



MEDICAID OVERVIEW (CONTINUED): SUPPLEMENTAL PAYMENTS AND WAIVERS

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Overview

- Medicaid Waivers
- Supplemental Payments
  - Disproportionate Share Hospital (DSH) Payment
  - Indirect Medical Education (IME)/Graduate Medical Education (GME)
  - Upper Payment Limit (UPL) – Supplemental Payment

State Plan and Medicaid Waivers

Medicaid is a joint federal and state benefits program established by Title XIX amendments to the Social Security Act

State Plan for Medical Assistance

- Virginia's agreement with the federal government for administering the Medicaid program
- 25 state plan amendments (SPAs) on average annually
- Regulations in Virginia Administrative Code (12 VAC 30 Chapters 5-110)
- 90-day approval period

Medicaid Waivers

- Waive parts of the Social Security Act
- Different waiver types
  - **§ 1915(b)** establishes a managed care service delivery system
  - **§ 1915(c)** establishes home and community based services
  - **§ 1115** tests new research and demonstration projects
- Approval timeline uncertain

Section 1332 Waivers

Section 1332 Waivers are not Medicaid waivers and cannot change Medicaid program requirements

Hawaii was first state to receive approval to waive small business health options program – January 1, 2017

More recently, 1332 waivers focus on reinsurance programs in the individual market

- Alaska – July 2017
- Minnesota – Sept 2017
- Oregon – October 2017

Targeted reinsurance programs aim to reduce premiums in the individual market and keep participating insurers in the health marketplace

States contribute to part of the cost of high-cost patients

Section 1115 Demonstration Waivers

Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid that differ from federal program rules

50/50 match for Virginia for current population

Uncertain timeline for approval by CMS

Must be budget neutral for the federal government

34 states with 42 approved, 20 states with 22 pending waivers (as of Dec 2017)

Kentucky Overview

Kentucky is transitioning its traditional Medicaid expansion to an 1115 Waiver expansion

Evolution of Kentucky's Medicaid Expansion Program

Jan 2014 KY originally expanded Medicaid through a State Plan Amendment (SPA)

Sept 2016 KY applied for an 1115 waiver to change the traditional Medicaid expansion

Jan 2018 CMS approved KY's 1115 waiver application

Key Waiver Components

1. Healthy Behavior Incentives
2. Community Engagement Requirements
3. Cost-sharing (Premiums)
4. Premium Assistance for Employer Sponsored Insurance (ESI)
5. Limited Non-Emergency Medical Transportation (NEMT)
6. No Retroactive Eligibility
7. Lock-out period for failure to comply
8. New Substance Use Disorder (SUD) services

Kentucky Overview (continued)

Kentucky's new 1115 waiver provides important considerations

Waivers are highly negotiated and must align with federal administration requirements

After 18 – 24 months of negotiations, Kentucky is the first state to receive §1115 waiver approval that includes "community engagement" requirements

Waiver implementation can be complicated

Implementation of Kentucky's waiver may not be able to move forward due to a lawsuit filed January 24, 2018

Some requirements bring administrative complexity

Experience from other programs, like TANF, are instructive, since KY has not yet implemented

Medicaid Work Requirements

Considerations on work requirements

- No track record to gauge impact on employment due to work requirements as a condition for health coverage.
- Clearer evidence that improved health supports ability to continue working.
- Low wage employment may not reduce the need for health coverage
- Work requirements for other programs have created substantial administrative burden on states

Indiana Overview

Indiana's Medicaid expansion waiver expires on January 31, 2018 and Indiana has a pending 1115 waiver proposal to extend its program

Evolution of Indiana's (IN's) Medicaid Expansion Program

Jan 2015	CMS approved IN's 1115 waiver application to expand Medicaid coverage
Feb 2015	Implemented Medicaid Expansion
Jan 2017	IN submitted an 1115 waiver to extend Medicaid expansion through January 2021
July 2017	IN submitted an 1115 waiver amendment to establish Medicaid work requirements
Current Status	Waiver is pending and negotiations are ongoing with CMS

Key Waiver Components

1. Tiered Benefit Packages Requiring Contributions for Many Health Services
2. Personal Wellness and Responsibility (POWER) Account, which Functions Like a Health Savings Account (HSA)
3. Healthy Behavior Incentives
4. Graduated Co-payments for Non-emergency Use of the Emergency Department (ED)
5. Waive Non-emergency Medical Transportation
6. Voluntary, State-funded Work Referral Program

Indiana Overview (continued)

Indiana's 1115 waiver provides important considerations

Complex programs can create member confusion

- 84% of members cited reasons other than affordability for not making required monthly contributions
- 26% of members reported confusion about membership and plan type
- 30% did not know a payment was required or due

Required monthly contributions can be an enrollment barrier

57,189 members were disenrolled or not enrolled due to non-payment

Healthy behavior incentives may promote preventive care

More members received at least one qualifying preventive care service in the first full demonstration year

Michigan Overview

Michigan recently amended its Medicaid expansion waiver to implement a tiered benefit package with a Marketplace Option

Evolution of Michigan's Medicaid Expansion Program

Dec 2013	CMS approved Michigan's 1115 waiver to expand Medicaid
Apr 2014	Implemented Medicaid Expansion
Dec 2015	CMS approved Michigan's 1115 waiver amendment for beneficiaries to choose between Medicaid managed care or premium assistance for Marketplace coverage through a Qualified Health Plan (QHP)
Apr 2018	Michigan's waiver amendment will take effect April 1, 2018. Beneficiaries choosing Medicaid managed care must complete a healthy behavior requirement or transition to a QHP.

Key Waiver Components

1. Tiered Benefit Package
2. Premiums and Health Savings Accounts
3. Copayments Based on Previous 6 Months
4. Eligibility Not Contingent on Payment
5. Healthy Behavior Incentives
6. Full Coverage Including Retroactive Eligibility

Michigan Overview (continued)

Michigan's Medicaid expansion offers important insights

Medicaid expansion can bring significant savings to the state

A 2017 New England Journal of Medicine study found financial savings following Medicaid expansion

Medicaid expansion provides economic benefit beyond savings

In 2017, Michigan saw an estimated increase of 37,775 jobs in health care and related sectors

Many enrollees already work or face functional employment barriers

A December 2017 University of Michigan study found:

- nearly half of Michigan's expansion enrollees have jobs
- imposing work requirements may disrupt care for the chronically ill

Outcomes to Date

Medicaid expansion improves:

Access to Care And Overall Health

At community health centers, expansion was associated with improved quality measures:

- asthma treatment
- cervical cancer testing
- obesity
- hypertension control

Medicaid expansion resulted in a 36% increase in smoking cessation prescriptions

Prescriptions to treat Substance Use Disorder (SUD) increased by 43% in expansion states

The Employment and Labor Market

Medicaid expansion creates new jobs

- Colorado: 31,074 new jobs
- Kentucky: 40,000 jobs with average salary of $41,000

Insurance coverage removes employment barriers

- 74.8 % of Ohio enrollees who are unemployed report health coverage makes it easier to look for jobs
- In Michigan, 55% of those who were out of work said the coverage made them better able to look for a job

Supplemental Payments Background

Overview

- What are they and why do we use them?
- Different types of supplemental payments
- Considerations under Managed Care
- Financing the state share
- Key takeaways

What are Supplemental Payments?

- Higher reimbursements targeted to certain providers impacted by lower Medicaid payments.
- Increased demand as Medicaid reimbursements rates remain flat and numbers of uninsured still high.

Types of Supplemental Payments

- DSH payments to hospitals with high Medicaid and uninsured patient populations.
- Medical education program payments to teaching hospitals. (UVA, VCU, CHKD)
- Enhanced payments for DSH, GME and IME supporting indigent care at UVA, VCU and CHKD
- Upper Payment Limit Supplemental Payments to private partner and private teaching hospitals, certain physicians, public nursing homes, and CSB and VDH clinics.

Total Expenditures for Supplemental Payments

- All Supplemental Payments: $807.4 million
  - DSH $192.7 million
  - GME $68.1 million
  - IME $398.0 million
  - Other $148.6 million

(Dollars represent a combination of federal and state funding.)

DSH Payments

- Federal requirement of DSH payments began 1989
- Purpose is to “take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs”
- Federal law establishes:
  - Minimum criteria for qualifying as “DSH” hospital
  - Minimum criteria for DSH “payment adjustment”
- States have latitude to be more expansive in defining DSH hospitals and in setting the DSH adjustment
- Virginia has different formulas for different types of hospitals
- 50 DSH-eligible hospitals

Graduate Medical Education Payments (GME)

- Purpose – Support cost of training health professionals in hospitals (residents/interns and allied health professionals)
- 37 Hospitals receive GME (10 are out-of-state (OOS))
- 4,812 Resident/Intern FTEs in GME hospitals in 2016
- Methodology
  - Residents/Interns - Medicaid cost per resident/intern (FFS and MCO) from a base year inflated forward
  - $100,000 payments each for 15 new residents approved for FY18

Indirect Medical Education Payments (IME)

- Purpose – recognize higher diagnostic and treatment costs at hospitals with teaching programs
- 30 Hospitals received IME payments in FY18
- Methodology
  - IME factor (formula based on ratio of residents to beds)
  - Multiplied by inpatient operating payments (FFS and MCO)
- UVA, VCU and CHKD receive enhanced formula payments for IME

Upper Payment Limit – Supplemental Payments

- Bridges the gap between Upper Payment Limit and FFS Medicaid payments
- Upper Payment Limit
  - What Medicare would pay for hospitals, nursing facilities and clinics
  - Average commercial rate for physicians
- Since most supplemental payments are financed by Intergovernmental Transfers, payments are usually for public providers or partners of public entities
- Transition from FFS supplemental payment to managed care supplemental payments

Impact of Managed Care

- Interest in supplemental payments in managed care is growing with implementation of CCC Plus and Medallion 4.0. (Ex. EVMS budget amendment in FY16)
- 2016 federal rule requires states to use direct payments that combine regular and supplemental rates.

Financing the State Share

- Federal government typically pays 50%
- Sources of state support
  - General Fund Appropriations to DMAS
  - Hospital Provider Assessment (39 states use)
  - Intergovernmental Transfers from local governments or other public entities (largest source in VA)

Key Takeaways

- Increased requests for supplemental payments over the past decade driven by:
  - Lack of inflation adjustments for provider reimbursements
  - ACA reductions in Medicare funding
  - High numbers of uninsured in Virginia without expanded eligibility

Key Takeaways (continued)

- Public providers are likely to continue requesting supplemental payments as long as they are virtually cost- and risk-free.
- With Medicaid transition to managed care, provider interest is shifting from FFS to managed care supplemental payments, which have new and complex rules.