

New York Health Act FAQ

Federal Waivers

Q: In order to efficiently integrate existing federal funds (Medicare, the federal share of Medicaid and CHIP, ACA subsidies) into the new system, the New York Health program will seek waivers from the federal government that will enable bulk transfer of these funds to the state based on global, prospective budgeting. How would these waivers work? And what options are available should such waivers not be forthcoming?

A: Over half the funds that provide and administer health care services in New York come from federal and federal-state public programs. These include Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and Affordable Care Act (ACA) refundable tax credits.

The New York Health Act (NY Health) explicitly provides that the Commissioner of Health will seek federal waivers that will allow these funds to be integrated smoothly and efficiently into the NY Health trust fund (See the bill Introduction and Section 5109).

Medicaid and CHIP

States manage and partially fund the Medicaid and CHIP programs. Matching funds are provided by the federal government. Currently, federal funding is conditional upon verifying the eligibility of each Medicaid and CHIP participant. New York would seek a waiver to allow these funds to be received in bulk, based upon past receipts and estimates of future eligibility and costs, bypassing the need for case-by-case verification. This would be similar to a global funding waiver currently in effect for Rhode Island’s Medicaid program. Since this already exists, it would not be easy for the federal government to deny this waiver since there is precedent.

New York already has a number of approved Medicaid waivers that allow the state to provide services that are not part of original Medicaid including, among others, long-term care services in the home and community, and certain behavioral health and addiction services. These waivers would be expected to continue, along with others in effect, or under development, that allow integrative approaches and capitated payment methods that move away from the less efficient fee-for-service model.

Medicare

The federal Medicare program does not have state-based “waivers”, but it does have “demonstration projects” as defined by the 1967 and 1972 amendments to the Social Security Act. These can potentially serve the same purpose. They are intended to promote research that might assist Congress and the Department of Health and Human Services (HHS) in designing reforms that would increase the efficiency and cost-effectiveness of the Medicare program, without compromising health care quality. These reforms could include changes in

payment methodology that would allow for seamless articulation of the Medicare program with NY Health.

Most such demonstration projects were expected to be proposed initially by Congress and HHS and managed and evaluated by the Center for Medicare and Medicaid Services (CMS). The legislation was not initially designed to support state-specific operational program reforms, although the research has led to some innovative technical improvements and a few state-based operational waivers, such as one that allows Maryland to establish uniform pricing and, more recently, global budgeting for all hospitals in the state. Maryland is now seeking to extend its Medicare pricing policy to physician reimbursement.

The Maryland waiver shows that significant changes in payment methods in a state have been treated by CMS as compatible with the intent of the original Medicare legislation.

Medicare Advantage may be used if a Medicare waiver is unavailable

In 1973, Congress codified federal rules for provider collectives that offered services on a capitated basis, and Medicare was authorized to develop demonstration projects that would allow such HMOs to manage services for older adults. This became the basis for the Medicare Part C (Medicare Choice+) legislation in the Balanced Budget Act of 1997 and the Medicare Advantage (MA) legislation in 2003. Although nearly all MA organizations have been private, usually for-profit, insurance companies, the 1973 law refers to “public or private” entities that could be authorized by the federal government to be providers of such programs.

Over 38% of Medicare recipients were enrolled in MA programs in New York as of 2017. Such programs typically offer an expanded set of benefits, usually optical, dental, and hearing, along with a prescription drug component. The MA organizations typically limit their expenditures by offering only a narrow network of providers, by requiring substantial co-pays, and sometimes by requiring a premium add-on.

A public or quasi-public entity serving as an MA plan could ease the way toward integrating Medicare into NY Health. Medicare recipients in New York State would be considered to be members of the state’s MA plan. They would, of course, receive the same comprehensive benefits as everyone else. The federal government already uses capitated payments for such plans, replacing inefficient fee-for-service reimbursements. This would help to smoothly integrate federal funds into the NY Health trust fund, if a waiver (or demonstration project) could not be negotiated.

Since this would be a new situation, there are new issues that might arise. The original Medicare Advantage amendments were intended to encourage insurance marketplace competition, to drive down premiums and allow consumers a broader range of health plan choices. A state MA plan would be part of the single-payer plan that eliminates competition for basic comprehensive health insurance. NY Health, as a single payer program, will, of course, be

expected to reduce health care spending and allow for total freedom of choice of provider. Comprehensive benefits will cover everything covered by MA plans, and more, with no cost-sharing.

New York's dual-eligible plan already incorporates Medicare Advantage

New York is already using the Medicare Advantage program in a “demonstration project” to accomplish some program integration that was not originally envisioned in the Medicare legislation.

One major goal of the Affordable Care Act was to find ways to integrate Medicaid and Medicare for so-called “dual-eligible” patients, including long-term care. In 2008, dual-eligibles constituted only 20 percent of Medicare beneficiaries nationally but 31 percent of Medicare spending. They constituted 15 percent of Medicaid beneficiaries but 39 percent of Medicaid spending.

Section 2602 of the ACA set up a Federal Coordinated Health Care Office, reporting to the administrator of CMS. Among the purposes of the office are to more effectively integrate benefits under Medicare and Medicaid for dual-eligibles, simplify the processing of claims, and improve care continuity and the quality of health and long-term care services. The new office, in effect, becomes the waiver vehicle through which Medicare is integrated with Medicaid into a single payment stream managed by states.

New York is one of 17 states authorized to carry out such a demonstration project. It is called Fully-Integrated Duals Advantage (FIDA) and is part of the state's Medicaid Redesign Team reform effort launched in 2012. Although New York already had two small integrated programs, including the Program for All-inclusive Care for the Elderly, or PACE, the FIDA initiative aimed to eventually include all dual-eligibles and become part of the ongoing effort of New York to transition Medicaid recipients into managed care and managed long-term care environments where, in theory, costs can be controlled and quality improved.

The new federal office uses the MA program to carry out its integration efforts. New York's FIDA initiative was set up as a set of MA plans using private insurance companies to manage the demonstration project. Medicare payments are made according to the MA model.

Medicare wrap-around

As a fallback option, a state could set up a Medigap-like plan that would “wrap around” traditional Medicare and ensure comprehensive coverage. Such a plan would run parallel to Medicare as it currently exists and provide any needed extra payments to providers. While such an approach would limit the administrative savings that could be achieved, since providers would still have to submit individual bills to the Medicare program, an efficient electronic claims processing system could minimize the additional administrative effort by providers.

There are also provisions under Section 1395kk of the Medicare law that allow the federal government to hire contractors to maintain data and administer benefits under certain conditions. A state or state-related entity could qualify as such a contractor and thus could process Medicare claims as well as claims made directly to NY Health.

ACA Innovation waivers can bypass ACA requirements

The Affordable Care Act Section 1332 offers innovation waivers that allow a state to opt out of ACA requirements (for instance, the requirement to create a “marketplace” to offer private insurance plans) in order to introduce new approaches that could the provider reimbursement process and/or technical areas such as data collection and claims processing.

The waiver option was included in the ACA on a bipartisan basis because it could cover approaches that were of interest to both conservative and liberal members of congress. The discussion leading up to the enactment of the law explicitly included single-payer options, and the state of Vermont submitted a 1332 waiver request for the single-payer legislation it passed in 2011 (the request was later withdrawn when the governor tabled the plan.).

In order for a 1332 waiver to pass muster, the new system must offer benefits at least as comprehensive and as affordable as would have been the case without the waiver, and it must cover at least as many residents. In addition, the state must present a ten-year budget that demonstrates that the system will not add to the federal deficit. The NY Health program would readily meet these “guardrail” provisions.

At a minimum, such an innovation waiver will allow a state to receive ACA refundable premium tax credit funds directly. A waiver can also allow a state to develop uniform pricing along with innovative claims processing systems. NY Health will likely use a single “back office” to manage payments to providers in order to limit administrative expenses.

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