



# NGA Health Care Sustainability Task Force Report

Approved February 22, 2014

# NGA Health Care Sustainability Task Force

## I. Overview

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Governors across the country face significant challenges in their efforts to ensure the sustainability of health care programs amidst rapidly rising health care costs. Budget pressures created by increasing health care expenditures threaten the ability of states to invest adequately in education, public safety and other priorities while maintaining services provided by Medicaid and the Children’s Health Insurance Program (CHIP). Likewise, ever-increasing health care costs strain family budgets and burden businesses that are striving to grow and be competitive in a global marketplace.

To put these programs on a fiscally sustainable path, governors are increasingly exploring alternatives to the less desirable cost-cutting methods that involve reducing provider payments, limiting benefits and restricting coverage. State health programs are driving innovation in the delivery and payment of services by testing new models for health care transformation that aim to lower the trajectory of health care spending while improving quality and outcomes.

Realizing the full potential of these transformation efforts will require a new era of collaboration between states and their federal partners. Such an enhanced state-federal partnership is the key to providing states with the flexibility they need to develop, test and implement new models that support the shared goal of improving the quality and efficiency of Medicaid/CHIP.

The National Governors Association (NGA) launched the Health Care Sustainability Task Force (Task Force) to identify legislative and regulatory actions that the federal government can pursue to reduce barriers to innovation and further support state health care initiatives. Co-chaired by Tennessee Governor Bill Haslam and Oregon Governor John Kitzhaber, the Task Force is comprised of the following 10 governors with the immediate past leadership of the NGA Health and Human Services Committee serving as *ex-officio* members.

Governor Robert Bentley, Alabama	Governor Mike Beebe, Arkansas
Governor Jerry Brown, California	Governor Martin O’Malley, Maryland – <i>ex-officio</i>
Governor Brian Sandoval, Nevada – <i>ex-officio</i>	Governor Susana Martinez, New Mexico
Governor Andrew Cuomo, New York	Governor John Kitzhaber, Oregon – <i>co-chair</i>
Governor Dennis Daugaard, South Dakota	Governor Bill Haslam, Tennessee – <i>co-chair</i>
Governor Gary Herbert, Utah	Governor Peter Shumlin, Vermont

The Task Force staff advisory committee convened regularly from late May through November 2013. At the outset, staff identified principles that governors believe should serve as the foundation for state-federal efforts. These principles, detailed in section II of this report, provided a framework for the development of recommendations in four key areas:

- Federal Support of State Health Care Innovation
- Medicare-Medicaid Enrollees (Dual Eligibles)
- Long-Term Services and Supports
- Payment and Delivery Reform

The recommendations presented in section III of this report reflect the consensus view of the Task Force following several months of consideration, as well as meetings with officials from the U.S. Department of Health and Human Services. Although each recommendation addresses a specific challenge or obstacle currently facing states, the Task Force recognizes that there are several existing federal efforts underway to support state-driven health care initiatives. With this report, the Task Force seeks to broaden and increase the dialogue between governors and the federal government to achieve the shared state-federal goal of improving the quality and long-term viability of critical health care programs.

## II. Key Principles

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At the 2013 NGA Summer Meeting in Milwaukee, Wisconsin, governors adopted the following principles identified by the Task Force as the basis of state-federal efforts to control costs, enhance health care quality and improve population health.

- ***Financial Sustainability***  
Reduce the growth rate of Medicaid spending, adjusted for enrollment, without reducing eligibility or making changes that adversely affect the quality of care or the health of the population being served.
- ***Flexibility***  
Allow for flexibility to pursue delivery system changes that achieve the desired outcomes, provided that eligibility and benefits are not substantially changed.
- ***Federal Investment***  
Make necessary up-front federal investment in states so long as states can demonstrate a return on that investment in Medicaid and can leverage those efforts with multiple payers.
- ***Payment for Performance Outcomes***  
Shift from payment for procedures or encounters (volume) to a system of balanced incentives that rewards improvements in quality and costs (value), and that promotes transparency and accountability.
- ***Accountability and Transparency***  
Adopt common, objective quality measurements and transparent performance metrics for all payers, including Medicare.
- ***Multi-payer Strategy***  
Partner with Medicare and the private sector, including health care providers, health plans and employers to pursue health care reform efforts beyond Medicaid.

### **III. Federal Recommendations**

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#### **Federal Support of State Health Care Innovations**

##### **Background**

Governors are undertaking significant efforts to transform health care delivery by transitioning to value-based systems that reward quality and outcomes over volume. The federal government is supporting many of these initiatives, such as medical homes, accountable care organizations (ACOs) and bundled payments, by working with states as they submit Medicaid waivers and state plan amendments (SPAs).

States appreciate the work that the Centers for Medicare and Medicaid Services (CMS) has been doing to streamline and improve the waiver and SPA review processes, including creating online templates and efforts to make previously-approved SPAs publicly available and searchable. For many states, however, the current process of negotiating with CMS represents a significant barrier to state-led transformation initiatives. Although experiences vary, many states report that the waiver and SPA review process is complex, cumbersome and does not recognize the fundamental need for a broader set of reforms that go beyond benefit, fee schedule and eligibility changes. In addition, states are not permitted to make time-tested successful waivers a permanent part of their Medicaid programs.

While states recognize that it is difficult for CMS to standardize the review and approval of waivers, they believe steps can be taken to improve the state-federal negotiation process and strengthen federal support of state initiatives.

##### **Recommendations**

Governors stand ready to work with the federal government to implement the following recommendations for enhancing support of state health care innovations:

##### ***Flexibility***

- CMS should continue building on subregulatory guidance that provides guidelines and instructions for states to innovate within Medicaid/CHIP. For example, further guidance on flexibility in structuring Medicaid provisions related to health care delivery and payment models that are consistent with the state's health care marketplace, while aligned with the purpose and objectives of the Medicaid/CHIP programs, would be helpful. Additional information about this flexibility is imperative for state planning purposes.
- CMS and other federal partners should standardize and streamline the process of reviewing and approving state proposals to innovate in Medicaid/CHIP, including waivers and state plan amendments. Reasonable timelines for federal and state decision points and deliverables should be defined at the outset of these processes, including timelines for federal and state executive leadership status updates.
- To facilitate replication of best practices, CMS should identify and make available previously approved Medicaid state plan amendments and waivers and allow expedited processing of waivers granted in other states. Additionally, CMS should expedite the development of additional templates for waiver and state plan amendment requests that states can use through a web-based interface such as MACPro.

- CMS should develop a path to permanency for Medicaid waivers that have been shown to work effectively. This is especially the case for managed care waivers. CMS should also adopt a rapid cycle evaluation process for these waiver programs to allow for more timely learning and replication in other states. This process could be modeled after the current authority of the Health and Human Services (HHS) secretary to make permanent any Center for Medicare and Medicaid Innovation (CMMI) demonstration deemed successful.
- Congress should modify Section 1115 of the Social Security Act to modernize the application and usefulness of a Medicaid waiver. It should clarify that the purpose of a 1115 waiver is to:
  - Develop a program to “research or demonstrate” the effectiveness of a specific health care delivery or payment model; and
  - Allow a state Medicaid/CHIP program to participate in a broader, multi-payer health care transformation plan and to continue operation of such model once its effectiveness has been established.

### ***Federal Investment***

- HHS, in partnership with other federal agencies, should create a single point of entry for introducing, negotiating and processing state proposals that can innovate and transform state health care systems. A single point of entry is especially needed for proposals that involve a variety of federal health care programs and require approval from multiple federal entities outside Medicaid, such as Medicare, CMMI, the Center for Consumer Information and Insurance Oversight, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration and the Medicare-Medicaid Coordination Office.
- CMS should build on the Medicaid and CHIP learning collaboratives and technical assistance teams that inform states of best practices as they develop and implement their health care transformation plans. This includes work in the area of value-based purchasing and data analytics. Broader and transparent participation in the learning collaboratives should be encouraged, and dissemination of that work should be broader. CMS could be a more significant resource to states in this area.

### ***Accountability and Transparency***

- CMS should more clearly define parameters for state health care transformation proposals, including ways to streamline quality and other performance outcomes. A common set of evaluation measures could be used for both statewide transformation efforts as well as for smaller, more limited demonstrations.

### ***Multi-Payer Strategy***

- States should have the opportunity to apply for multi-payer payment reform demonstrations based on a state’s design and approach rather than being restricted to only CMS proposals. Instead of responding to a CMMI Funding Opportunity Announcement, CMS should allow states to come forward with proposals, and after appropriate vetting, allow for Medicare and Medicaid to participate in state-driven multi-payer models as well.

## Medicare-Medicaid Enrollees (Dual Eligibles)

### **Background**

Individuals who qualify for Medicare and Medicaid, referred to as dual eligibles, represent the most chronically ill segments of the populations covered by Medicare and Medicaid and account for a disproportionate share of state and federal spending for both programs. The care they receive is often fragmented or episodic, resulting in poor health outcomes, unnecessary spending and an inefficient system of care.

Recognizing these challenges, states are increasing their efforts to improve the coordination and quality of care for dual eligibles. Working with CMS, a number of states are implementing new models of care that improve service integration between the two programs and align payment for dual eligible beneficiaries. Many states are also using existing options, such as fully integrated Medicare dual-eligible special needs plans (D-SNPs) and the Program of All-Inclusive Care for the Elderly (PACE), to improve the coordination and quality of care for these populations.

Although the federal government seeks to partner with states in these efforts, federal policies may at times impede care coordination, limit access for beneficiaries and shift costs to Medicaid. For example, while there are initiatives underway (e.g., accountable care organizations) to provide coordinated care to Medicare beneficiaries, the federal government has not developed specific care management efforts for Medicare beneficiaries who are in the process of spending down personal assets to Medicaid eligibility levels. Among other challenges, states also have limited flexibility to develop and implement programs that meet the varying needs of the dual eligible population and reflect the unique circumstances within their states.

### **Recommendations**

Governors stand ready to work with the federal government to implement the following recommendations to improve the care of dual eligibles:

#### ***Flexibility***

- To support state interest in better aligning Medicare and Medicaid financing and improving care integration for dual eligibles, the Medicare-Medicaid Coordination Office should create a formal process and accompanying guidelines for states to pursue alternatives to the Financial Alignment Initiative (FAI), including but not limited to D-SNP demonstrations. CMS should establish an application process and set forth clear parameters for participation in advance.
- CMS should establish a work group with states to conduct a comprehensive review of existing options to serve dual eligibles and identify policy changes that would: (1) allow states to serve broader populations through these programs and (2) support states' ability to finance these programs through greater flexibility and shared savings. Such reforms could include granting states the ability to serve as Medicare administrators or to operate health plans, and establishing a new state plan option for states to pursue permanent integrated care models for dual eligible populations.

#### ***Accountability and Transparency***

- CMS should commission the National Committee for Quality Assurance to develop a standard set of performance measures around quality and access for all fully integrated programs and demonstrations

serving dual eligibles, including Fully Integrated Dual Eligible SNPs, PACE, Medicaid managed long-term services and supports (MLTSS) and FAI demonstrations. A common set of measures would facilitate program evaluation, enhance administrative efficiency and improve the ability of the public to compare programs.

### *Multi-Payer Strategy*

- Congress should permanently authorize fully integrated D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.<sup>1</sup>
- CMS should formally involve states in the D-SNP procurement and contracting processes to promote coordination of administrative services and health care benefits provided by Medicare and Medicaid. Moreover, at the discretion of each state, CMS should allow for three-way contracting between states, the federal government and D-SNPs. Prior to engaging in three-way contracting, CMS should provide states with a clear delineation of responsibilities and authorities for each party.<sup>2</sup>
- CMS should develop recommendations and policy options that support care management efforts (e.g., medical homes) designed to more effectively manage services for “pre-duals.” These efforts should include targeting high-cost Medicare beneficiaries with chronic conditions and functional impairments who are in the process of spending down personal assets to Medicaid eligibility, as well as low-income “partial duals” who are participating in the Medicare Savings Program financed through Medicaid. Such efforts should be designed to delay or prevent these Medicare beneficiaries from becoming prematurely eligible for Medicaid services.
- CMS should take the following actions to minimize cost-shifting from Medicare to Medicaid:
  - Require Medicare coverage of skilled nursing care after a hospitalization to be exhausted before Medicaid assumes responsibility. This policy is especially important to enforce with Medicare Advantage plans.
  - Streamline Medicare’s utilization review policy related to durable medical equipment and home health care, and amend the definition of “medical necessity” to align with Medicaid.
  - Improve Medicare’s mental health benefit to ensure full parity with other health services and align that benefit with state scope of practice laws so that Medicaid does not become the primary payer for these services.
- Building on current efforts, CMS should provide Medicaid agencies with electronic data submissions on Medicare expenditures and services, including pharmacy benefits, provided for dual eligible beneficiaries. Data submissions should be timely and presented in a format that states can readily analyze and interpret.

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<sup>1</sup> See also National Association of Medicaid Directors (NAMD), *Advancing Medicare and Medicaid Integration: Improving the D-SNP Model for Dually Eligible Beneficiaries*, September 2013, 12-13; and MedPac, *Report to Congress*, March 2013, 236-238.

<sup>2</sup> See also NAMD, 13-14.

## Long-Term Services and Supports

### **Background**

The current approach to paying for and delivering long-term services and supports (LTSS) in the United States places significant financial pressure on families and all levels of government while leaving many individuals without access to the coordinated, high-quality services on which they depend for daily living.

As the primary payer for these services, states are seeking solutions that will improve quality and coordination of LTSS while lowering the trajectory of spending for these services. Certain federal policies, however, limit state efforts to achieve these goals. For example, a major impediment for states in prioritizing home and community-based services (HCBS) is the restriction on the use of Medicaid funding for limited room and board costs in community-based residential alternatives. States also face barriers to using existing home and community-based LTSS options, such as the Balancing Incentive Program and the Money Follows the Person demonstration, and to investing in initiatives that result in savings to federal programs.

### **Recommendations**

Governors stand ready to work with the federal government to implement the following recommendations for LTSS:

#### ***Financial Sustainability***

- The federal government should work with states to establish a shared-risk/savings demonstration allowing states to test the use of multi-state compacts to enable portability of long-term care policies. Under the proposed demonstration, any potential reductions in public expenditures arising from a compact would be shared with participating states.<sup>3</sup>
- Congress should develop policies (e.g., tax exemptions, deductions and credits) to provide incentives for private payment of LTSS and/or family caregiving. Such policies could include establishing a tax-advantaged savings account to allow families and individuals with disabilities to save for qualified disability expenses such as health care, housing, transportation and employment support.
- Congress should encourage individuals with disabilities to participate in the labor force by authorizing a demonstration project to test the feasibility of providing LTSS to individuals with disabilities who choose to work. Such a demonstration should target workers with a severe disability whose income from work precludes Supplemental Security Income (SSI) or Social Security Disability Insurance eligibility. Workers enrolled in the demonstration would be subject to cost-sharing requirements for Medicaid LTSS benefits that wrap around individual coverage or employer-sponsored health benefits.<sup>4</sup>

#### ***Flexibility***

- CMS should streamline existing home and community-based LTSS options, such as the Balancing Incentive Program and the Money Follows the Person demonstration, into a permanent optional state plan benefit for

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<sup>3</sup> See also Commission on Long-Term Care, Report to Congress, September 2013, 79.

<sup>4</sup> See also Commission on Long-Term Care, 62.

states. In addition, the Balancing Incentives Program should be broadened so that more states are eligible to receive an enhanced federal financial participation (FFP) if they are able to increase the percentage of beneficiaries receiving HCBS.

- CMS should streamline the Medicaid waiver process for HCBS. Such an effort should include consolidating the waivers where possible, using a common set of quality measures across all HCBS waivers and simplifying the oversight and administration by streamlining reporting requirements.
- CMS should change “freedom of choice” requirements for Medicaid LTSS providers to default to HCBS so that an individual cannot be placed in an institution without being apprised of available HCBS alternatives and affirmatively choosing institutional placement. An individual would enroll in HCBS first absent extenuating circumstances.<sup>5</sup>

### ***Federal Investment***

- Congress should develop policies and clear methodologies to allow states to share in Medicare savings that accrue from states’ management of LTSS. Such policies should ensure that savings to the Medicare program concurrently accrue to a state Medicaid program to the extent that a state’s management of LTSS contributes to a reduction in Medicare spending. CMS should make administrative changes to implement these policies under existing statutory authority; and, if necessary, CMS should work with states to develop and present to Congress a legislative proposal giving the agency any additional legislative authority needed to implement these policies.
- In calculating budget neutrality for HCBS and other LTSS-related waivers, CMS and other federal partners should account for and allow states to share in savings to all federal programs, including vocational rehabilitation, Title V programs and the Ryan White HIV/AIDS program.
- Congress should enact legislation authorizing CMS to allow states to receive FFP for the provision of home and community-based services that reduce inpatient care and result in federal savings for non-Medicaid eligible individuals. If a state can demonstrate significant savings to the federal government, CMS should provide that state with the maximum FFP allowable for efforts to increase the use of lower-cost HCBS that achieve savings for the federal government. Such efforts could include providing HCBS that are designed to prevent or delay the spend-down of income and assets for seniors not eligible for Medicaid, but who are certified to receive skilled nursing care.
- Under its existing budgetary authority, CMS should permit FFP for limited room and board supplements in a community-based residential alternative setting, particularly for individuals with income at or below the SSI federal benefit rate.<sup>6</sup>
- To encourage individuals with disabilities to participate in the labor force, Congress should develop a limited Medicaid benefit through which state Medicaid agencies would have the option to pay for personal care attendants, transportation or other limited support services for individuals with disabilities and incomes up to 300 percent of the federal poverty level irrespective of level of care.

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<sup>5</sup> See also Patti Killingsworth, Testimony to the Commission on Long-Term Care, August 2013.

<sup>6</sup> Ibid.

### *Multi-Payer Strategy*

- CMS should provide site-neutral Medicare payment based on the service provided across post-acute and LTSS settings to reduce incentives for serving individuals in more costly settings. For example, CMS could go beyond the Bundled Payments for Care Improvement initiative to establish additional models for paying providers of post-acute care and LTSS that reflect the service provided rather than the site of care.<sup>7</sup>
- Congress should broaden the Medicare benefit for LTSS. As part of that effort, Congress should take the following actions:
  - Eliminate the requirement that Medicare pays for skilled nursing facility care only after a prior hospitalization lasting at least three days.
  - Eliminate the requirement that a Medicare beneficiary must be homebound to receive home health services.
  - Eliminate Medicare's in-the-home criterion for durable medical equipment (e.g., wheelchairs) to prevent Medicaid from becoming the primary payer.
- CMS should include the coordination of LTSS in their various Medicare delivery and payment initiatives, including medical homes, accountable care organizations (ACOs), the Bundled Payments for Care Improvement initiative and the Independence at Home Demonstration.
- To continue the important work of the Senate Commission on Long-Term Care, Congress should establish a bipartisan long-term care task force that includes governor representation.

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<sup>7</sup> See also Commission on Long-Term Care, 42.

## Payment and Delivery Reform

### **Background**

The share of the U.S. economy devoted to health care has grown substantially over the past 40 years, rising from 7.2 percent in 1970 to 17.9 percent in 2010.<sup>8</sup> Although the growth in health care spending has slowed in recent years, CMS projects that health spending will rise to represent nearly one-fifth of the national economy by 2022.<sup>9</sup>

This growth of health care spending and expansion of health insurance coverage are driving state efforts to implement payment and delivery system reforms that improve care quality and health outcomes while reducing expenditures for Medicaid/CHIP. These programs are now part of a continuum of health care coverage that includes state health insurance marketplaces and private sector coverage. This larger context offers the opportunity for states, working with the federal government and the private sector, to redesign the payment and delivery of services provided by Medicaid/CHIP and other programs.

The federal government has initiated several efforts to collaborate with states, most notably through the State Innovation Model (SIM) initiative and other demonstrations supported by the CMS Innovation Center. Certain federal policies, however, limit state-led transformation efforts. For example, the federal government does not adequately invest in and account for state initiatives that reduce federal spending, nor do federal programs such as Medicare participate sufficiently in state-led initiatives. In addition, federal policies with respect to health care workforce training are outdated and do not ensure the supply of health professionals needed to support delivery system transformation.

### **Recommendations**

Governors stand ready to work with the federal government to implement the following recommendations for payment and delivery reform:

#### ***Financial Sustainability***

- Congress should enact legislation giving states the option to pursue and test flexible payment and delivery transformation initiatives, including models that are not explicitly authorized in statute, under a sustainable budget arrangement. Congress should establish clear parameters for states to undertake such initiatives and allow states to realize a return on their investment by sharing in federal savings that accrue as a result of proven state health care transformation.

#### ***Flexibility***

- As mentioned in the context of federal support of state health care innovation, and especially as it applies to payment and delivery reforms, CMS should establish a streamlined negotiation process with a single point of entry for states pursuing the authority to develop and implement new initiatives.

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<sup>8</sup> Kaiser Family Foundation, *Health Care Costs: A Primer* (Washington, DC: Kaiser Family Foundation, 2012), 1, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf> (accessed December 11, 2013).

<sup>9</sup> U.S. Department of Health and Human Services, "National Health Expenditures Projections 2012-2022," Forecast Summary (Washington, DC: Centers for Medicare and Medicaid Services Office of the Actuary, 2012), 1, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf> (accessed December 11, 2013).

- CMS should work with states participating in the SIM initiative to replace the current preponderance-of-care requirement with achievable goals tailored to the unique circumstances of each state. For example, states should have the option to focus on specific geographic regions or take a statewide approach.

### ***Federal Investment***

- Congress should develop additional financial incentives that allow states to share in federal Medicare and Medicaid savings due to state health care transformation initiatives. As part of that effort, Congress should:
  - Allow states to receive increased Medicaid FFP for implementation of Integrated Care Models (e.g., health homes and Medicaid ACOs) that result in federal savings; and
  - Provide up-front federal investment to states with appropriate safeguards and accountability requirements to support transformation initiatives that demonstrate savings to Medicare and Medicaid over a 10-year budget window.
- In calculating budget neutrality or return on investment for state health care innovation proposals, CMS and the Office of Management and Budget should account for savings outside the Medicaid program, such as those resulting from decreased spending for Medicare, the Federal Employee Health Benefit Program, the Veterans Health Administration and federal subsidies for consumers purchasing coverage through a health care marketplace.
- Congress should require CMS to provide states with flexibility to use federal funds for initiatives that improve patient outcomes and lower health care spending (e.g., allow states to use Title V funding for children’s oral health care or supportive housing services). Congress also should direct HHS to establish an inter-agency working group with state participation to develop a comprehensive list of ways states could redirect federal funding to support reduced spending and improve quality.
- Congress should establish a federal health care workforce commission with state representation to facilitate health care delivery and payment reforms by:
  - Examining current federal spending for workforce training and recommending specific federal legislative and regulatory policy changes needed to ensure states have an adequate supply and a proper mix of health care professionals (e.g., shifting federal support for graduate medical education from specialty to primary care); and
  - Developing legislative and regulatory proposals to align Medicaid and Medicare payment policies within state scope of practice laws.

### ***Accountability and Transparency***

- To promote health care price transparency, Congress should require CMS to build on its quality comparison websites to include pricing data as well as quality data for the top 10 categories of Medicare and Medicaid providers. Additionally, Congress should authorize and direct CMS to require that health plans (e.g., Medicare Advantage and Qualified Health Plans) publicly release provider payment data for publication on the agency’s websites.

### ***Multi-Payer Strategy***

- HHS should work with governors to identify strategies for developing statewide and regional multi-payer initiatives that support the ability of providers to migrate to an alternative value-based payment system. Such

groups should develop a demonstration program that brings together health plans, providers, employers, Medicare and state Medicaid programs to:

- Allow networks of providers to assume risk for the provision of care for all or most of their patients; and
- Develop unified quality and reporting requirements to help ensure quality of care and provider accountability.