Strategies used by states
Maximizing federal funds
Use the State Plan to maximize the reach of Medicaid

1. Expand the adult population under ACA – 90% FFP for all covered services (minimum benefit = Essential Health Benefits) for newly eligible adults up to 138% FPL

2. Add coverable services to Medicaid benefit package: ACT, health homes, 1915(i) option; lift artificial utilization restrictions; achieve BH parity with med/surg, peer supports

3. Increase provider reimbursement rates – provider taxes one way to “self-finance” for some provider types; transfer from DCF another

Brings new federal funding to state: no federal cap, no budget neutrality tests.
Take full advantage of MCO flexibilities

1. “In lieu of” or “downward substitution” services allows capitated MCOs to pay for non-state plan, cost effective settings/services as an alternative to covered settings and services
   • Includes the ability to use short stay (no more than 15 days) IMD services as an alternative to inpatient BH treatment, CSUs

2. MCOs also can change patterns of service utilization across covered services (reduce use of institutional services, encourage utilization of community based services, spend more on BH to reduce spending on physical health care, etc.)

Doesn’t increase overall federal revenue to FL, but can move funds to BH system, including to services not otherwise covered by Medicaid.
Demonstration waivers: Section 1115

• When a state wants to spend federal Medicaid funds in a way not otherwise allowed
  • For people not otherwise eligible
  • For services not otherwise eligible
  • In a delivery system approach that doesn’t follow all the Medicaid requirements (statewideness, comparability, free choice of provider, use of alternative payment models, etc.)

• Secretary may waive many (but not all) provisions of Medicaid requirements or provide expenditure authority not otherwise allowed

• Negotiated “terms and conditions” govern the agreement (3-5 years)
Demonstration waivers are at Secretary’s discretion

• Must advance the purpose of the program (as interpreted by the Secretary)

• Must meet a test of *budget neutrality* for the federal government over the period of the demonstration

• Requires an evaluation and public reporting on progress toward explicit demonstration goals and compliance with terms and conditions

Additional expenditure authority is generally linked to achieving the demonstration’s goals.
The way “rev max” works under Section 1115:

- States negotiate to get new federal Medicaid funds, matching other state or local dollars spent on “designated” non-Medicaid services or people.

- States negotiate to use new federal funds to invest in specific Medicaid program improvements:
  - NOT just to offset state or local GR (to finance status quo)
  - NOT just to finance non-Medicaid activities or improvements

- Federal “budget neutrality” (i.e., offset the cost of new federal matching arrangements) through overall reductions in Medicaid program costs over the course of the demonstration period.

- New federal matching arrangements are time limited to the demo period.
Section 1115 examples
A recent history of Section 1115

• 1990s and 2000s – generally focused on using *managed care* (a waiver of free choice, statewideness, etc.) and *covering the uninsured* or assuring access for uninsured

• After ACA – the focus shifted to supporting *fundamental delivery system reform* to promote *accountable systems of care*
  • To experiment with *alternative payment models (value based)*
  • To achieve *full integration* across physical, behavioral and LTSS
  • To improve care/outcomes/costs for *high need populations*
  • To begin to address *social determinants* of health
Oregon: Health System Transformation

• In 2012, established **Designated State Health Programs (DSHP)** initiative to bring new federal dollars to support system reform – creating local Coordinated Care Organizations (CCOs)
  • Federal expenditure authority for state funded services for “Medicaid-like people or services” not otherwise Medicaid coverable
  • Including regional acute psychiatric inpatient, residential treatment (youth), community crisis, supported employment, homelessness services, etc.

• Terms and conditions: if demonstration goals on **quality measures and rate of growth** not realized, **penalties** assessed against next year’s DSHP claim; cannot be renewed, extended beyond 6/30/2017

• **New federal funds** earned on DSHP **invested in reform** (create primary care homes, provide TA, fund incentive payment pool)
Virginia: Governor’s Access Plan, SUD/IMD

- Governor’s Access Plan (GAP) 2014
  - *Expand access to health care* for people with significant behavioral and medical needs;
  - Ages 21-64, SMI criteria, uninsured, below 65% FPL, in community
  - Entitled to *limited health and behavioral health benefit package* (no inpatient, etc.)
  - Goals – improve access, integration and outcomes for health and behavioral health; reduce use of ED; reduce Social Security Disability Determinations; reduce interactions with criminal justice system

- Addiction and Recovery Treatment Services Delivery System Transformation 2015
  - Response to July 27, 2015 State Medicaid Director letter: call for demos
  - Adopts American Society of Addiction Medicine (ASAM) standards of care and provider qualifications
  - Promotes integration of physical care and full continuum of SUD services and supports
  - Expenditure authority for residential SUD treatment services in ASAM-compliant IMDS
California: A Bridge to Reform 2012

- Created public hospital system Delivery System Reform Incentive Payment (DSRIP) program within the Safety Net Care Pool; specific financial penalties for failure to achieve specific goals;
- DSRIP funded by federal expenditure authority for non-Medicaid programs (children services, AIDS Drug Assistance Program, county MH services, etc.)
- DSRIP incentives paid for Infrastructure development, development of medical homes and other practice transformation, incentives for improved population/disease specific outcomes
Florida: Managed Medical Assistance (MMA)

• In 2011, Governor Rick Scott signed legislation to implement Statewide Medicaid Managed Care (SMMC); two components
  • Long-term Care (LTC) program (1915 b/c waiver)
  • Managed Medical Assistance (MMA) program (1115 waiver)
• In 2013, Medicaid Reform Waiver amended to rename MMA program and expand managed care statewide
• Provides primary care, acute care, dental care, and behavioral health
• Key components of the MMA program include: choice counseling, competitive procurement of plans, customized benefit packages, healthy behavior programs, risk-adjusted premiums based on health status
Florida: Managed Medical Assistance (MMA)

• Waiver continued use of IGT (from an earlier waiver) to provide Low Income Pool (LIP) to support access to hospitals for uninsured

• 2016 - amended MMA waiver to include pilot program to provide additional behavioral health services and supportive housing assistance services for adults with SMI, SUD or co-occurring, who are homeless or at risk of homelessness
  • These are flexible services that could have been added, statewide, under a State Plan Amendment; waiver needed to do a regional pilot in Regions 5 and 7

• 2017 - extension MMA waiver requested for the 3 year period July 1, 2017 through June 30, 2020.
A changing environment

A new Administration in Washington
Implications of possible Federal block grants on revenue maximization

• Federal Medicaid financing no longer an unlimited entitlement

• Traditional block grants cap total federal financing (a prior year used as base year) and limit any new federal funding growth to explicit Congressional appropriations or a pre-established fixed or indexed rate. State actions cannot grow federal funding.

• Per capita caps (a prior year used as base year) limit federal funding growth on a per enrollee basis instead of in aggregate, as above. Total federal financing would be impacted by number of people covered and by the mix of people covered (children, adults, elderly or disabled). Otherwise, state actions cannot grow federal funding.
Why Would a State Accept Block Grants or Per Capita Spending Caps?

• **Flexibility** – many federal requirements would no longer apply

• **States might change:**
  • Benefits, eligibility, payment rates/approaches
  • Personal responsibility
    • Require higher copayments or premiums on working adults, elderly or persons with disabilities; add copayments for children
    • Impose work requirements, “personal responsibility” or “healthy behavior” conditions not currently allowed

• **But Note:** Prior block grant proposals enacted by Congress have not eliminated all Federal program requirements.
  • For example, when the TANF block grant was created, maintenance of effort and Federal work requirements were among the “strings” left in place.
Keep in mind: most of Medicaid spending is for elderly and disabled populations.

Elderly, Blind and Disabled population is 22.47% of enrollment and drives 61.3% of expenditures.
Implications for Section 1115 waivers?

• Short term:
  • New administration may have an openness to some program flexibilities that Obama administration rejected (conditioning Medicaid on employment activities; enforceable premiums and cost sharing for individuals below poverty; others)
  • Likely will see use of Section 1115 to experiment with block grant or per capita cap reform strategies (VT, RI, OR have experimented with versions of this under Section 1115 already)

• Longer term:
  • If Congress adopts a block grant, will Section 1115 waivers be relevant or needed? Available?
Does Changing Environment = “Wait and See”? 

• NO 

• Instead: makes it more important to have a clear set of goals, an understanding of where and how the delivery and financing system could be improved, and to know your own business 

You want to be at the table, with your ideas on the table, so you can help shape the new environment
State-identified options for revenue maximization in SMI/SUD system
State Report on Revenue Max

Four types of options were explored:

1. Options that “free up” GR through program changes that allow state to draw down federal Medicaid match

2. Options that re-direct “freed-up” general revenue to provider payment and/or incentive programs

3. Options that use existing GR expenditures to draw down federal funds to be used for system transformations (DSHP & DSRIP)

4. Options that bring new funding into the system
State Report on Revenue Max

Nine individual options:

1. Seeking Medicaid Eligibility for People with SMI and/or SUD (1115 or 1915(c) waiver)

2. Covering Targeted Case Management and Other Services as Medicaid-Funded Services for People with SUDs (SPA or 1115 waiver)

3. Eliminate current limits on certain Medicaid covered behavioral health services (SPA or 1115 waiver)

4. Add Medicaid coverage of certain services for the SMI/SUD population (1115 waiver)
State Report on Revenue Max

5. Increase the Capitation Rate for Medicaid Enrollees with Chronic Mental Illness and Substance Use Disorders (unknown)*

6. Increase Reimbursement Rates for Behavioral Health Services (unknown)

7. Make Supplemental Payments to Providers using Designated State Health Program (DSHP) (1115 waiver)*

8. Implement Innovative Programs to Provide Incentives for Improved Outcomes for Behavioral Health Conditions (1115 waiver)*

9. Make Supplemental Payments to Providers using IGTs or CPEs (unknown)*

*Could be performance based strategies
1. Seeking Medicaid Eligibility for People with SMI and/or SUD Populations
   • Age 21 and older
   • Non-pregnant, non-Medicare, non-Medicaid eligible
   • Income at 100% FPL or below
   • DCF funds used to provide state match for both behavioral health and physical health care benefits
   • Likely delivered through MMA system
   • Consider using 1915c and i as alternative to 1115?
Impact

• Demonstration for SMI/SUD
  • Pros:
    • Positive impact on health care outcomes for beneficiaries in the demonstration
    • May have a positive impact on state DSH and county funds for inpatient services
    • Additional revenues for BH providers for beneficiaries in the demo
  • Disadvantages:
    • Costs for all individuals with SMI/SUD would most likely exceed available SGR
    • Significant portion of current state DCF funds would be needed for other health care services
    • Likely the dollars would be transferred from DCF to ACHA. MMAs would be responsible for managing these individuals—unlikely state or CMS would be comfortable with FFS only
State Report: Use Section 1115 Waiver

1. (continued) Limited demonstration for a smaller sub-set of individuals
   • Subpopulations
     • Mothers of substance-exposed newborns, up to 3 years of full Medicaid coverage, or
     • Uninsured parents/caretakers of children in child welfare system, if parents have SMI/SUD (estimated 27,000)
   • Services delivered through MMA plan
   • DCF funding provides state match for behavioral and medical services
1. (continued) Limited demonstration for a smaller sub-set of individuals
   • Subpopulations
     • Mothers of substance-exposed newborns, up to 3 years of full Medicaid coverage, or
     • Uninsured parents/caretakers of children in child welfare system, if parents have
       SMI/SUD (estimated 27,000)
   • Services delivered through MMA plan
   • DCF funding provides state match for behavioral and medical services
Impact

- Limited Demonstration
  - Pros:
    - Positive impact on health care outcomes for beneficiaries in the demonstration
    - More targeted group for demonstration may be affordable
    - Additional revenues for BH providers for beneficiaries in the demo
  - Disadvantages:
    - Significant portion of current state DCF funds would be needed for other health care services
    - A significant number of individuals with SMI and/or SUD would not receive needed benefits
    - Likely the dollars would be transferred from DCF to ACHA. MMAs would be responsible for managing these individuals—unlikely state or CMS would be comfortable with FFS only
State Report: Use the State Plan

2. Covering Targeted Case Management for SUD for Medicaid population
   - Delivered through MMA or ME
   - Could require MMA to subcontract with MEs
   - Identify targeted population (how narrow or wide)
   - Identify qualifications of provider network
   - May need an 1115 if capped TCM participation
Impact

Targeted Case Management:

• Pros:
  • Little if any impact on current Medicaid beneficiaries getting DCF funded case management (CM)
  • Additional Medicaid beneficiaries could receive TCM that are not currently getting DCF funded CM
  • Provider qualifications could largely limit the TCM providers to current DCF CM
  • Opportunities for MEs to develop better care management capacity (internally and/or within network)
  • DCF funds could be retained in system versus transferred to ACHA

• Disadvantages:
  • TCM activities could be more narrowly defined than DCF CM activities
  • ACHA or plans may impose treatment limitations for TCM that don’t exist for DCF CM
  • Reimbursement rates for TCM may be less than current DCF reimbursement rates
  • Providers may have additional documentation requirements under Medicaid
  • CMS may not approve caps on services
3. Eliminate current limits on certain Medicaid covered behavioral health services
   • May need to address this given Medicaid parity rule
   • Delivered through MMA through existing arrangements
Impact

• Remove Limitations
  • Pros:
    • Medicaid beneficiaries may experience better care if they receive additional services
    • May lessen administrative burden on providers to track limits or request authorization for additional units
    • May address some issues regarding parity
  • Disadvantages:
    • Expenditures for these services are less predictable—may exceed DCF match projections
    • Possible DCF revenues would be transferred to ACHA to increase MMA rates
State Report: Use the State Plan or 1115

4. Add any coverable SMI/SUD DCF-covered services to the Medicaid benefit (further offset current DCF spending on Medicaid beneficiaries)
   • Could be added to state plan and delivered through MEs or possibly MMA
   • Might use Section 1915 (i): State Plan home and community based services to provide these services to a targeted sub-set of population
   • Might use Section 1915(c) waiver to target those with hospital or NF LOC
   • May need 1115 authority for certain services and/or limitations (like caps)
Impact

• Adding Coverable DCF Services to State plan
  • Pros:
    • No adverse impact on current consumers receiving these DCF funded services
    • Increase access to these services by current Medicaid beneficiaries who need but do not receive DCF funded services
    • Would provide additional Medicaid revenue for providers who currently render DCF services
    • Medicaid beneficiaries may have more choices regarding providers
  • Disadvantages
    • Medicaid provider qualifications may increase the number of providers who can render these services—wouldn’t be limited to existing pool
    • Service activities could be more narrowly defined than current DCF activities
    • ACHA or plans may impose treatment limitations for services that don’t exist for DCF services
    • Reimbursement rates for services may be less than current DCF reimbursement rates
    • Providers may have additional documentation requirements under Medicaid
    • May require a transfer of DCF funds to ACHA for MMAs
    • If included in MMA plans—MEs role for these services would be limited to non-Medicaid beneficiaries
    • Expenditures for these services are less predictable—may exceed DCF match projections
5. Increase the Capitation Rate for Medicaid Enrollees
   - Identify which service rates to increase (select services or all)
   - Could be tied to a pay for a pay for performance strategy—which could be managed by ME
Impact

• Increasing Capitation Rates
  • Pros:
    • Increases revenues for existing Medicaid providers
    • No adverse impact on current Medicaid beneficiaries receiving services
  • Disadvantages
    • Better rates may attract additional organizations to become Medicaid providers
    • May require a transfer of DCF funds to ACHA for MMAs
    • May not have a significant impact on increasing the number of beneficiaries that will receive these services
State Report: Use the State Plan

6. Increase rates for SMI/SUD providers
   • Identify which service rates to increase (select services or all?)
   • May require state plan change
State Report: Use 1115 Demonstration Waiver

7. Make Supplemental Payments to Providers using Designated State Health Program
   • Identify a pay for performance strategy
   • Identify which outcomes to incentivize
   • MMA could contract with ME to implement strategy
Impact

• Pros:
  • Would likely improve health outcomes for individuals with SMI and SUD
  • Would increase provider reimbursement
  • May be an attractive option to CMS

• Cons:
  • All provider may not earn incentive payment
  • Additional reporting requirements for MEs and/or providers
  • Long lengths of time for approval from CMS and implementation
8. Implement Innovative Programs to Provide Incentives for Improved Outcomes for Behavioral Health Conditions (focus on Health Homes)
   • MMA contract with MEs for additional care coordination
   • MEs contract with health homes, with additional funding for new health home services (might include refinancing some existing DCF services for Medicaid beneficiaries)
   • Enhanced match available for 8 quarters for health home services; only regulation match rate in later quarters
   • If using DSRIP will require an 1115 Waiver
   • Would allow for significant system transformation under DSRIP
Impact

• Innovative Programs
  • Pros:
    • Would likely improve health outcomes for individuals with SMI and SUD
    • Would enhance the care coordination capacity within BH systems
    • Would initially require less state match for 2 years (10 versus 40%)
    • Would delegate care management responsibility from MMA to BH system
    • Would allow funds for system transformation not generally coverable under state plan
  • Disadvantages:
    • ME and/or provider may have to assume risk if health home payment is capped (case rate or capitation).
    • Additional reporting requirements for MEs and/or providers
    • Enhanced match is temporary—state would need to find revenues for match in two years
    • Long lengths of time for approval from CMS and implementation
State Report: State Plan or 1115

9. Make Supplemental Payments to Providers—Three different Strategies
   • Intergovernmental Transfers
   • Certified Public Expenditures
   • Designated State Health Plans
Impact

• Supplemental Payments
  • Pros:
    • Would increase revenues to providers
    • May have a positive impact on health outcomes for Medicaid beneficiaries (depending on which vehicle used (CPEs vs. DSHP))
  • Cons
    • Significant CMS oversight and reporting on several options (IGT)
Options for Florida SMI/SUD System
Targeted populations, services?

• From providers: use current DCF GRF for non-Medicaid population, non-Medicaid services to leverage rev max

• Consider eligibility expansion for targeted benefits

• From DCF: priorities include parents of children at risk of out of home placement; mothers of newborns who are substance exposed; top 15% (by cost) of SMI/SUD population in current Medicaid MCO arrangements; more timely access for children in CW system
Constraints for reform in Florida?

- Legislature doesn’t support expansion of entitlement to Medicaid
- Providers, MEs want to assure that funds gained from rev max stay in BH system
- DCF prefers strategies that don’t transfer GR from DCF to AHCA (loss of engagement and direction)
- CMS doesn’t support use of Section 1115 for status quo rev max
- Governor may want a block grant under a waiver
- Really hard to get data to price out reform options
Short term goals and long term goals for SMI/SUD

• Short term: protect current revenue, offset any GR cuts to DCF (SMI/SUD)

• Long term: more effective system to support sustainable physical and behavioral health coverage, improve population outcomes

• Overall: How best to serve patient needs?
  How best to mitigate the disruption to state funded services
  How best to preserve (recreate) the system of care

• Goals drive the strategy, including what Medicaid authorities to use
<table>
<thead>
<tr>
<th>Goal</th>
<th>State Plan</th>
<th>MCO Flexibility</th>
<th>1115 Waiver</th>
<th>Funding Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – Offset GRF loss</td>
<td>X (benefits, rates, admin claiming)</td>
<td>X (increase use of com’ty services, including crisis, allowable residential)</td>
<td></td>
<td>New federal funds for existing Medicaid population could perhaps offset loss of some BH GRF needed to support increased capitation rates; state would need to mandate minimum payment rates if rates increased</td>
</tr>
<tr>
<td>B – Expand access to broadened benefit package for uninsured</td>
<td>X (adult expansion under ACA)</td>
<td>X (targeted expansion proposal)</td>
<td></td>
<td>Could be managed via MCOs (requires GRF to fund new enrollee cap rates) or through stand-alone using DCF GRF; adult expansion under ACA requires less GRF; 1115 strategy would have to protect GRF for non-Medicaid coverable services</td>
</tr>
<tr>
<td>C – Increase funding to provider system</td>
<td>X (rates, benefits, admin claiming)</td>
<td>X</td>
<td></td>
<td>Transfer BH GRF to AHCA to support increased cap rates, etc; state mandates minimum payment rates; need to protect GRF for non-Medicaid coverable services</td>
</tr>
<tr>
<td>D – Alternative delivery model or service design, current populations;</td>
<td>X (health home)</td>
<td>X (amend 1115 waiver; 1915(b) waiver; IMD reforms)</td>
<td></td>
<td>Amend state’s approach to BH population to have MEs provide comprehensive, integrated services; adopt health home model; seek IMD reforms</td>
</tr>
</tbody>
</table>
Short Term—Recommended reform #1

• Pursue state plan changes to lift current artificial limits on Medicaid service units for Medicaid beneficiaries
  • Assessment
  • Case management
  • Day treatment
  • Group and individual therapy

• Strategy is to eliminate service limitations to maximize federal support for existing Medicaid services
Short Term--Recommended reform #2

• Add Medicaid coverage of certain services for Medicaid-eligible SMI/SUD populations
  • TCM for SUD-only population
  • Crisis stabilization
  • Supportive housing, supportive employment
  • Residential detox, residential services (non-IMD)

• Strategy is to maximize Medicaid support for currently-offered SMI/SUD services otherwise paid with DCF GR
Short Term-- Recommended reform #3

- Increase reimbursement rates for BH services
  - Savings from drawing down federal dollars to fund services previously funded by 100% GR could be re-allocated to increase reimbursement rates for providers under Medicaid or the MEs.
  - Could require MMA plans to contract with MEs and provide incentive payments.
- Strategy is to draw additional federal match against increased Medicaid reimbursement for SMI/SUD providers and assure more adequate Medicaid rates
Long Term – Recommended reform #4

• Implement health home state plan option for SMI/SUD population
  • Enhanced federal matching funds (90%) for health home services for first 8 quarters
  • Enhanced funds could be invested in health home practice transformation
  • Health home payments could be reimbursed outside of MMA structure

• Strategy is to use new federal option (if it survives ACA repeal efforts) to create a model that supports integration of physical and behavioral health services within the SMI/SUD system

• Potentially a component of #2, but might take longer to negotiate and implement that other benefit additions
Long Term – Recommended reform #5

• Pursue a Section 1115 waiver amendment to achieve improved outcomes for top 15% of Medicaid MMA enrollees (by cost) who have MH/SUD conditions
  • Redesign Medicaid benefit to expand coverage and lift limits (#1 and #2 above)
  • Create a Designated State Health Program (DSHP) from (time limited) new federal match on current DCF spending for non-Medicaid populations;
  • Use DSHP funds to invest in developing the capacity of MEs to provide specialty care management for high cost, complex SMI/SUD populations and to reward providers for improved outcomes/lower overall costs
  • Possibly target expansion to high priority populations (e.g., parents of children in child welfare, mothers of substance exposed newborns, etc.)

• Strategy is to use one-time federal dollars from DSHP to improve DCF system performance and sustainability over time and to maximize on-going federal revenue through Medicaid
Section 1332 Innovation Waivers
Section 1332: State Innovation Waivers*

1. Authorizes states to develop new approaches to deliver health reform. States can request a waiver from many of the ACA’s requirements related to private health insurance, including those concerning covered benefits, subsidies, the marketplaces, and the individual and employer mandates.

2. The waiver must ensure coverage is at least as comprehensive and affordable as the ACA, must cover a comparable number of residents, and can’t add to the federal deficit.

3. The waivers are available beginning January 1, 2017 and approved for five-year periods, and can be renewed.

4. While section 1332 gives states flexibility over the ACA’s private coverage provisions, it does not create new waiver opportunities for public coverage programs.

5. States that wish to modify its Medicaid program must seek permission using a so-called section 1115 waiver, which federal officials will evaluate independently of any changes the state might propose under section 1332.

*This is an ACA provision and may be repealed
Section 1332: Authorizes waivers of four components of the ACA

1. **Individual Mandate** - States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health coverage

2. **Employer Mandate** - States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable coverage to their full-time employees

3. **Benefits and Subsidies** - States may modify the rules governing covered benefits and subsidies (premium credits, cost-sharing reductions)

4. **Exchanges and QHPs** - States can modify or eliminate QHP certification and the Exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage
Section 1332: State Waivers

1. The first three state 1332 waivers focused on small group market reform (Hawaii, Massachusetts, Vermont)

2. California filed a waiver (Sept. 2016) that seeks to provide unsubsidized health plans to undocumented individuals.

3. Super Waivers - The possibility of combining section 1332 changes with 1115 waiver authority would provide states with the opportunity to significantly alter the coverage arrangements available to their residents, particularly the low-income, vulnerable populations traditionally served by Medicaid.

4. States are currently thinking about broader use of a 1332 waiver, and we expect that the next Administration will consider broadening state flexibility.
FL Gov. Scott Letter to Representative McCarthy
Suggestions for ACA replacement – January 6, 2017

**Health Insurance**

1. Repeal the individual and employer mandates, allowing people to choose to deposit funds into a health savings account instead of giving the money to an insurance company
2. Allow insurance companies to sell across state lines, and allow for more competition in the marketplace
3. Allow greater flexibility in the design of benefit packages, so people can choose the benefit package that best meets their needs
4. Families should be able to choose one insurance plan that works for the entire family, and not be forced to put their children into different plans than their parents.

**Medicaid**

5. Flexibility using managed care model – per capita rate cells annually reviewed, and report on nationally recognized quality metrics
6. Repeal burdensome regulations, including the Managed Care Rule, the Access Rule and the Outpatient Drug Rule
7. Advanced review and meaningful input into all future proposed Medicaid guidance and regulation
8. Create a predictable path to permanence for Florida’s 1115 waiver and eliminate wasted administrative resources on constant negotiation and re-negotiation
9. Utilize 90-10 match for the most vulnerable populations, incentivizing states to expand home and community-based services
10. Realign the methodology for calculating Medicare Part B premium cost of living adjustments that have resulted in a disproportionate burden on states