ACL
Association for Community Living

Human Services in Turbulent Times: Tax Reform, Repeal/Replace, Medicaid Transformation and the New Federal-State Dynamic

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Agenda

Challenging times for health and human services providers:

- Prospects for significant policy changes dictated by federal government, hostile to Medicaid and facing huge federal deficits, thanks to tax reform.
- Potential political realignment and transitions in New York, adding to uncertainty for health and human services providers.
- Workforce issues, burdensome regulatory oversight, and fiscal challenges remain for human services field.
- Preparing and positioning for these turbulent times can make one worry.

Worried?

Top Ten Things to Worry About

Service Delivery:

1. Integration of behavioral health
2. Telehealth and electronic health records

Workforce:

3. Professional licensure
4. Disconnect with emerging labor policies
4. Justice Center and regulatory burdens

Future of Medicaid:

6. Block grants, per capita caps, tax reform
7. DSRIP, VBP & Social Determinants of Health
8. Managed care and coordinated care for all?
9. Medicaid as welfare or health insurance?
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Service Delivery: Integration of Behavioral Health

Integrating BH and SUD services with physical health has been widely endorsed—but not easily achieved:

- November, 2017, CMS released guidance encouraging States to pursue waivers targeting substance use disorders—and that modifies the IMD exclusion for provision of SUD services.
- None of the approved waivers have allowed states to obtain funds for residential mental health services in IMDs—an issue likely to be revisited as states seek more flexibility to treat patients across full continuum of care.
- Meanwhile, NYS continues to seek to integrate physical and behavioral health services and streamline licensing.
- Integration of behavioral health poses challenges and requires changes on both sides of the equation.

Challenges/Opportunities in Integration of BH Services

Federal law can impede or facilitate integration of physical and behavioral health care.

Opportunities

Section 1115 Waivers covering Substance Use Disorder Treatment

- Allow waiver of Institutions for Mental Diseases (IMD) exclusion in the context of "improv[ing] access to high quality, clinically appropriate treatment for opioid use disorder (OUD) and other substance use disorders (SUDs)"

Medicaid Managed Care Rules

- Allow MCOs to cover individuals in IMD if no more than 15 day stay

Challenges

Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2)

- Limits information sharing of alcohol or drug abuse treatment information
- Requires detailed patient consent forms listing providers
- SAMHSA proposed changes, but significant consent barriers remain

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Service Delivery: Telehealth

- Telehealth offers potential opportunities for accessing medical interventions from remote locations in a more timely, cost-effective manner—but will laws and regulations keep pace with the promise of the new technology?
- NYS law had been quite restrictive in terms of Medicaid fee for service reimbursement for telehealth services, requiring client/patient to be in specified "originating sites."
- New legislation enacted in budget removes that limitation—and directs DOH, OMH, OPWDD and OASAS to begin rationalizing their approaches to the issue.

Service Delivery: Electronic Health Records

- Providers must manage health information in a manner that advances their clinical goals and business needs, while complying with HIPAA, the Federal Common Rule, the "Part 2" substance use treatment rules and state privacy requirements—during a time of growing risk of inadvertent or malicious data breaches.
- In the absence of a commensurate investment in the technological infrastructure, BH providers left behind.
- Prospects for integration of BH services diminish without ability of full array of BH providers to share data and electronic health records with rest of service system

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Workforce: Professional Licensure

- Human services workforce shortages and quality issues on collision course with professional licensing laws.
- Prolonged social work debate is emblematic of the issues.
- Workforce shortages, particularly (but not only) in child psychiatry, underscore need to obtain access to services by "advanced practitioners" or "mid-level practitioners."
- Overly limited scopes of practice limit what licensed practitioners can do—and absence of credentialing for unlicensed direct care professionals may unreasonably limit their roles, career paths.
- Professional licensing rules may also inhibit robust use of telehealth as a means to assure access to care.

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Workforce: Disconnect with Emerging Labor Policies

Enactment or promulgation of new labor laws and regulations do not appear to reflect the unique challenges of the human services workplace:

- Minimum wage implementation—in context of chronic underfunding of personnel in human services sector.
- Overtime rules that do not reflect the essential coverage requirements, inevitable need for extended shifts and chronic workforce shortages.
- Predictable scheduling requirements at purport to apply to an unpredictable workplace .

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Workforce: Justice Center and Regulatory Burdens

- Intense scrutiny of staff and management of services under Justice Center's jurisdiction and governed by OPWDD regulation compounds challenges of recruiting, motivating and retaining key staff.
- Even though changes appear to be underway at the Justice Center, workforce climate is adversely affected by hostile compliance environment and "Monday-morning" second-guessing of clinical and support service providers.
- Need to identify appropriate means of providing critical oversight to review quality and prevent abuse—and make appropriate investments in direct care staff, their credentialing and career opportunities.

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Medicaid Provisions in "Repeal and Replace" Proposals

Changes to Medicaid under repeal and replace proposals extended beyond just the ACA

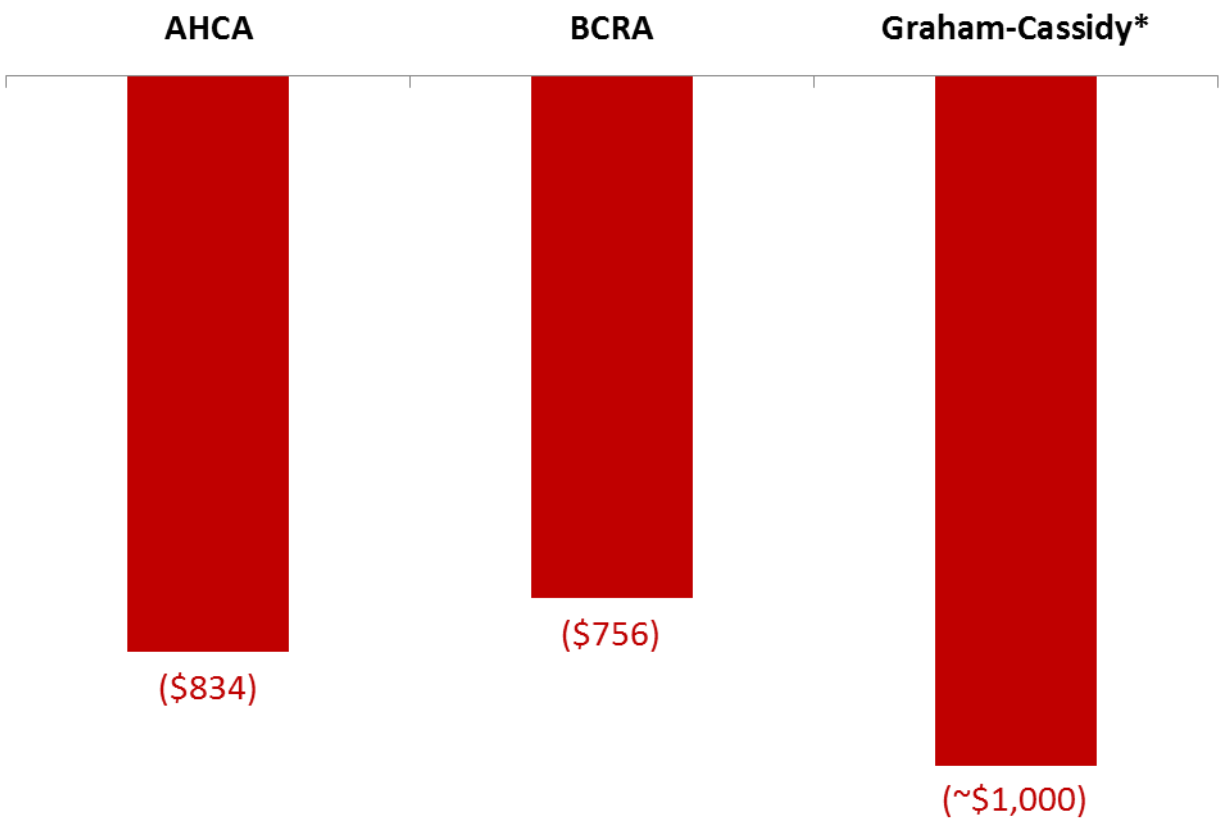
- **Deep Medicaid cuts**
- **End the Medicaid expansion**
  - Some proposals had a phase out of enhanced match
  - Graham-Cassidy eliminated not only the enhanced match but the ability of states to cover low income adults even at regular match
- **Cap on virtually all federal Medicaid funding**
  - Complicated formulas, but all used a per capita cap to build to an aggregate cap
  - State responsible for any spending above the cap
- **Other Medicaid changes** (e.g., DSH, retroactive eligibility)
- **No new programmatic flexibility, except option to impose work requirements**

Proposals impacting federal Medicaid funding are likely to re-emerge

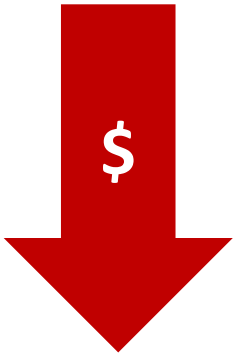
Impact of Repeal Proposals on Medicaid Spending

AHCA, BCRA, and Graham-Cassidy all would have resulted in significant cuts in federal Medicaid funding

CBO Estimated Reductions in Federal Medicaid Spending, FY 2017-2026 (billions)



- AHCA and BCRA allowed marketplace subsidies to be available to expansion adults
- Graham-Cassidy provided block grant funding for various uses



Reductions in federal spending grow in the out years

Medicaid's Financing Structure: Current v Proposed

	Current	Block Grants	Per Capita Cap
Federal Funding	Open ended	Aggregate cap	Per enrollee cap (by eligibility group)
Risk	Federal government and state share enrollment and spending risk	States bear risk of both higher enrollment and health care costs	States bears spending risk of higher health care costs
Annual Trend	Determined by health care costs in the state and individual state spending decisions	National trend rate	National trend rate
Ability to Accommodate Medical Advances or Public Health Crises	Federal payments automatically responsive	Federal payments not responsive	Federal payments not responsive
Spending Outside of Cap	N/A	Unknown/TBD	Unknown/TBD
State Flexibility	State flexibility subject to federal minimum standards; Section 1115 waivers provide additional flexibility	Increased flexibility, but some minimal standards and accountability	Increased flexibility, but some minimal standards and accountability

New York Enrollee Medicaid Spending Varies by Category

State Ranking of Medicaid Spending (Federal and State) per Full Benefit Enrollee, FY 2014

#	Total		Children		Adults*		Disabled		Aged	
1	MA	$11,091	VT	$5,214	NM	$6,928	**NY**	**$33,808**	WY	$32,199
2	**NY**	**$10,307**	AK	$4,682	MT	$6,539	CT	$31,004	ND	$31,155
3	RI	$9,541	NM	$4,550	AK	$6,471	AK	$28,790	CT	$30,560
4	AK	$9,481	RI	$4,290	AZ	$6,460	ND	$28,692	**NY**	**$28,336**
5	DC	$9,083	MA	$4,173	VT	$6,062	DC	$28,604	DE	$27,666
10	VT	$7,951	AZ	$7,167	**NY**	**$5,339**	AZ	$22,040	MT	$26,704
18	WV	$6,821	**NY**	**$2,707**	CT	$4,538	UT	$19,718	IA	$21,163
47	AL	$4,976	NV	$1,940	FL	$2,993	MS	$12,960	CA	$12,019
48	FL	$4,893	MI	$1,926	CA	$2,855	KY	$12,856	UT	$11,763
49	IL	$4,682	IN	$1,858	NV	$2,367	SC	$12,830	IL	$11,431
50	GA	$4,245	FL	$1,707	ME	$2,194	GA	$10,639	NC	$10,518
51	NV	$4,010	WI	$1,656	IA	$2,056	AL	$10,142	NM	N/A
U.S. Average		**$6,502**		**$2,492**		**$4,141**		**$18,518**		**$17,522**

- New York has among the highest per capita Medicaid spending levels relative to other states, ranking 2nd in total per capita Medicaid spending per enrollee.
- New York spent more than most states on the Disabled ($33,808 vs. US, $18,518), and Aged ($28,336 vs. US, $17,522), and above average on Children ($2,707 vs. US, $2,492) and Adults ($5,339 vs. US, $4,141).

Tax Reform and its Implications

- Tax Cuts and Jobs Act enacted at the close of 2017 will have profound impact on federal budget for many years.
- Significant reform to overall structure of tax system: largest (and most positive) impact is on corporate tax rate
- Adverse impact on state and local governments as a result of SALT deduction: expected to accelerate departure of high income NYers elsewhere—and will place additional stress on State budget (i.e., Medicaid).
- Revenue impact to federal government: ***net*** reduction of $1.5 trillion over 10 years (takes into account offset of revenue increases against cuts)—which will place more pressure on "entitlement reform" (i.e., Medicaid).

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Future of Medicaid: DSRIP, VBP & SDOH

- Delivery System Reform Incentive Payment (DSRIP)—"once in a lifetime" opportunity in year 4 of 5 year program: some results shown in reducing preventable readmissions and emergency room visits.
- Did not result in as much of an investment in community-based providers and uncertain how effort is sustained.
- Value-Based Payments: not a passing fad. Roadmap approved in April, 2017; effort mirrored on Medicare and commercial insurance side.
- Social Determinants of Health: Effort shifting to broader environmental issues affecting healthcare, including housing, nutrition and related commitments.
- First 1000 Days Initiative: ten point plan

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Future of Medicaid: Care Coordination for All?

- Since early 1980s, managed care has been Medicaid direction
- Reaffirmed by Medicaid Redesign Team and resulted in mandatory enrollment of SPMI population in mainstream managed care/HARP; mandatory managed long term care enrollment; gradual implementation of care coordination for I/DD population
- Pace of "managed care for all" has slowed or been reversed:
  - ✓ Prolonged delays in incorporating people with traumatic brain injury and school-based health centers in Medicaid managed care;
  - ✓ Recent delay in proceeding with carve-in of care-at-home, foster care and seriously emotionally disturbed children
  - ✓ Carve-out of nursing home population from MLTC program
- Impact of 2016 Federal managed care "megarule", raising the standards for state oversight of Medicaid managed care.

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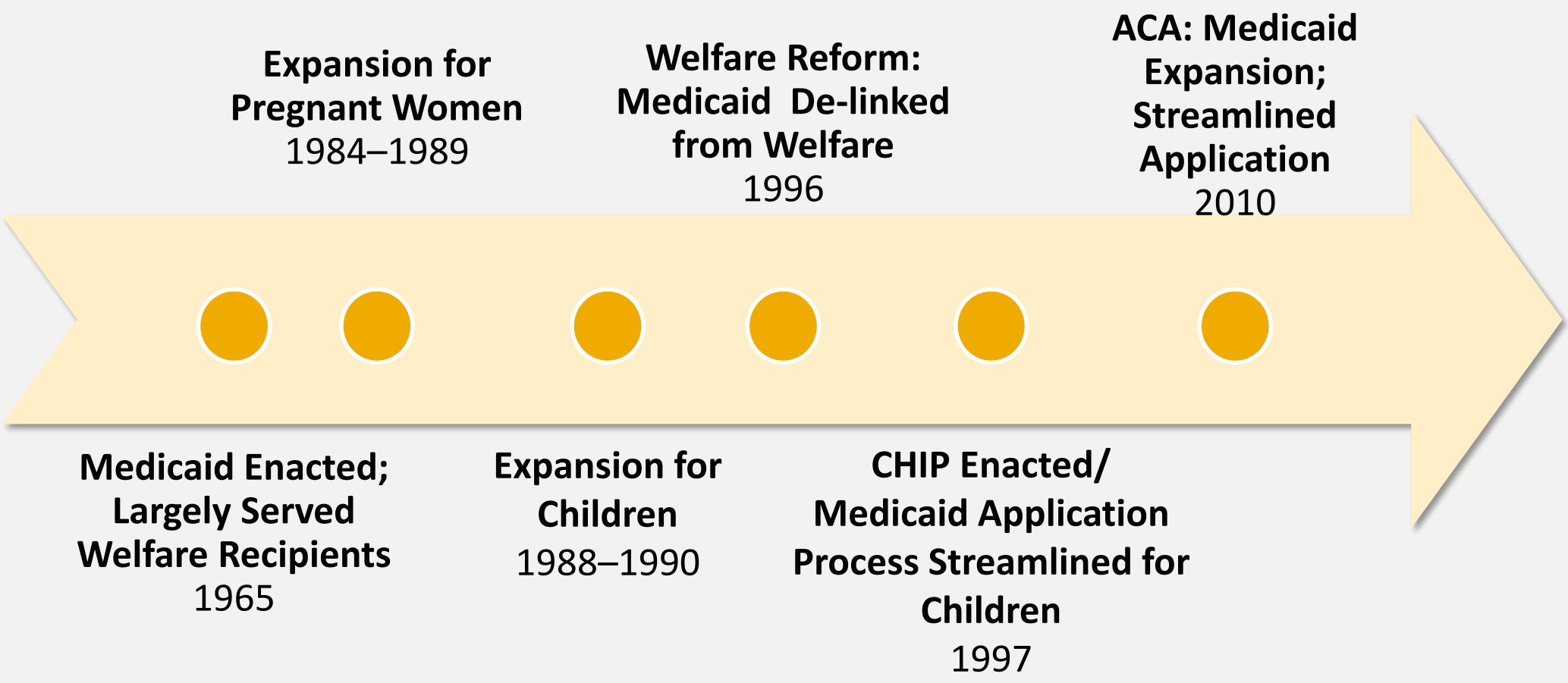
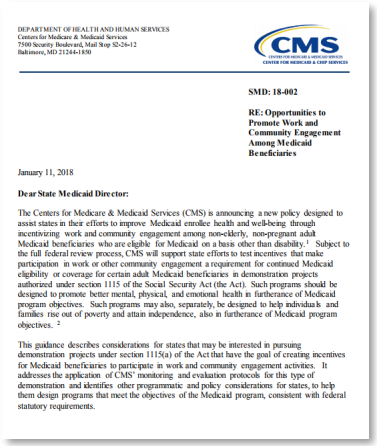
Medicaid Has Evolved Since Enactment in 1965



Emerging View of Medicaid Under the Trump Administration

The Trump Administration aims to return Medicaid to its welfare roots and focus the program on the most vulnerable

"….we shouldn't just celebrate an increase in the rolls, or more Medicaid cards handed out… for able-bodied adults, we should celebrate helping people move up, move on, and move out." **[CMS Administrator Seema Verma, 11/7/2017]**



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTER FOR MEDICAID & CHIP SERVICES

SMD: 18-002

RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries

January 11, 2018

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is announcing a new policy designed to assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible for Medicaid on a basis other than disability.[1] Subject to the full federal review process, CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act (the Act). Such programs should be designed to promote better mental, physical, and emotional health in furtherance of Medicaid program objectives. Such programs may also, separately, be designed to help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program objectives. [2]

This guidance describes considerations for states that may be interested in pursuing demonstration projects under section 1115(a) of the Act that have the goal of creating incentives for Medicaid beneficiaries to participate in work and community engagement activities. It addresses the application of CMS' monitoring and evaluation protocols for this type of demonstration and identifies other programmatic and policy considerations for states, to help them design programs that meet the objectives of the Medicaid program, consistent with federal statutory requirements.

"…programs should be designed … to help individuals and families rise out of poverty and attain independence…" **[SMD 18-002]**

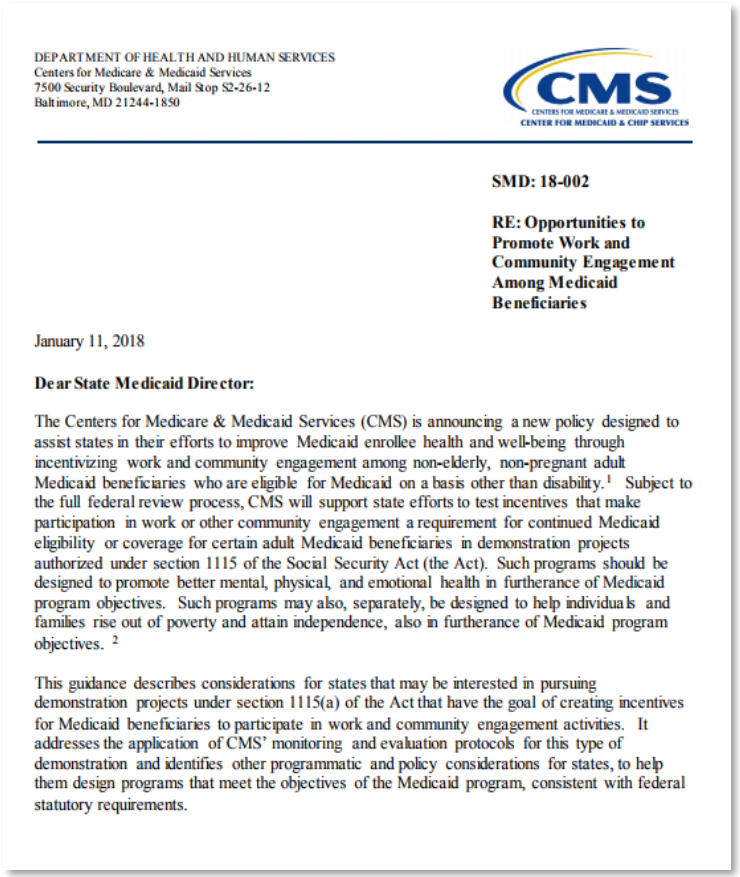
Waivers Seek to Advance New Medicaid View

More than a dozen states have submitted waivers proposing new coverage conditions

Policy	New Waiver Features
Premiums	• Premiums above 2% of household income • Nonpayment resulting in loss of coverage • Lockouts for nonpayment
Cost Sharing	• Penalties for non-emergent ED visits • Missed appointment fees
Work	• Work requirements as a condition of eligibility
Eligibility	• Lifetime coverage limits • Lockouts for failure to timely renew eligibility • Drug testing as a condition of eligibility • Partial expansion
Benefits	• Elimination of retroactive coverage or transportation benefits • Closed drug formularies
Applicability	• New policies not limited to expansion adults

Trump Administration Open to Work Requirements

CMS released guidance in January stating that it would permit states to implement work and "community engagement" requirements



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"…CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility…" **[SMD 18-002]**

ACL May 1, 2018

Administering Work Requirements

States will grapple with new IT and operational demands and costs required to implement work requirements

Administrative requirements for states implementing work requirements

- Enrollee education and noticing
- Determining and validating exemptions from requirements
- Tracking, validating, and enforcing requirements
- Monitoring and evaluation

Implementation Will Require State Resource Commitments

*Kentucky Governor Matt Bevin (R) has requested **$23.5 million in state funds** from the Kentucky Legislature to support implementation of the state's Section 1115 demonstration, which includes work requirements*

Future of Medicaid: Welfare or Coverage Program

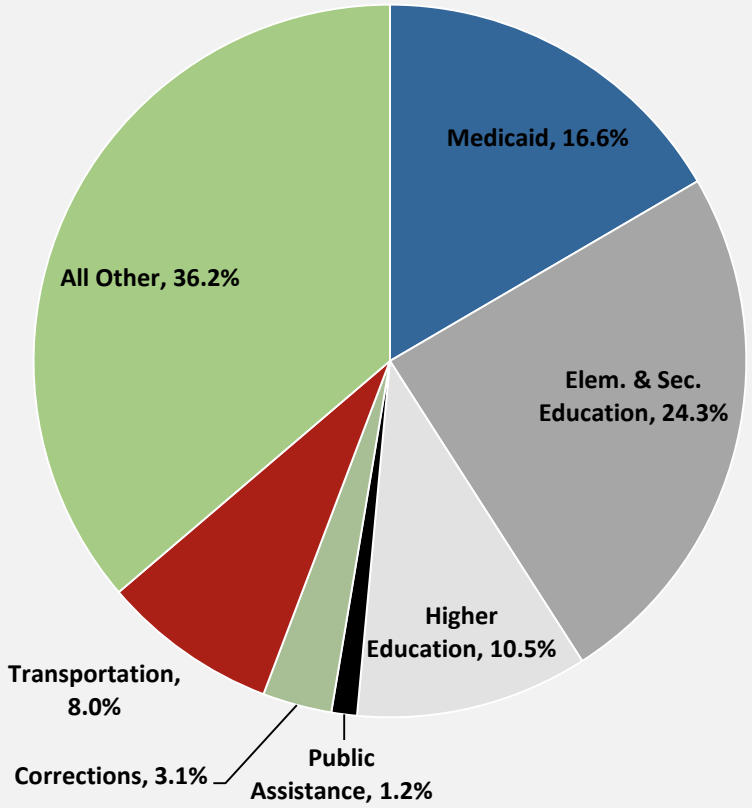
What Medicaid means for New York:

- Thanks to ACA's Medicaid expansion, Medicaid now enrolls approximately **one in three New Yorkers**
- **Over half of all births** in NY are covered by Medicaid;
- ***48% of kids 0-18*** and ***59% of kids 0-3*** are Medicaid;
- And not just a big city phenomenon:
  - ✓ Since ACA, grew by 15.4% in NYC—but **by 45% elsewhere**
  - ✓ Medicaid grew by 24.5% in urban areas, but by **over 37% in rural New York**

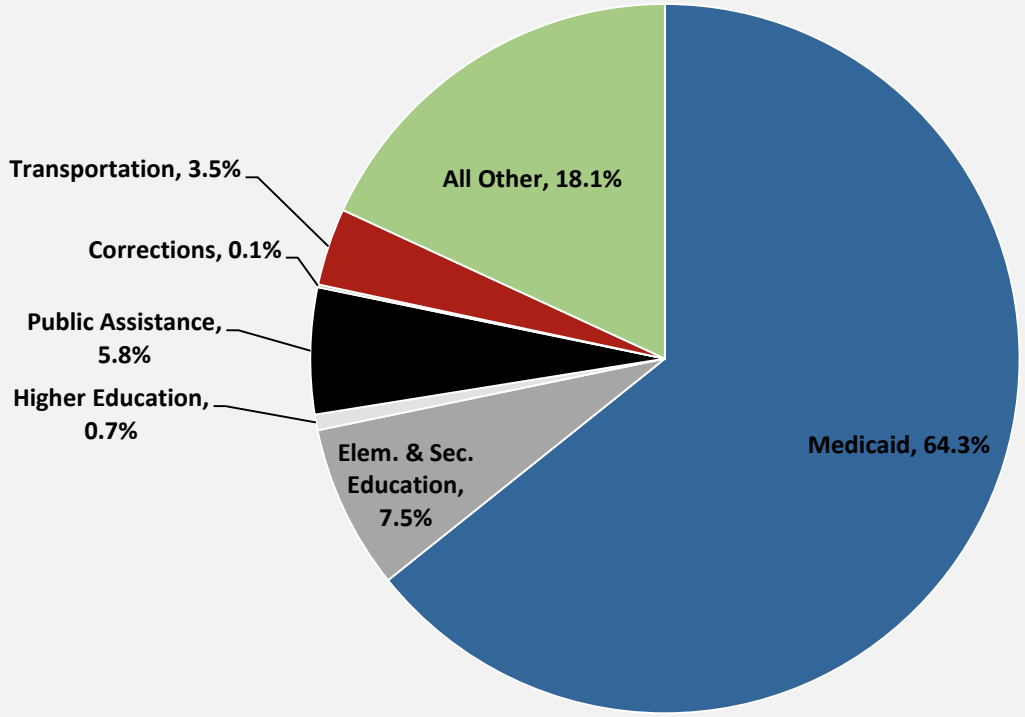
And Medicaid has a huge fiscal impact on the State:

Medicaid and New York State Budget

NY Medicaid Spending as Share of Budget (State Funds Only), SFY 2015



Medicaid as a Share of Federal Funds to New York, SFY 2015



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Jason Helgerson transitions to Donna Frescatore

Future of Medicaid: End of Helgerson Era

- Challenging task to complete Helgerson legacy
- While Jason Helgeron was a visionary and thoughtful policy leader, task will be to implement the many initiatives that have been advanced.
- Donna Frescatore assumed to be interim leader, pending appointment next year of new Medicaid Director—and, as such, she may not be given the opportunity to advance her own policy initiatives.
- Fulfilling ad implementing the pending policy initiatives will be full time job.
- Frescatore may be, by experience, more focused on implementation and may be more managed care-friendly.

What do we do about the top ten things to worry about?

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Discussion and Questions

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