

Medi-Cal Explained

Webinar: Waivers And State Plan Amendments

UNDERSTAND THE BASICS

OCTOBER 24, 2019



Agenda

- 12:00 Welcome, Chris Perrone, CHCF
- 12:10 Overview of State Plans and Waivers, Cindy Mann, Manatt Health
- 12:25 Medi-Cal Waivers: Past, Present and Future, Jennifer Ryan, Harbage Consulting
- 12:40 Q&A
- 12:55 Closing, Catherine Teare, CHCF



Cindy Mann



Cindy Mann is a partner at Manatt Health. She brings more than 30 years of experience in federal and state health policy. She previously served as deputy administrator at the Centers for Medicare & Medicaid Services and director of the Center for Medicaid and CHIP Services.

Jennifer Ryan



Jennifer Ryan is executive vice president at Harbage Consulting. She has 25 years of federal, non-profit, private, and academic health policy experience. From 2009 through 2014, Jennifer was part of the leadership team at the Center for Medicaid and CHIP Services, most recently serving as the Director of the Intergovernmental and External Affairs Group.

Medi-Cal Explained

Medicaid Policy Levers: State Plans and Waivers

California Health Care Foundation
October 24, 2019

Overview

- Background: Medicaid Governance and Financing
- Medicaid Authorities: State Plan, Section 1915 Waivers, Section 1115 Waivers
- Section 1115 Deeper Dive: Scope of Authority, History and Current Direction, Process

Medicaid Governance and Financing

○ Medicaid is jointly administered by states and the federal government.

- In California, the Department of Health Care Services (DHCS) is the designated state Medicaid agency.
- At the federal level, the Centers for Medicare & Medicaid Services (CMS) oversees policy and implementation.

○ Funding is shared by states and the federal government.

- In California, the federal government pays 50% of most costs; some coverage and some services qualify for a higher match (e.g., family planning services).
- Under Medicaid financing rules, there is no cap on the amount of the federal share.

Medicaid Governance and Financing

- To receive federal Medicaid funds, states must comply with federal requirements.
 - For example, states must cover “mandatory” groups, such as low-income children, and “mandatory” benefits, such as nursing home care.
- Without a waiver, states have flexibility to expand eligibility and benefits beyond federal minimum standards, subject to federal parameters.
 - For example, states may cover children at income levels above federal minimums and they can cover additional benefits, such as home and community-based services.
- Without a waiver, states have broad discretion to design their delivery system and payment rates, subject to federal parameters.
 - For example, rates paid to managed care organizations are left to states to determine but must be “actuarially sound,” based on data, and reviewed by CMS.
- Waivers can provide additional flexibility and funding.

State Plan and State Plan Amendments

A state plan is the “agreement between a state and the federal government describing how that state administers its Medicaid and Children's Health Insurance Program (CHIP) programs.” States submit state plan amendments (SPAs) to make changes to or update their Medicaid state plan.

Approval of SPAs is **not discretionary** with CMS; if the SPA seeks to make a change that is an option authorized under the law, it must be approved. State plan provisions do not expire, unless a state sets an expiration date.

For example:

- Eligibility SPA — Adding or dropping an optional eligibility group
- Benefit SPA — Adding, dropping, or modifying an optional benefit
- Cost-sharing SPA — Adding, dropping, or modifying copayments
- Managed Care SPA — Adopting, dropping, or changing the scope of managed care

Section 1915 Waivers

Section 1915 waivers are limited in scope; they offer states authority relating to:

- Managed care (above and beyond what states can do without a waiver)
- Selective contracting
- Home and Community-Based Services (HCBS)

Review and approval is relatively routine; in some cases, authority overlaps state plan authorities. Section 1915 waivers are approved for 2–3 years, and extensions are available.

For example:

- Managed care — Mandate enrollment in managed care beyond what can be done through the state plan
- Selective contracting — Limit the providers offering a particular service, such as an enrollment or transportation broker
- HCBS — Authorize HCBS with or without enrollment caps

Section 1115 Waivers

Section 1115 of the Social Security Act gives the secretary of the Department of Health and Human Services (HHS) authority to approve demonstration projects (referred to as waivers) to allow states to use funds or design their programs in ways not otherwise allowed by law.

Waivers can be more or less comprehensive and are initially approved for 3 or 5 years; they may be amended and renewed.

Waiver approval **is discretionary**; each administration establishes its waiver policies within guidelines established by law or tradition.

Section 1115 waivers must:

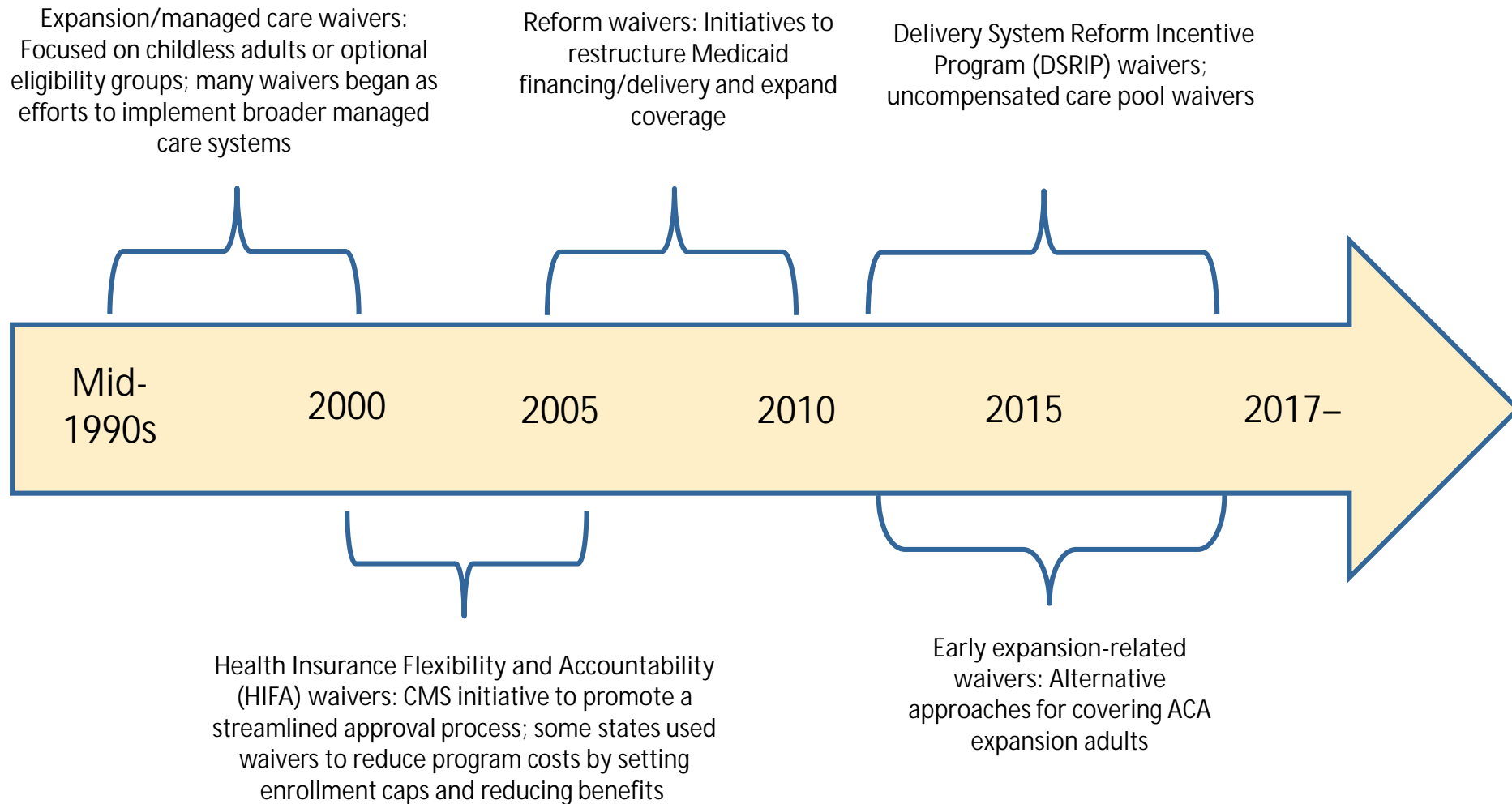
- ✓ Promote the objectives of the Medicaid program
- ✓ Be budget neutral to the federal government
- ✓ Receive public input during the development process
- ✓ Be subject to independent evaluation

Section 1115 Waivers: Deeper Dive

- The secretary of HHS has broad, but not unlimited, authority to approve a state's requests to waive compliance with certain provisions of federal Medicaid law and authorize expenditures not otherwise permitted by law.
- Approval is limited to “experimental, pilot or demonstration projects” which, in the judgment of the secretary, are likely to assist in promoting the objectives of the Medicaid program.
- Certain provisions of the law cannot be waived; for example:
 - The share of the state's Medicaid expenditures paid by the federal government (Federal Medical Assistance Percentage, or FMAP)
 - Income and asset rules relating to nondisabled, nonelderly individuals (modified adjusted gross income, or MAGI, rules)
 - Cost-sharing requirements (limited waiver authority)

By longstanding practice, waivers must be budget neutral to the federal government.

Section 1115 Waiver Policies Evolve Over Time



Current Federal Section 1115 Priorities: Holdover Policies and New Directions

- Work requirements and other conditions on eligibility not otherwise permitted by law
- Phaseout of DSRIP; limits on uncompensated care pool payments
- Supporting social determinants of health
- Waiver financing constraints
- Block grants?

Process: Section 1115 Waiver Public Transparency Requirements



States and CMS must offer notice and opportunity for public input.

Waiver Applications and Renewals

- State-level public input:
 - States must provide at least a 30-day public notice and comment period prior to submission
 - Must include at least two public hearings
 - Tribal consultation
- Federal-level public comment period:
 - Once a state proposal is submitted and deemed complete, CMS must provide at least a 30-day public notice and comment period

Waiver Amendments

- Approved waivers routinely require a similar process for waiver amendments

Process: State/Federal Negotiations



Waivers are approved (or denied) after a series of negotiations between the state and CMS.

- Before submitting a formal application, states often discuss ideas with CMS or share a concept paper.
- Once the waiver application is formally submitted, the state and CMS negotiate until resolution; other federal “partners” are involved to varying degrees. There is no time limit for approval or denial.
- The waiver approval package includes:
 - An award letter listing sections of the law waived or modified and noting proposals denied or not acted on
 - Special terms and conditions
 - A budget neutrality agreement

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS	
NUMBER:	No. 11-W-00300/8
TITLE:	Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration
AWARDEE:	Montana Department of Public Health and Human Services
I. PREFACE	
<p>The following are the Special Terms and Conditions (STCs) for the Montana Health and Economic Livelihood Partnership (HELP) Program section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Montana to operate this demonstration program. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the Social Security Act (the Act). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population will begin on November 1, 2015, at which time Medicaid eligible adults can receive services through a third party administrator (TPA) with coverage effective January 1, 2016. This demonstration will sunset after June 30, 2019, consistent with the current legislative time frame for the Montana Health Economic Livelihood Partnership (HELP) Act, but may continue through December 31, 2020, if the Montana legislature authorizes the state to continue the demonstration and the state provides notice to CMS, as described in these STCs.</p> <p>The STCs have been arranged into the following subject areas:</p>	
I.	Preface
II.	Program Description and Objectives
III.	General Program Requirements
IV.	Populations Affected
V.	Benefits
VI.	Delivery System
VII.	Premiums and Copayments
VIII.	Continuous Eligibility
IX.	General Reporting Requirements
X.	General Financial Requirements
XI.	Monitoring Budget Neutrality
XII.	Evaluation
XIII.	Health Information Technology
XIV.	T-MSIS Requirements
XV.	Schedule of Deliverables
CMS Approved: November 2, 2015 Demonstration Period: January 1, 2016 through December 31, 2020	
Page 1 of 34	

Thank you

Cindy Mann, Partner
Manatt Health
cmann@manatt.com
(202) 585-6572

Medi-Cal Explained

California's Medicaid Waivers: An Overview

Jennifer Ryan
Executive Vice President, Harbage Consulting
for the California Health Care Foundation

October 24, 2019



At the intersection of health care policy, politics and communications.

Overview

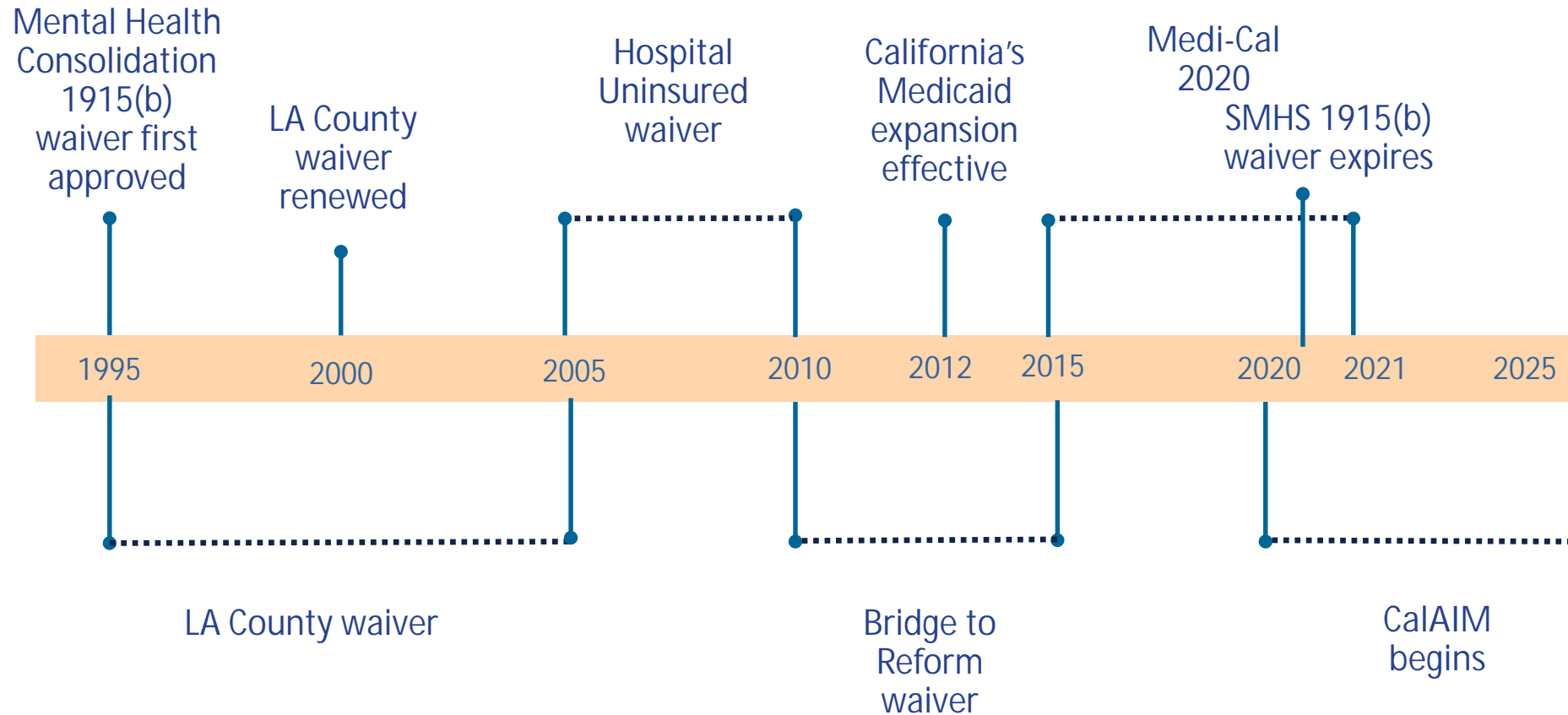
History of California Waivers

- Section 1115 waivers
 - History: 1995–2015
 - Medi-Cal 2020
- Section 1915(b) waivers
 - Consolidated Specialty Mental Health Services (SMHS)

Looking to the Future

- California Advancing and Innovating Medi-Cal (CalAIM)
- 1115 and 1915(b) waiver renewals

California's Waiver History



California's 1115 Waiver History

1995–2005: Los Angeles County Waiver

- One of the first 1115 waivers in the nation
- Designed to restructure the LA Department of Health Services and its approach to delivering indigent care in return for increased federal funds
- Goals were to improve access to county-funded ambulatory services and make hospital care more efficient

2005–2010: Hospital Uninsured Waiver

- Changed the state's hospital payment structure
- Significant new federal matching funds for coverage of low-income uninsured individuals
- Shored up county and state budgets

California's 1115 Waiver History

2010–2015: Bridge to Reform Waiver

- Delivery System Reform Incentive Payment (DSRIP) program
- Low-Income Health Program (LIHP)
- First authority to transition Seniors and Persons with Disabilities (SPDs) into mandatory Medi-Cal managed care
- Creation of Drug Medi-Cal Organized Delivery System

Legacy Programs Under 1115 Waiver Authority

- 2012: Community-Based Adult Services (CBAS) transitioned to managed care
- 2014: Cal MediConnect and Coordinated Care Initiative (CCI)
- 2016: California Children's Services (CCS) Whole Child Model

Medi-Cal 2020 1115 Waiver



Whole Person Care Pilots

County-based initiatives that coordinate primary care, behavioral health, and social services for enrollees with complex health needs

25 pilots in operation across the state are building infrastructure, integrating service delivery across agencies and providers

Delivering wrap-around services including care coordination, disease management, access to housing supports, respite care, and sobering centers



Public Hospital Redesign and Innovation in Medi-Cal (PRIME)

Incentive funding for 17 Designated Public Hospitals and 35 District and Municipal Public Hospitals to undertake quality improvement and performance measurement efforts

Hospitals are paid for their performance on a series of metrics related to clinical projects designed to improve care delivery

Medi-Cal 2020 1115 Waiver



Global Payment Program

Statewide pool of funding combining a portion of California's federal Disproportionate Share Hospital allotment with uncompensated care funding

Supports public health care system efforts to provide health care for California's uninsured population and promote the delivery of more cost-effective and higher-value care



Dental Transformation Initiative

Incentive payments to dental providers to increase preventive services for children, treat more early childhood caries, and increase continuity of dental care

Drug Medi-Cal Organized Delivery System



In 2015 California was the first state to receive 1115 waiver authority for federal Medicaid matching funds to provide substance use disorder treatment benefits in an institution for mental disease (IMD).

Evidence-based services designed in accordance with American Society of Addiction Medicine (ASAM) levels of care.

Services are delivered through county-based behavioral health managed care plans.

30 counties are participating in the waiver program, providing access to treatment and prevention services for 93% of the state's Medi-Cal population.

Expires on December 31, 2020.

California's 1915(b) Waiver History

1995–1997: Medi-Cal Psychiatric Inpatient Hospital Service Consolidation Waiver

- Consolidated Inpatient Psychiatric Services under county mental health departments

1997–2000: Medi-Cal SMHS Consolidation

- Made county mental health plans responsible for hospital, outpatient, professional, case management, and other SMHS
- Included mental health services originally provided through the previous program, including psychiatric inpatient hospital, psychiatric, and psychologist services

California's 1915(b) Waiver History

2000–Present: Consolidated SMHS Waiver

- Enrollees who meet medical necessity criteria for specialty mental health services must receive those services through the Mental Health Plan (MHP) in their county
- Currently approved through June 30, 2020
- DHCS has requested a 6-month extension to align with the Medi-Cal 2020 waiver expiration date of December 31, 2020

Restructuring 1115 Waiver Budget Neutrality

Budget Neutrality

- States have historically been able to use savings generated by one initiative to pay for other initiatives (e.g., using managed care savings to pay for coverage expansions)
- California has relied heavily on these managed care savings to finance many of its successful coverage efforts and other initiatives

New CMS Policy

- Budget neutrality savings from more than 5 years ago can no longer be applied in financing 1115 waiver renewals
- Using more recent cost data for budgets has nearly eliminated states' ability to carry forward savings accumulated during previous waiver periods

Looking to the Future

Beyond Medi-Cal 2020

- PRIME, Whole Person Care, Global Payment Program, and Dental Transformation Initiative federal funding currently expires on December 31, 2020.
- Changes to CMS budget neutrality policy have caused California to consider the future of Medi-Cal in new ways.
- Desire to move programs into more statewide and consistent managed care delivery system, rather than using demonstration authority.
- Focus on improving care coordination for residents with the most complex needs and addressing the social determinants of health.

The Future of Medi-Cal

- 1115 waiver renewal request will be much more limited due to budget neutrality changes
- State instead is moving most services into managed care/1915(b) waiver authority
- Committed to sustaining many of the efforts that started under Medi-Cal 2020



Next Steps

- Robust CalAIM stakeholder engagement process (November 2019–February 2020)
- Develop 1115 waiver renewal request (spring/early summer 2020)
- Develop 1915(b) waiver submission (spring/early summer 2020)
- Negotiate waiver terms and conditions with CMS (June–December 2020)
- Work with Medi-Cal managed care plans, counties, providers, advocates and other critical partners to implement CalAIM (January 2021 and beyond)

Questions?

Jennifer Ryan
Executive Vice President
Jennifer@harbageconsulting.com
443-537-5443



At the intersection of health care policy, politics and communications.

Medi-Cal Explained

For more
information
about the
CalAIM process
and to subscribe
for updates:

www.dhcs.ca.gov/calaim

Download the
webinar
materials at:

www.chcf.org/waiver-webinar