

# MEDICAID WAIVER 101 JUNE 11, 2009

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# Waiver 101

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- Waiver basics
- What can and cannot be waived
- Budget neutrality
- Costs not otherwise matchable
- Sources of savings
- Issues and challenges for California

# Waiver Basics

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- Authorized by section 1115 of the Social Security Act
- Can make changes to a small portion of program – or at the other end of the spectrum, a state's entire Medicaid program can be placed under a waiver
- Some provisions are not waiveable under any circumstances

# What Can and Cannot be Waived

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- Anything in section 1902 is waiveable
- For expenditures, anything not covered in section 1903 can be approved as a “cost not otherwise matchable”
- The FMAP rate, DSH allotments, and provisions relating to nonqualified aliens are *not* waiveable
- The Secretary of HHS is often reluctant to grant waivers that are contrary to recent Congressional actions

# Budget Neutrality

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- Budget neutrality – which is not a legal or regulatory matter – prevents the federal government from spending more than would/could be the case in the absence of the waiver
- Budget neutrality is negotiated between the state and federal government
- Key elements of the negotiation are the:
  - ▣ “With waiver” cost projections
  - ▣ “Without waiver” theoretical baseline cost (and what can be counted is negotiable)
  - ▣ The inflation factor by which the “without waiver” baseline can grow
- Budget neutrality can be calculated in the aggregate, on a per capita basis, or a combination of the two

# Costs Not Otherwise Matchable

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- One of the most powerful provisions in section 1115 allows the Secretary of HHS to grant approval of costs not otherwise matchable or CNOM
- The most common use of CNOM is for coverage of nondisabled childless adults because there is no other legal mechanism to extend Medicaid eligibility to these individuals
- State and local program spending can also be approved as a CNOM
- The “catch” is that there has to be budget neutrality “room” for CNOM expenditures, as they can only be counted on the “with waiver” side of the equation

# Sources of Savings

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- States have found savings from a number of sources:
  - Managed care
  - Redirection of DSH
  - Pooling of UPL or other funds

# Issues and Challenges for California

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- Historically low baseline
- Cost savers such as managed care were implemented, but savings not “captured” in a section 1115 waiver
- The federal flexibility needed to recapture savings – in effect – to treat California like other states – would come at a cost
- The federal government would expect significant reforms and possibly increased coverage in exchange for budget neutrality flexibility

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# Medical Homes

# Medical Homes

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- What is a medical home?
- How can the medical home model benefit specific populations?
- Benefit to California
- Why include in a waiver?

# What is a Medical Home?

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- More than just a usual source of care
- Central point among all the team members involved with a patient, including:
  - ▣ Patient
  - ▣ Family members
  - ▣ Other caregivers
  - ▣ Primary care providers
  - ▣ Specialists
  - ▣ Other health care and non-clinical services

# What is a Medical Home?

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- Reimbursement methodologies reflect cost of managing and overseeing the program
- Performance measures
- Performance bonuses can be used

# Benefits to Specific Populations

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- Seniors and physically disabled (including duals)
- Individuals with serious mental illness
- Children with special health care needs

# Benefits to California

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- Political viability as compared to full risk managed care
- Potential to “bend the trend”

# Why Include in a Waiver?

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- Authority to make up-front investment
- Vehicle to capture and redirect savings
- Ability to design creative reimbursement structures
- Flexibility to target key populations
- Geographic diversity

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# Disease Management/ Managed Care

# Disease Management and Managed Care

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- What is disease management?
- Managed care and Medi-Cal
- Benefit to specific populations
- Benefit to California
- Why include in a waiver?

# What is Disease Management?

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- Care coordination services for individuals with chronic diseases or multiple diseases
- Disease management should:
  - ▣ Help patients better manage their own care
  - ▣ Help patients navigate the health care system
  - ▣ Improve quality of life, quality of care

# What is Disease Management?

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- Care coordination services need to be reimbursable, including:
  - ▣ Phone calls and home visits by care managers
  - ▣ Development of patient care plans
  - ▣ Assistance with keeping appointments and referrals to medical or social support services
  - ▣ Communication between providers

# Managed Care and Medi-Cal

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- Currently, mandatory for all populations other than the Aged, Blind and Disabled (ABDs) in counties where managed care is available
- About half of Medi-Cal beneficiaries are in managed care
- Stakeholders have long been concerned managed care limits care to lower costs

# Managed Care and Medi-Cal

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- A waiver could be used to require managed care plans to provide the disease management services Medi-Cal beneficiaries need
- Measure health plan performance
- Use pay for performance or performance bonuses

# Benefits to Specific Populations

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- Seniors, physically disabled and Dual Eligibles
- Children – CCS is carved out of Medi-Cal managed care
- Individuals with chronic or other serious medical conditions
- Mentally ill

# Benefits to California

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- Opportunity to improve managed care for all Medi-Cal beneficiaries
- Build on four pilot Medical Care Management (MCM) programs

# Why Include in a Waiver?

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- Could generate cost savings at the federal level
- Ability to expand care coordination services
- Sources of the non-federal share for increased spending must be identified

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# Payment Reforms/Financing Options

# History

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- For more than 25 years, CA has endured significant pressures on the state budget
- Focus has been on budget reductions or controls and intergovernmental transfers to minimize state general fund expenditures
- CA has sought ways to maintain inpatient hospital services to Med-Cal enrollees and the uninsured while reducing pressure on the general fund
  - ▣ Selective Provider Contracting Program – 1982
  - ▣ SB 1255 hospital supplemental payment program – 1989
  - ▣ Disproportionate share hospital (DSH) program – 1991 (175% DSH -1997)

# History

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- Effect of state budget pressure on hospitals
  - Very low Medi-Cal payment rates to both private and public hospitals for more than 25 years
  - Substantial increase in the fiscal obligations of county taxpayers and the University of California
  - Created a reimbursement system that encourages the delivery of inpatient hospital care

# History

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- CA Medicaid managed care program
  - ▣ Established in early 1970s
  - ▣ To promote improved access, reduce costs under the Medi-Cal program
  - ▣ To help further reduce general fund obligations to the Medi-Cal program
  - ▣ Expanded in the 1990s
- CA implemented Medi-Cal managed care under a 1915 (b) waiver and not under a section 1115 Medicaid waiver
  - ▣ No expansion of Medi-Cal coverage to childless adults
  - ▣ Method to reduce Medi-Cal expenditures

# History

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- Spending opportunity under section 1115 waiver
  - ▣ “Credit” from the federal government for the savings produced under the managed care delivery system
- States can use those savings to create new spending and receive federal match
- For the past several years, CA has effectively reduced both state and federal government obligations to the Medicaid program
- CA does not receive “credit” from the federal government for those savings
  - ▣ CA Medicaid managed care program – operates under 1915 and State plan, not 1115
- Kaiser Family Foundation
  - ▣ In 2006, CA second lowest per enrollee spending in the nation

# History

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- CA method of controlling program cost
  - ▣ Freeze rates for physicians and many other providers
- Only 2 general across the board rate increases for Medi-Cal - 1985 and 2000
- There have been a few targeted rate increases - more rate decreases
- Health care inflation has far exceeded the increases in provider rates that have occurred over the last 24 years

# History

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- 2008 Medi-Cal physician fees
  - ▣ 83% of the national average
  - ▣ Rank 47<sup>th</sup> overall among states when adjusted for geographic differences in the cost of providing medical care
- From 2003 through 2008, Medi-Cal physician fees grew by 2% on average compared to:
  - ▣ 15% growth in average Medicaid physician fees nationally
  - ▣ 21% general inflation during this period<sup>1</sup>
- Extraordinary low Medi-Cal fees
  - ▣ Severely compromise CA's ability to create health delivery system reform in lower cost, more coordinated care settings

<sup>1</sup>Stephen Zuckerman, Aimee Williams, and Karen Stockley, Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare, Urban Institute, April 2009.

# Current Status

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- Unintended consequences
  - ▣ Historical decisions and current fiscal crisis compromise CA's ability today to effectively institute reform of the health care delivery system
- CA must work with the federal government
  - ▣ Ensure reform of CA's health care delivery system is consistent with the direction contemplated by the Obama Administration
- Up-front investment by the federal government
  - ▣ Help to provide immediate fiscal relief
  - ▣ Help to secure longer term health care reform goals

# Current Status

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- Hospital Financing 1115 Waiver – 2005
  - ▣ Conversion of SB 1255 program and ½ of DSH program to Safety Net Care Pool (SNCP)
  - ▣ Changed financing from IGTs to CPEs
- The SB 1255 payments
  - ▣ Historically utilized to help subsidize the uncompensated care of furnishing hospital services to Medi-Cal and uninsured individuals
  - ▣ SNCP capped at \$766 million

# Current Status

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- Under the section 1115 waiver, CA was able to:
  - i. Replace historical general fund commitments to the regular Medi-Cal inpatient hospital payment rates made to public hospitals by utilizing CPEs as the funding source of such Medi-Cal payments;
  - ii. Continue subsidizing both hospital and non-hospital uncompensated care costs for uninsured individuals through the establishment of the SNCP;
  - iii. Convert the financing of the historical DSH payments made to public hospitals up to 100% of the hospital-specific DSH limit from IGTs to CPEs;

# Current Status

- iv. Access its 175% DSH authority for public hospitals utilizing IGTs derived from county tax dollars and by replacing historical DSH payments made to private hospitals with Medicaid supplemental payments funded by the state general fund;
- v. Establish the Coverage Initiative, which provided federal matching funds for local health coverage programs;
- vi. Match state health care programs such as California Children Services (CCS) and Genetically Handicapped Persons Program (GHPP), and nursing home care to draw down federal funds freeing up state general fund for use in paying for private hospitals and for state general fund savings; and,
- vii. Replace IGT payments to private hospitals with general fund matched payments using savings from (i) and (vi).

# Current Status

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- Cost based reimbursement systems:
  - ▣ Highly inefficient way to pay for care
  - ▣ Promotes high cost services - the more a hospital spends the more reimbursement it receives
  - ▣ Compromises hospitals' ability to generate revenue for capital investment
  - ▣ Administratively complex - documentation processes are detailed, labor intensive, and take several years to finalize
- Emphasis on inpatient reimbursement under Medi-Cal provides a disincentive to moving care to lower cost non-hospital settings
- As currently constructed, CA's funding is unable to achieve reform of the existing "institutional based" health care delivery system

# Reimbursement/Financing Options

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- Budget Crisis!
  - ▣ CA's current budget deficit - reported to be as high as \$23 billion
- Must secure “up-front” federal investment – only way to:
  - ▣ Sustain services provided to Medi-Cal enrollees and the uninsured
  - ▣ Begin the process of reforming the health care delivery system
- Front-end federal investment
  - ▣ Tied to milestones of health care reform
  - ▣ Implemented over the duration of the 1115 waiver demonstration

# Reimbursement/Financing Options

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- Need to create increased spending authority under the 1115 waiver
- Request a budget neutrality ceiling that includes “hypothetical spending”
  - ▣ Recognition of historical savings realized by the federal government
- Hypothetical spending should consider the significant historical federal savings realized under the:
  - ▣ Medi-Cal managed care program
  - ▣ Fee-for-service payment rates to hospitals and physicians
  - ▣ Prohibition on instituting a hospital tax
  - ▣ Uncompensated costs in excess SNCP cap

# Reimbursement/Financing Options

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- Request immediate increased spending in the public and private hospital settings
  - ▣ Help subsidize increasing uncompensated care during severe fiscal crisis
- Phase-in approach to redirect a portion of hospital spending to more efficient delivery system settings
  - ▣ Consistent with the Administration's preliminary instructions on health care reform
- The federal government will only pay for its share
- Must identify source(s) for the non-federal share

# Reimbursement/Financing Options

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- Make greater use of provider taxes/fees as the State's share of expenditures
  - ▣ Federal law permits the collection of tax revenue up to 5.5% of provider revenue
- Increase payments up to the upper payment limit (UPL)
  - ▣ UPL – “reasonable estimate of what Medicare would pay”
- Maximize use of IGTs and/or CPEs
- Request initial federal investment to the system to begin reform
  - ▣ Request federal matching funds for additional health care programs currently funded by State and/or local-only revenues

# Reimbursement/Financing Options

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1. Remove the cap on the SNCP and apply a growth rate
2. Move away from CPEs under Medi-Cal inpatient hospital, the SNCP, and DSH and replace with permissible IGTs
3. Reimburse public hospitals up to 100% or 150% of the UPL funded with permissible IGTs
4. Establish a rate system to promote efficiency - move from a per diem system to a discharge payment system similar to other Medicaid programs

# Reimbursement/Financing Options

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5. Rebalance payments between inpatient and outpatient hospital services - take away the disincentive for treating people in lower cost settings
6. Assess whether the historical Medi-Cal payment allocation formulas still apply and whether they properly reflect the cost of providing care to the Medi-Cal and uninsured populations
7. Remove the current ban on a hospital tax – potential to generate increased Medi-Cal payment rates to private hospitals

# Reimbursement/Financing Options

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8. Identify additional State and/or local only health programs for which no federal matching currently occurs and request federal match on those programs
9. Consider seeking a federal law change that would allow DSH to also be used for public clinic systems so that care can be shifted to lower cost settings
10. Expand the use of public hospital provider based federally qualified health centers (FQHCs) to increase federal reimbursement
11. Better integrate managed care payments into payments for the safety net

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# Pay For Performance/ HIT & E-Prescribing

# Pay for Performance

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- What is pay for performance?
- Benefit to California
- Why include in a waiver?

# What is Pay for Performance?

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- Require providers to measure and report care quality data
- Provider performance bonuses or increased reimbursement levels for higher performing providers
- Target priority areas, such as reducing hospital readmissions or healthcare acquired infections
- Could include ending payments for never events
- Gain-sharing with hospitals

# Benefit to California

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- Drive quality improvements for beneficiaries
- Increasing reimbursement rates may increase provider participation, and thus beneficiary access
- Improve accuracy in data reporting

# Why Include In a Waiver?

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- Authority to make up-front investment
- Vehicle to capture and redirect savings
- Ability to design creative reimbursement structures
- Flexibility to target key quality improvement areas

# Health Information Technology & E-Prescribing

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- What is HIT and e-prescribing?
- Benefit to California
- Why include in a waiver?

# What is HIT and E-Prescribing?

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- Moving from paper-based records to electronic record-keeping and information sharing
- Electronic Medical Records (EMRs)
- Health Information Exchanges
- Disease Registries

# Benefit to California

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- Initiatives have broad political support
- Reduce medical and prescription errors
- Lower administrative costs, particularly through  
e-prescriptions
- Support and expand existing e-prescription pilots

# Why Include In a Waiver?

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- Authority to make up-front investment
- Vehicle to capture and redirect savings