MAPOC Meeting

July 14, 2023

Agenda

- Rx 101
- Medicaid Financing
- Overview of major changes that passed this session + our plan to implement
- Justice-involved waiver

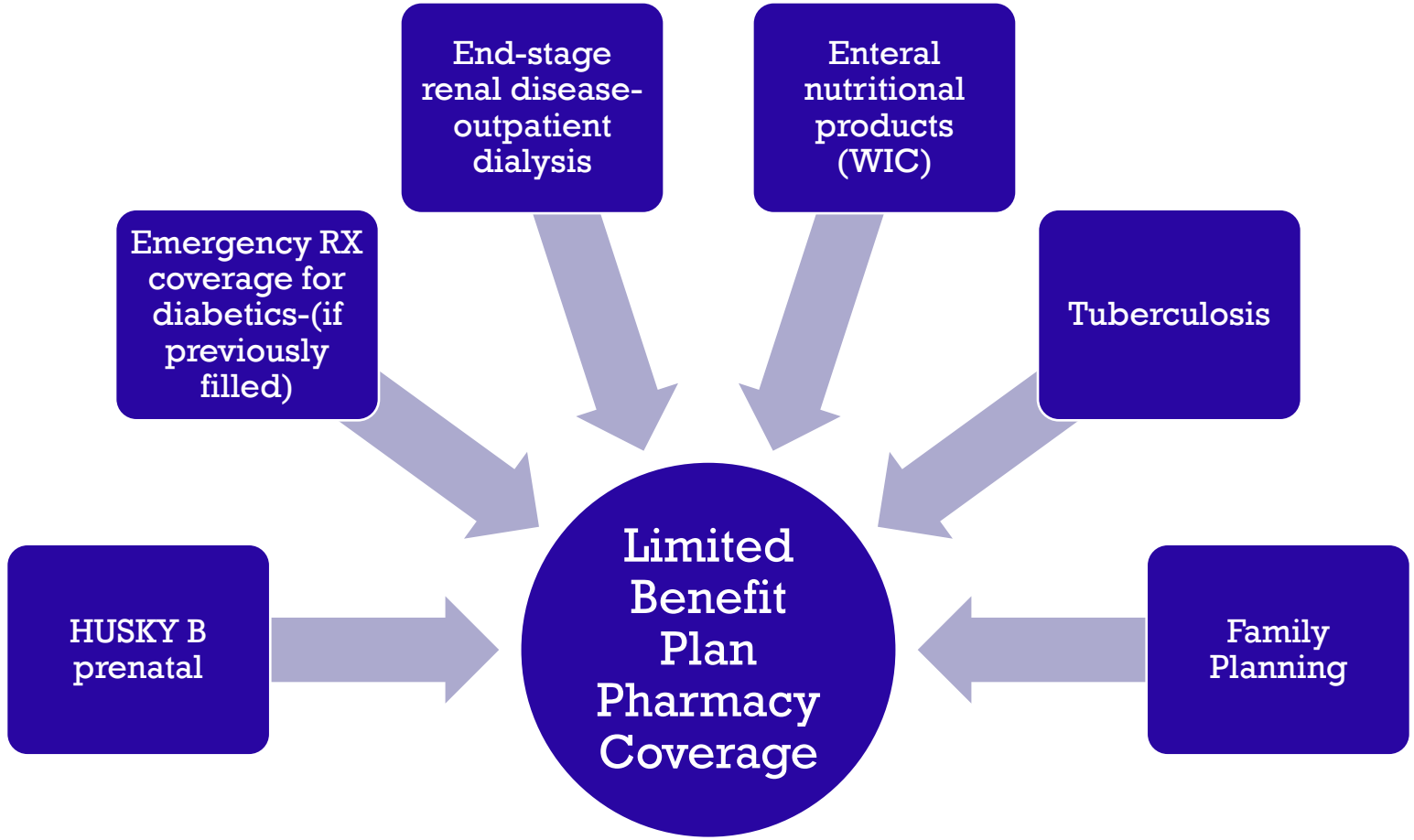
Rx 101

Connecticut Medicaid provides pharmacy coverage through 4 HUSKY benefit plans

Outpatient prescription drug coverage is an optional benefit that all state Medicaid programs have elected to provide (§ 1905(a)(12) of the Social Security Act (the Act)).

HUSKY A	HUSKY B	HUSKY C	HUSKY D
Medicaid for children, teens, parents, relative caregivers and pregnant women	Children's Health Insurance Program (CHIP) for children and teens up to age 19	Medicaid for adults 65 and older and adults with disabilities, including long-term services and supports and Medicaid for Employees with Disabilities	Medicaid for low-income adults without dependent children

Limited Benefit Plan Pharmacy Coverage



Currently serving approximately 1 million members

July 2021-June 2022

- 10.5M Paid Claims
- ~100K Pharmacy Calls Handled (client and provider)
- Over 750 Enrolled Pharmacies
- 12M Eligibility Transactions
- 12.2M Medication Histories

How are medications covered?

Food and Drug Administration

- Medications that have been **approved by the Food and Drug Administration (FDA)** for safety and effectiveness

OBRA 90

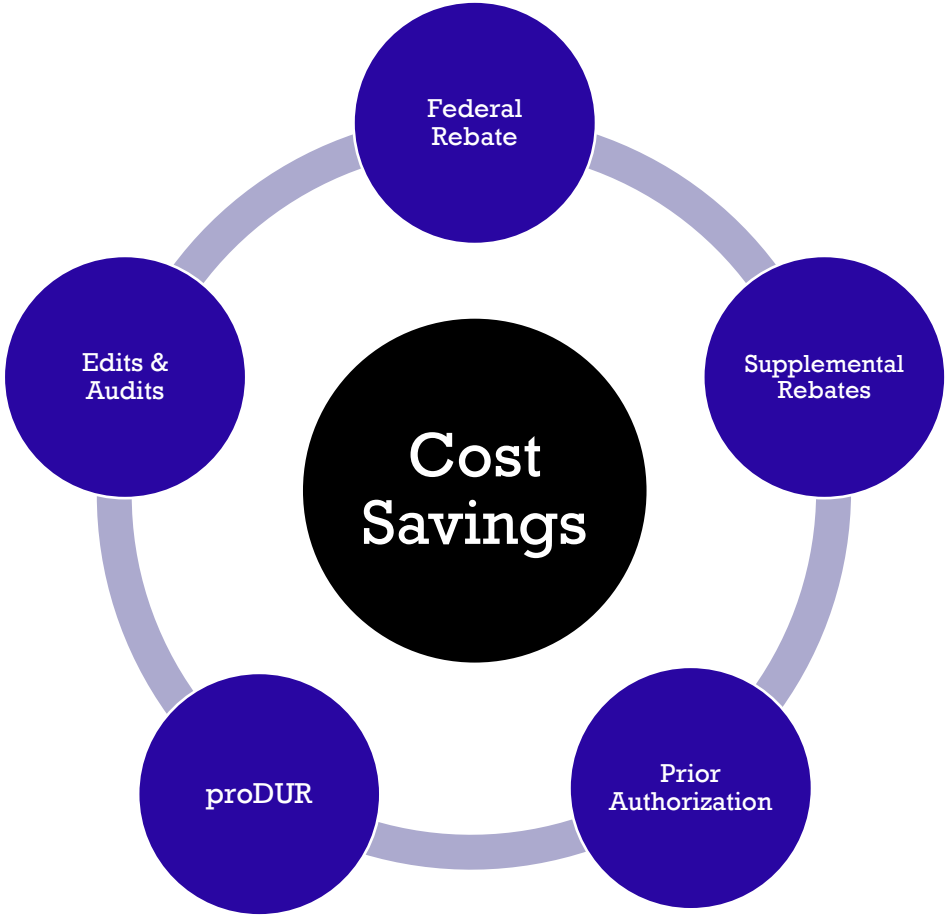
- The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) established the Medicaid Drug Rebate Program.
- A drug's manufacturer must enter into a Medicaid national drug rebate agreement with the Secretary of the U.S. Department of Health and Human Services in order for a medication to be covered.

State Medicaid Programs

- In exchange for rebates, state Medicaid programs must generally cover **all of a participating manufacturer's drugs** when prescribed for a medically accepted indication, although states are allowed to limit the use of some drugs through **preferred drug lists, prior authorization, and quantity limits.**

Connecticut Medicaid has multiple initiatives that provide cost savings

To help offset the costs of pharmacy coverage that the various benefit plans provide, multiple cost savings initiatives have been implemented



Drug Rebates are a major contributor to pharmacy cost savings

Federal Drug Rebates

- Drug manufacturer to enter into, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of the manufacturer's drugs.
- Manufacturers must pay rebates on a fixed percentage to states on these drugs when the drugs are dispensed to Medicaid beneficiaries and paid for by Medicaid.

Approximately $1B/year

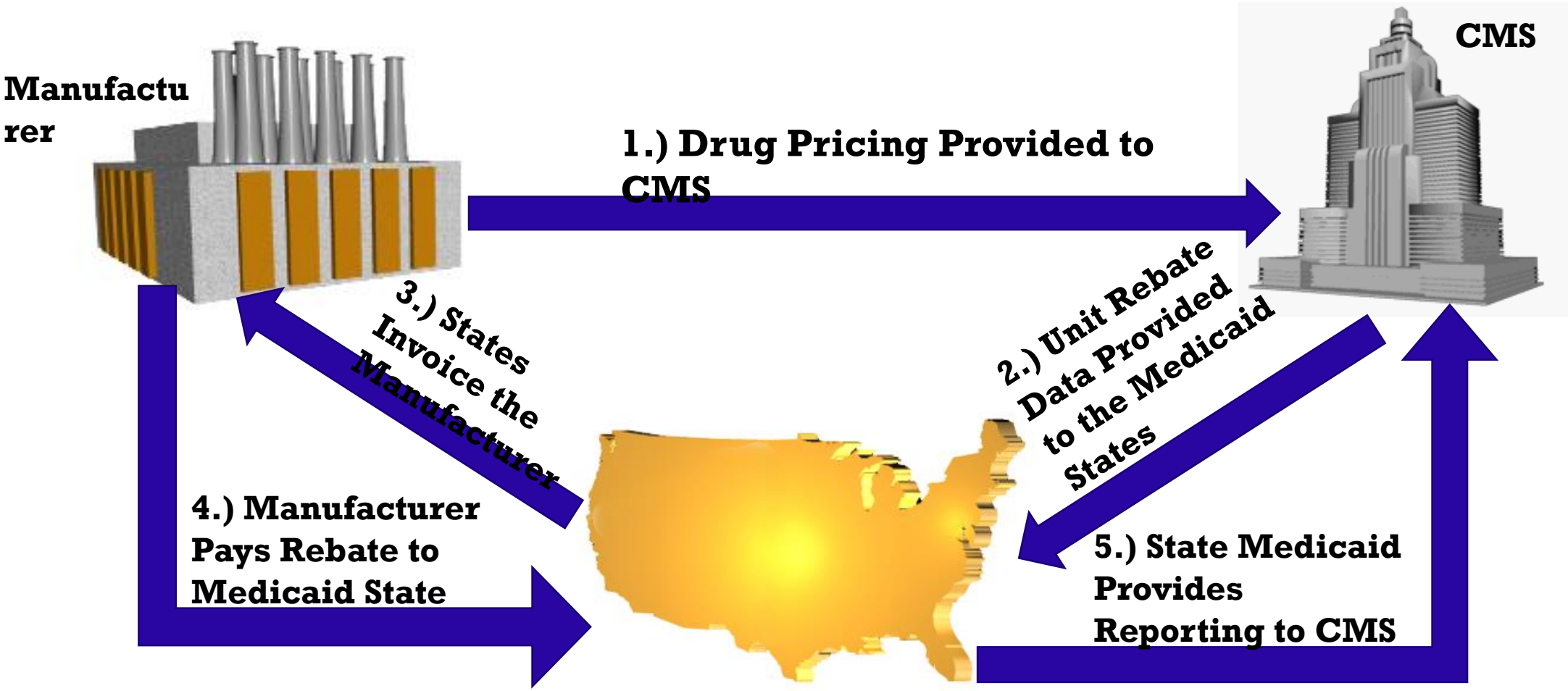
Supplemental Drug Rebates

- Additional rebates the state negotiates with the manufacturer to increase cost savings above and beyond the mandated federal rebate.
- Products reviewed and approved by the Pharmaceutical and Therapeutics Committee are placed on the Preferred Drug List.

Approximately $120M/year

Total provider reimbursement approximately $1.7B/year before rebates and federal claiming

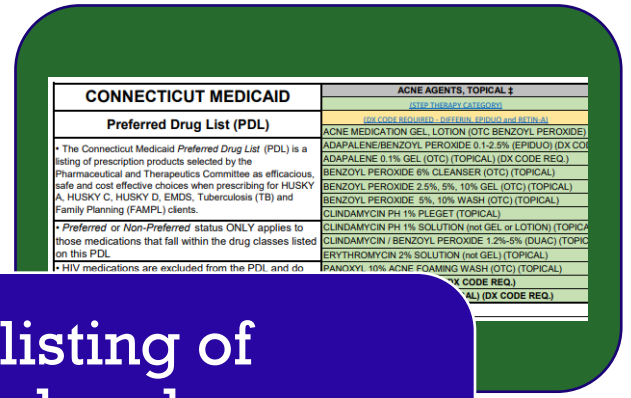
Federal Drug Rebate involves manufacturers, CMS, and the state Medicaid program



Connecticut has access to Supplemental Rebates by participating in Magellan Rx's The Optimal Pharmacy Solution (TOP$) Program

- Multi state pool is leveraged to obtain more competitive supplemental rebates. Includes Connecticut, Idaho, Louisiana, Maryland, Nebraska, Washington, and Wisconsin
- Achieve quality pharmaceutical care while achieving optimal state savings
- A Preferred Drug List (PDL) is utilized to shift utilization to preferred products which often times have supplemental rebates

Preferred Drug List (PDL)


CONNECTICUT MEDICAID

Preferred Drug List (PDL)

• The Connecticut Medicaid *Preferred Drug List* (PDL) is a listing of prescription products selected by the Pharmaceutical and Therapeutics Committee as efficacious, safe and cost effective choices when prescribing for HUSKY A, HUSKY C, HUSKY D, EMDS, Tuberculosis (TB) and Family Planning (FAMPL) clients.

• *Preferred* or *Non-Preferred* status ONLY applies to those medications that fall within the drug classes listed on this PDL

ACNE AGENTS, TOPICAL ‡

(STEP THERAPY CATEGORY)

(DX CODE REQUIRED - DIFFERIN, EPIDUO and RETIN-A)

ACNE MEDICATION GEL, LOTION (OTC BENZOYL PEROXIDE)
ADAPALENE/BENZOYL PEROXIDE 0.1-2.5% (EPIDUO) (DX CO
ADAPALENE 0.1% GEL (OTC) (TOPICAL) (DX CODE REQ.)
BENZOYL PEROXIDE 6% CLEANSER (OTC) (TOPICAL)
BENZOYL PEROXIDE 2.5%, 5%, 10% GEL (OTC) (TOPICAL)
BENZOYL PEROXIDE 5%, 10% WASH (OTC) (TOPICAL)
CLINDAMYCIN PH 1% PLEGET (TOPICAL)
CLINDAMYCIN PH 1% SOLUTION (not GEL or LOTION) (TOPICA
CLINDAMYCIN / BENZOYL PEROXIDE 1.2%-5% (DUAC) (TOPIC
ERYTHROMYCIN 2% SOLUTION (not GEL) (TOPICAL)
PANOXYL 10% ACNE FOAMING WASH (OTC) (TOPICAL)

The Connecticut Medicaid Preferred Drug Lists (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics Committee as efficacious, safe, and cost-effective choices when prescribing for Medicaid patients.

- The purpose of the Medicaid Pharmaceutical & Therapeutics Committee is to develop and implement a voluntary Medicaid preferred prescribed drug designation program, as stipulated in the Connecticut General Statute Chapter 319V, section 17b-274d.
- Pharmaceutical and Therapeutics Committee (P&T) members are composed of physicians, pharmacists, nurses, and a consumer representative who serve in an advisory capacity to assist the Department in the development of the PDL and the selection of drugs to be included on the PDL

Drugs not listed on the PDL require prior authorization

OBRA 90 - patient safety and claims review

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90), section 1927(g), mandates that pharmacists conduct prospective and retrospective medication reviews whenever an outpatient prescription is dispensed to a Medicaid recipient.

Prospective Drug Utilization Edits are provided on pharmacy claims in real time to alert pharmacists of potential medication related problems

Alerts to pharmacy providers

- Drug-Drug interaction (DD)
- Drug-Age-Geriatric alert (GR)
- Overutilization Alert (ER)
- High Dose Alert (HD)
- Ingredient Duplication (ID)
- Therapeutic Duplication (TD)
- Drug Pregnancy Alert (PG)

Retrospective Drug Utilization Review (RDUR) is performed by KEPRO on pharmacy claims and reviewed by a board of pharmacists and practicing clinicians

DUR Board -The purpose of the Connecticut Medical Assistance DUR Board is to review paid claims and identify outliers with regard to the prescribing and dispensing of drugs by Medical Assistance providers and the use of medications by Medical Assistance recipients. The DUR Board's mission is to facilitate the appropriate and cost-effective delivery of pharmaceutical care with non-biased, independent professional reviews of published literature for advisement on educational programs.

KEPRO retrospectively reviews CT Medicaid member's drug profiles

- 1,000 adult and 1,000 pediatric patient profiles reviewed monthly for potential medication-related problems
- Review 800 pharmacy restriction profiles monthly patients who use multiple pharmacies, multiple prescribers, or both, and whose profiles show patterns of abuse and/or gross overuse
- Creates and sends letters to prescribing providers whose patient's have been identified with a medication-related problem.
- Publish quarterly newsletter to educate prescribers and pharmacies on the latest medication updates and information
- CMS annual report

Connecticut Medicaid partners with ASOs

- Complex drug regimens (Hep-C, CAR-T therapy) through ICM (Intensive Care Management) program
- Send claims reports directly to providers for high-risk groups (pregnant, high opioid utilization, including multi use providers and multiple pharmacies)
- Review prior authorization (PA) requests for compliance

Current Initiatives

Greater Diabetic Coverage Through Pharmacy

Vaccinations (Covid, Flu, Shingles, etc.)

Combating the Opioid Epidemic →

Deep Dive to Follow

E-Prescribing → *Discussion to Follow*

THE OPIOID EPIDEMIC BY THE NUMBERS

70,630
people died from drug overdose in 2019[2]

10.1 million
people misused prescription opioids in the past year[1]

1.6 million
people had an opioid use disorder in the past year[1]

2 million
people used methamphetamine in the past year[1]

745,000
people used heroin in the past year[1]

50,000
people used heroin for the first time[1]

1.6 million
people misused prescription pain relievers for the first time[1]

14,480
deaths attributed to overdosing on heroin (in 12-month period ending June 2020)[3]

48,006
deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending June 2020)[3]

SOURCES

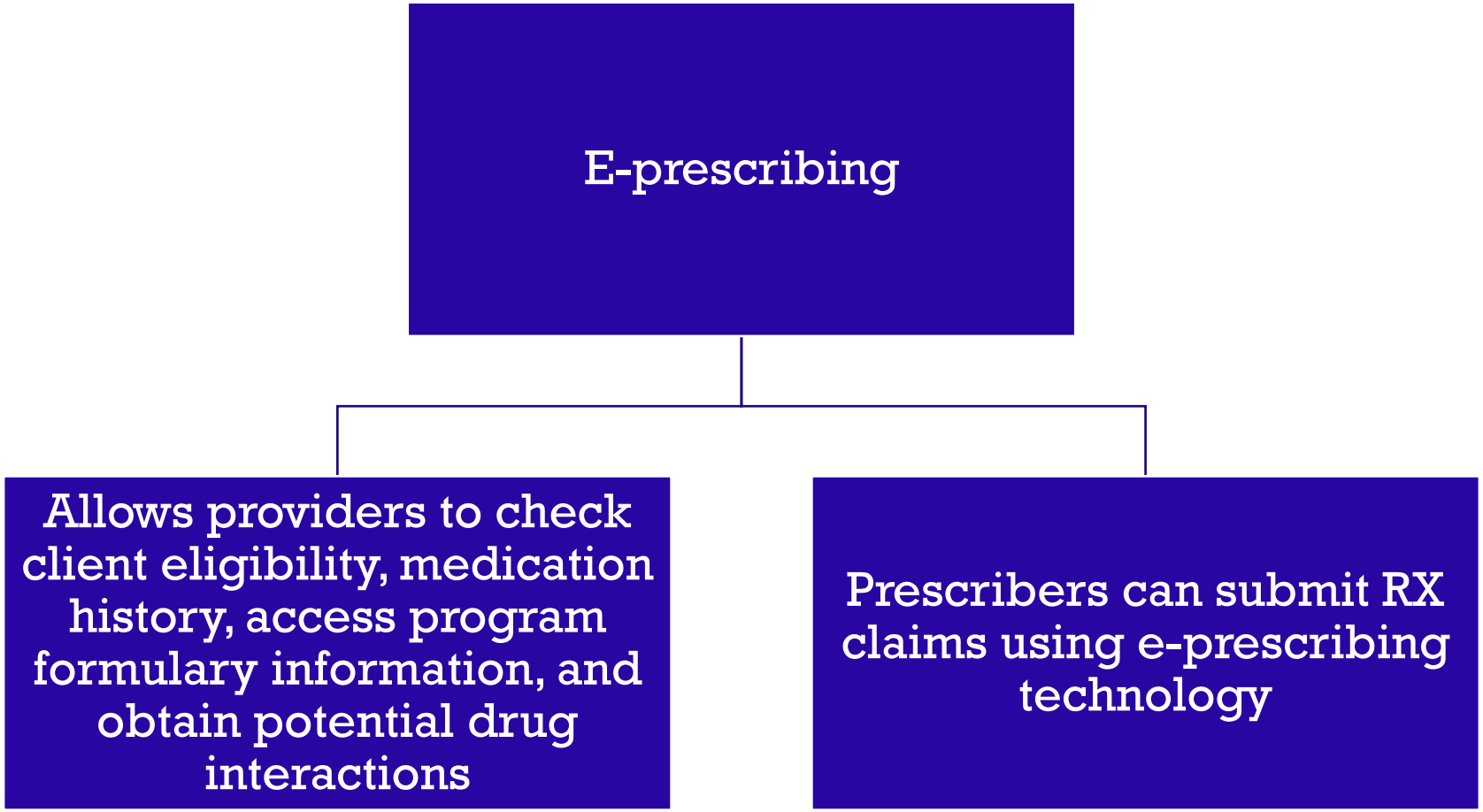
1. 2019 National Survey on Drug Use and Health, 2020.
2. NCHS Data Brief No. 394, December 2020.
3. NCHS, National Vital Statistics System. Provisional drug overdose death counts.

HHS.GOV/OPIOIDS

Many initiatives have been implemented to address and combat the Opioid Crisis

- Provider notification concerning Section 7 of Public Act 16-43 which instructs prescribers to limit opioid RXs to a 7 day supply
- Opioid PA (bypass for oncology/ hematology)
- Increase in refill % to limit premature refills
- Narcan (RX and OTC)
- Prescriber outreach and education

E-Prescribing



Questions?

Medicaid Financing

Medicaid Budget Overview

- The Medicaid share of the DSS General Fund budget is approx. 71% in SFY 2024 and 2025.
- The DSS Medicaid budget is net funded. DSS receives an appropriation for the state share of Medicaid expenditures (approx. 35% with PHE enhanced FMAP and approx. 40% with regular FMAP).
- Over time, the state share of Medicaid expenditures has remained steady while the majority of the growth has been on the federal share of expenditures.

Medicaid Budget Overview – Federal Match Rates by HUSKY Program

- HUSKY A and C – The majority of services are matched at 50% (56.2% during the PHE) with some exceptions including personal care attendant services under Community First Choice which are matched at 56% (62.2% during the PHE), family planning services which are matched at 90%, and the first year of Money Follows the Person (MFP) which is matched at 75% for eligible services.
- HUSKY D (Newly Eligible) - The majority of services are matched at 90%
- HUSKY D (Non-Newly Eligible) - The majority of services are matched at 50% (56.2% during the PHE) with some exceptions including personal care attendant services under Community First Choice which are matched at 56% (62.2% during the PHE), family planning services which are matched at 90%, and the first year of MFP which is matched at 75% for eligible services.
- Breast and Cervical Cancer Coverage Group – all services are matched at 65% (69.34% during the PHE) with the exception of family planning services which are matched at 90%.

Medicaid / CHIP Budget Overview – Phase Down of Enhanced Match Rate

	Base Medicaid Match Rate	Medicaid Enhanced Match Rate	Revised Match Rate
QE 3/31/2023	50%	6.2%	56.2%
QE 6/30/2023	50%	5.0%	55.0%
QE 9/30/2023	50%	2.5%	52.5%
QE 12/31/2023	50%	1.5%	51.5%
	Regular CHIP Match Rate	**CHIP Enhanced Match Rate**	**Revised CHIP Match Rate**
QE 3/31/2023	65%	4.34%	69.34%
QE 6/30/2023	65%	3.50%	68.50%
QE 9/30/2023	65%	1.75%	66.75%
QE 12/31/2023	65%	1.05%	66.05%

Medicaid Budget Overview – Administrative Claiming

- The base match rate for Medicaid administrative expenses is 50%. This match rate remained at 50% during the PHE.
- Enhanced match is available under Medicaid administration through the Centers for Medicare and Medicaid Services (CMS) Advanced Planning Document (APD) process.
- APDs are requests to CMS to seek approval for enhanced Medicaid match on administrative costs associated with projects to replace or modernize eligibility and Medicaid processing systems. They are grouped as follows:
  - PAPD – Planning Advanced Planning Document - This type of APD requests 90% Medicaid reimbursement rate for Medicaid allocable admin costs associated with the planning phase of a system upgrade or replacement project.
  - IAPD - Implementation Advanced Planning Document – This type of APD requests 90% Medicaid reimbursement rate for Medicaid allocable admin costs associated with design, development, and implementation (DDI) phase of a system upgrade or replacement project. Any training provided during the DDI phase receives 75% Medicaid reimbursement rate.
  - OAPD – Operational Advanced Planning Document. This type of APD requests 75% Medicaid reimbursement rate for Medicaid allocable admin costs related to projects that have finished the DDI phase and have initiated the operational activities.

Overview of major changes that passed this session + our plan to implement

Major Medicaid and DSS Projects from 2023 Legislative Session: Eligibility

Statute/Bill Number	Summary	Effective Date
PA 23-204 (§)283-285	Extends HUSKY health benefits to children ages 15 and under, rather than ages 12 and under, who meet program income limits but are ineligible due to immigration status	7/1/24
PA 23-204 (§)302	Expands eligibility for HUSKY C by raising the income limit to 105% of FPL, after all income disregards.	10/1/24
PA 23-204 (§)264-270	Modifies TFA requirements - Increases income disregards - Extends time limits from 21 to 36 months - Raises asset limit from $3,000 to $6,000	 1/1/24 4/1/24 10/1/23
PA 23-204 (§)271	Raises asset limit for SAGA from $250 to $500	10/1/23

Major Medicaid and DSS Projects from 2023 Legislative Session

Statute/Bill Number	Summary	Effective Date
PA 23-204 (§)275	Requires DSS to issue individualized quality metrics reports to nursing homes in preparation to an acuity-based reimbursement adjustment	Effective from passage
PA 23-204 (§)274 & 277	Rebases ICF and RCH rates	7/1/23
PA 23-186 (§)1	Requires DSS to conduct a two-part study of Medicaid rates of reimbursement, with the first phase focused on physician specialists, dentists and behavioral health providers. (Enacted budget includes funding for provider increases in FY 25.)	Effective from passage
N/A	Enacted budget includes funding to support the addition of agency-based services under the Community First Choice program.	7/1/23

Major Medicaid and DSS Projects from 2023 Legislative Session

Statute/Bill Number	Summary	Effective Date
PA 23-204 (§)282	Requires DSS to raise adult rates for at-home complex nursing services equal to the pediatric rates	1/1/24
PA 23-101	Provide Medicaid reimbursement for certain mental health evals at school-based health centers in public schools	7/1/23
PA 23-94	Requires DSS to cover bariatric and specified medical services under certain circumstances (medication and nutritional counseling	7/1/23

Major Medicaid and DSS Projects from 2023 Legislative Session

Statute/Bill Number	Summary	Effective Date
PA 23-30	Requires DSS to develop a plan to increase eligibility for adult day services under the CT Home Care Program for Elders (CHCPE)	2/1/24
PA 23-186	Medicaid reimbursement for community health workers	TBD
PA 23-137 (§)5	Expand the Medicaid waiver program for people with autism spectrum disorder	7/1/24

Justice-Involved 1115 Demonstration Waiver

Background

- There is a long-standing prohibition within Medicaid that does not allow Medicaid reimbursement for services provided to individuals incarcerated in a public institution. This is known as the "inmate exclusion."
- In 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which required HHS to provide guidance to states on how to seek 1115 demonstration authority to waive the inmate exclusion in order to improve care transitions to the community for incarcerated individuals.
- Prior to the release of this guidance, 14 states submitted a request to the Centers for Medicare and Medicaid Services (CMS) to waive the inmate exclusion prohibition.
- In January 2023, California received approval from CMS to waive the inmate exclusion rule with agreed upon rules and procedures.
- In July 2023, Washington was the second state to receive approval for their waiver.

Connecticut is well situated

- Waiver requires states to:
  - Develop a process to get individuals on to Medicaid
    - *Since 2014, CT has had a process in place to expedite eligibility for individuals leaving prison and court, allowing individuals to immediately access pharmacy and treatment services.*
    - *DOC already has a system which tracks end of sentence*.
  - Suspend rather than terminate eligibility upon prison entry
    - *CT stopped terminating eligibility for individuals under three year sentences several years ago.*

The timing is good

- Public Act 22-133 required DOC to develop a plan for the provision of health care services, including mental health care, substance use disorder and dental care services, to inmates of correctional facilities under the jurisdiction of the department.
  - This year, the Senate Chair of Public Health introduced legislation requiring DPH oversight of DOC health services.
- An 1115 waiver may provide a cost-effective way to address these concerns.
- Similar to the Substance Use Disorder waiver, states would be required to reinvest any resulting revenue into the system. This would permit investments in both inmate and community medical and support services, including housing and job training, with the revenue generated from services already being provided.

CMS Waiver Milestones

- **Milestone 1:** Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.
- **Milestone 2:** Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community.
- **Milestone 3:** Promoting continuity of care to ensure access to services both pre- and post-release.
- **Milestone 4:** Connecting to services available post-release to meet the needs of the reentering population.
- **Milestone 5:** Ensuring cross-system collaboration.

Potential Services

- Evaluation for all individuals;
- Pre- and post- release care management to support re-entry;
- Physical and behavioral health clinical consultation services;
- Laboratory and radiology services;
- Medications and medication administration;
- Medications for addiction treatment (MAT), for all FDA-approved medications, including coverage for counseling;
- Services provided by community health workers with lived experience

Potential Target Population (from CA model)

- Youth:
  - All incarcerated youth (under age 19) who are Medicaid eligible are eligible to receive services – no demonstrated health care need is required
- Adults:
  - Meet one of the following health care need criteria:
    - Mental illness
    - Substance use disorder
    - Chronic conditions/significant clinical condition
    - Intellectual or developmental disability
    - Traumatic brain injury
    - HIV/AIDS
    - Pregnant/postpartum

Planning Process

- Multi-state agency leadership and workgroups are meeting in order to:
  - Develop waiver application and budget neutrality
  - Develop the service model
  - Develop operational procedures
  - Evaluate existing healthcare services and what type of entity delivers that services (e.g., private provider vs. state agency)
  - Estimate inmate healthcare costs and utilization 90 days prior to release
- State Agency Partnership:
  - DOC, Judicial Branch, DDS, DMHAS, OPM and DSS