

October 9, 2015

Victoria Wachino, Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Dear Ms. Wachino:

As the Ranking Republican Member of the Health Care & Wellness Committee in the Washington State House of Representatives, I would like to comment on the Washington State Medicaid Transformation Waiver. I am in opposition of granting this waiver for the following reasons.

There is nothing in the waiver description or the concept paper that would encourage any behavior change towards one's health. If there is no buy-in by the person covered, all the healthcare services rendered will not be effective.

There is an assumption being made in the overall concept of the waiver that a shift in expenditures will reduce overall spending in healthcare. There is no reduction of spending but a shift in where money will be spent.

I believe that this will obligate the state to more spending down the road when the waiver has expired and obligations such as maintenance of effort will take effect. Of course there is no mention of maintenance of effort anywhere but that seems to show up as another obligation for the state of Washington.

The Managed Care Organizations (MCOs) which will be expected to manage and deliver care have several concerns. They will be asked to "reform delivery". What exactly does this mean? This is just one example of many ambiguous terms and ideas in the waiver application. The negotiations of this waiver will take place behind closed doors with no input by those who will be expected to carry out agreed upon directives decided by CMS and the Health Care Authority. The MCOs are also concerned about the roles that the Accountable Communities of Health (ACH) will have over future contracts.

The following comments relate to the Concept Paper – Global Medicaid Transformation Waiver.

While the definition of a Health System includes medical, mental health, substance abuse disorder, and long term care services, it also includes other services such as housing and employment. This is under the umbrella of a “transformed system”. This would be a further obligation taken on by the state taxpayer under the disguise of improved health.

On page 17 of the Washington State Medicaid Transformation Waiver Application, (Waiver Application), “Through the Demonstration Washington will develop criteria to target supportive housing and supported employment services to Medicaid beneficiaries who are most likely to benefit from the service.”

On page 23 of the Waiver Application, “whether the provision of foundational community supports – supportive housing and supported employment - will improve health outcomes and reduce costs for a targeted subset of the Medicaid population.”

The payment reform that is proposed in the concept paper will make a goal of having 80 percent of payments to providers to be on the value based continuum by 2020. If there is going to be a move from the current system, are doctors, hospitals and other providers willing to take on the risk with the value based payment?

On page 45 of the Waiver Application, under Value Based Payments, “In general, managed care payments will be consistent with the State Plan. However, transformation projects will drive movement from traditional fee-for-service-based provider payments toward reengineered payment systems in which there is increasing financial risk for health care and outcomes across a continuum of care and across different parts of the health system. ACHs will maximize the value-based payment effect by bringing to bear the impact of community service linkages on measurable health system outcomes.”

Risk shifting will happen with no input from those whom take on the risk.

The basis of savings to CMS 1991-1993 biennium to 2013-2015 is from moving patients out of skilled nursing homes which was 82 percent of the nursing home spending in 91-93 down to 38 percent in 13-15. By moving people into community based settings there has been significant savings to the Federal government of about \$5.8 billion. There will be a bigger push to keep even more patients in lower cost settings and I suspect a much higher acuity level of patients in a lower level care facility. Which may not be appropriate care levels for the patient’s needs.

“Each Accountable Communities of Health will provide critical real time information to the State and participating members including managed care systems, to identify local area gaps, needs and priorities, and facilitate improved coordination and delivery of Medicaid services.” I would read this to mean they will be they will have a lot of influence on managed care companies and wonder if that would mean who gets contracts for managed services. It also means that there will have to be permanent employees to do reporting and other paperwork. I view this as an expansion of government because of the reporting and tracking requirements that will be undoubtedly required will have to be reported.

“ACHs members will be asked to co-invest in the evidence based interventions with a 10 percent share of costs by year 3 and a 50 percent share of costs by year 5. Each ACH will be expected to design a shared contribution schedule that aligns with the level of gain or benefit from Delivery System Reform Incentive Payments financed transformation activities”. The ACHs have not indicated how this investment will be accomplished. How is this going to be funded?

Non-Federal Share. *“to access federal funding for delivery system transformation, the state will be expected to fund the non-federal share, meaning it must match any federal investment with a equal state or local share. This is significant because it determines the amount of funding the state can receive to finance transformational activities.”* This will mean state taxpayer money for this grand experiment.

There is no description as to how the money will flow to the ACHs or any accountability of where that taxpayer money goes and how it will be used. This is another example of ambiguous concepts used throughout the waiver with few details.

Another issue is that there is no specific definition of savings – other than a general statement of how this will decrease overall health care spending. This has not been identified. Who will determine what savings have happened, the amount of savings that occurred and who has attributed or deserves credit for this savings?

While all this work is being done with the intent or goal to save money to the taxpayer, the waiver is shifting expenditures into different areas and has no overall savings.

Based on these comments and concerns, I oppose the granting of this waiver by the Centers for Medicare and Medicaid Services (CMS).

Sincerely,

Joe Schmick
State Representative
9th Legislative District