What Are States Doing About Medicaid Innovation?

2018 APPD Spring Roundtable

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April 14, 2018

manatt

Overview of Today's Agenda

I. Update on the Federal Legislative Landscape

- Recent Efforts to Legislatively Alter the Medicaid Program
- Delay in DSH Reductions

II. Increasing Administrative and State-Based Focus on Medicaid

- Recent Fee-For-Service Medicaid Access Rule
- Anticipated Changes to "Public Charge"
- Expected Changes to the Medicaid Managed Care Rule
- Shifting Focus of Medicaid Program and Use of Coverage Waivers

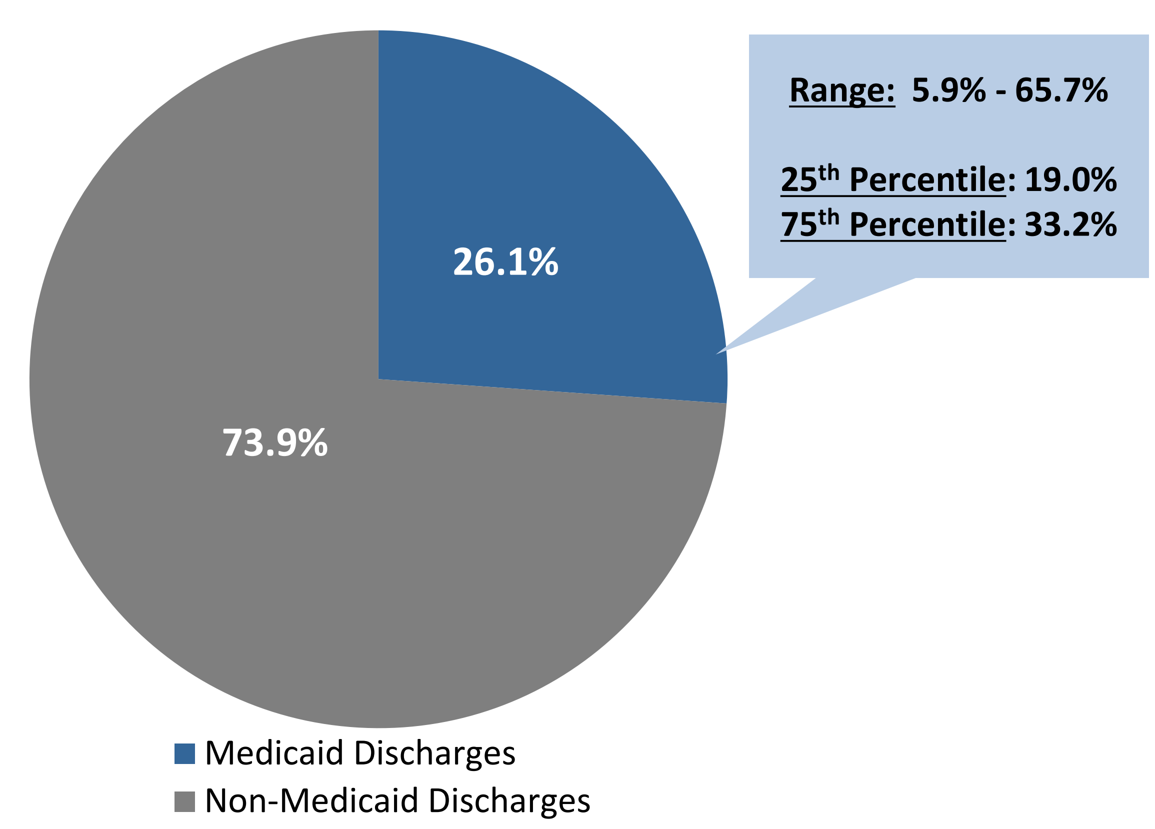
III. Medicaid Coverage and Funding for Payment & Delivery System Reform

- Medicaid Coverage and Funding Strategies for Payment & Delivery System Reform
- Alternative State Strategies

IV. Discuss Next Steps for AMCs

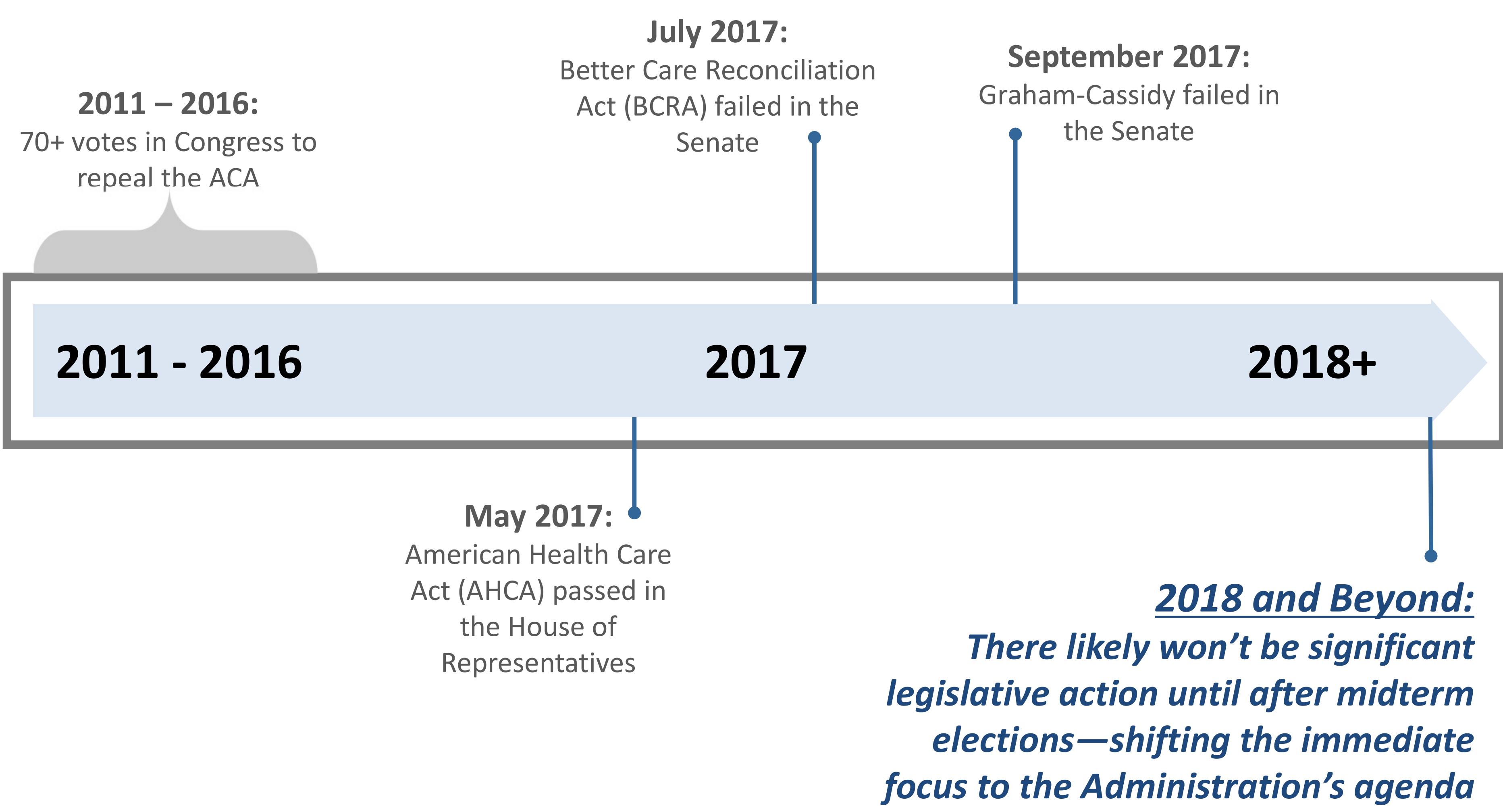
The Importance of Medicaid to Academic Medical Centers

Medicaid accounts for more than 1 out of 4 discharges for the median teaching hospital,* with considerable variation across individual institutions



*Among 156 institutions that reported FY 2016 Medicaid data to the Association of American Medical Colleges (AAMC) Council of Teaching Hospitals (COTH) Annual Survey of Hospital Operations & Finance

2017 Saw Significant Efforts to Legislatively Alter the Medicaid Program



DSH Reductions Were Again Delayed Under the February-Passed Bipartisan Budget Act of 2018

Under the ACA, federal DSH allotments were reduced to account for an expected decrease in uncompensated care due to expansion coverage; the cuts (originally set to take effect in 2014) have been legislatively delayed several times

Reductions in DSH Funding ($B) from FY 2018 – FY 2025

	2018	2019	2020	2021	2022	2023	2024	2025
DSH Cuts Under MACRA *(prior legislative vehicle)*	$2 billion	$3 billion	$4 billion	$5 billion	$6 billion	$7 billion	$8 billion	$8 billion
DSH Cuts Under Bipartisan Budget Act of 2018	**$0**	**$0**	$4 billion	$8 billion	$8 billion	$8 billion	$8 billion	$8 billion

The HHS Secretary Develops the Methodology for Proposed DSH Reductions

Regulations proposed in July 2017 would de-emphasize how well states target DSH payments to hospitals with high Medicaid and uncompensated care

Projected Decrease in State and Federal DSH Allotments in Dollars ($M) and as a Percentage of Unreduced Allotments by State, FY 2020

171.0
6.5
2.3
2.4
1.1
14.7
.8
.1
11.1
4.6
667.7
70.6
4.9
27.5
10.1
12.4
208.7
180.6
96.4
310.8
267.6
89.4
33.5
39.4
30.6
1.4
6.8
10.7
*
152.4
183.4
450.4
247.0
54.4
156.6
96.9
104.0
3.9
2.7
NH: 93.9
39.4
VT: 24.6
1448.0
MA: 433.1
RI: 69.8
CT: 190.0
467.2
NJ: 581.8
DE: 1.8
MD: 54.4
DC: 50.4

0-9.9%
10%-19.9%
20%-29.9%
30%-39.9%
40%-49.9%
Greater than 50%

* Tennessee is not subject to DSH allotment reductions because its DSH allotment is specified in statute §1923(f)(6)(A) of the Social Security Act

1). MACPAC March 2018"Analyzing Disproportionate Share Hospital Allotments to States," https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf; 2). 82 FR 35155 (July 28, 2017) to be codified at 42 CFR 447

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Recent Medicaid Fee-For-Service Access Rule

Proposed Changes to Medicaid FFS Access Rule

On March 22nd, CMS issued a proposed rule to modify existing Medicaid fee-for-service access monitoring rules; the comment period is open until May 22

The proposed regulation would make three changes to the current FFS access regulations:

1. **Exempt states from most access monitoring requirements in states with managed care penetration rate ≥85%***
2. **Exempt states from most access monitoring requirements when making "nominal" provider rate changes** (≤4% in one SFY and ≤6% over two years)
3. **Modify the information other states must submit to CMS when making non-nominal provider payment changes**

In the 2015 *Armstrong v. Exceptional Child Center* case, the Supreme Court held that **providers cannot sue in federal court to enforce the Medicaid requirement that payments be sufficient to ensure access**

*The proposed rule requires submission of an alternative analysis along with supporting data to demonstrate compliance with access standards when there is a rate change

Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold . 83 Federal Reg. 12696, to be codified at 42 CFR 447

Anticipated "Public Charge" Regulations

"Public Charge" Regulatory Changes Expected Soon

The Department of Homeland Security (DHS) is close to releasing a proposed rule that would expand the list of benefits considered when assessing an immigrant's candidacy for entering or remaining in the U.S.

DEPARTMENT OF HOMELAND SECURITY

8 CFR Parts 103, 212, 213, 214, [237], and 248

[CIS No. 2499-10; DHS Docket No. USCIS-2010-0012]

RIN 1615-AA22

Inadmissibility on Public Charge Grounds

AGENCY: U.S. Citizenship and Immigration Services, DHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department of Homeland Security (DHS) proposes to change how it determines whether an alien is inadmissible to the United States because he or she is likely at any time to become a public charge consistent with section 212(a)(4) of the Immigration and Nationality Act (INA). Aliens who are seeking adjustment of status or an immigrant visa, or who are applicants for admission, must all establish that they are not likely at any time to become a public charge. Moreover, DHS will require aliens seeking an extension of stay or change of status demonstrate that they are not using or receiving, nor likely to use or receive, public benefits.

DHS proposes to define the term public charge as the term is used in section 212(a)(4) of the INA. DHS also proposes to define the types of public benefits that are considered in public charge inadmissibility determinations. DHS proposes to clarify that it will make public charge determinations based on the totality of an alien's circumstances. DHS also proposes to clarify when an alien seeking adjustment of status or immigrant visa, who is inadmissible under section 212(a)(4) of the INA, may be admitted in the discretion of DHS upon the giving of public charge bond. With the publication of this proposed rule, DHS withdraws the proposed regulation on public

DRAFT

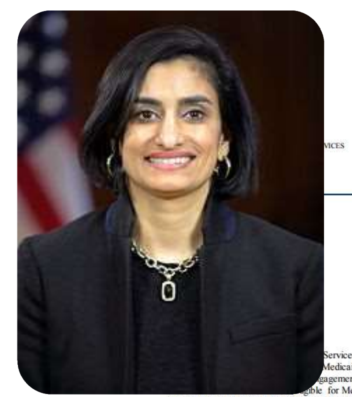
1

A leaked version includes significant expansion of public benefits considered for public charge purposes, including:

- ***Medicaid***
- ***CHIP***
- ***Government-subsidized health insurance*** *(e.g., Marketplace premium tax credits)*

Shifting Focus of Medicaid Program and Use of Coverage Waivers

Changing Direction under the Trump Administration



SMD: 18-002

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

Services (CMS) is announcing a new policy designed to Medicaid enrollee health and well-being through gagement among non-elderly, non-pregnant adult gible 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.

"….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]

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

President Trump this week issued an Executive Order on Economic Mobility:
"we can lift our citizens from welfare to work, from dependence to independence, and from poverty to prosperity"

1115 Waivers are a Key Vehicle for States and the Administration to Advance their Priorities

Waiver Requirements

- **Federal Medicaid law requires that waivers:**
  - "Further the objectives" of the Medicaid program
  - Be authorized for a demonstration purpose, subject to evaluation
  - Affect a section of the federal Medicaid law subject to waiver (e.g., federal match rate is not waivable)
- **By longstanding practice, waivers must be budget neutral to the federal government**
- **Public comment periods for new waivers and renewals are required at the state and federal levels; public input requirements more limited for amendments**

Common Waiver Uses

Managed Care Waivers: New populations and new services

Delivery System Reform Waivers: Often involve substantial federal investment; 12 states have DSRIP-type waivers

Uncompensated Care Pool Waivers: Payments – typically for hospitals – to reimburse for uncompensated care; 9 states have UCC waivers

Expansion-Related Coverage Waivers: Allows states to modify features of Medicaid coverage (e.g., premiums, higher copayments)

Source: Social Security Act (SSA) § 1115; See SSA § 1916(f) for cost sharing waiver limitations.

**States may only waive the previsions in SSA § 1902.*

Recent 1115 Waivers Seek to Make New Significant Changes

Recently submitted waivers propose new coverage conditions, some of which the Administration has weighed in on – and others of which remain to be determined.

Policy	Features of New Waiver Requests
Premiums	• Premiums above 2% of household income ***(approved KY, IN)*** • Non-payment resulting in loss of coverage for those below 100% of the federal poverty level
Work Requirements	• Work requirements as a condition of eligibility ***(approved KY, IN, AR)***
Eligibility	• Lifetime coverage limits • Partial expansion to <138% of the federal poverty level, with enhanced federal match • Elimination of presumptive eligibility • Reduction of retroactive eligibility
Lockouts	• Lockouts for failure to timely renew eligibility ***(approved KY, IN)***
Applicability	• New policies not limited to expansion adults ***(approved KY, work requirements, premiums > 2%; approved IN, work requirements)***

Implications of New Coverage Waivers on Academic Medical Centers

Impedes continuity of care and care coordination, making it more difficult to manage members with complex health and social needs

- Barriers to obtaining and maintaining coverage; increased churn

More uninsured, more uncompensated care

- Barriers to obtaining timely coverage

Potential for additional states to expand

- Increased flexibility may encourage more states to expand (e.g., Utah, Virginia, North Carolina)

Expected Changes to the Medicaid Managed Care Rule

Changes to Medicaid Managed Care Rule Expected this Summer

The 2016 Medicaid Managed Care final rule addresses numerous issues, several of which are of particular importance to AMCs

- Actuarial Soundness
- Plan Payments to Providers
- Provider Networks
- Pass-Through Payments
- Medical Loss Ratio (MLR)
- Coverage of Services
- Marketing & Enrollment
- Grievances & Appeals
- Program Integrity
- Accreditation & Quality

It is unclear what changes will be made to the rule; it is currently under review by the Administration

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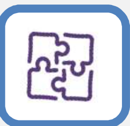
Medicaid Coverage and Funding Strategies for Payment & Delivery System Reform

Key State Reform Priorities

Accelerating value-based payment

Strengthening advanced primary care



Integrating physical and behavioral health

Expanding complex care management

Addressing social determinants of health

Implementing these reforms often requires significant capacity building. States have utilized DSRIP, designated state health programs (DSHPs), Medicaid managed care and other mechanisms to fund their priorities to date

2018 Landscape: Approach to Delivery System Reform Waivers

Trump Administration is providing flexibility in some areas, but also scaling back opportunities to finance delivery system reform through 1115 waivers

No new DSRIP waiver approvals likely

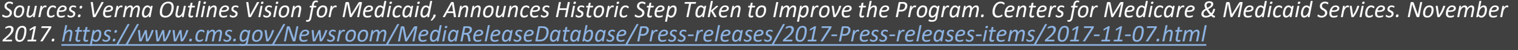
- States with existing waivers expected to be able to continue through end of current approval period
- Extensions unlikely to be approved on same terms
- Unclear if the Administration will adopt a new strategy for delivery system reform

Guidance issued terminating DSHPs as a financing source for Medicaid 1115 waivers

- DSHPs are health-related programs that have been funded entirely by the state (sans federal funds), for which CMS approved federal matching as part of a broader 1115 waiver

Uncompensated Care (UCC) Pools

- State may only use UCC pool funding to cover cost of care to uninsured individuals; not Medicaid shortfalls



Alternative State Strategies

Medicaid managed care contract requirements

Directed payments

Key Ways States Are Advancing Contract Requirements

More rigorous procurement

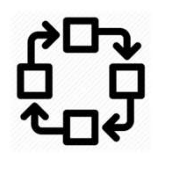
- More directive requirements around care management strategies, provider payment, quality, and administrative efficiency
- Increasingly creative accountability metrics tied to payment
- Funding for specific delivery system reforms

Increasing accountability for whole-person care

- Additional targets for value-based payment

- Requirements around behavioral health integration

- Requirements to address social determinants of health



Reducing administrative redundancies

- Centralized credentialing and streamlined provider applications

Accelerating Value-Based Payment

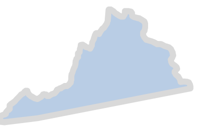
Of 36 state managed care contracts reviewed, 27 states require plans to engage in VBP with network providers, and 2 other states include provisions in their contracts that encourage or otherwise enable plans to engage in VBP

SOME STATES

Have no specific VBP contracting requirements

TEXAS

Requires plans to shift from volume-based payment to alternative payment models subject to a PMPM penalty; target of 50% of payments and 25% attributed to risk by CY 2021



VIRGINIA

VBP goals requiring plan expenditures tied to VBP to increase at least 20% or represent at least 50% of plans' expenditures within 3 years; seeks to align incentives to State's priorities (e.g., addressing opioid use, integrating BH care)

OHIO

Plans must submit strategy to ensure 50% of payments to providers are "value-oriented" by 2020. Plans must ensure provider participation in episode-based payment and Medical Home efforts

NEW YORK

Mandatory "roadmap" requires 80-90% of plans' total expenditures to be at "Level 1" (low risk) VBP arrangements (or higher) and 35% of their total expenditures to be in "Level 2" (or higher) by 2020

- ***Less Risk***
- ***Less Prescriptive***
- ***Less Infrastructure Need***

- ***More Risk***
- ***More Prescriptive***
- ***Greater Infrastructure Need***

Source: Manatt Health analysis of state managed care contracts

Strengthening Advanced Primary Care

State Medicaid programs are building specific payment and care delivery models into Medicaid managed care contracts to drive advanced primary care

- CMMI has been a substantial source of (non waiver) federal funding for advanced primary care initiatives since 2011 (MAPCP, SIM, CPC/CPC+, TCPi)
- A mix of state and federal initiatives are aligning priorities across payers to maximize and streamline incentives for practices
- As noted, Medicaid managed care rule permits states to require plans to participate in multi-payer delivery system reform initiatives

Tennessee's 3 health plans launched a statewide aligned PCMH program in 2017. Providers commit to providing population health management, care management support, and care coordination, among other areas and may receive an annual outcome payment based on quality and efficiency performance

Oregon established the Patient-Centered Primary Care Home (PCPCH) Program in 2009 to create access to patient-centered, high quality care and reduce costs by supporting transformation

Sources: 42 CFR 438.6(c); Comprehensive Primary Care (CPC) Program. Ohio Medicaid. http://www.medicaid.ohio.gov/Providers/Paymentinnovation/CPC.aspx; Patient-Centered Medical Homes (PCMH). TennCare. https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/patient-centered-medical-homes-pcmh.html; About the Patient-Centered Primary Care Home Program. http://www.oregon.gov/oha/HPA/CSI-PCPCH/Pages/About.aspx; http://pcpci.org/sites/default/files/webinar-related/PCPCH%20Program%20Update_FINAL.pdf

Integrating Physical and Behavioral Health

States developing specific managed care models that address needs of people with behavioral health diagnoses, providing enhanced benefits and funding

North Carolina is developing two types of integrated managed care products that will offer physical, behavioral, pharmacy, and LTSS services: Standard Plans and BH I/DD Tailored Plans (TPs). TPs will target beneficiaries with intensive BH needs or with an I/DD or TBI and provide access to enhanced care management

New York integrated adult BH into managed care in 2015 and created specialized Health and Recovery Plans (HARP) for adults with significant BH needs. HARPs integrate physical health, mental health and substance use services; provide enhanced HCBS; and provide enhanced care management

Sources: How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services. The Commonwealth Fund. May 2017. http://www.commonwealthfund.org/publications/issue-briefs/2017/may/arizona-medicaid-integration-behavioral-health; How Oregon Dramatically Increased SBIRT in Primary Care. IRETA. http://ireta.org/webinar-library/how-oregon-dramatically-increased-sbirt-in-primary-care/; CCO Incentive Measures Since 2013. August 2017. http://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/incentive-measures-since-2013.pdf; NY RFQ for Behavioral Health Benefit Administration , July 2015;. https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/plan_process/docs/2015-7-3_nys_adult_behavior_hlth_ros.pdf

** Claims-based SBIRT measure used from 2013-2016 has been removed as an EHR-based SBIRT measure is developed for 2019*

Expanding Complex Care Management

States can take full advantage of the flexibility under Medicaid to design and fund robust care coordination

- Medicaid managed rule outlines requirements around coordination and continuity of care. MCOs must, among other requirements:
  - Ensure each enrollee has an ongoing source of care and a person or entity formally designated as primarily responsible for coordinating services
  - Conduct initial screening within 90 days of enrollment, and share results with state and any other MCOs serving the enrollee
- MCOs must conduct an enrollee assessment and create a treatment and service plan for enrollees with special health care needs

North Carolina

- Plans will be responsible for: care needs screening; risk scoring/stratification; comprehensive assessment; and care management. Plans must contract with Advanced Medical Homes and Local Health Departments, entities that can take primary responsibility for care management
- State Care Management Strategy integrates social determinants of health by:
  - ✓ Screening for social service needs
  - ✓ Conducting in-depth assessments for individuals with high unmet social needs
  - ✓ Requiring plans to hire a staff member who understands and can help consumers navigate the local housing market

*Source: 42 CFR 438.208; * Also applies to PIHPs and PAHPs; NC Care Management Strategy under Managed Care, https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf*

Addressing Social Determinants of Health (SDOH)

States can incentivize or require MCO plan investment in social interventions to address social determinants of health

- Classify certain **social services as covered benefits** under the state's Medicaid plan
- Use **VBP requirements** to drive provider investment in social interventions
- Use **incentives and withholds** to encourage plan investment in social interventions
- Integrate SDOH measures **in quality improvement** or **performance measurement**
- Reward plans through **higher rates** for effective investments in social interventions
- Explore use of **value-added** and **"in lieu of"** services

States can use similar strategies for initiatives beyond social determinants

Source: Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 2018. http://www.commonwealthfund.org/publications/fund-reports/2018/jan/social-inteventions-medicaid-managed-care-rate-setting; Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. KFF. October 2017. https://www.kff.org/report-section/medicaid-moving-ahead-in-uncertain-times-managed-care-initiatives/

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States Can Set Higher Payment Standards for Particular Provider Types or Services

States can leverage managed care contracts to direct provider payments to advance delivery system and payment reform and performance improvement goals

Mechanisms

States may:

- ✓ Require plans to set higher reimbursement standards for particular provider types or services, or to offer higher rates overall
- ✓ Require plans to implement value based purchasing models that are directed at particular providers/are prescriptive in payment terms

Guardrails

- ✓ Expenditures must be directed equally and using the same terms of performance for a class of providers
- ✓ Arrangements must be expected to advance at least one of the goals and objectives of the state's quality strategy
- ✓ States must seek annual CMS approval using pre-print form
- × Payments *cannot* be linked to IGTs

Source: 42 CFR 438.6; Manatt Health analysis.

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Upcoming DSRIP Waiver Renewals

Waiver Expiration Date	States with DSRIP Waivers	Date Expenditure Authority Expires
2018	Kansas	December 2018
	New Mexico	
	Rhode Island	
2020	California	December 2020
	New Hampshire	
2021	New York	March 2021
	Washington	December 2021
2022	Massachusetts	June 2022
	New Jersey	
	Texas	September 2022

Approved Section 1115 Medicaid Waivers, as of April 9, 2018. Henry J Kaiser Family Foundation. Available: http://files.kff.org/attachment/Which-States-Have-Approved-and-Pending-Section-1115-Medicaid-Waivers-Approved

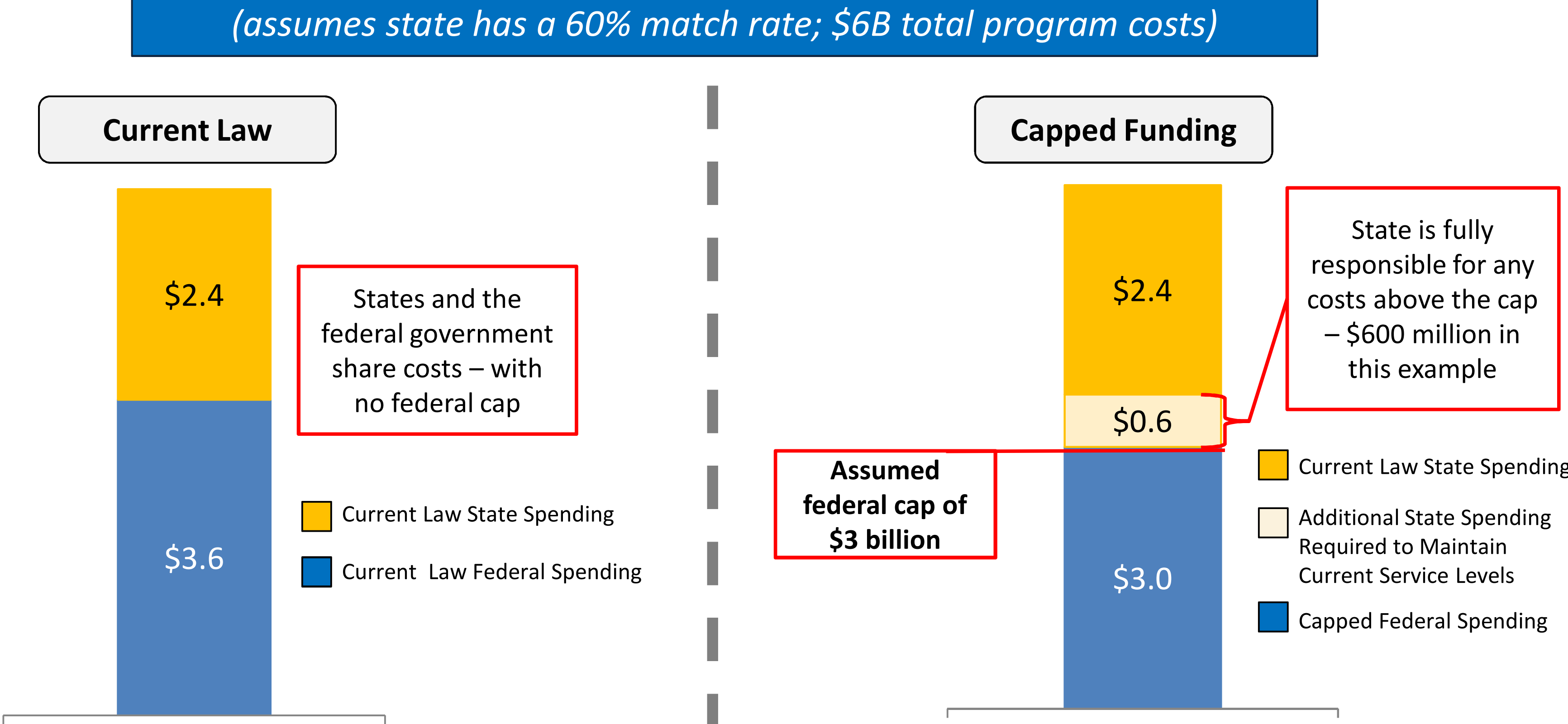
CMS Will No Longer Approve or Renew Federal Funding for DSHPs

States with Federal DSHP Financing	Expenditure Authority Approved Through Date	Total DSHP Funding Over 5 Year Demonstration Period
Rhode Island	December 2018	$80 M
California	December 2020	$375 M
New Hampshire	December 2020	$71 M
New York	March 2021	$2,000 M
Arizona	September 2021	$91 M
Vermont	December 2021	$40 M
Washington	December 2021	$928 M
Alabama	March 2022	$313 M
Massachusetts	June 2022	$1,250 M

Source: CMS State Medicaid Director Letter, "Phase-Out of Expenditure Authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations, December 15, 2017. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf
***Note**: The dollars reported below include both the state and the federal funding for the designated state health program*

Recently Proposed Legislation Would Have Drastically Changed the Medicaid Program

- **Capped funding proposals end the federal government's obligation to share all allowable program costs with states**
- **Instead, federal payments would be capped and grow based on a national trend rate**



Note: The federal match rate varies by state for most medical services; match rate for administrative costs and some services are the same for all states.

Impact of Per Capita Cap Financing

Proposals to Date Would Have:

Sharply Reduced Federal Payments

- Cuts grow over time
- CBO projected $1 trillion impact to the program under Graham-Cassidy

Shifted Risk to States/Providers/Beneficiaries

- Do not account for actual healthcare costs, public health crises; new blockbuster drugs/other medical advances

Locked in Historic State Funding Decisions

Created Budget Uncertainty

- Highly sensitive to annual fluctuation in trend rates

Design Decisions

Setting the trend rate; proposals to date have ranged from Consumer Price Index (CPI) to CPI Medical to CPI Medical +1 (and varied by population group)

Setting the base period

Treatment of supplemental payments (e.g., GME)

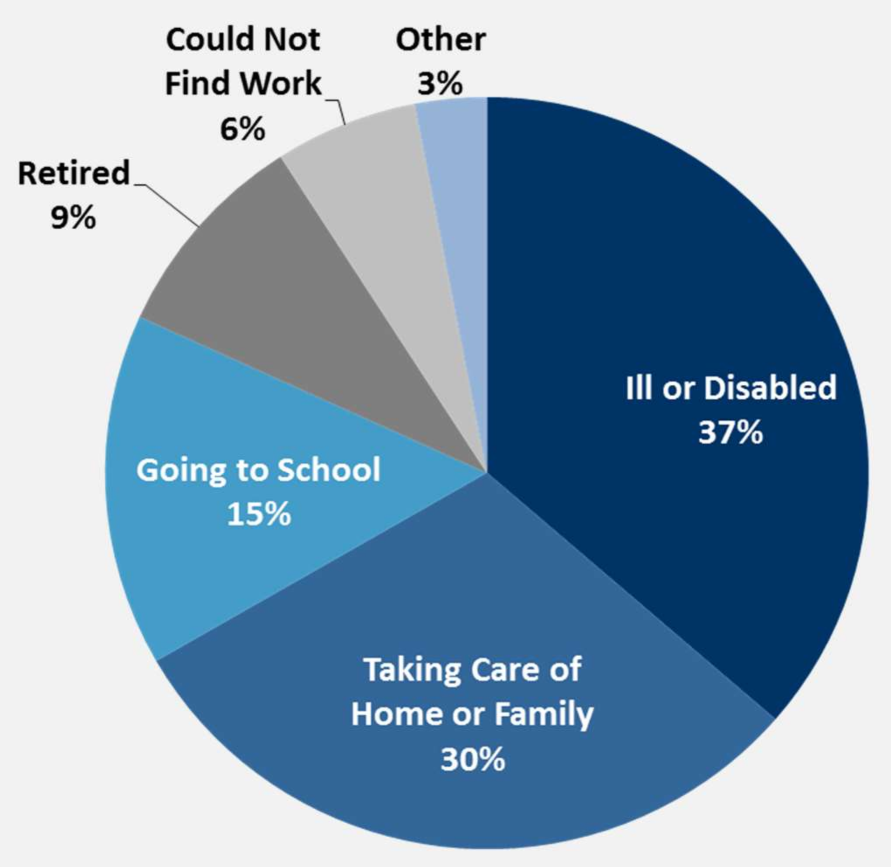
Carving out certain population groups and/or services.

Approved and Pending Coverage Waiver Features

	Approved			Pending												
	AR	IN	KY	AL	AZ	KS	MA	ME	MI	MS	NC	NH	NM	OH	UT	WI
Premiums *(some states with lockout)*	✓	✓	✓		✓	✓	✓	✓	✓		✓		✓			✓
Cost Sharing	✓	✓	✓		✓		✓	✓	✓		✓	✓	✓		✓	✓
Work Requirements	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓	✓	✓
Elimination of Presumptive Eligibility								✓							✓	
Prompt Enrollment Waiver		✓	✓										✓			
Drug Screening																✓
Limits on Enrollment Duration					✓										✓	✓
Partial Expansion							✓									
Late Renewal Paperwork Penalty/Lockout		✓	✓													
Non-Emergency Medical Transportation Waiver		✓	✓				✓									
Retroactive Coverage Waiver	✓	✓	✓				✓	✓				✓	✓		✓	

Deep Dive: Work Requirements Implications

60% of 24.6M non-elderly adults without SSI work full or part-time



Among the 40% of Medicaid enrollees that do not work, 67% are ill or disabled, or taking care of home or family and another 15% are going to school

Source: Available at https://thefga/wp-content/uploads/201508/work-requirements-research-paper-1/pdf

Deep Dive: Do Work Requirements Make Sense for Medicaid?

Challenges:

- **High risk that even exempt populations would lose coverage**
- **Significant administrative effort and cost** – *Kentucky plans to spend $17.5 million in state funds and $170 million in federal funds to build the technology platform to track compliance*
- **Opportunity cost as State Medicaid agency attention becomes refocused from delivery system/payment reforms**

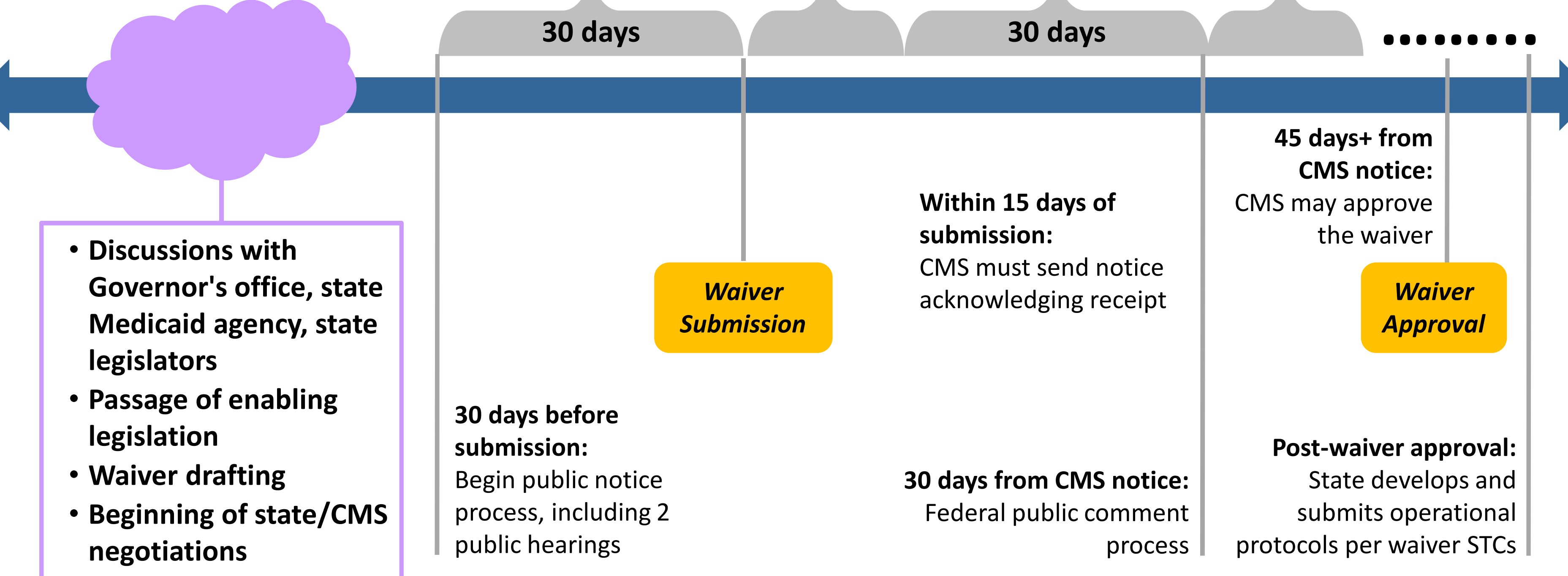
Evidence from SNAP: work requirements lead to substantial declines in enrollment

Kansas: SNAP enrollment among childless adults fell nearly 70% (from 30,000 to 8,337 in the first 16 months after work requirements were implemented)

Maine: SNAP enrollment among childless adults fell nearly 80% (from about 14,000 to 2,700) in the three months after work requirements were implemented

Sources: https://www.courier-journal.com/story/news/politics/2018/02/14/kentucky-medicaid-changes-bevin-work-requriements/319384002/; https://thefga/wp-content/uploads/201508/work-requirements-research-paper-1/pdf

Opportunities to Influence the Waiver Process



1. Waiver Development: Opportunity to identify unintended consequences and shape waiver

2. State Comment Period: Opportunity to formally comment on waiver

3. Federal Comment Period: Final opportunity to formally comment on waiver

4. Development of Operational Protocols Opportunity to inform waiver implementation procedures

Note: In 2017, CMS permitted some states (e.g., Indiana, Kentucky, North Carolina) to conduct concurrent state and federal public comment periods in instances when a state was amending a previously submitted waiver amendment request