

THE **NATIONAL PARTNERSHIP**
FOR THE **HEALTH CARE**
SAFETY NET

**Medicaid Waiver Activity: Implications for
Essential Hospitals and Health Centers**

April 15, 2015

AGENDA

1. Introduction to Medicaid Waivers and Why States Use them
2. Recent Important Examples of the Use of Waiver Authority
 1. Medicaid Expansion through “Private Option”
 2. Delivery System Reform Incentive Payment programs
3. Questions?

SPEAKERS

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Medicaid Waiver Basics



What Do We Mean by a “Waiver”?

- Federal law and regulation and guidance outline requirements for all Medicaid programs
- State Medicaid Plan provides detail on state implementation within federal requirements, for fee for service
- For Medicaid managed care, state contract with plans outlines implementation
- *But what if the state wants to do something not otherwise permitted by federal Medicaid rules and still get federal matching funds*



Requests waiver of federal Medicaid requirements



Authorities for Medicaid Waivers

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□ **Section 1115 Demonstration Projects**

Additional flexibility to test new or existing approaches to financing and delivering care through Medicaid and CHIP

□ **Managed Care Waivers**

▣ **Section 1915(b): Provide services through managed care delivery systems or otherwise limit people's choice of providers**

▣ **Section 1915(c) Home and Community-Based Services Waivers**

□ **Center for Medicare and Medicaid Innovation authority**



What Could a State Do Under an 1115 Demonstration Project?

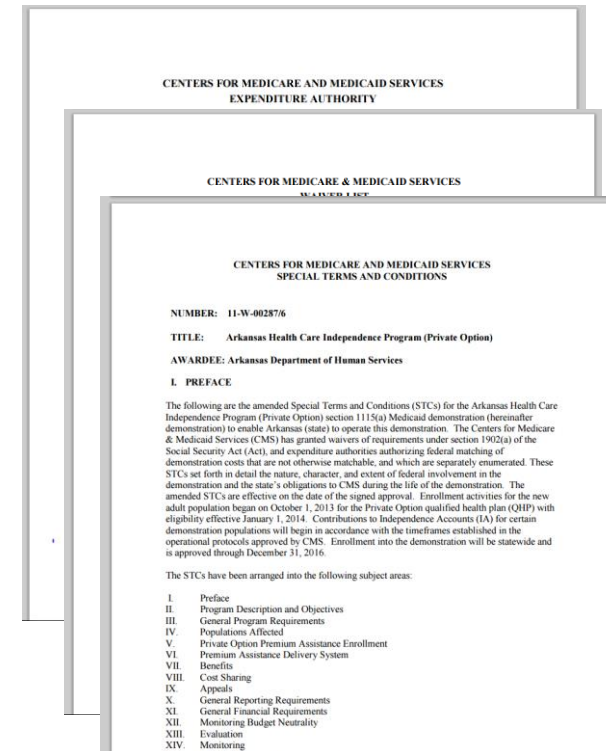
- Expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Less than statewide implementation
- Sub-populations
- Selective contracting
- Different “amount, duration or scope” of services for target population
- Incentive payments not tied to services provided (DSRIP)
- Non-Medicaid services (social services, housing supports, etc.)
- Payments for uncompensated care (Medicaid MC and FFS, and uninsured)
- Innovative regional care coordination
- Payment reform



Elements of Section 1115 Demonstration Projects

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- ❑ Waiver authority
- ❑ Expenditure authority
- ❑ Special Terms and Conditions
- ❑ Budget neutrality
- ❑ Public process requirements
- ❑ Discretionary approval authority
- ❑ Term 3-5 years
 - ❑ Amendment and renewal processes



Recent Uses of Medicaid Waivers

Medicaid Expansion through Premium Assistance for Exchange Coverage

- FQHCs, 1115 Waivers and the Challenges of Medicaid Expansion Through Premium Assistance
- Top of Mind Issue for Essential Hospitals





FQHC Services and Payment Protections in the Federal Medicaid Statute

Medicaid law:

- establishes services of an FQHC as a required Medicaid service.
- defines those services to include the so-called Medicare rural-health center “core” services and any other ambulatory services included in the state’s Medicaid plan.

Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1905(I) of the Social Security Act (SSA).



FQHC Services and Payment Protections in the Federal Medicaid Statute

Medicaid law establishes payment requirements under which FQHCs must be reimbursed for their services based on:

- a Prospective Payment System (PPS) that provides for payment for each face-to-face/per visit encounter or
- an alternative payment methodology that is agreed upon by the state and the FQHC and which will result in no less payment to the FQHC than it would have received under PPS.

Section 1902(bb) of the SSA.



FQHC Services and Payment Protections in the Federal Medicaid Statute

The “benchmark” provisions in the Medicaid statute that allow states to limit services to the ACA’s Medicaid expansion population requires that:

- this population continue to have access to FQHC services
- and that FQHCs be paid no less than PPS for those services.

Section 1937 of the SSA.



Section 1115 Waivers Can Undercut FQHC Service and Payment Protections

Section 1115 of the SSA allows the Secretary of HHS to waive certain provisions of the Medicaid statute if, in her judgement, it is likely to assist promoting objectives of the Medicaid program.

The FQHC Medicaid protections can be waived under Section 1115



Section 1115 Waivers Can Undercut FQHC Service and Payment Protections

States that are seeking to expand Medicaid to those newly eligible under the ACA can only require these new eligibles to receive their Medicaid coverage through Qualified Health Plans (QHPs) and premium assistance if the State receives an 1115 waiver.



Section 1115 Waivers Can Undercut FQHC Service and Payment Protections

This process can result in vulnerability to FQHCs if the State also seeks to waive FQHC protections as part of its 1115 waiver demonstration.

There has been a long history of Section 1115 waiver demonstration programs that have been harmful to FQHCs.




Section 1115 Waivers Can Undercut FQHC Service and Payment Protections

Health centers, PCAs, and NACHC have used the current 1115 transparency regulations* to try to safeguard FQHC services and payment in the 1115 waivers, particularly in the premium assistance demonstration programs

- State public notice and public hearings
- Federal public notice and approval process

*42 CFR 431.400 et seq



How are these FQHC service and payment issues playing out in State Medicaid expansions through premium assistance and 1115 waivers?

Arkansas, Iowa, and Pennsylvania

Other states



Related Issues and Approaches

- Actual access to FQHC services
- Inclusion of all FQHC services
- Cost-sharing and Section 330 grant requirements



Related Issues and Approaches

- Managed care and PPS wrap-around payments from the states
- Shared savings
- Alternative Payment Methodologies

Top of Mind Issues for Essential Hospitals

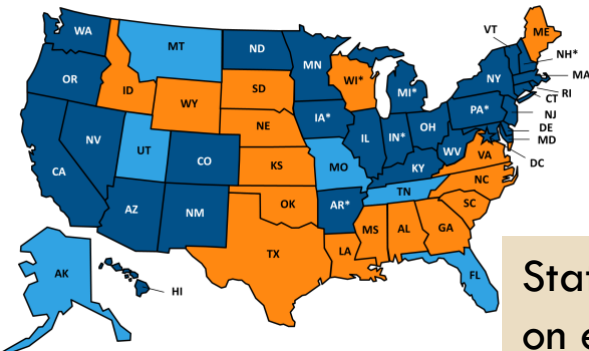
- Beneficiaries in private option remain Medicaid eligible
 - ▣ Impact on other programs linked to treatment of Medicaid patients
- Maintaining support for essential hospital missions that might not be a focus of QHPs
- Rates
- Wrap-around services and waivers (non-emergency transportation, EPSDT, out of network family planning, etc.)
- Potential fall-out from new trends to include premium contributions, lock-out and even disenrollment
- Requests of work-related requirements (although CMS has not approved)



Political and Practical Trade-Off



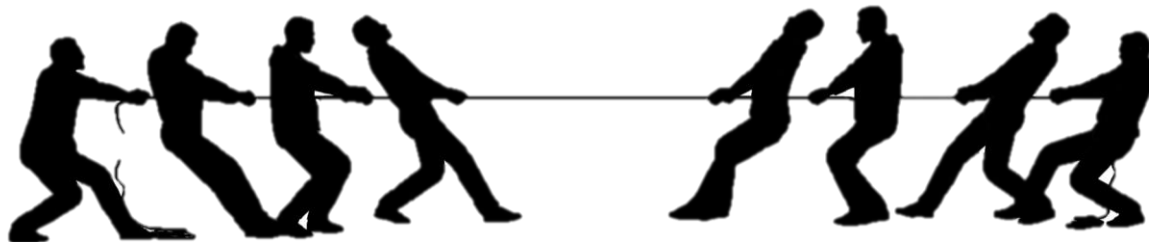
CMS wants expansion, but how far are they willing to go



States want their stamp on expansion



Providers want coverage for their patients, but need the support to treat the most vulnerable



Recent Uses of Medicaid Waivers

Delivery System Reform Incentive Payments
(DSRIPs)



What is a DSRIP?

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- Groundbreaking new type of payment:
Medicaid incentive payments to providers that undertake intensive delivery system reform
- State makes payments based on achievements of milestones
- Not considered payment for services
- Non-federal share may be financed by state or local sources
 - ▣ Generally, but not all, by public entities (IGTs)
- Amount of funding involved in CA (\$6.5B/5 years)



Implementation through 1115 Waiver

Enables innovation and flexibility

- Provides authority for federal matching of incentive payments not tied to delivery Medicaid services
- DSRIP structure and \$ outlined in STC's

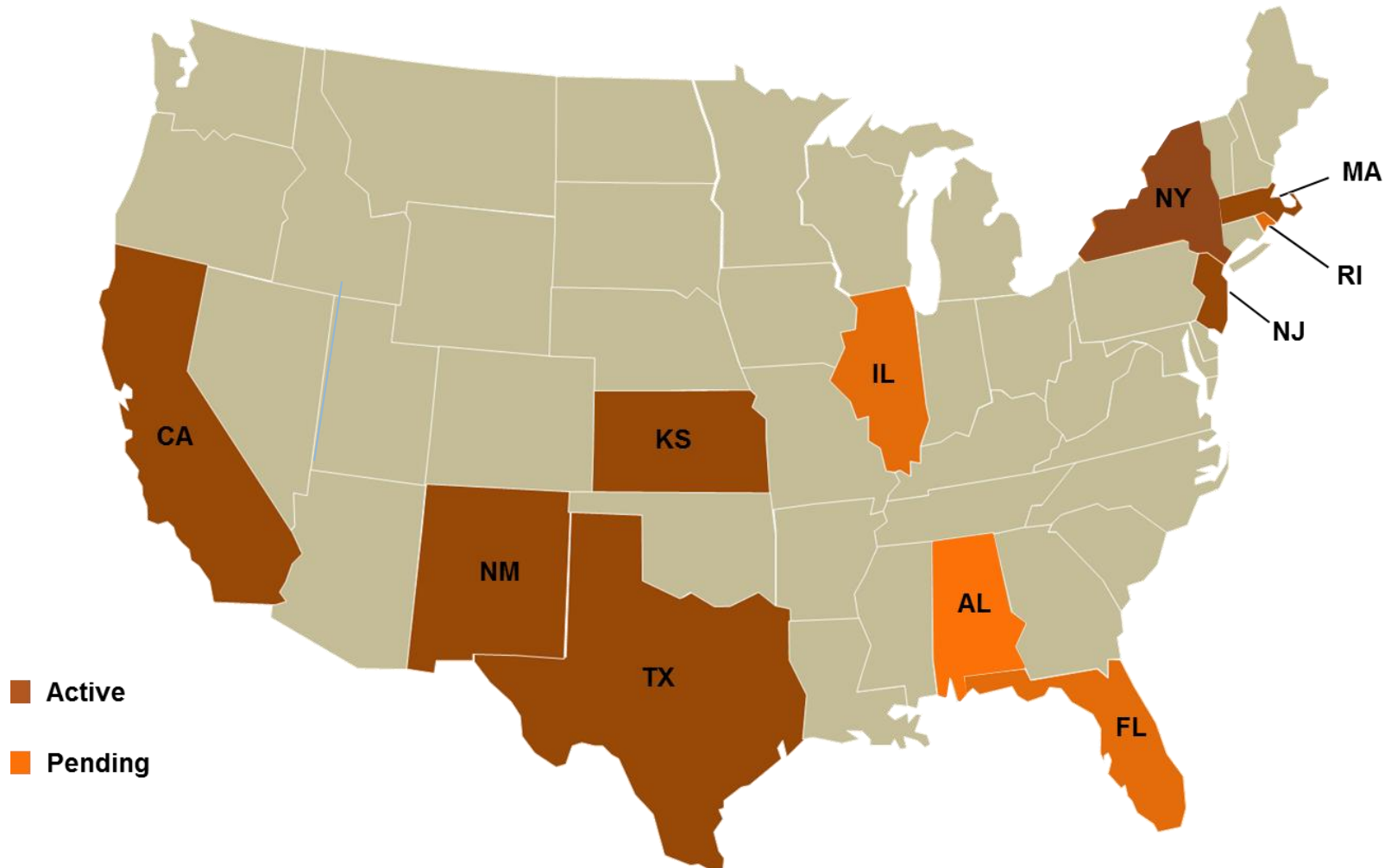
But comes with its own challenges...

- Federal funding with waiver cannot exceed federal spending without the waiver
 - ▣ Waiver must save enough federal \$ to cover DSRIP costs
- Need source of non-federal share financing
- Approval at CMS discretion
 - ▣ What does federal government want for its investment?



Active and Pending DSRIPs

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Basic Elements of a DSRIP

- Outline of requirements and authorities in Federal STCs and Expenditure Authority
- State DSRIP Plan approved by CMS
- Pre-approved project(s) and quality metrics
- Pre-approved project-related milestones and metrics
- Incentive payments



What Kind of Delivery System Reform is Expected?

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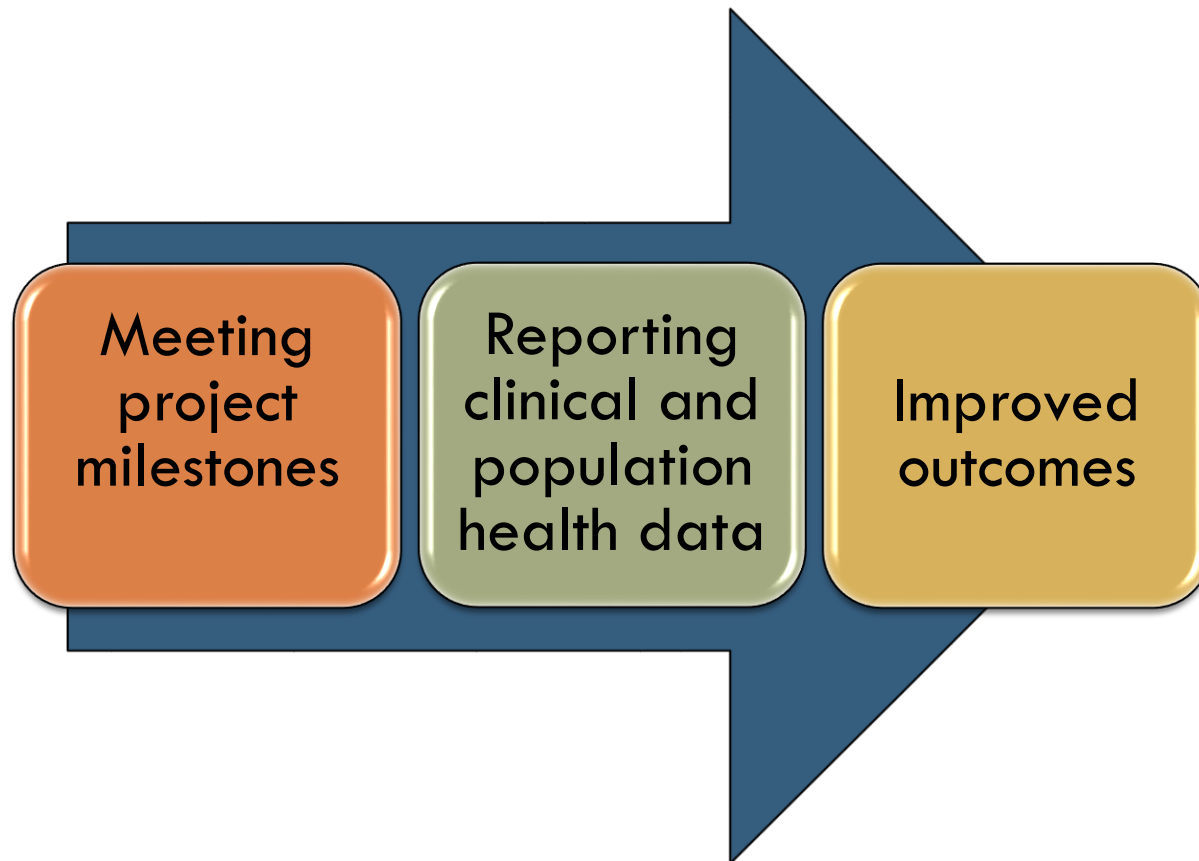
- Pre-approved projects designed to move towards the Triple Aim, for example:



What Kind of Delivery System Reform is Expected?

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- Performance measurements based on:



Funding and Scope Varies Widely

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State	Total Funding	Participants	Time-frame	New Funding?	Source of State Match
CA	\$6.5B	21 public hospitals	5 years	New/ Existing	IGTs
TX	\$11.4B	300+ providers (public and private)	5 years	New/ Existing	IGTs (partnerships)
MA	\$691M	7 hospitals (public and private safety net)	3 years*	Existing	IGTs by public; state general revenues for private
KS	\$100M	2 hospitals (public and private)	5 years	Existing (transition)	IGTs by public; state general revenues for private
NJ	\$611M	All hospitals	5 years	Existing (transition)	State general revenues
NM	\$29M	29 hospitals (public and sole community providers)	5 years	Existing (transition)	IGTs
NY	\$6.4B	Safety net providers (public and private)	6 years^	New/ Existing	IGTs

*Extended after original 3-year term

^Approval for years 2-6 contingent on new waiver approval



Increasing Focus on Supporting State Policy Goals

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CA: Hospital-specific projects with alignment across categories

TX: Region-wide transformation plans

MA: prepare for payment reform

NJ: Healthy NJ chronic disease reduction effort

NY: Reducing avoidable hospital use



Increasing Emphasis on Collaboration among Providers

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Learning Collaboratives

“As important as individual hospital efforts will be, there is even greater potential value in leveraging the hospitals’ efforts for delivery system transformation through the sharing of best practices.”

~MA Master DSTI Plan

Regional Healthcare Partnerships (TX)

“Multiple, complementary initiatives will be occurring in the same RHP simultaneously, reinforcing each other in the transformation of care delivery.”

~TX RHP Planning Protocol

Performing Provider Systems (NY)

“DSRIP is about collaboration. No single provider or even a group of providers that does not cover the full spectrum of health care delivery will meet the program’s requirements.”

~NY Department of Health



Other Trends



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- Project selection process tightening
- Milestones more rigorous, with explicit “stretch” goals
- Pay for performance, not just reporting
- Incentivizing improvement
- Focus on population health
- Independent evaluation



What's New about the New York DSRIP?

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- Performing Provider Systems
 - ▣ Required partnering among array of providers
 - ▣ DSRIP performance funding allocated within the PPS
 - ▣ Antitrust protection and waiver of certain state regulatory barriers
 - ▣ Attribution
- New \$ (not just old supplemental payments), but intensive project selection and ambitious milestones
- Interim Access Assurance Fund
- Putting DSRIP funding at risk for statewide performance
- Sustainability through managed care



CA Proposed Public Safety Net System Transformation & Improvement Program

- One of 6 Delivery System Transformation and Alignment Programs in waiver renewal request
- Build upon DSRIP
- Eligibility
 - ▣ Designated Public Hospital Systems from initial DSRIP *plus*
 - ▣ Opportunity for scaled participation of 42 health care district systems (mainly rural) over transition period
- More standardized approach to projects
- Outcomes focused metrics to show statewide changes

Five core domains:

- **System Redesign**— focused on redesigning ambulatory care for primary and specialty care, integration of post acute care, integration of behavioral health and primary care
- **Care Coordination for High Risk/High Utilizing Populations** – focused on care management, reducing avoidable acute care utilization, palliative care, patient experience
- **Prevention** – focused on core areas such as cardiac health, cancer, and perinatal care
- **Resource Utilization Efficiency** – focused on appropriate use of antibiotics, high cost imaging and pharmaceuticals
- **Patient Safety** – focused on improving performance on metrics related to potentially preventable events and reducing inappropriate surgical procedures

A Few (of Many) Take-Aways

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- Significant work for providers, state, and CMS
- Consider what would be a realistic scale for your circumstances (relationships with other providers, capacity, etc.)
- Alignment with State policy goals and other efforts
- Include in design process considerations of sustainability post-DSRIP



Particular Issues for Hospitals

- Tension between core operating funding and payment only upon achievement
 - ▣ DSRIP not intended to replace operating funds (including supplemental payments for services)
- Financing, particular as add new partners without access to non-federal share funds
- inpatient use
- Regulatory challenges to collaboration with community partners
- Funding for initial investments



QUESTIONS & COMMENTS

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