STATE OF WASHINGTON
**HEALTH CARE AUTHORITY**
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August 28, 2015

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| Senator Randi Becker | Senator Linda Parlette | Representative Joe Schmick |
| 2nd Legislative District | 12th Legislative District | 9th Legislative District |

**RE: PROPOSED SECTION 1115 MEDICAID TRANSFORMATION WAIVER COMMENTS**

Dear Senator Becker, Senator Parlette and Representative Schmick:

Thank you for your comments on the draft application for a Section 1115 Medicaid transformation waiver. The application submitted to the Centers for Medicare and Medicaid Services (CMS) earlier this week benefited considerably from the comments received during the 30-day public comment period. This letter addresses the concerns you raised in your August 21, 2015 communication. For clarity I have restated each question and provided an answer below.

**Question 1:**

> *While the Application maintains that this is "budget neutral," an additional $3 billion in federal funding is being requested. There is a lack of specificity in the Application about how this transformation will be carried out, including how the financing will work, how it will be staffed, and what the long-term risks are to the state because of this additional federal investment.*

It is true that the state seeks additional federal investment in the amount of $3B over five years. The approach to "budget neutrality" must ensure that the federal government does not spend any more under the waiver than what they would have spent without the waiver. The trend In Medicaid spending nationwide is higher than Washington State's spending trend, both historically and projected over the course of the 5-year demonstration. Given this dynamic, the waiver application does not expose the state to additional long-term risk. The premise of our waiver application is a reinvestment of federal savings already generated and projected to be generated from Washington's Medicaid reform efforts.

Your questions about specificity in staffing, financing and implementation plans are important. These specifics have not yet been determined. HCA will be including legislative fiscal and policy staff in a workgroup to specifically address areas of interest as the waiver conversation progresses and specific plans are identified. We also envision additional updates to the Joint Legislative Select Committee on Health Care Oversight at the request of the Chairs.

We believe the upcoming negotiation process with CMS will result in terms that effectively mitigate any risk of long-term exposure to the state budget. If we are unable to negotiate satisfactory terms that appropriately account for prior and future savings to the federal government, we are prepared to exit negotiations.

**Question 2:**

> *The creation of Accountable Communities of Health (ACH) as described in the Application creates an additional administrative layer between HCA and managed care organizations (MCOs), behavioral health organizations (BHOs), and providers. It also designates ACHs as the fiscal intermediary between HCA and the MCOs, BHOs, and providers for pass-through of the transformation dollars. This appears to create additional administrative costs and requirements. It is unclear how these efforts are not duplicative of existing efforts and how they are efficient and economic.*

Accountable Communities of Health (ACH) are recognized in the application as a uniquely qualified, multi-sector entity, capable of addressing health transformation efforts that no single entity could carry out alone. ACHs are being launched now with financial support from the State Innovation Model test grant and funding previously appropriated by the Legislature in the FY 2013-2015 budget. We do not believe managed care health systems or providers acting alone are capable of carrying out delivery system transformation in the areas envisioned in the waiver. To be sustainable, transformation of this magnitude requires regional assessment of opportunities, administration of new investments (not current Medicaid expenditures) and local accountability – tasks that an ACH will be uniquely capable of delivering. HCA will ensure that ACHs are prepared for this role; each ACH will have readiness assessed as part of the transformation envisioned in the waiver. If an ACH is unable or unwilling to meet the State's expectations under the waiver, a separate governing and administrative entity will be selected.

**Question 3:**

> *There appears to be a lack of consistent measurement requirements both between the ACHs and the current forecast process. The Application allows each ACH to pick its own set of transformation activities and the Application itself uses caseload categories that differ from our current forecast process. These inconsistencies will make comparing ACHs both to each other and to current practice difficult.*

The eligibility categories referenced in the application are different from those used in the forecast process. Below, we provide a crosswalk identifying which forecast populations are included in each application category. In addition, this information will be discussed in the legislative-executive fiscal workgroup mentioned above. We agree that common measurement across transformation activities, for ACHs, managed care health systems, and providers, will ensure we are working towards consistent Medicaid priorities with credible and comparable measurement of progress. Comparisons between ACHs will utilize the core measures established by the Legislature under HB 1519, SB 5732 (2013) and HB 2572 (2014).

1. Disabled Adults & Children: CN Bind/Disabled, MN Blind/Disabled, CN Medicaid Buy-In/HWD, CN BCCT
2. Non-Disabled Children: CN Children, SCHIP, CN Family Medical<19
3. Non-ABD 'Classic' Adults: CN Pregnant Women, CN Family Medical>=19
4. Aged: CN Aged, MN Aged
5. Expansion Adults: Aligned with forecast category

**Question 4:**

*Expanded eligibility for long-term services and supports (LTSS) will require additional staff both for eligibility determination and customer service. There may be other staffing needs for these programs as well. The Application does not indicate how these programs are to be staffed in either the short- or long-term or the funding sources required for this staffing.*

Under Initiative 2, the new benefits and eligibility group will be funded by the waiver with 100% federal funds, inclusive of services and staffing. The 5-year demonstration is designed to test whether the delay or diversion from intensive long term services is significant enough to support its continued funding post-waiver. The waiver document does not commit additional state resources in the short or long-term to this task.

**Question 5:**

*There is little fiscal detail contained in the Application about how savings will be achieved, shared or reinvested. House Bill 2572, as enacted during the 2014 legislative session, had significant savings expected as a result of health care transformation. Original projected savings were dampened in the final 2014 budget. Budgeted savings were not realized in 2015 and there are indications they will not be realized in 2016. It is unclear when savings are to begin under this new model, what those savings are, and how they will be reinvested when there are no savings currently being realized.*

The waiver savings expectation for federal funds was addressed above under question 1. The waiver application anticipates no state savings over the course of the demonstration. It specifically relies on federal savings and the reinvestment of those savings in the Medicaid program.

It is important to note that, health care transformation proposed under the waiver is distinct from activities assumed to provide the savings associated with HB 2572 and SB 6312 (2014). Achievement of savings assumed in the 2014 health care transformation bills should be discussed separate from the waiver submittal. We also invite a further discussion on the interaction between forecast trend assumptions, savings goals and actual health care spending trends in Washington and across the nation.

Thanks again for your questions and please allow us to follow-up if we can add any greater clarity to these responses.

Sincerely,

Nathan Johnson
Chief Policy Officer
Health Care Authority

cc:

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