WAIVERS ACROSS THE UNITED STATES:
WHERE ARE WE HEADING?

Collaborative Connections – Impacting Care
A Learning Collaborative Summit
February 22 2017

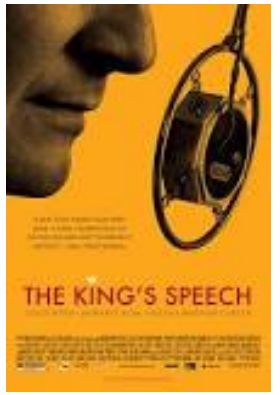
Barbara Eyman
Eyman Associates, PC

WHAT I AM GOING TO DISCUSS

- How Did We Get Here?
- Current CMS Policy *(At Least for Now…)*
  - Managed Care Rule
  - Uncompensated Care Pools
  - DSRIPs
- Medicaid Waivers in the Future (*As Far As I Know…)*
- *What I Will Not Be Discussing*

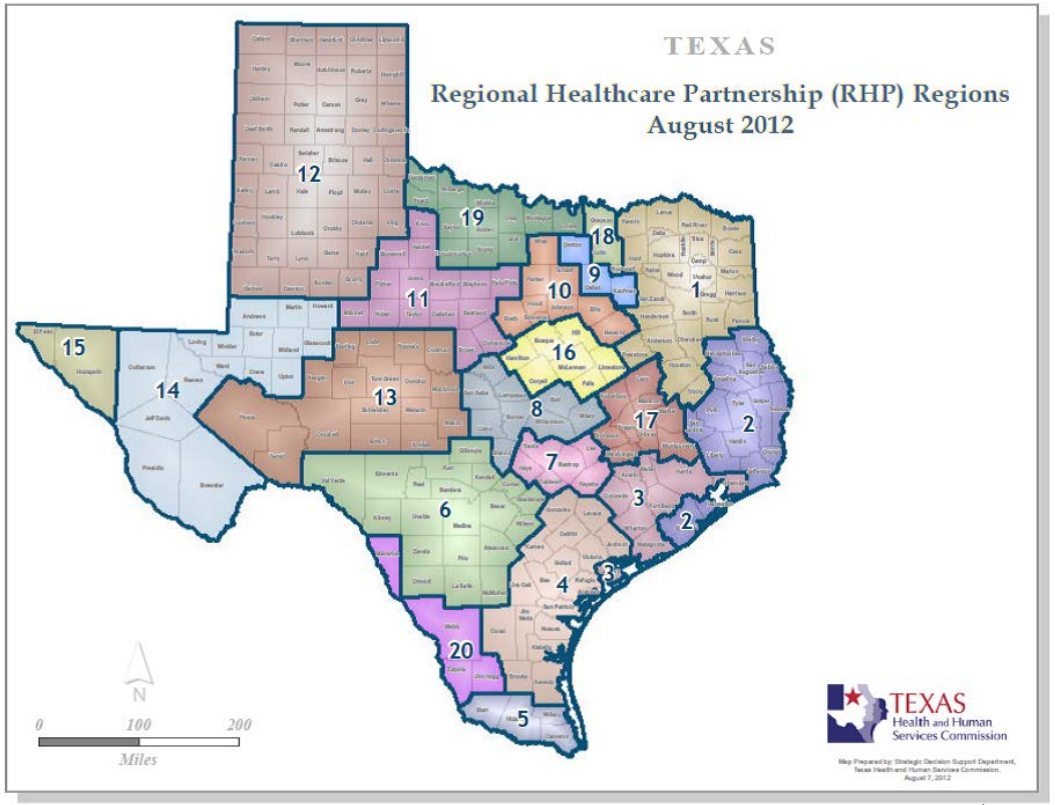
REMINDER: HOW DID WE GET HERE?

- Pre-Waiver
  - Mixed Managed Care/FFS
  - Hospitals Reliant on Supplemental "UPL Payments"
- Texas Healthcare Transformation and Quality Improvement Program
  - Original 5-Year Term: Dec. 2011-Sept. 2016
  - September 2015: Extension Request Oct. 2016-Sept. 2021
  - May 2016: Temporary Extension Through Dec. 2017
  - January 2017: 21-Month Extension Request



TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT WAIVER

- Main Elements
  - Star Plus Managed Care
  - UC Pool - Currently Funded at $3.1B/Year
  - DSRIP – Currently Funded at $3.1B/Year



[CURRENT?] FEDERAL MEDICAID POLICY:

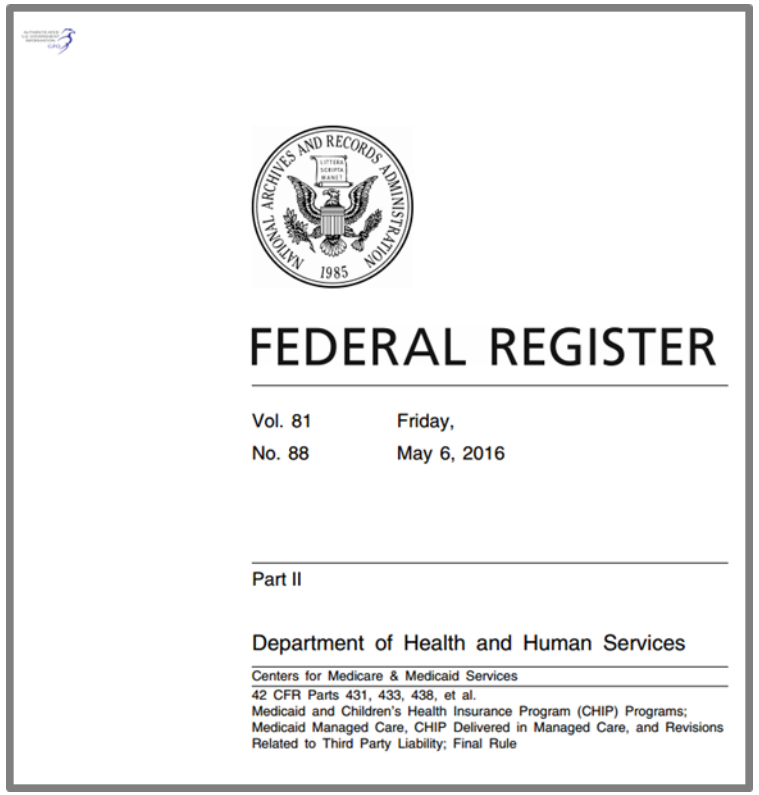
MANAGED CARE

UC POOLS

DSRIPs

MANAGED CARE

- Medicaid Managed Care Rule Issued May 2016
  - First Update Since 2002
  - 420 Federal Register Pages
  - Significant New Requirements for States
- Impact on Supplemental Payments



FEDERAL REGISTER

Vol. 81 Friday,
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Part II

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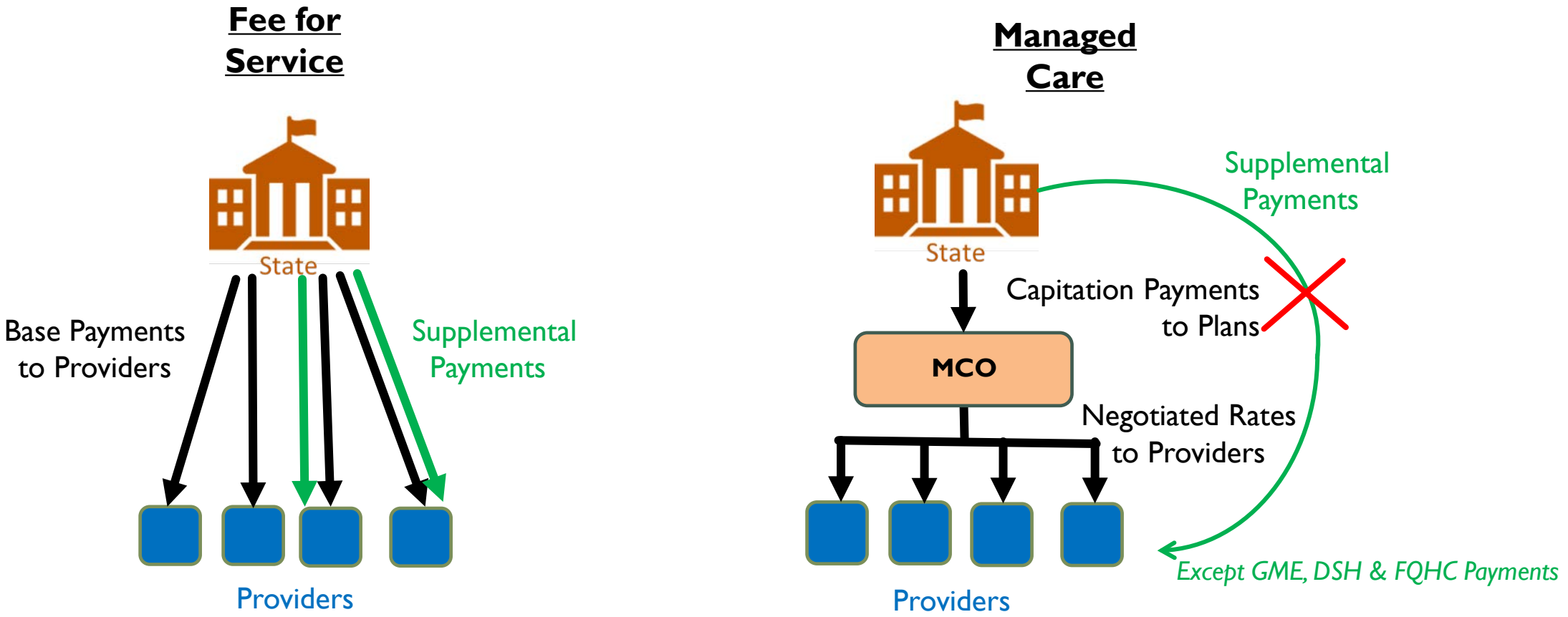
42 CFR Parts 431, 433, 438, et al.
Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule

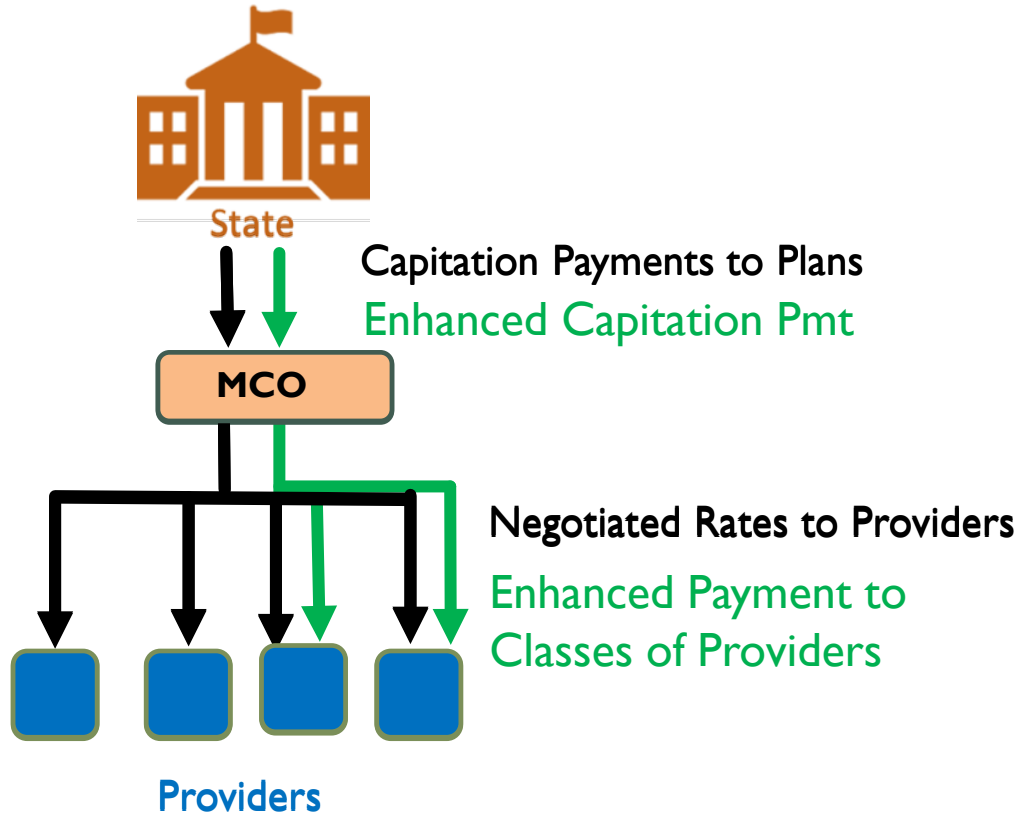
SUPPLEMENTAL PAYMENTS UNDER NEW MANAGED CARE RULE

- No Direct Supplemental Payments
  - Except GME, DSH, FQHC
- Directed Payments
  - Except:
    - Value-Based Payments
    - Delivery System Reform Payments
    - Uniform Rate Increases/Minimum/Maximum Fee Schedules
- Pass-Through Payments
  - Except Existing Pass-Through Payments During Transition Period

DIRECT[8] PAY PROHIBITION UNDER MANAGED CARE

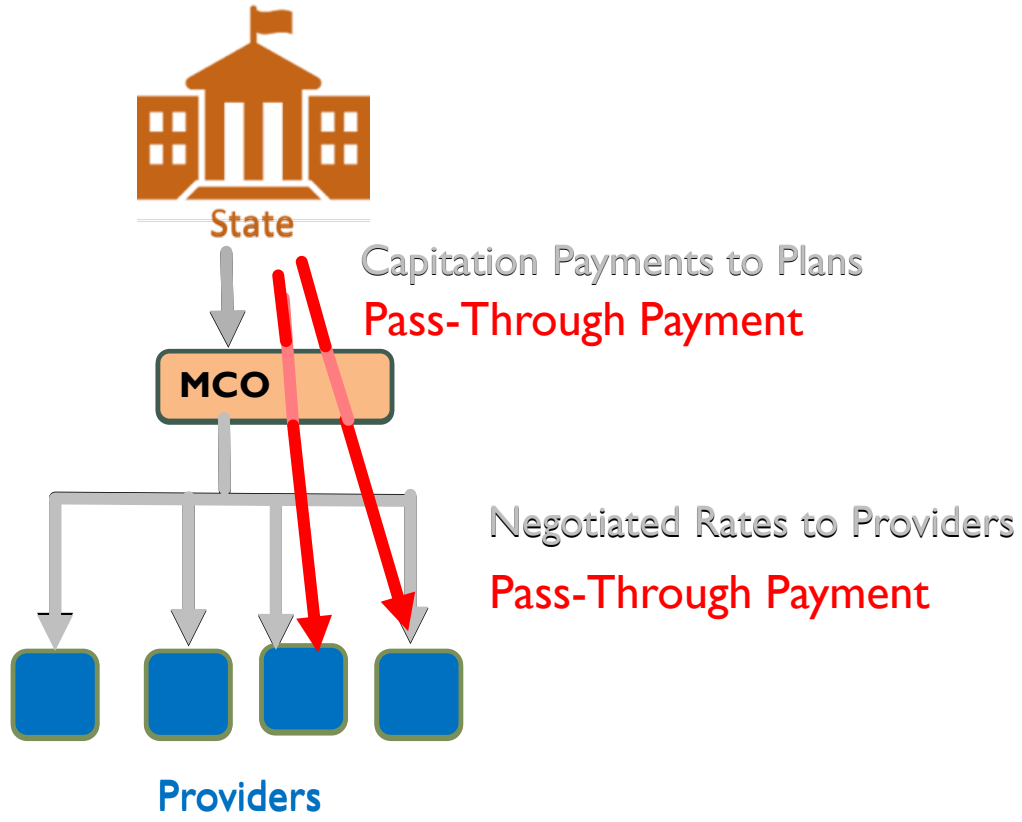


DIRECTED EXPENDITURES UNDER MANAGED CARE



- When Can States Require Plans to Make Specific Payments to Specific Providers?
  1. Value-Based Payments
  2. Delivery System Reform Payments
  3. Uniform Rate Increases/Minimum or Maximum Fee Schedules
- Further Conditions Apply

PASS-THROUGH PAYMENTS



Pass-Through Payments

- Not based on utilization
- State Requires Plan to Pass Funds Through to Providers
- Not Actuarially Sound

MCO RULE ON PASS-THROUGH PAYMENTS

- Pass-Through Payments Are Permitted During a Transition Period
  - 10-Year Phase-Down for Hospitals
  - 5 Year Transition (No Phase-Down) for Physicians & NFs
- Oops!
  - Rule Finalized January 18, 2017 Further Restricts Pass-Throughs
    - No New Pass-Throughs Permitted
    - No Increase in Existing Pass-Throughs
  - Pass-Through Rule Delayed Pursuant to Trump Executive Order
    - 2 Day Delay

[CURRENT?] FEDERAL MEDICAID POLICY:

MANAGED CARE

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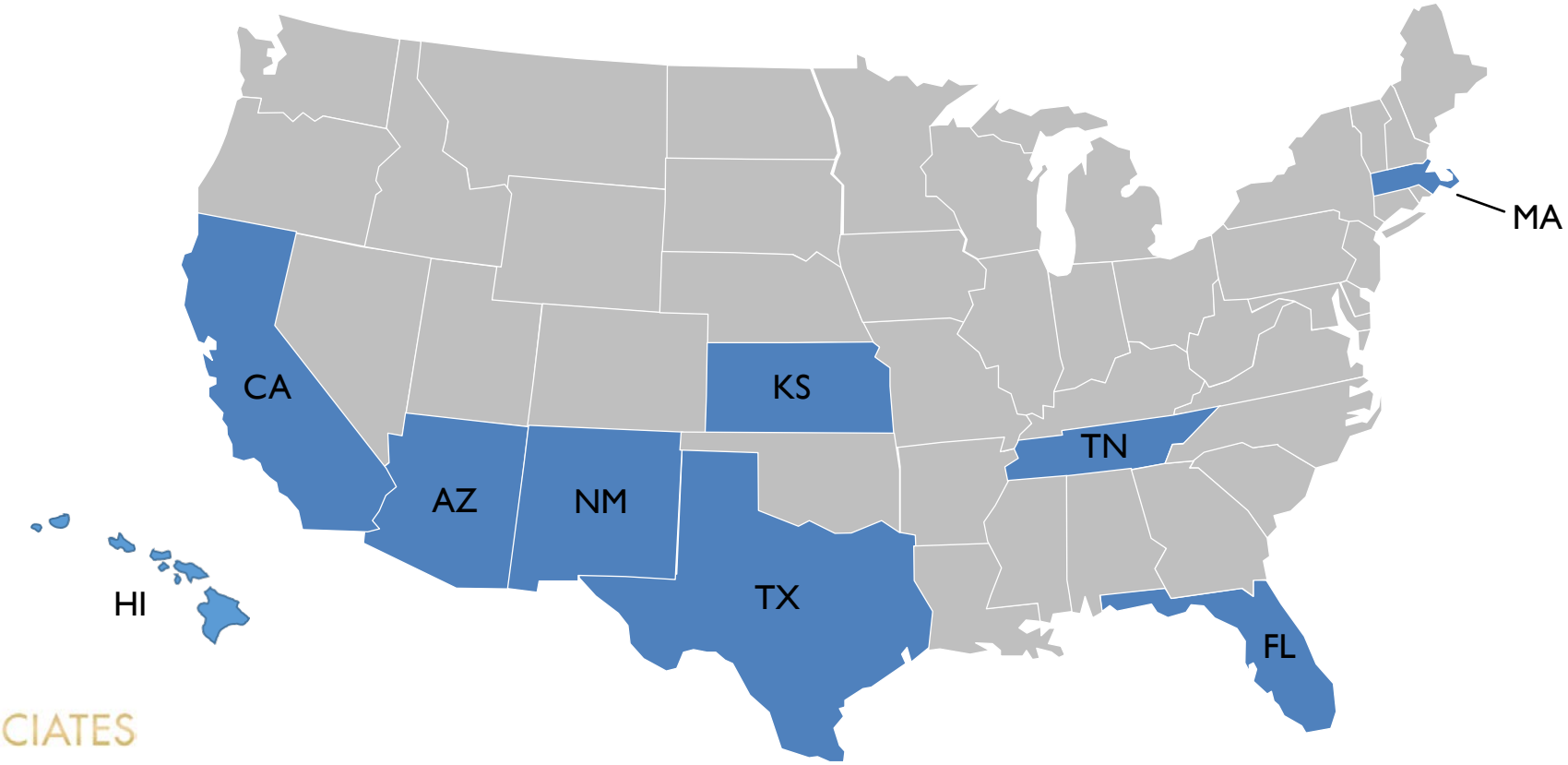
UNCOMPENSATED CARE POOLS: THEN

- UC Pools Approved in 9 States as a Means of Preserving Supplemental Payments as States Move to Managed Care



NOW: CMS PRINCIPLES FOR UNCOMPENSATED CARE POOLS

1. Coverage is the best way to assure beneficiary access to health care for low income individuals and uncompensated care pool funding should not pay for costs that would otherwise be covered in a Medicaid expansion;
2. Medicaid payments should support the provision of services to Medicaid and low income uninsured individuals; and,
3. Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

These principles apply whether or not a state expands Medicaid

Letter from Eliot Fishman, CMS, to Kay Ghahremani, HHSC
Nov. 20, 2015

FLORIDA LOW INCOME POOL (LIP)

- LIP Established in 2006 as State Implemented Managed Care
  - Renewed Through 2015
- In 2015, FL Sought an Additional 2 Years at $2.2 Billion/Year
  - April 2015: CMS Announces New UC Pool Policy in a Letter to Florida
  - October 2015: LIP Extended for 2 Years, Reduced to $607.8 Million in 2nd Year

- Only Documented Charity Care Costs for Individuals Below 200% FPL
- No Costs for Persons Who Would Be Eligible for Expansion
- No Medicaid Shortfall

CALIFORNIA GLOBAL PAYMENT PROGRAM

- GPP Approval Period: 12/30/2015 – 12/31/2020
- Combines DSH and UC Funding into a $2.9B/Year Pool

- De-Links Waiver Pool Payments from Cost and Reconciliations

CALIFORNIA GLOBAL PAYMENT PROGRAM

- Payments Tied to Value-Based Point System:
  - Traditional Outpatient
  - Non-Traditional Outpatient
  - Technology-Based Outpatient
  - Inpatient and Facility Stays

- Over Time, Point Values for Traditional Services Reduced in Favor of Services that Advance Program Objectives:
  - Expanding Access
  - Better Resource Allocaiton
  - Successful Wellness Services
  - Patient Transition into Integrated Care

[CURRENT?] FEDERAL MEDICAID POLICY:

MANAGED CARE

UC POOLS

DSRIPs

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAMS: THEN

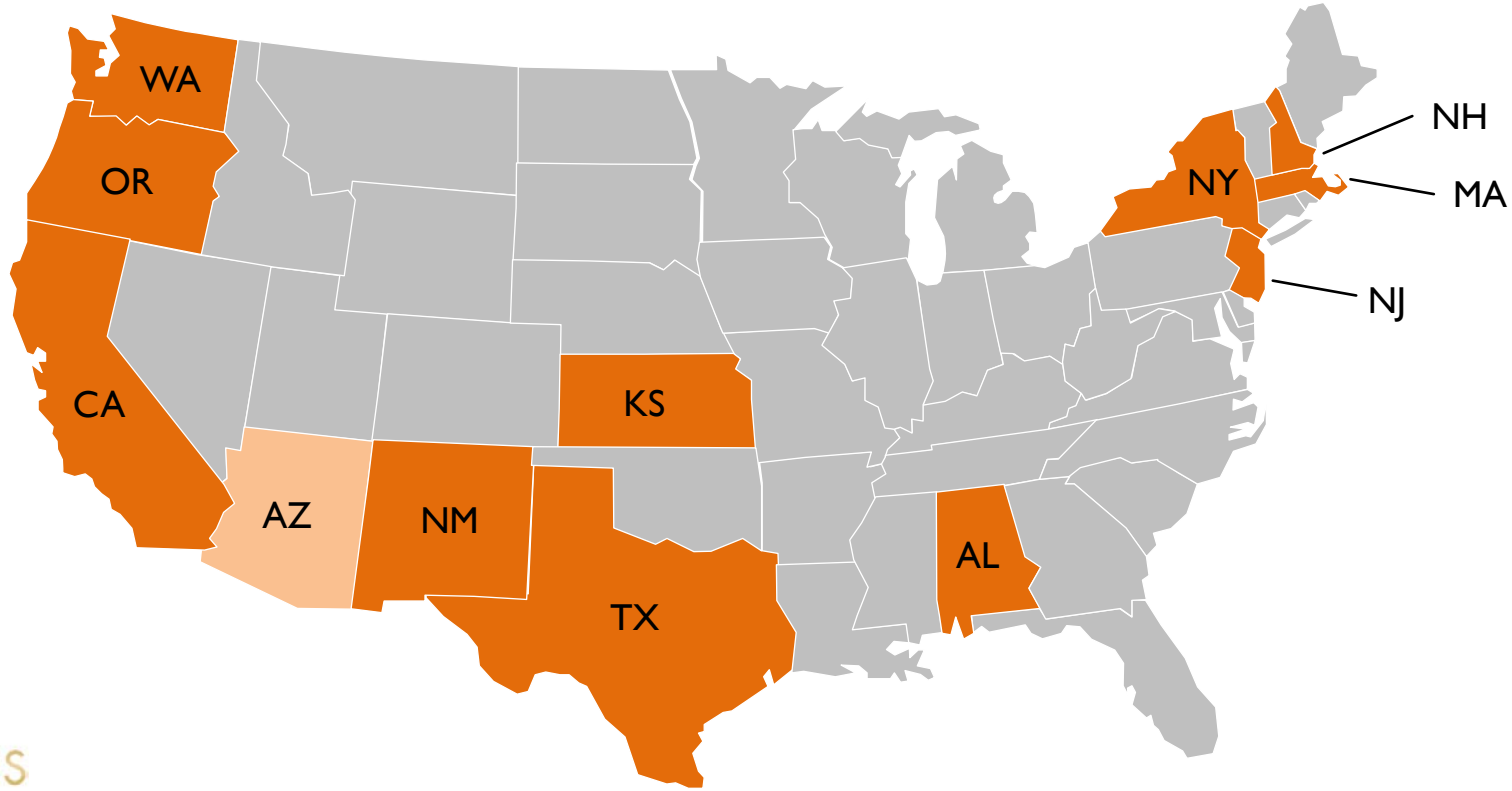
- First DSRIP Approved in California in 2010
  - Centered on Public Hospitals
  - Projects and Goals Were Hospital-Driven
  - Brand New Concept – Revolutionary in Medicaid
- Texas and Massachusetts Approved in 2011
  - Texas Introduces Regionalization of DSRIP
  - Projects Based on Community Needs Assessments
  - Regional Health Partnerships New and Innovative

WHY DSRIPs?

- Tying Supplemental Payments to Accountability
- Leveraging the Federal Investment – Ensuring a Bang for the Buck
- Supporting ACA Goals
  - Triple Aim/Don Berwick
- *BUT:*
  - The Bureaucracy
  - The Oversight
  - The Details
  - The Hassle

DSRIPs: NOW

- 11 States with Approved DSRIPs, Other Proposals Pending
- New DSRIP Approved in Washington on January 9, 2017



GENERAL DSRIP POLICY

- Time-Limited
- Focus on Sustainability (e.g. Transition to APMs)
- Increasing Focus on Payments for Outcomes
- Encouraging System-Wide Reform
- Engaging Community-Based Partners
- Payments at Risk for Achieving Statewide Goals
- A Growing Focus on Behavioral Health Integration

DSRIP RENEWALS: CALIFORNIA

- 5-Year Extension, 2016-2020
- Renamed "PRIME" (Public Hospital Redesign and Incentives in Medi-Cal)
- $7.5 Billion/5 Years (Annual Funding Reduced in Last 2 Years)
- Purpose:
  - Supporting Adoption of APMs by Managed Care Plans for PRIME Participating Entities
  - Better Integration of Physical and Behavioral Health Services
  - Improved Outcomes and Access for Those with Complex Needs
- 60% of Assigned Beneficiaries Must Receive Care through an APM by 2020
- Whole Person Care Demo

DSRIP RENEWALS: MASSACHUSETTS

- Early Approval of Extension from July 1, 2017-June 30, 2022
- Statewide ACOs
- Replaces Earlier "DSTI" with DSRIP
  - DSTI Focused on 7 Safety Net Hospitals-"Glidepath" Funding Provided Under Renewal
  - $1.8 Billion/5 Years

MASSACHUSETTS DSRIP

- Goals:
  - Promoting Member-Drive Integrated, Coordinated Care, Holding Providers Accountable for Quality and Total Cost of Care
  - Improving Physical/Behavioral Health Integration, LTSS and Health Related Social Services
  - Sustainably Supporting Safety Net Providers to Ensure Continued Access

MASSACHUSETTS DSRIP

- DSRIP Funds Paid through ACOs, Community Partners (CPs), Statewide Investments
  - Startup Costs for ACOs
  - "Flexible Services"
  - Statewide Infrastructure and Workforce Capacity
- At-Risk Funding
  - Increases to 20% Over 5-Year Waiver Term
  - Accountability Scores for ACOs, CPs, State
  - ACOs At Risk for Total Cost of Care; Quality and Utilization

NEW DSRIPs: WASHINGTON

- Accountable Communities of Health (ACH)
  - $1.125 Billion/5 Years
  - 9 Regional Collaborations
    - MCOs, Community Organizations, Providers
  - Governing Board, 50%+ CBOs
  - ACH's Conduct Needs Assessment, Compile and Submit Projects, Certify Achievement of Milestons
    - No Funds Flow Through ACHs
  - Statewide Goal of moving 90% of provider reimbursement to APMs by 2021

DSRIP ALTERNATIVE: ARIZONA

- Arizona Applied for $1.4 Billion DSRIP
- January 18, 2017, CMS Approved a $300 Million "Targeted Investment Program"
- Authorized under Managed Care Rule Directed Expenditure Authority, Not Under Waiver Authority
  - Payments Made Through MCOs
  - Lump-Sum Payments Based on Achievement of Metrics

FUTURE FEDERAL MEDICAID POLICY

KEY PLAYERS

Tom Price,
HHS Secretary

Seema Verma,
CMS
Administrator
(Nominee)

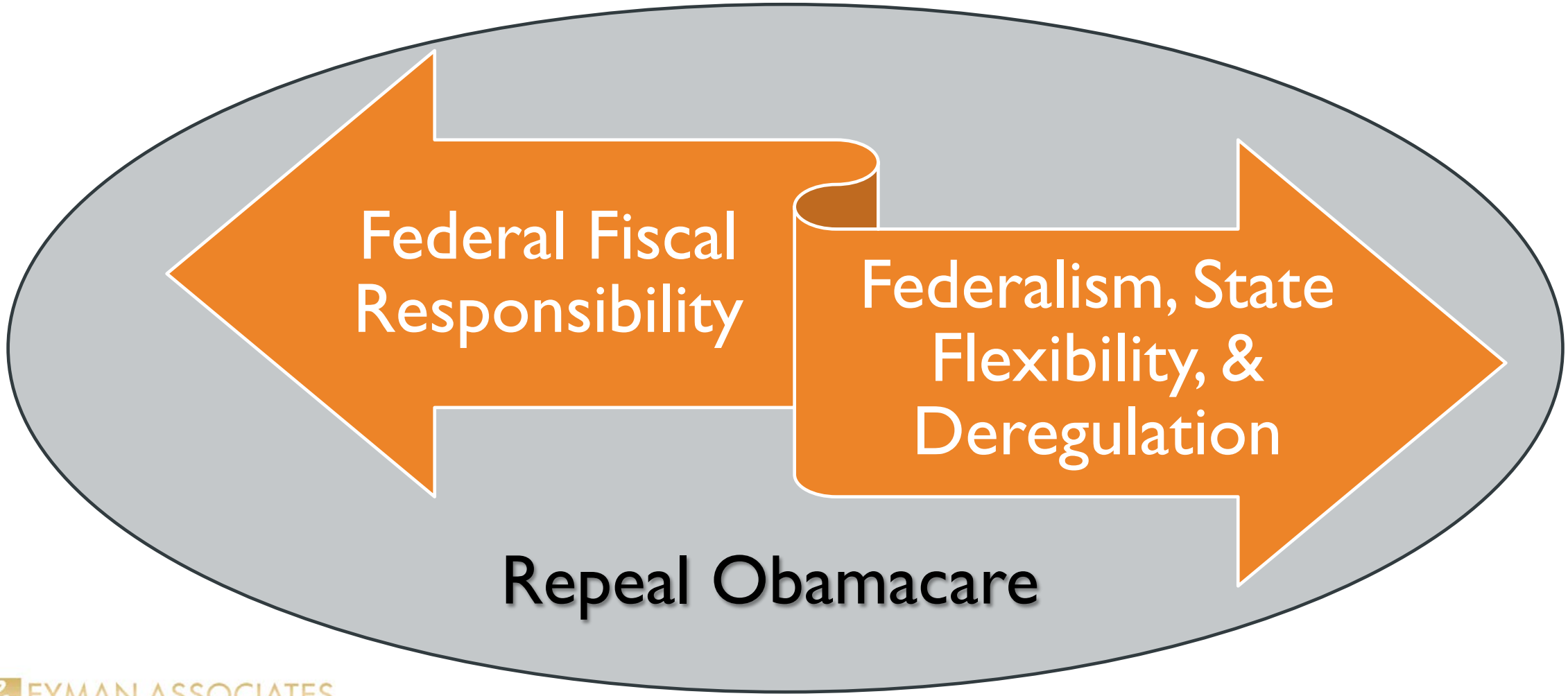
Director of Medicaid and CHIP Services (Tim Hill, *Acting Director)*

Eliot Fishman,
Director of State
Demonstrations

AND ALSO…

Mick Mulvaney
OMB Director

THE ADMINISTRATION'S BALANCING ACT



THE GOALS

"I will work toward ushering in a new era of state flexibility and leadership."

"We cannot afford to waste a single taxpayer dollar."

Seema Verma,
Testimony Before the Senate Finance Committee,
February 16, 2017

DAY ONE

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release January 20, 2017

EXECUTIVE ORDER

- - - - - - -

MINIMIZING THE ECONOMIC BURDEN OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PENDING REPEAL

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. It is the policy of my Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended (the "Act"). In the meantime, pending such repeal, it is imperative for the executive branch to ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market.

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MINIMIZING THE ECONOMIC BURDEN OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PENDING REPEAL

Sec. 2. To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.

MINIMIZING THE ECONOMIC BURDEN OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PENDING REPEAL

Sec. 3. To the maximum extent permitted by law, the Secretary and the heads of all other executive departments and agencies with authorities and responsibilities under the Act, shall exercise all authority and discretion available to them to provide greater flexibility to States and cooperate with them in implementing healthcare programs.

MINIMIZING THE ECONOMIC BURDEN OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT PENDING REPEAL

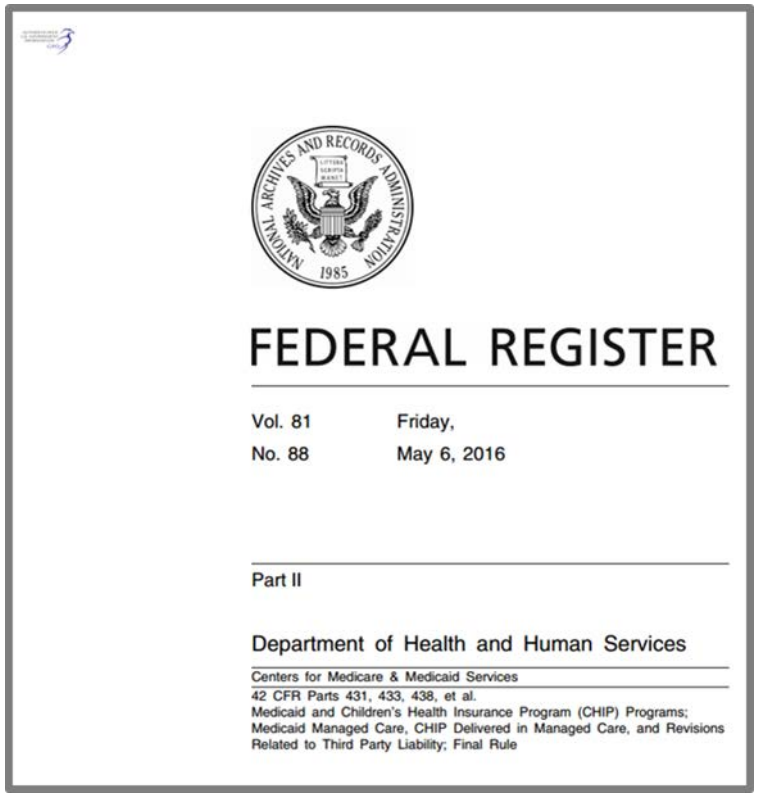
Sec. 6. (a) Nothing in this order shall be construed to impair or otherwise affect:

…

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

MANAGED CARE RULE: WILL CMS REVISIT?

- Juggling Priorities
- Pressure from Governors?
- Bandwidth
- Executive Order on Regulations
- Significant Investment by Career Staff in the Rule
- Pass-through Payments, Directed Expenditures Could Drive Up Federal Spending
- Willingness to Waive?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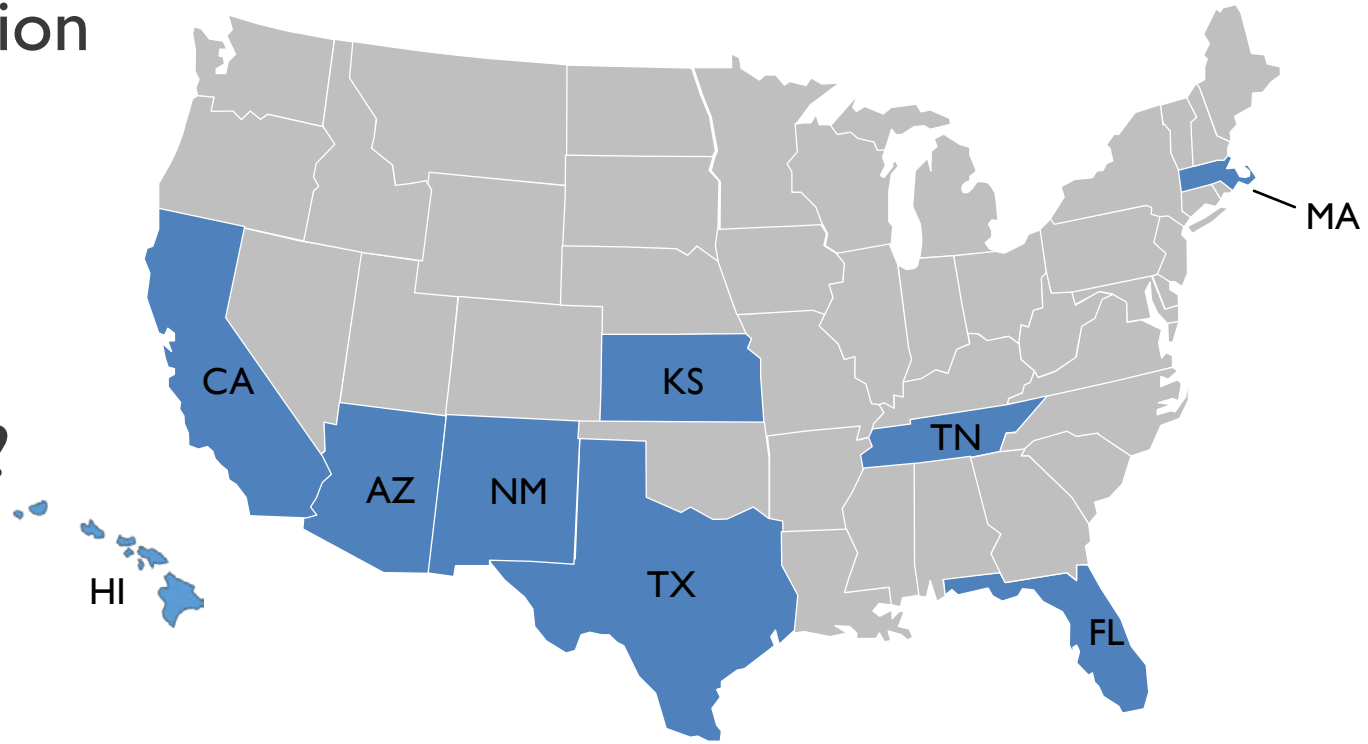
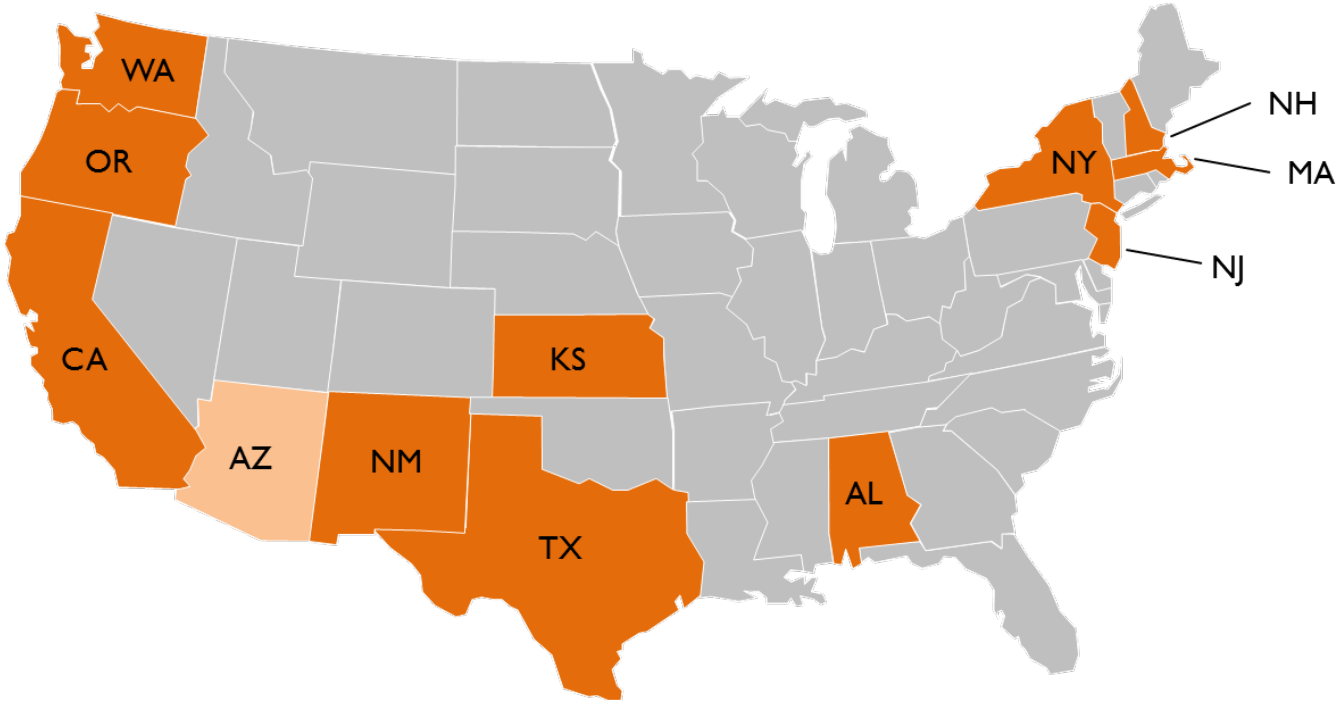
UC POOL POLICY

- Remove penalty for non-expansion states?
- State flexibility vs. fiscal conservatism
- Rates v. Supplemental Payments?
- Alternative to rewriting MCO directed expenditure rules

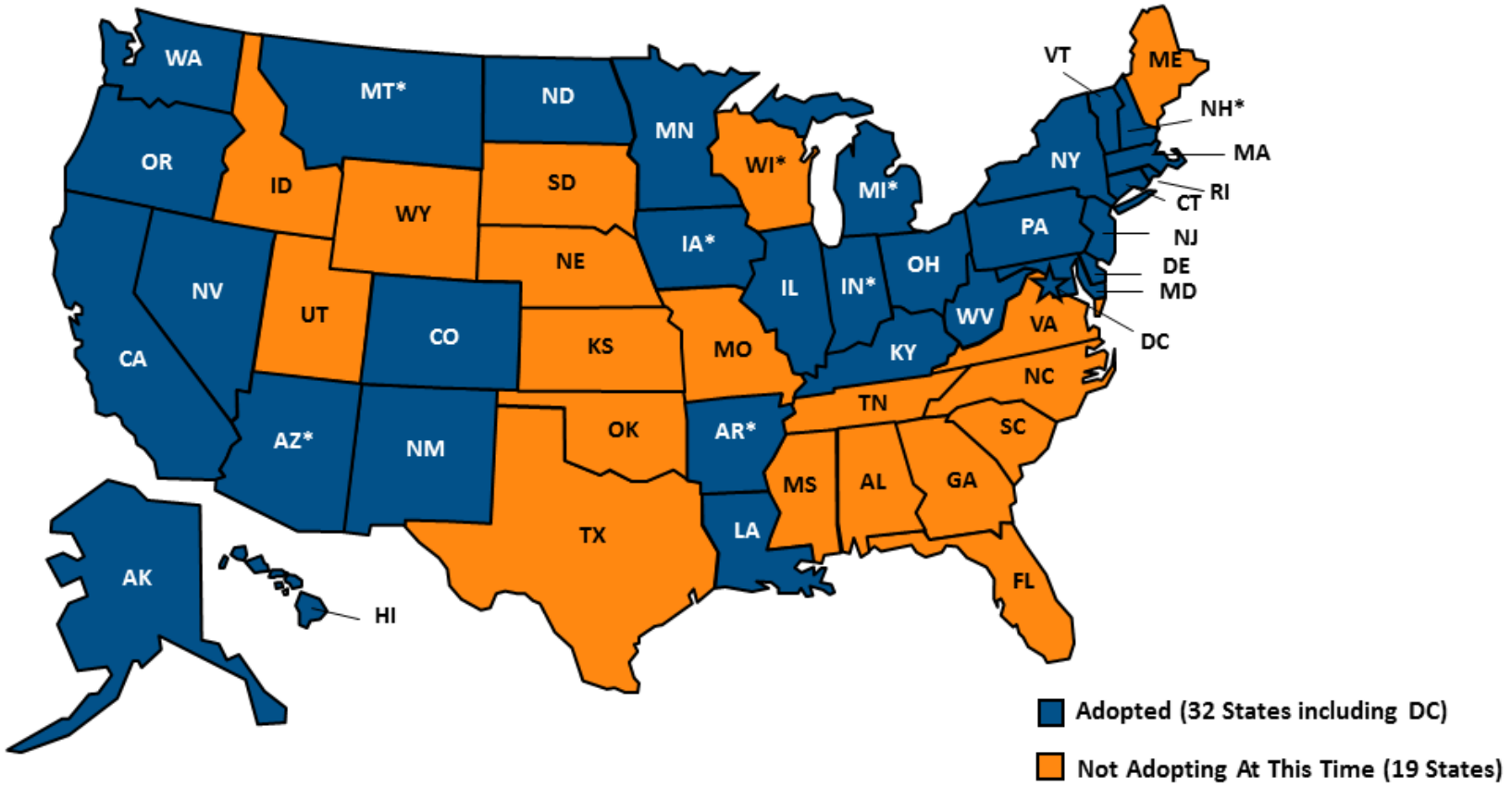


DSRIPs

- Delivery System Reform has bipartisan, apolitical support
- Reduce Complexity?
- Ease Approval Process?
- But…DSRIPs are expensive!



Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

THE HENRY J. KAISER FAMILY FOUNDATION

EXPANSION THROUGH WAIVERS

Current Expansion Policy

- ☑ Partial Expansion Does Not Qualify for Enhanced FMAP (eg < 138% FPL)
- ☑ Essential Benefit Package
- ☑ No Enrollment Caps
- ☑ Premium Assistance Permissible (within Federal Guideposts)
- ☑ Premiums, within Limits
- ☑ Healthy Behavior Incentives
- ☑ Waive Retroactive Coverage
- ☑ Temporary Lockout for Unpaid Premiums
- ☑ Higher Cost-Sharing for Non-Urgent ER Use

States Are Seeking:

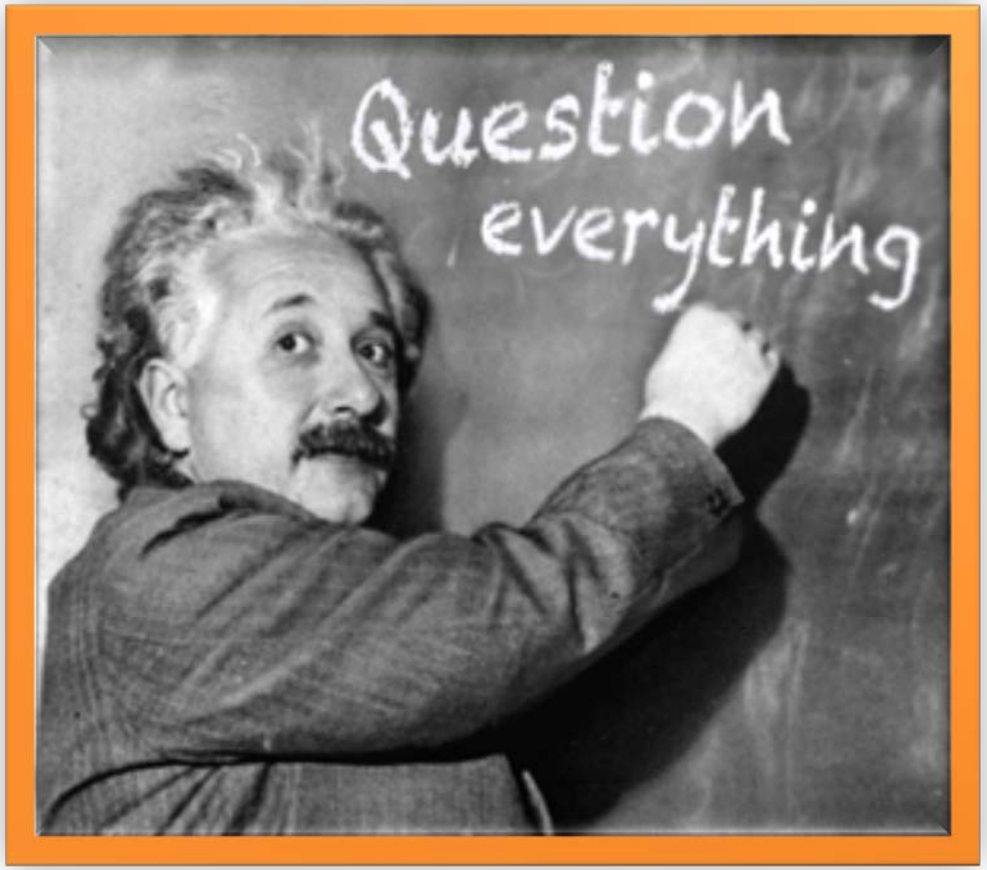
- ❑ Expansion Only to 100% FPL
- ❑ Premium & Cost Sharing "Skin in the Game"
- ❑ Eliminate Wrap-Around Benefits (eg EPSDT)
- ❑ Work Requirements
- ❑ Enrollment Caps

… and possibly…

- ❑ Block Grant Funding

THE FUTURE OF MEDICAID?

- Block grants?
- Per capita caps?
- Expansion repeal?
- Federal funding cuts?



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