All-State Medicaid and CHIP Call
February 27, 2024

Agenda

- Overview of Newest CMS Innovation Center State-Based Models
- Medicaid and CHIP Coverage of New Treatments and Opportunities to Improve Care for Sickle Cell Disease
- Open Mic Q and A

Overview of Newest Innovation Center State-Based Models

Medicaid and CHIP All State Call

February 2024

Contents

- Overview of the CMS Innovation Center
- Overview of newest CMS Innovation Center state-based models
  - Making Care Primary (**MCP**) Model
  - States Advancing All-Payer Health Equity Approaches and Development (**AHEAD**) Model
  - Transforming Maternal Health (**TMaH**) Model
  - Innovation in Behavioral Health (**IBH**) Model
  - Cell and Gene Therapy (**CGT**) Access Model
- State participation options

The CMS Innovation Center Statute

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles"

Three scenarios for success under Statute:

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

Vision: What's to Come Over the Next 10 Years

Making Care Primary (MCP) Model

Not accepting new applicants

- # Making Care Primary Overview

  - Provides additional payment, data, learning support to make primary care accountable for patient outcomes
  - 8 regions, 10.5-year model test starting July 2024
  - Three tracks to meet primary care organizations where they are:

- **Track 1**: Least Advanced: Least value-based care experience, more guaranteed support for care delivery transformation, FFS payment for services
- **Track 2**: More performance-based payment, less upfront; partial population-based payment
- **Track 3**: Most Advanced: Most performance-based payment, full population-based payment for primary care

Benefits of Participation in MCP

CMS Innovation Center designed MCP with lessons learned from previous primary care models to build a supportive payment and care delivery structure to advance health equity. The following are national and state level supports for participants to achieve model goals.

On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

Key features:

- Upfront Infrastructure Payment for eligible participants
- Phased in shift from FFS to population-based payment over Tracks 1 and 2
- No downside adjustment based on performance, rewards are focused on key clinical outcomes first

Tools to Improve Care Coordination

Data to improve patient care integration and learning tools to drive care transformation

Key features:

- Specialty care performance data sharing, prioritizing cardiology, orthopedics, and pulmonology
- New specialty integration payments to improve communication and collaboration
- Connection to health information exchange

Health Equity Advancement

Support to deliver coordinated, high-quality health care to diverse populations

Key features:

- Process for identifying and addressing health disparities in the populations that practices serve
- Increased payment for patients that require more intensive services to meet health goals.
- Focus on screening and referrals to address Health Related Social Needs (HRSNs)

Collaboration & Learning

National and state level supports for participants to achieve model goals

Key features:

- Payers partnering to support participants needs for success, including technical assistance, data, and peer-to-peer learning
- Access to independent practice facilitation and coaching, especially for small and safety net organizations who request it

Payers as Partners for MCP Success

CMS Innovation Center is partnering with public and private payers to implement MCP, fostering comprehensive primary care organization transformation, and expanding regional primary care enhancement. Through these partnerships, CMS will foster alignment in areas to reduce clinician burden and payer fragmentation, allowing providers to focus on practice transformation.

Directional Alignment

- CMS will work with payers in MCP states to encourage close alignment in areas that directly reduce burden on clinicians
- CMS will partner with payers to establish MCP-aligned plans, with shared goals, learning priorities, and access to data, tools, and peer-to-peer learning

Medicaid Engagement

- CMS has partnered with state Medicaid agencies (SMAs) to streamline primary care payment reform and learning priorities across Medicare and Medicaid
- MCP will continue to work closely with SMAs to streamline requirements and learning supports

Local Implementation

- CMS, SMAs, and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state
- CMS will provide flexibility for payers to include additional measures that reflect local priorities for their patient population(s)

Timeline and Next Steps

Timeline

- **Late February: Applicants Notified of Acceptance**
- March - mid April: Participation Agreement Signing Window
- **July 1, 2024: Model Start**

Next Steps

- Review applications for eligibility (attribution, Medicare status, program integrity, etc.)
- Notify applicants of acceptance status, and prepare for onboarding/model launch
- Conduct deep-dive webinars on Making Care Primary features for accepted applicants
- Onboard participants for payment and data sharing to start in Q3 2024.

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

Applicants: State governments
Cohorts 1&2: Applications due 3/18/24
Cohort 3: Applications due 8/12/24

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS – Statewide Quality and Equity Targets

Components

Cooperative Agreement Funding

Hospital Global Budgets (facility services)

Primary Care AHEAD

Strategies

- Equity Integrated Across Model
- Behavioral Health Integration
- All-Payer Approach
- Medicaid Alignment
- Accelerating Existing State Innovations

AHEAD Timeline

The AHEAD Model will operate from 2024 through 2034. The timeline includes the Pre-Implementation Period, the Model Implementation Period, and the Cooperative Agreement Period of Performance. Each Cohort has a unique timeline.

AHEAD is currently soliciting states through a Notice of Funding Opportunity.

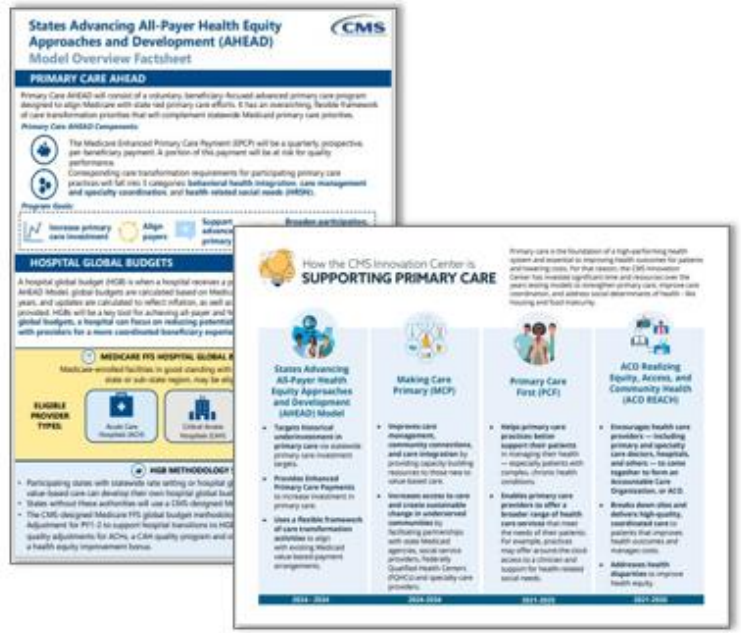
Cohort Timeline	Cohort 1	Cohort 2	Cohort 3
Application Due Date	3/18/2024, by 3:00pm ET	3/18/2024, by 3:00pm ET	8/23/2024, by 3:00pm ET
Pre-Implementation Period	18 months (7/1/2024 – 12/31/2025)	30 months (7/1/2024 – 12/31/2026)	24 months (1/1/2025 – 12/31/2026)
Model Implementation Period	9 years (1/1/2026 – 12/31/2034)	8 years (1/1/2027 – 12/31/2034)	8 years (1/1/2027 – 12/31/2034)
Cooperative Agreement Period of Performance	5.5 years (Ends 12/21/2029)	5.5 years (Ends 12/31/2029)	6 years (Ends 12/31/2030)

The Cooperative Agreement Period of Performance spans the Pre-Implementation Period and includes some years in the Implementation Period.

Applicant Resources

The AHEAD Model team has developed multiple resources to support Applicants, available via links below and the Model's webpage at https://www.cms.gov/priorities/innovation/innovation-models/ahead.

- Model Overview Factsheet
- Hospital Global Budget Factsheet
- Hospital Global Budget Methodology
- AHEAD Overlaps Factsheet
- AHEAD Model Infographic
- Frequently Asked Questions
- CMS Innovation Center Primary Care Models Comparison
- AHEAD Mailbox: AHEAD@cms.hhs.gov



All states interested in applying to participate in the AHEAD Model will submit applications through http://grants.gov. Stay tuned for upcoming events to learn more about the AHEAD Model!

Transforming Maternal Health (TMaH) Model

Applicants: State Medicaid Agencies
Application period: Spring-Summer 2024

TMaH Overview

The **Transforming Maternal Health (TMaH)** Model is a 10-year state-based model that focuses exclusively on improving maternal health care for people enrolled in Medicaid and CHIP.

TMaH will support up to 15 participating state Medicaid agencies in developing a whole-person approach to pregnancy, childbirth, and postpartum care by addressing individual's physical, mental health, and social needs.

TMAH has a 3-year Pre-Implementation Period, during which states receive targeted technical assistance to advance each model element and achieve required milestones, and a 7-year Implementation Period to execute the model.

Model Goals

- Reduce disparities in access and treatment
- Improve outcomes and experiences for mothers and their newborns
- Reduce overall program expenditures

Partnerships

CMS will accept applications for TMaH from SMAs. CMS will work with SMAs, who will work with MCEs (where applicable) and maternal health providers and supports to implement the model.

State Medicaid Agencies (SMAs)

SMAs are the **only eligible applicants**. Medicaid agencies in the 50 states, D.C., and U.S. territories are eligible to apply. CMS will issue awards for up to 15 states.

Managed Care Entities (MCEs)

Participating MCEs in selected states (where applicable) will collaborate with SMAs to create and implement a plan to participate.

Maternal Health Providers and Supports

Health systems, hospitals, birth centers, federally qualified health centers (FQHCs), maternal quality advocacy organizations, maternal health providers and supports, Tribal providers, safety net providers, and CBOs will coordinate with SMAs and MCEs to participate.

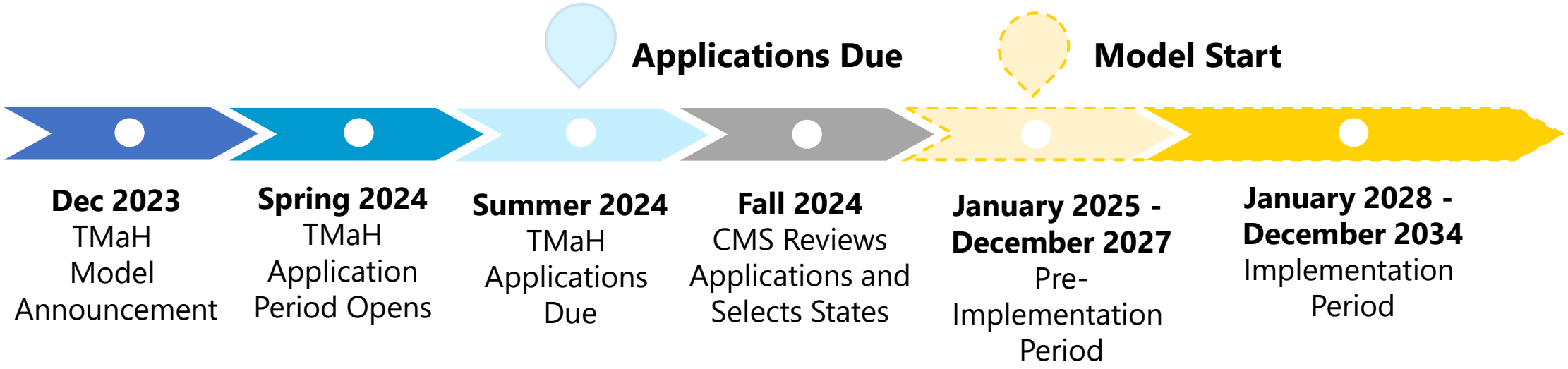
Additional information about the participation requirements will be available in the TMaH Notice of Funding Opportunity (NOFO) released in Spring 2024.

TMaH Structure

The TMaH Model will support SMAs as they implement policy and build their provider capabilities to transform the maternal health care experience under three key areas.

TMaH Model Timeline

The TMaH will release a Notice of Funding Opportunity (NOFO) for state Medicaid agencies in Spring 2024. Applications will be due in Summer 2024.



Interested in TMaH?

Visit the TMaH Website
Additional Information on TMaH Website:
https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-model

Sign up for the TMaH listserv
Subscribe to the TMaH Model Listserv https://public.govdelivery.com/accounts/USCMS/subscriber/topics for updates, including event announcements and additional resources.

Innovation in Behavioral Health (IBH) Model

Applicants: State Medicaid Agencies
Application period: Spring-Summer 2024

IBH Model Overview

Improve Quality and Outcomes for Patients

IBH aims to **improve the quality of care and health outcomes for adults with moderate to severe behavioral health (BH) conditions**, including mental health conditions and/or substance use disorders (SUDs).

Support Community-Based BH Providers

The model supports community-based BH practices to provide **person-centered care in a BH setting**. BH providers will work as part of a **care management team**, coordinating with other providers to best serve beneficiaries.

Enable Whole-Person Care For Patients

The care management team will address **behavioral and physical health (PH) issues as well as health-related social needs (HRSNs),** non-medical issues that could adversely affect a person's health, such as housing and food insecurity.

Intended Outcomes

- Enhanced quality and delivery of whole person care
- Increased access to BH, PH, and HRSN services
- Improved health and equity outcomes
- Fewer avoidable emergency department and inpatient visits
- Strengthened health IT systems capacity

IBH Model Structure

Model Participants

States

CMS will select up to 8 states through a Notice of Funding Opportunity (NOFO). States will lead IBH implementation.

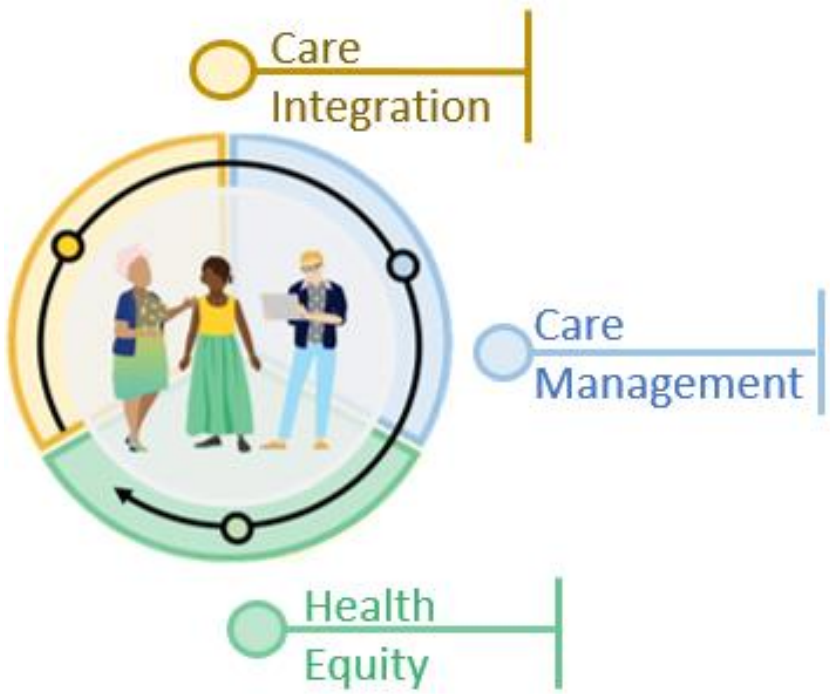
BH Practices

Practices must be licensed in the selected states and willing to provide IBH Model services.

Beneficiaries

Adult Medicaid and Medicare beneficiaries with moderate to severe MH conditions and/or SUDs.

Care Delivery Framework

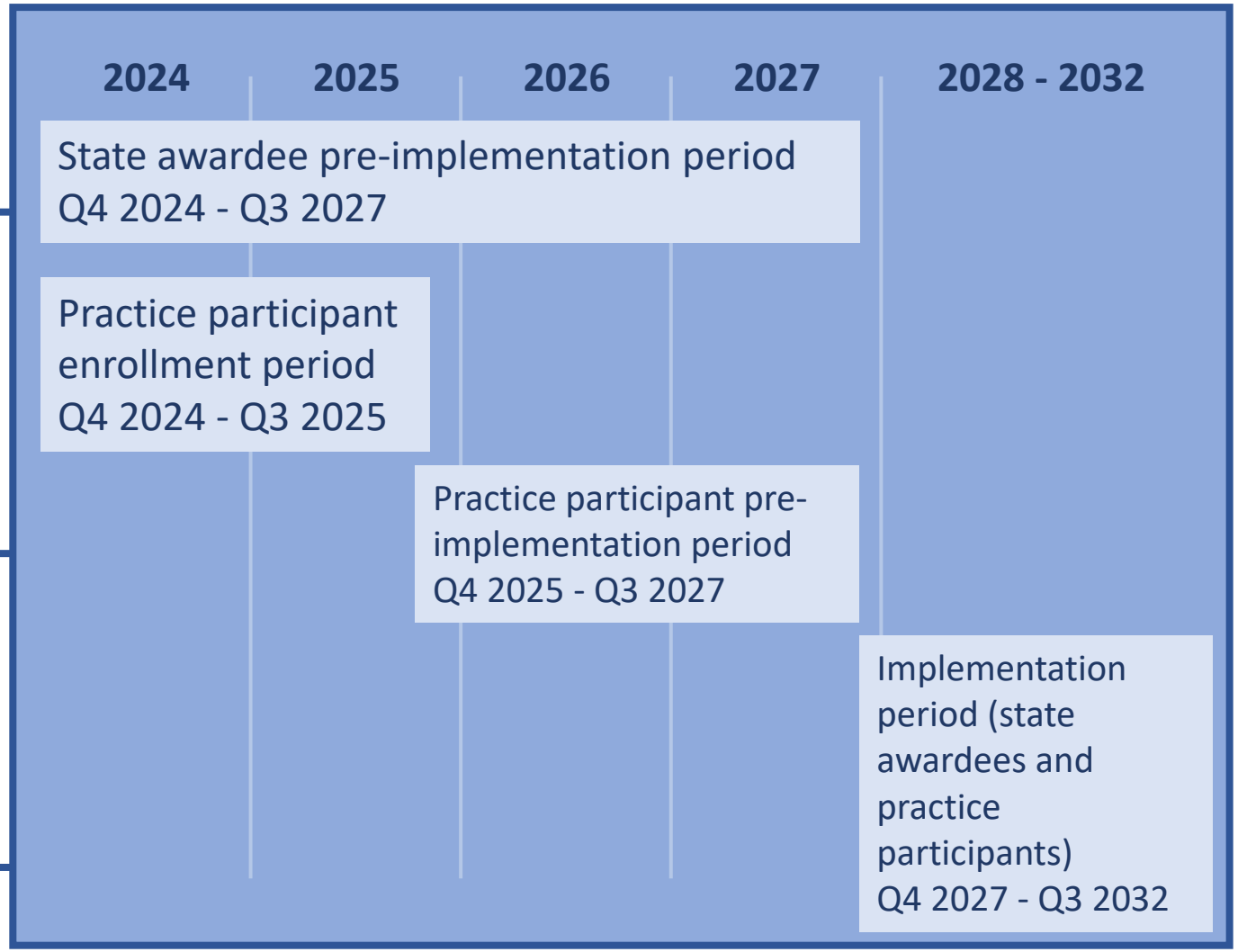


Payment Approach

- **Aligned Medicare and Medicaid APMs** to address funding gaps in the BH system while promoting accountable care
- **Cooperative Agreement funding** to states to support practice participants and develop Medicaid APM
- **Infrastructure funding to practice participants** who participate in Medicare to support health IT investments and practice transformation
- **Integration Support Payment (ISP)** to Medicare practice participants to support delivery of the care delivery framework

IBH Model: Timeline

- CMS will release a Notice of Funding Opportunity for the model **in Spring 2024**
- The model **will launch in Fall 2024** and is anticipated to operate for eight years in up to eight states
- The IBH Model includes a pre-implementation period **(model years 1-3)** and an implementation period **(model years 4-8)**



Final timeline will be detailed in the IBH Notice of Funding Opportunity

Additional Information

- IBH Website
- IBH Fact Sheet (PDF)
- IBH Press Release
- IBH Model Patient Journey Map (PDF)
- IBH Model Frequently Asked Questions
- IBH Email: IBHModel@cms.hhs.gov
- Sign Up for email updates

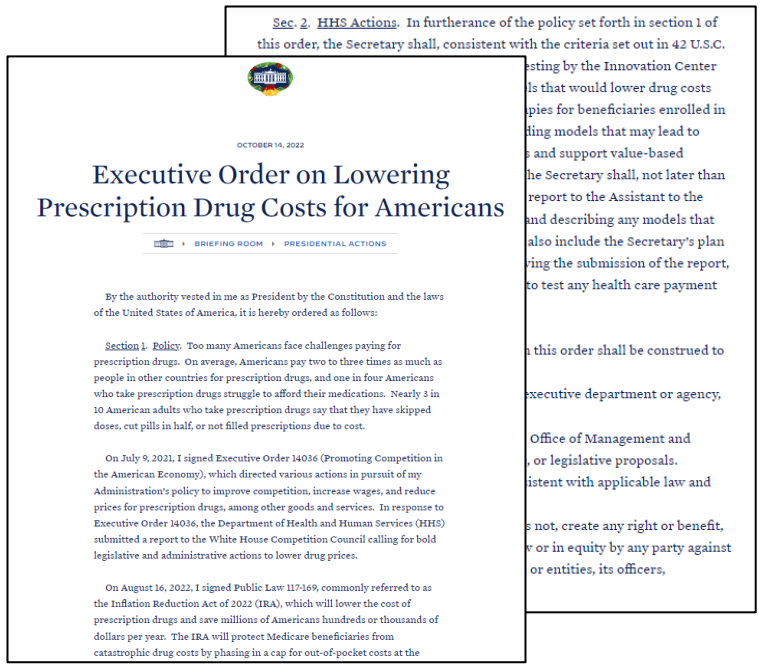
Cell and Gene Therapy (CGT) Access Model

Applicants: State Medicaid Agencies
Application period: December 2024-February 2025

Model Background

The CGT Access Model aims to reduce healthcare costs by creating outcomes-based agreements between manufacturers and states.

The Cell and Gene Therapy (CGT) Access Model was developed in response to **President Biden's Executive Order 14087, Lowering Prescription Drug Costs for Americans** and intends to drive down prescription drug costs, building on the Inflation Reduction Act.



OCTOBER 14, 2022

Executive Order on Lowering Prescription Drug Costs for Americans

BRIEFING ROOM › PRESIDENTIAL ACTIONS

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Policy. Too many Americans face challenges paying for prescription drugs. On average, Americans pay two to three times as much as people in other countries for prescription drugs, and one in four Americans who take prescription drugs struggle to afford their medications. Nearly 3 in 10 American adults who take prescription drugs say that they have skipped doses, cut pills in half, or not filled prescriptions due to cost.

On July 9, 2021, I signed Executive Order 14036 (Promoting Competition in the American Economy), which directed various actions in pursuit of my Administration's policy to improve competition, increase wages, and reduce prices for prescription drugs, among other goods and services. In response to Executive Order 14036, the Department of Health and Human Services (HHS) submitted a report to the White House Competition Council calling for bold legislative and administrative actions to lower drug prices.

On August 16, 2022, I signed Public Law 117-169, commonly referred to as the Inflation Reduction Act of 2022 (IRA), which will lower the cost of prescription drugs and save millions of Americans hundreds or thousands of dollars per year. The IRA will protect Medicare beneficiaries from catastrophic drug costs by phasing in a cap for out-of-pocket costs at the

Sec. 2. HHS Actions. In furtherance of the policy set forth in section 1 of this order, the Secretary shall, consistent with the criteria set out in 42 U.S.C. esting by the Innovation Center ls that would lower drug costs pies for beneficiaries enrolled in ding models that may lead to s and support value-based he Secretary shall, not later than report to the Assistant to the nd describing any models that also include the Secretary's plan ring the submission of the report, to test any health care payment

this order shall be construed to

executive department or agency,

Office of Management and , or legislative proposals. istent with applicable law and

s not, create any right or benefit, or in equity by any party against or entities, its officers,

The model is a framework wherein **CMS negotiates with manufacturers on behalf of states** for outcomes-based agreements, or OBAs, for CGTs that cover beneficiaries for whom Medicaid is the primary payer.

MODEL GOALS

- Improve Beneficiary Access to Transformative CGT Therapies
- Reduce Health Care Utilization and Expenditures
- Improve Health Outcomes

Model Structure

The CGT Access Model seeks to test whether a CMS-led approach to negotiating and administering OBAs for CGTs, in the context of a comprehensive strategy for addressing a range of barriers to equitable access to cell and gene therapies, will improve access and health outcomes for people with Medicaid, and reduce health care costs.

Role of CMS

CMMI will negotiate key terms and agreements between states and manufacturers, including CGT market access and rebate payments.

Participant Eligibility

All States and Territories that participate in the Medicaid Drug Rebate Program (MDRP) can participate in the model if they meet requirements.

Manufacturers must participate in the MDRP and market FDA-approved or -licensed gene therapies for the treatment of severe SCD.

CMS will negotiate discounted pricing

with manufacturers to relieve the burden on states and increase access for beneficiaries.

CMS will tie manufacturer payment to specific outcomes,

such as reduction in pain-crises and patient-reported outcomes.

CMS will offer optional funding

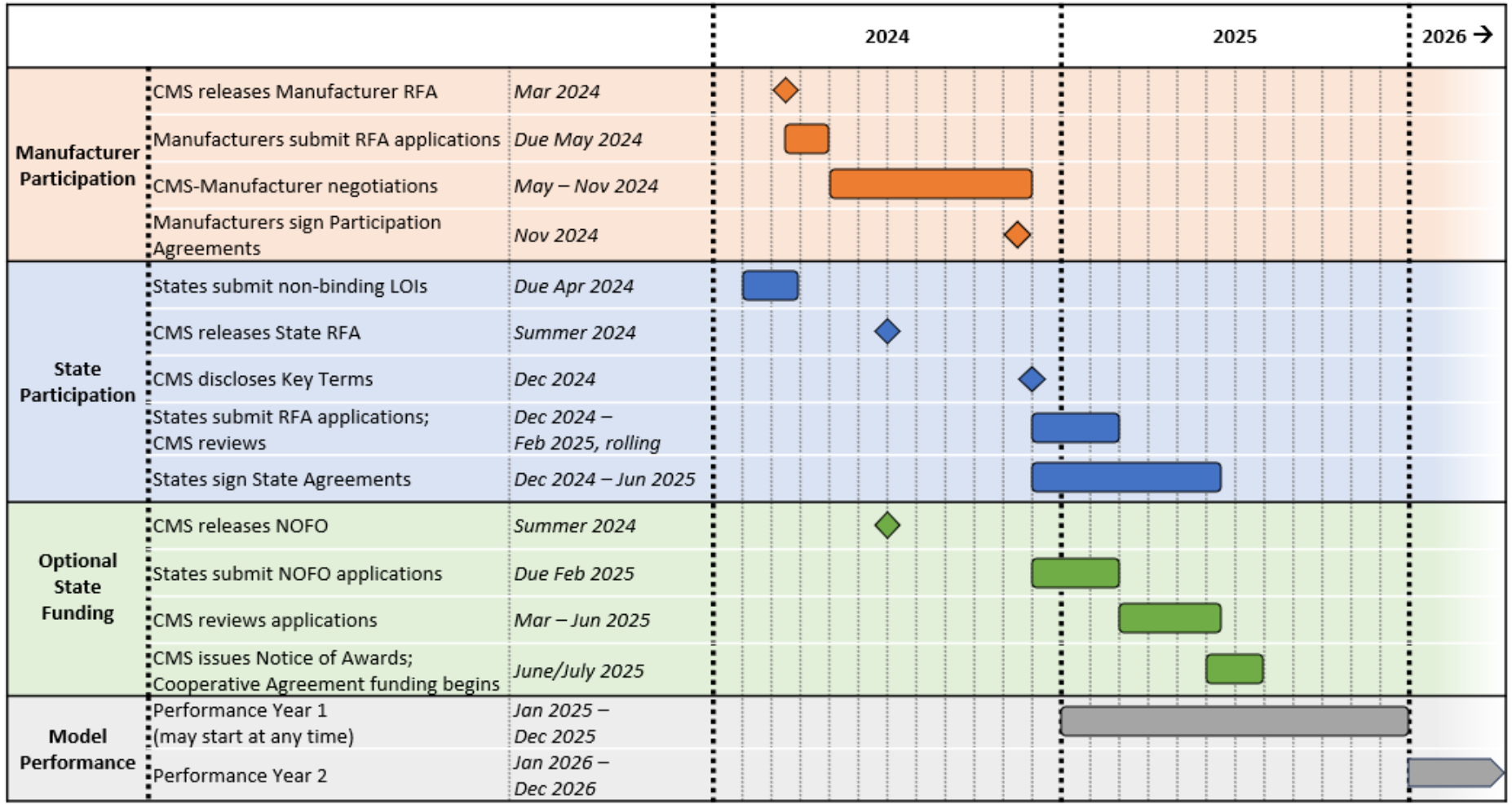
to states to support activities that promote equitable access to care.

CMS will support states to operationalize the model,

such as providing technical assistance, specifying requirements on data collection, and negotiating the OBAs as well as collecting clinical and claims outcomes.

Model and Application Timeline

The CGT Access Model will operate for up to 11 years, depending on the OBA term for each state.

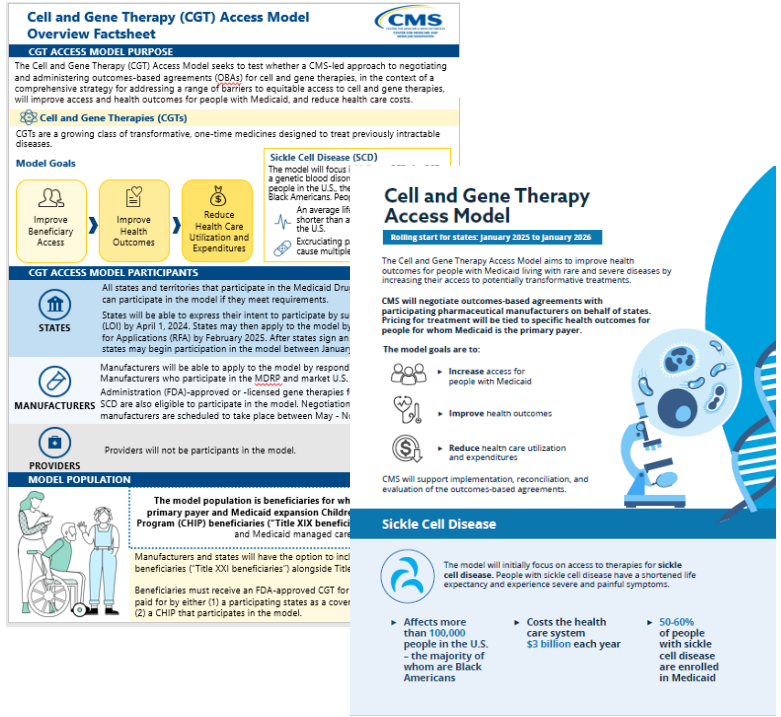


LEGEND

- Manufacturer activities
- State activities
- Funding timeline
- Model performance timeline

Model Resources

The CGT Access Model team has a host of resources to support interested organizations. To see the latest resources, visit the model's website at https://www.cms.gov/priorities/innovation/innovation-models/cgt



Model Factsheet and Infographic
Read through the CGT Model Overview Factsheet and the CGT Model Infographic on the model website to learn more.

Helpdesk
If you have questions for the model team, please reach out to us via email at to CGTModel@cms.hhs.gov.

State Participation Options

Options for State Participation in Multiple Models

- **States may apply for multiple new Innovation Center state-based models.**
- States interested in multiple models should reach out to each model of interest to understand participation options and exclusions between the models being considered, which may include exclusions and overlaps policies at the state, sub-state/geographic, provider, and/or beneficiary level.
- If selected to participate in multiple models, CMS will work with states to ensure the models are implemented in accordance with each model's overlaps policy and other requirements.
- The model overlaps policies *do not restrict beneficiary freedom* to select the provider(s) of their choice.
- CMS will share information on model participation and overlaps to help inform state applications and decision-making:
  - AHEAD Model Overlaps Policies Fact Sheet
  - Additional model overlaps policies will be shared on model websites, as available

Key Dates & Additional Information

	MCP	AHEAD	TMaH	IBH	CGT
Announced	*6/8/23*	*9/5/23*	*12/15/23*	*1/18/24*	*1/30/24*
Overview Webinar	*6/27/23*	*9/18/23*	2/28/24	2/29/24	*2/6/24* *2/8/24*
NOFO or RFA released	*8/14/23*	*11/16/23*	Spring 2024	Spring 2024	Summer 2024
Application due	*12/14/23**	Cohorts 1 & 2: 3/18/24 Cohort 3: 8/12/24	Summer 2024	Summer 2024	December 2024-February 2025 (rolling)***
Model start date	7/1/24	Cohort 1 & 2: 7/1/24; Cohort 3: 1/1/25**	January 2025	Fall 2024	January 2025-January 2026
Webpage	Link	Link	Link	Link	Link

*At this time, states have been selected. **CMS does not plan to expand to additional states, and the provider application period is closed**.
**Dates are for AHEAD's Pre-Implementation Period start date. Payments to providers start during the Implementation Period, which varies based on Cohort.
***Refers to both NOFO and state RFA.

Medicaid and CHIP Coverage of New Treatments and Opportunities to Improve Care for Sickle Cell Disease

Medicaid and CHIP All State Call
February 2024

Sickle Cell Disease in Medicaid

- CMS is committed to improving access, quality, and experience of health care for individuals living with sickle cell disease (SCD).

- Approximately half of people nationwide affected by sickle cell disease (SCD) are enrolled in Medicaid.[1]

- Individuals with SCD may experience significant pain and other serious medical problems, such as infection, lung problems, stroke, and pregnancy complications. [2]

- In 2017, 78% of Medicaid and Children's Health Insurance Program (CHIP) beneficiaries with SCD had an emergency department visit, and 49% had at least 1 inpatient hospital stay. [2]

1 https://www.cms.gov/files/document/sickle-cell-disease-action-plan.pdf
2 https://www.medicaid.gov/sites/default/files/2020-09/sickle-cell-disease-infographic.pdf

New Treatment Options for Sickle Cell Disease

- On December 8, 2023, the Food and Drug Administration approved two milestone treatments, the first cell-based gene therapies for SCD.
  - Casgevy and Lyfgenia are both approved for the treatment of SCD in patients 12 years of age and older with a history of vaso-occlusive crises[3]
  - Of 31 patients treated with Casgevy, 93.5% were free from severe vaso-occlusive crises for at least 12 months during the 24-month follow-up period.
  - Of 32 patients treated with Lyfgenia, 88% had complete resolution of vaso-occlusive events between 6 and 18 months after infusion.

- These products are made from the patients' own blood stem cells, which are modified and given back in a single infusion as part of a hematopoietic stem cell transplant.
  - Prior to treatment, the patient undergoes myeloablative conditioning with high-dose chemotherapy

[3] For more specific information, see: https://www.fda.gov/news-events/press-announcements/fda-approves-first-gene-therapies-treat-patients-sickle-cell-disease

Medicaid Coverage of Gene Therapy Drug

- Outpatient prescription drug coverage is an optional benefit that all state Medicaid agencies currently provider under the Medicaid statute (section 1905(a)(12) of the Social Security Act).
- State Medicaid agencies that provide outpatient prescription drug coverage are required to cover all covered outpatient drugs offered by any manufacturer that agrees to provide rebates.
- Drugs that are administered in an inpatient hospital setting are considered covered outpatient drugs if they are directly reimbursed.
- As both Casgevy and Lyfgenia are expected to be administered in inpatient settings, they may therefore be covered outpatient drugs and subject to Medicaid rebates, if they are directly reimbursed.
- States have discretion to establish certain utilization controls such as prior authorization.

Separate CHIP Coverage of Gene Therapy Drug

- Prescription drugs are an optional benefit states may cover in a separate CHIP.
- Unlike Medicaid, separate CHIPs that cover prescription drugs are not required to cover all covered outpatient drugs offered by manufacturers that agree to provider rebates.
  - Separate CHIPs are not included in the Medicaid Drug Rebate Program, so this requirement does not apply to separate CHIPs.
- States have the option to seek rebates from manufacturers for prescription drugs covered in separate CHIPs, but they are **not** best price exempt.
- Therefore, states have the option to cover both Casgevy and Lyfgenia and states may establish utilization controls.

State Opportunities in Value-Based Purchasing

- We encourage states to explore innovative contracting arrangements with willing manufacturers.[4]
  - For example, several states have received CMS approval to enter into value-based purchasing (VBP) supplemental rebate agreements with manufacturers. Such arrangements are intended to allow states to collect supplemental rebates for certain drugs when linked to an observed or expected therapeutic or clinical value in a select population.
  - States that have not yet done so may obtain CMS approval through a State Plan Amendment (SPA) to enable states and willing manufacturers to enter into such agreements.
  - Alternatively, manufacturers may offer a VBP arrangement to all states, even those states without an approved SPA, if they want to report varying best price amounts

[4] https://www.medicaid.gov/sites/default/files/2022-03/state-rel-189-vbp.pdf

Services Related to Gene Therapy

- The process for gene therapy includes:
  - Evaluation for gene therapy
  - Preparation during which patients may have changes in medications and transfusion therapy
  - Aphresis for cell harvesting
  - Chemotherapy and then infusion, both in an inpatient setting
  - Follow-up care and monitoring

- Federal law outlines mandatory Medicaid and CHIP benefits, which states are required to provide, and optional benefits that states may cover if they choose.
  - Examples of mandatory Medicaid benefits include inpatient hospital services, laboratory and X-ray services, physician services, and family planning services.
  - Examples of mandatory CHIP benefits include well-baby and well-child visits, mental health and substance use disorder prevention, and age-appropriate vaccines.

Access to Out-of-State Providers in Medicaid

- Some beneficiaries will require access to out-of-state providers.
  - In accordance with 42 CFR 431.52(b)(3), if a state determines, on the basis of medical advice, that needed medical services are more readily available in another state (for example, if there are no in-state SCD gene therapy providers), then the state must pay for services from the out-of-state provider. Note: All applicable provider enrollment requirements must be followed.
  - While there are no similar requirements for separate CHIPs, states may provide access to out-of-state providers through the access to care assurances in the CHIP state plan as described at 42 CFR 457.495(c).
- The Medicaid transportation assurance is a requirement to make certain that every Medicaid beneficiary who has no other means of transportation has access to transportation needed to receive covered care.[5]
  - This also includes related travel expenses such as the cost of travel, lodging, and meals for beneficiaries and their caregivers as necessary for the beneficiary to receive the covered service.
  - This requirement generally does not apply to separate CHIPs, except for those that provide the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit consistent with Medicaid requirements.

[5]For information, please see the Medicaid Transportation Coverage Guide.

Medicaid Optional Benefit for Sickle Cell Disease (1/2)

- The American Jobs Creation Act of 2004 created an optional Medicaid SCD benefit under which States can cover additional services that might not otherwise be covered in the state plan.[6]
  - Under the optional SCD benefit, states may add new optional benefits (such as genetic counseling) for individuals with SCD or increase the rates at which they pay for mandatory or already covered optional benefits. As determined by the state, services may be provided via telehealth.

- While the American Jobs Creation Act of 2004 did not extend these options to separate CHIPs, states may elect to add SCD services as a covered benefit in separate CHIP.

[6] See SMDL 05-003 for additional information.

Medicaid Optional Benefit for Sickle Cell Disease (2/2)

- Using this optional benefit, states may pay for SCD services at a different rate than they pay for similar services provided to individuals with other diseases.[7]
  - For example, under this benefit, if a state wanted to increase payment rates for SCD blood transfusions, it could do so through rate setting for the SCD benefit without having to increase payment for all Medicaid blood transfusions. Payment levels, however, must still be set within Federal requirements, including under section 1902(a)(30)(A) of the Act.

- States may also use this benefit to establish different coverage limits for SCD services under Federal amount, duration, and scope provisions at 42 CFR section 440.230 from those that apply to services in other benefit categories in section 1905(a) of the Act.

- Federal match may be available for Medicaid administrative expenditures related to activities, including certain educational activities, that promote Medicaid awareness and access to SCD, consistent with §1903(a)(3)(E) of the Social Security Act.

[7] See SMDL 05-003 for additional information.

Innovation Center: Cell and Gene Therapy (CGT) Access Model

- The CGT Access Model is a voluntary model for states and manufacturers that tests whether a CMS-led approach to developing and administering outcomes-based agreements for cell and gene therapies improves Medicaid beneficiaries' access to innovative treatment, improves their health outcomes, and reduces health care costs and burdens to state Medicaid programs.[8]

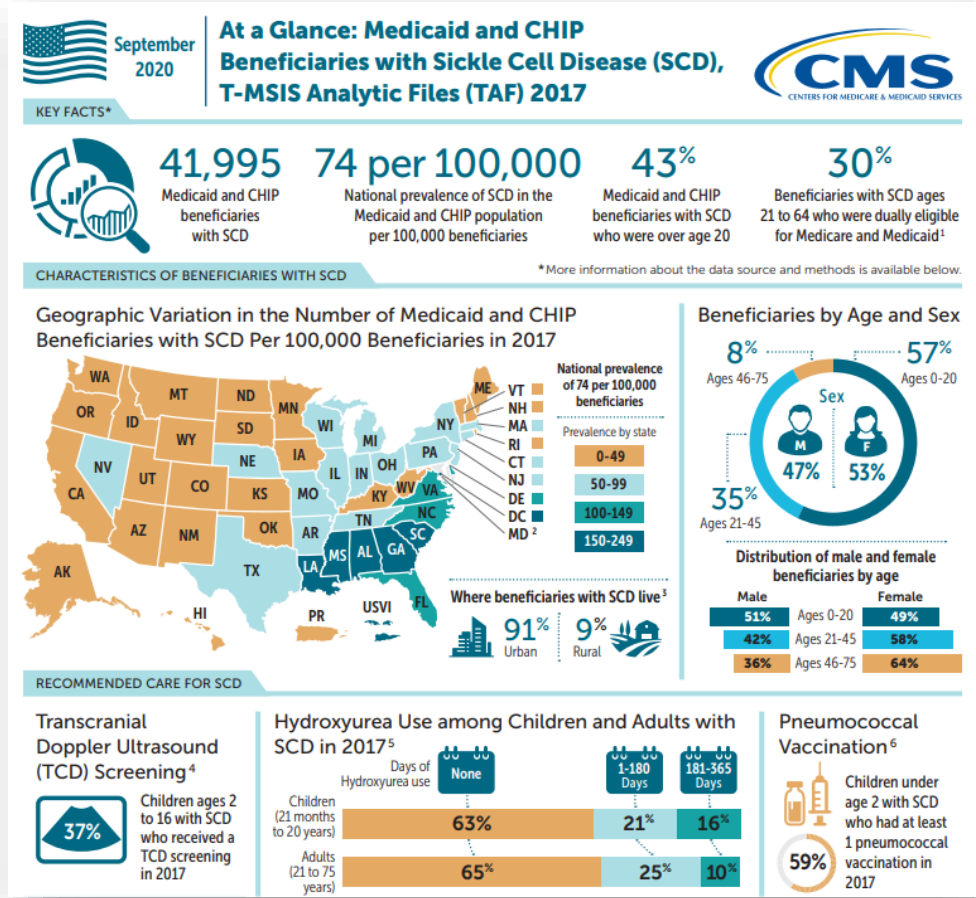
- CMS and pharmaceutical manufacturers negotiate a set of key terms, which would include pricing (that is reflective of rebates paid by the manufacturer) and outcome measures that would form the basis for individual contracts between the manufacturer and participating states.

- State Medicaid agencies decide whether to sign the negotiated contract. If agreed, manufacturers will be obligated to provide states with supplemental rebates that reflect model-negotiated terms. In turn, states will be obligated to implement an agreed-upon standard access policy.

- CMS will provide support through technical assistance and funding to participating states.

[8] See SMDL 05-003 for additional information.

Opportunities to Improve Care in SCD



Infographic available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/sickle-cell-disease-infographic.pdf

- States have opportunities to improve the care of children and adults with SCD.
  - Data show that gaps in recommended care for Medicaid and CHIP beneficiaries with SCD, specifically in rates of transcranial doppler ultrasound screening and pneumococcal vaccination for children, and in rates of hydroxyurea use among children and adults in 2017.
- The CMCS Quality Improvement (QI) Program provides state Medicaid and CHIP QI partners with information, tools, and expert support.
  - Technical assistance is available to help states build QI knowledge and skills, develop QI projects, and implement, spread, and scale-up QI initiatives.
  - Please contact MedicaidCHIPQI@cms.hhs.gov

For additional information on the CMCS QI program, see https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/index.html

Questions