



HEALTHY CALIFORNIA FOR ALL

Accessible, Affordable, Equitable, High Quality, Universal

Virtual Commission Meeting

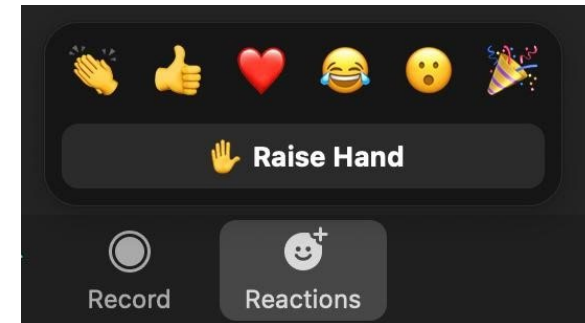
September 23, 2021

Virtual Meeting Protocols



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- This meeting is being recorded.
- Commissioners:
 - You have the ability to mute and unmute and the option to be on video.
 - Please mute yourselves when you are not speaking.
 - To indicate that you would like to speak, please use the “raise hand” feature:
- Members of the public:
 - You can listen to and view the meeting.
 - During the public comment period, you will have access to the “chat” feature for written comment, and you can use the “raise hand” feature to request to speak. You can also email comments to HealthyCAforAll@chhs.ca.gov.
 - Public comment provided during the meeting will be a part of the public record.



Opening Remarks and Community Engagement Update

Mark Ghaly, MD, Commission Chair and Secretary
of California Health and Human Services Agency

Community Engagement Recap



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- Purpose
 - Gain input from Californians whose voices are often unheard in policy discussions
 - Via residents and community-based organizations, gain perspectives of those impacted by potential unified financing proposals
 - Consider feedback in context of existing data and previous research
- Approach
 - Approximately 2000 individuals and over 60 leaders of advocacy and community-based organizations serving low-income Californians were engaged in this process
 - The process included surveys in multiple languages, a synthesis of existing research and literature and interviews with advocacy organizations and community-based groups that serve low-income residents of our state

Community Engagement Findings



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- 65% of those surveyed and interviewed indicated support for a single statewide government run health care program, with much higher support from communities of color
- Affordability is a top priority to address in future design work
- Wide agreement that simply having health coverage does not guarantee good access to health services
- Comprehensive and integrated services were key priorities -- including dental, vision, behavioral, long term care, connection to social supports/services
- Over 90% want a system that “treats everyone with dignity and respect”
- 88% want to be involved in their health care decisions and many want to be involved in designing a new system

Commissioner Conversation



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- What should we remember from this community engagement work?
- How can we have authentic community involvement and consumer engagement in designing, building and governing a system of unified financing?



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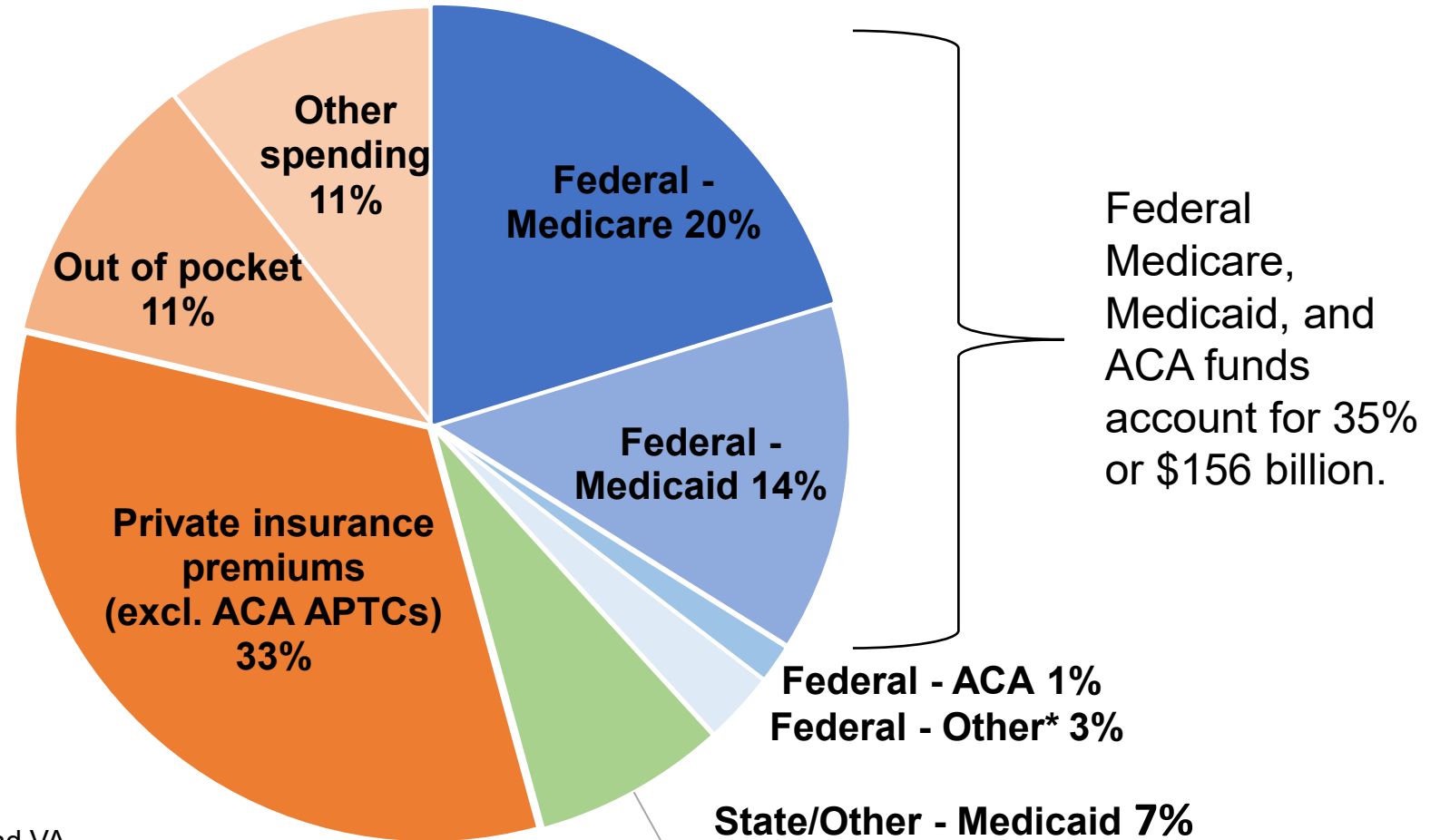
State/Federal Relationship and Financing Mechanisms

Estimated California Total Health Expenditures



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Total 2019 =
\$441 billion



* Indian Health Service, Military Health System, and VA.

"Other spending" includes public health, workers comp, state and local programs other than Medi-Cal, and other spending not captured elsewhere.

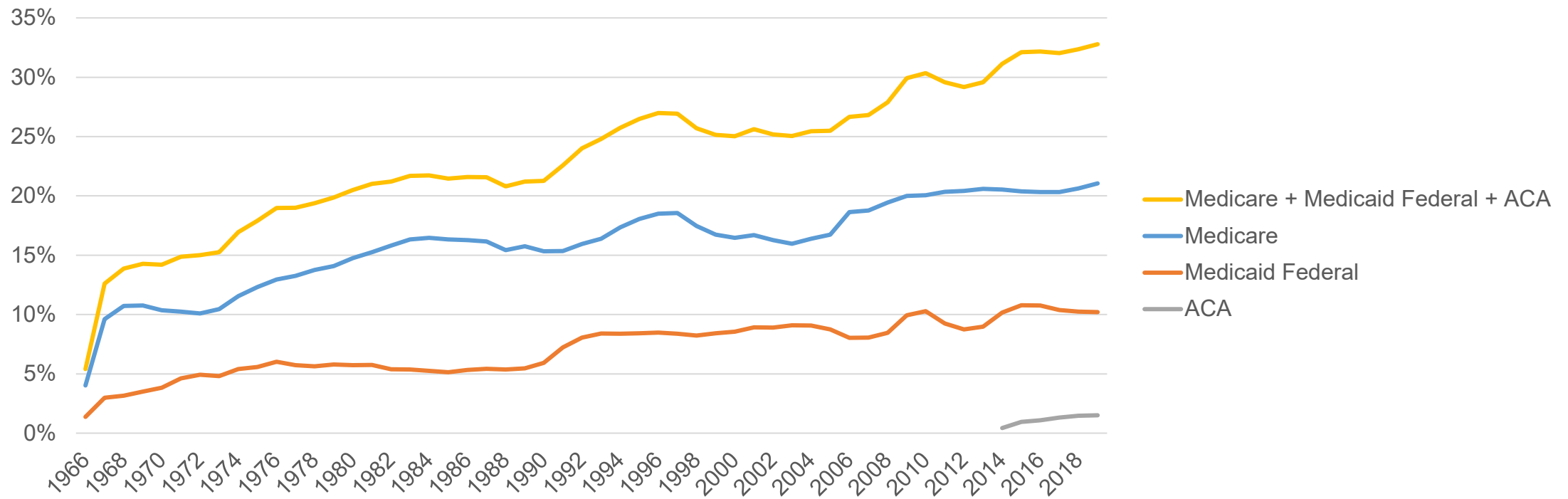
Source: Extrapolated from National Health Expenditures data among other sources, Federal and State Medicaid expenditures based on data provided by California Department of Finance.

Federal expenditures have grown over time



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Federal Program Expenditures as Percent of National Health Expenditures, 1966-2018



Note: ACA includes Advance Premium Tax Credits, Cost Sharing Reductions (in relevant years), and Basic Health Program

Sources: CMS National Health Expenditure data and IRS data on ACA

Key Questions



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Unified Financing is more feasible if the state can secure sustainable federal funding. In order to do so, the following are key:

- What are the strategies to secure funding – waiver, legislation, other?
- What are hurdles to securing federal support?
- How does California clear these hurdles?
- How do we ensure sustainable federal funding?

Opening Remarks

Carmen Comsti, JD

Lead Regulatory Policy Specialist
National Nurses United

Federal Waivers & Funding: What are they?



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What are federal waivers and federal health care authorities?

- Legal processes or authorities specified in federal health care statute
- Created by Congress
- Used to set aside certain legal requirements for federal health programs under federal health care law
- States can apply for waivers to the Centers for Medicaid and Medicare Services (CMS) / US HHS
- US HHS Secretary can approve waivers if a state applies for them
- Congress wrote the rulebook or guiderails that HHS must use when evaluating waiver applications

Why would California want federal waivers or other approvals?

- Integrate federal programs (Medicare, Medicaid, and the ACA) with state unified financing program as much as possible.
- Benefit from federal funding of health programs in California while remaining seamless for unified financing enrollees.
- Apply federal funds that would have been paid without a waiver to benefits under the unified financing program.

Framework for Understanding Federal Funding & Unified Financing



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- What waivers authorities or other Centers for Medicare & Medicaid Services (CMS) authorities are available?
- What will CMS look for to approve state federal waiver applications or other authorities?
- How does California design a system to meet CMS's criteria?
- How does California get federal waivers or other approvals?

Basic Roadmap:

Program Design/Enactment → Apply to CMS → Negotiate with CMS → Approval → Implement

Available Federal Waivers & Other Authorities (Part 1)

<p>Medicaid Demonstration or 1115 Waiver</p>	<p>Social Security Act § 1115 (42 USC § 1315)</p>	<p>Allows States to use or test new or existing approaches to financing and care delivery for Medicaid and CHIP.</p>	<p>Waiver requirements include:</p> <ul style="list-style-type: none"> - Budget neutrality - Budget ceiling based on recent cost data and growth trends - Must assist in promoting Medicaid’s objectives - Public notice & comment
<p>“Traditional” Medicare Demonstration Waiver</p>	<p>Social Security Amendments of 1967 § 402 (42 USC § 1395b-1)</p>	<p>Allows CMS to waive payment and benefit statutory requirements and allow states to:</p> <ul style="list-style-type: none"> - Change payments or reimbursements under Medicare - Cover additional services/benefits under Medicare to increase “efficiency” 	<ul style="list-style-type: none"> - Provider and beneficiary participation is typically voluntary - Improve access and quality and/or lower health care costs - CMS requires budget neutrality for Medicare-waiver-only projects
<p>Medicare Innovation Waiver or Section 1115A Waiver</p>	<p>Social Security Act § 1115A (42 USC § 1315a)</p>	<p>Allows States to test and evaluate “innovative” payment and service delivery models to reduce program expenditures for both Medicare and Medicaid recipients. Models selected by HHS “may include, but are not limited to” the 27 listed. (42 USC § 1315a(b)(2))</p>	<ul style="list-style-type: none"> - Does <u>not</u> need to be budget neutral for initial 5-year waiver term - Program must improve quality without spending increases or reduces spending without reducing quality

Available Federal Waivers & Other Authorities (Part 2)

<p>PPACA Section 1332 Innovation Waiver</p>	<p>Affordable Care Act § 1332 (42 USC § 18052)</p>	<p>Allows States to:</p> <ul style="list-style-type: none"> - Waive requirements on qualified health plans, health exchanges, related cost-sharing, and premium subsidies - Obtain ACA “pass-through” funds - Apply for multiple Medicare, Medicaid, PPACA, and other federal health programs at once (i.e., consolidated and coordinated waiver) - With HHS and Treasury approval 	<p>Waiver requirements include</p> <ul style="list-style-type: none"> - 10-year budget - Federal deficit neutrality - Passed state legislation enacting proposed program - At least as comprehensive - At least as affordable - Comparable number have coverage - Public notice and comment
<p>Medicare Administrative Contracting Authority</p>	<p>Social Security Act § 1874A (42 USC § 1395kk-1)</p>	<p>Allows HHS to contract out Medicare administrative functions, including Medicare payment determinations and provider reimbursement.</p>	<p>Contracting entity must:</p> <ul style="list-style-type: none"> - Have demonstrated capability - Meet conflicts of interest standards - Have sufficient assets - Meet performance requirements
<p>Medicare Shared Savings Program - Authority</p>	<p>Social Security Act § 1899 (42 USC § 1395jjj)</p>	<p>HHS statutory authority to approve Medicare participation in a shared savings program or accountable care organization.</p>	<ul style="list-style-type: none"> - Could be used to approve a UF program to participate in the Medicare shared savings program.
<p>Home- and Community-Based Service Waivers</p>	<p>Social Security Act § 1915(c) (42 USC § 1396n(c))</p>	<p>Allows States to home and community-based alternatives to institutional care under Medicaid for elderly and people with disabilities-</p>	<ul style="list-style-type: none"> - Relevant to long-term care expansion under UF. - Cost-effectiveness or budget neutrality.
<p>Freedom of Choice Waivers</p>	<p>Social Security Act § 1915(b) (42 USC § 1396n(b))</p>	<p>Allows HHS to waive Medicaid provisions to allow States to mandate Medicaid enrollment into certain programs or networks, limit eligible Medicaid providers, and use cost savings for added services for Medicaid beneficiaries</p>	<ul style="list-style-type: none"> - Could be used to enroll Medicaid beneficiaries into UF and to receive care from UF providers. - Cost-effectiveness or budget neutrality.

Securing Approvals: Section 1332 Consolidated Waivers



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Program Design/Enactment → Apply to CMS → Negotiate with CMS → Approval → Implement

Overview on Consolidated Waivers Under 42 U.S.C. § 18052(a)(5)

- Consolidated and coordinated application process for two or more waivers at once.
- Each waiver must independently satisfy their corresponding waiver's requirements.
- 1332 ACA Waiver has detailed and comprehensive list of procedural waiver application requirements.

Application Procedures Checklist for ACA Waiver:

- **Program description must be included in application:** The state includes a comprehensive description of the state program being proposed in its application.
- **State law passed:** The State has enacted law necessary (1) to implement the proposed program and (2) authorizing the State to apply for a 1332 waiver.
- **Copy of Legislation:** The state must attach required legislation to its waiver. required legislation to its waiver.
- **Other Requirements:** Includes actuarial and economic analyses and 10-year budget plan, meets substantive guardrails, notice and public comment, etc.

Formal Application/Negotiations v. Informal Discussions

- Congress has not given HHS authority to preapprove applications for a theoretical state program.

Budget Neutrality & Deficit Neutrality



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1115 Medicaid Waiver Requirement – Budget neutrality means that the expected costs under the demonstration underlying the waiver cannot be more than the expected costs were the demonstration not to occur.

- Budget neutrality formula not set in statute or regulation.
- Involves comparison of baseline expenditures (“without waiver”) to actual expenditures (“with waiver”).

Formulas in Current CMS Guidance:

- **Per capita formula:** Expenditure limit that varies by Medicaid caseload/enrollment.

(Projected Spending Per Eligible Individual, Per Month Without Waiver) x (Actual Monthly Caseload) = (Expenditure Limit)

- **Aggregate cap:** Fixed dollar limits that can be used for expenditures not easily associated with particular beneficiaries and can be used for capacity expansion.

(Projected total spending without waiver) = (Expenditure Limit)

- **Limited rollover savings:** After the first five years of the project, the amount of savings that can be rolled over to apply to the budget neutrality formula is reduced by 10% each year until it reaches 25%.

If budget neutrality not met, a State would be at risk of losing federal financial participation (i.e., federal funding share) for expenditures that exceed the budget neutrality limit.

1332 Waiver Requirement – Deficit neutrality means that net federal spending under the waiver cannot be more than the net federal spending without the waiver.

Federal Waivers in California



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Medi-Cal Waivers:

- CA Department of Health Care Services (DHCS) obtains approval from CMS to administer Medi-Cal waivers.
- Since 2005, has been, in significant part, operated under a 1115 Medicaid Waiver.
- Medi-Cal, in part, is currently operated under a 1915(b) Waiver for specialty mental health services and a 1915(c) Waiver on home- and community-based services.
- Various Section 1903 Waivers on broad-based and uniformity requirements on health facility and health program taxes and fees.

Medi-Cal Budget Neutrality Calculations (Two-Part Ceiling)

- Per capita limit on federal spending for Medi-Cal enrollees.
- Aggregate limit for Medi-Cal FFS expenditures on designated public hospitals (i.e., disproportionate share hospital funding).
- Upper payment limit for Medi-Cal FFS hospital services in CA has historically been 5% to 10% above reportable hospital costs.

CA DHCS notes that new waiver in CA usually require prior state legislative authorization.

Other Considerations



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- **What's in a name?** → Seamless integration of Medicare, Medicaid, and other federal programs into UF for individuals eligible for federal health programs.
- **Sustainable financing** → Reserves; diversity of nonfederal revenue sources; institutional global budgeting; bulk price negotiations; alternative budgeting formulas.
- **Federal and state accounting in UF budget** → For example, full-scope coverage for undocumented young and older adults in Medi-Cal without use of federal dollars.
- **Federal health care proposals** → American Jobs Plan proposal for increased federal long-term care funding and Medicare expansion.
- ***Becerra v. Gresham* and interpreting 1115 Medicaid Waiver authorization requirements**
 - Are Medicaid coverage gains required in a 1115 Medicaid Waiver? Does HHS have the discretion to approve a 1115 Medicaid Waiver if there is no substantial coverage loss?
- **Consultants' modeling of CA health expenditures under UF** → Anticipated aggregate savings achieved in Year 1 of UF with no cost-sharing and without long-term care. With long-term care, aggregate savings achieved by Year 3.

Consultants' detailed modeling estimates (Variation 2) (No cost-sharing, No LTSS, GDP Growth)

Year	Status Quo System (Baseline)	Direct Payments Scenario	Managed Care/ Health Plan Scenario
2022 (Year 1)	\$517.0B	\$501.2B (-3.1% of baseline)	\$504.9B (-2.3% of baseline)
2031 (Year 10)	\$850.4B	\$739.5B (-13.0% of baseline)	\$745.9B (-12.3% of baseline)

Key Takeaways and Other Resources



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- Can California integrate federal programs into a state single-payer or unified financing system? **YES**
- How? **Seamless incorporation of Medicare and Medicaid beneficiaries into the state program by:**
 - **Pass state legislation:** The legislature and Governor must establish a state program under state law before California can apply for waivers and enter formal negotiations with CMS.
 - **Waivers:** Apply for federal waivers to incorporate Medicare and Medicaid beneficiaries into the state program. (Combination of 1332, 1115, 1115A, and 1915 waivers and/or Medicare contracting and shared savings program authorities)
 - **Exceeding entitlements:** Provide Medicare and Medicaid beneficiaries benefits that exceed their entitlements under federal programs. (May need state program approved by HHS as a shared savings program that Medicare/Medicaid recipients enroll in.)
 - **HHS discretion:** HHS Secretary exercising their discretionary authority to waive federal health program requirements for new and innovative ways to get Medicare and Medicaid enrollees their care.
 - **Receipts for Feds:** Provide appropriate budgeting to CMS to maintain federal funding share.
- Do we need to change federal statute? **No. HHS Secretary given discretion, so long as guardrails are met, and not limited to waiver models listed in statute; CA need not ask for a block grant transfer from CMS.**
- See Hsiao, Kappel & Gruber. "Health System Reform Design: Achieving Affordable Universal Health Care in Vermont."²⁰ (2011) [analysishttps://hcr.vermont.gov/sites/hcr/files/FINAL_REPORT_Hsiao_Final_Report_17_February%202011_3.pdf](https://hcr.vermont.gov/sites/hcr/files/FINAL_REPORT_Hsiao_Final_Report_17_February%202011_3.pdf)

Opening Remarks

Andy Schneider, JD

Research Professor
Center for Children and Families
McCourt School of Public Policy at Georgetown University

Can the Secretary of HHS transfer federal Medicare and Medicaid funds to a Unified Financing System in California?

Summary of Presentation



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- The Secretary of HHS has no authority, by waiver or otherwise, to transfer federal Medicare funds to a State for a unified financing system
- The Secretary of HHS has no authority, by waiver or otherwise, to transfer federal Medicaid funds to a State for a unified financing system
- If California wants to use federal Medicare and Medicaid funds as part of a unified financing system, including single payer, it will need to persuade the Congress and the President to change federal law

Medicare



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- Accounted for 20% of California health spending in 2019 (\$89 B)
- 6.3 million Californians enrolled in 2019; they each have an individual entitlement to a defined set of health benefits
- Medicare makes payments on behalf of its beneficiaries for covered services to providers and plans, not to States
- The Secretary of HHS has authority to waive compliance with some Medicare rules, but that authority **does not** allow him/her to transfer federal Medicare funds to a State or its unified financing system

Medicare Waiver Authorities: Section 402



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- **Section 402(a) of the 1967 Social Security Amendments** authorizes the Secretary of HHS to conduct experiments or demonstrations to test “changes in methods of payment or reimbursement ... for health care and services under [Medicare and Medicaid]...”
- “In the case of any experiment or demonstration project under subsection (a), the Secretary may waive compliance with the requirements of titles XVIII and XIX of the Social Security Act **insofar as** such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment...”

Medicare Waiver Authorities: Section 1115A



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- **Section 1115A of the Social Security Act** authorizes the Secretary of HHS to “test innovative payment and service delivery models to reduce program expenditures under [Medicare and Medicaid] while preserving or enhancing the quality of care furnished to individuals under such [programs]”
- The statute lists 27 different models for testing; **none** of these is a unified financing system
- The Secretary may waive “such requirements of [Medicare law] ... as may be necessary **solely** for purposes of ... testing models ”

Medicaid



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- Accounted for 14% of health spending in California in 2019 (\$62 B)
- 12.6 million Californians enrolled in 2019; they each have an individual entitlement to a defined set of benefits
- Unlike Medicare, Medicaid is a federal-state matching program; the federal government will match on an open-ended basis what the state spends on covered services for eligible individuals
- The Secretary of HHS has the authority to waive compliance with certain Medicaid rules, but those authorities **do not** allow him/her to transfer federal Medicaid funds to a State unified financing system

Medicaid Waiver Authorities: Section 1115



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- Section 1115 of the Social Security Act
 - Authorizes the Secretary of HHS to enable States to conduct experimental, pilot, or demonstration projects which are “likely to assist in promoting the objectives of” Medicaid
 - For such projects, the Secretary may waive compliance with “any of the requirements of section... **1902**...to the extent and for the period he finds necessary to enable such State or States to carry out such project”
 - The financing provisions of Medicaid are in sections **1903** (open-ended matching for State expenditures) and **1905** (matching rates), which the Secretary **does not** have the authority to waive

Medicaid Waiver Authorities: Section 1115A and Section 402



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- Section 402 of the 1967 Social Security Amendments (Slide 25)
 - Secretary may waive Medicaid requirements “**insofar as** such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge...”
- Section 1115A of the Social Security Act (Slide 26)
 - Specifies **four** requirements that the Secretary may waive in order to test “innovative payment and service delivery models:”
 - 1902(a)(1) – requires that Medicaid program be in effect statewide
 - 1902(a)(13) – relates to payment for hospital and hospice services
 - 1903(m)(2)(A)(iii) – relates to “actuarially sound” rates for managed care plans
 - 1934 – relates to PACE programs

Other Analyses



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- Juliette Cubanski, Kaiser Family Foundation, “Implementation Considerations for Universal Coverage: Federal Law Considerations and Medicare,” Testimony before California Select Committee on Health Delivery Systems and Universal Coverage, (February 5, 2018) https://www.assembly.ca.gov/sites/assembly.ca.gov/files/Archives/2_-_final_cubanski.pdf
- Lanhee J. Chen and James C. Capretta, “Current Federal Health Care Waiver Authorities Will Not Pave the Way for the New York Health Act,” (January 2020), <https://nyhpa.org/wp-content/uploads/2020/01/Single-Payer-Medicare-and-Medicaid-Brief-Final-Jan-2020.pdf>
- Manatt Health, “Understanding the Rules: Federal Legal Considerations for State-Based Approaches to Expand Coverage in California,” (February 2018) <https://www.manatt.com/getattachment/6c6ebd95-d8da-40be-9529-04cbbb7b8142/attachment.aspx>



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Commissioner Discussion



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Public Comment



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Adjourn