)	▪ CMS's Da Vinci Project focuses on provider-payer information exchange and provider-provider interoperability, including electronic health record (EHR) development ▪ MACRA continues to incentivize clinicians to move to the use of certified EHR technology	▪ Open source programs encourage third-party systems development
Technology/Data Opportunities and Pressures (Transparency)	Increasing requirements and pressure for price and other transparency for both medical procedures and prescription drugs ▪ However, CMS is looking to loosen Medicare/Medicaid drug price reporting rules ▪ CMS's Blue Button initiative to enable beneficiary access to health care claims data and ability to share that data	▪ Uncertainty in level of transparency that will apply to prescription drugs ▪ Increased transparency requirements regarding medical procedures will pressure providers to use appropriate software to support data reporting

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	▪ The Department of Veterans Affairs and Department of Defense also participate in Blue Button	
Technology/Data Opportunities and Pressures (Data Security)	Plans, providers, vendors, and data systems continue to experience data breaches and hacking incidents; Medicare/Medicaid to drive need for improvements in technological solutions through more stringent program standards	▪ Increased transparency requirements regarding medical procedures will drive increased need for ensuring data security

