Medicaid Section 1115 Waivers: Pathways for Delivery Transformation

Spotlight on the States #7

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NATIONAL ASSOCIATION OF Community Health Centers

Introduction

In 2013, the Centers for Medicare & Medicaid Services (CMS) approved several § 1115 demonstration waivers that will permit applicable States to implement the Affordable Care Act's (ACA's) Medicaid expansion using private insurance. CMS has also approved a number of non-expansion § 1115 demonstration waivers that will permit States to reform their Medicaid programs towards incentivizing greater beneficiary engagement in wellness programs and health care decision-making. As additional waivers are approved, NACHC will provide updates on the § 1115 waiver demonstrations and their impacts on Community Health Centers and their patients.

Illinois 1115 Waiver Proposal, *The Path to Transformation*

On June 4, 2014, Illinois submitted to the Centers for Medicare & Medicaid Services (CMS) an 1115 demonstration waiver proposal entitled *The Path to Transformation*. Illinois proposes to include in the demonstration all mandatory and optional eligibility groups approved for Medicaid or CHIP coverage. While the Illinois State Legislature voted in 2013 to permit expansion of Medicaid under the Affordable Care Act (ACA), according to the waiver proposal, "State Plan changes related to eligibility requirements for groups affected by the ACA are not yet finalized." Therefore, groups that will be covered through comprehensive benefits under the waiver include those currently eligible for Medicaid in the State, as well as ACA adults and former foster children. No changes to beneficiary cost-sharing are proposed and no waiver of the Federally Qualified Health Center (FQHC) prospective payment system (PPS) is requested.

The waiver proposal outlines four "pathways" to transforming the Medicaid system towards greater coordination, focus on primary care and prevention, and improving population health. These pathways focus on (1) transforming the health care delivery system towards one centered on patient-centered health homes; (2) improving population health through increased health care delivery system coordination capacity and focus on prevention, primary care, and wellness; (3) enhancing the health care workforce; and (4) rebuilding and expanding home and community-based services. The first three pathways are summarized in more detail below, specifically as they relate to health centers.

Pathway One: Transforming the Health Care Delivery System

This pathway builds on the existing innovations in the State's Medicaid Managed Care program. According

to the waiver proposal, in order to provide options for care coordination services, Illinois recently implemented innovative, alternate models of care in addition to the traditional managed care organizations. The alternative models of care – "care coordination entities" (CCEs) and "accountable care entities" (ACEs) – are organized and managed by hospitals, physician groups, FQHCs, or social service organizations. They are required to provide a full continuum of services, which must include behavioral health. Both CCEs and ACEs are paid by way of a per-member, per-month (PMPM) care coordination fee, with the initial potential for shared savings. ACEs are required (and CCEs are encouraged) to begin moving to a risk-based arrangement after 18 months.

Pathway Two: Health Care Capacity Building

The second pathway outlined in the proposal centers around building the capacity of the health care system to provide population health management. By 2017, Illinois anticipates an additional 500,000 Medicaid enrollees under the ACA. According to the proposal, the new community needs assessment mandate offers opportunities for the State and local health departments "to collaborate with local hospitals and community health centers to share data and analyses and assure that as much attention as possible is directed to fulfilling the identified needs." The proposal also focuses on using 'front-end' prevention strategies to reduce the use of costly, back-end care in order to maximize the State's ability to provide health care coverage to more individuals. To that end, the *Path to Transformation* waiver will "leverage resources by investing in incentives that drive integration of public health services, with the goal to lower costs of traditional medical services." As part of the proposal, Illinois seeks to increase utilization of "community health workers," a term that remains as yet undefined in the proposal.

Pathway Three: Workforce Enhancement through Graduate Medical Education (GME)

According to the proposal, "Illinois is committed to implementing a health care workforce development strategy that will: 1) create new and sustainable health care worker roles, and ensure that all health care workers are paid a living wage; 2) enable medical professionals to work at the top of their training and education; 3) create capacity to serve underserved communities; and 4) promote team-based care within integrated delivery systems."

The waiver proposes to establish a Medicaid GME pilot program, which will invest $10 million annually in a program that mirrors the existing HRSA Teaching Health Center GME Program (THC). When federal funding for the THC program expires in 2015, the State proposes to provide continued funding of the current THC supported GME program(s). Other GME programs in Illinois would be encouraged to seek state funding under the same criteria currently in place for the THC program. The Illinois Department of Healthcare and Family Services (HFS) would oversee the administration of the Medicaid GME program, "including the development of performance metrics to ensure that programs generate primary care practitioners that serve in underserved areas in order to continue receiving funding." Additionally, the State proposes to invest $26 million annually in incentive-based payments for performance on specific metrics achieved by existing GME programs in designated medical specialties, including, in years one and two, the provision of significant training for residents with medical underserved populations and written curricula in population Medicaid based no practice in primary/general outpatient care settings. In years three and four, these metrics would factor in the placement of graduates in Health Professions Shortage Areas or medically underserved areas. Under this program, 75% of funds will be set aside for funding of GME programs that provide significant training for residents with medically underserved populations in years one and two – including FQHCs. The metrics for payment are expected to evolve and place a greater emphasis on incentivizing graduate

placement in HPSAs and medically underserved areas. Illinois requests that payments made under its Medicaid GME program be exempt from federal upper payment limit requirements and be paid directly by the State to qualified teaching hospitals and FQHCs.

To supplement these workforce training efforts, Illinois plans to commit $10 million annually towards a loan repayment program and is seeking designation of this investment as a Designated State Health Program. By July 1, 2015, the State proposes to establish loan repayment assistance to providers and other health care workers who commit to serving Medicaid populations in rural or other underserved areas (as designated by the Secretary or using state-developed criteria approved by the Secretary). The State says it is reviewing its existing loan repayment programs and "will modify them as needed to ensure alignment with health care workforce needs and based on available funds. This will include adding additional professions (e.g., social workers and other mental health and substance use disorder professionals, community health workers, direct care workers) that qualify for loan repayment and ensuring that all loan repayment programs are contingent on the recipient practicing in an underserved area." In addition, Illinois proposes to establish a bonus payment pool for hospitals that are designated as Critical Access Hospitals or classified by the state as a "safety net hospital" that establish their own loan repayment programs.

New York State Approved 1115 Waiver

On April 14, 2014, Governor Cuomo announced that New York State and the Centers for Medicare & Medicaid Services (CMS) had reached an agreement on the State's proposed 1115 demonstration waiver (commonly referred to as the "MRT" waiver). The waiver amendment enables the State to reinvest, over a five-year period, $8 billion of the approximately $17.1 billion in federal savings generated by existing Medicaid Redesign Team ("MRT") reforms. Prior to this waiver, the State expanded Medicaid under the ACA through the "traditional" approach. A central part of the overarching MRT waiver is New York State's Delivery System Reform Incentive Payments (DSRIP) program, which will provide roughly $6.4 billion in support for the transformation of the State's health care delivery system. The State's vision is that, upon conclusion of the demonstration, participating provider groups will contract directly with Medicaid managed care plans to meet the health care needs of eligible Medicaid beneficiaries. Additional details of the approved waiver can be found in the CMS Special Terms and Conditions ("STCs"), the Program Funding and Mechanics Protocol, and the Strategies and Metrics Menu[1]; a high level summary of the program, specifically as it relates to health centers, is provided below.

The main objective of the DSRIP program is to "provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs." Under the DSRIP program, providers will organize into Performing Provider Systems. Participating providers will receive funding through Medicaid to design and implement projects – selected from a pre-approved "menu" of strategies and metrics (noted above) – and will be eligible for incentive payments if the program(s) meet or exceed specified performance metrics. A nine month project planning period will run from April 1, 2014, through December 31, 2014, when final DSRIP project plans are due. Project implementation will begin on April 1, 2015.

[1] Available at: http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_cms_official_docs.htm

Specifically, the DSRIP will fund provider incentive payments to reward safety net providers (described below) when they undertake a number of pre-approved projects, all of which are designed to transform the systems of care that support Medicaid beneficiaries and low income uninsured by addressing five key elements: (1) appropriate infrastructure, including changes in the workforce and care coordination services; (2) integration across settings; (3) assuming responsibility for a defined population, as approved and defined by the State for each DSRIP project based on geographic and member service loyalty factors; (4) reducing avoidable hospital use in Medicaid by 25%; and (5) managed care contracting reforms to establish and promote accountability.

Eligible providers will fall into two categories: major public hospitals and "safety net" providers, which include "non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business and must be associated with Medicaid, uninsured and Dual Eligible individuals"[2] – including health centers. The state will consider exceptions to the safety net definition on a case-by-case basis, if it is deemed in the best interest of Medicaid members and subject to additional approval requirements.

To participate in a DSRIP program, safety net providers must form coalitions ("Performing Provider Systems") led by a lead applicant; individual providers will not be eligible to participate on their own. Each Performing Provider System must provide a description of the proposed governance structure and a process by which the System will progressively advance towards becoming an Integrated Delivery System. Performing Provider Systems must design and implement at least five, but no more than ten projects that meet the following objectives for a defined population:

- Creates appropriate infrastructure and care processes based on community need, in order to promote efficiency of operations and support prevention and early intervention;
- Integrates settings through the cooperation of inpatient and outpatient, institutional and community-based providers, in coordinating and providing care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while managing total cost of care; and
- Manages population health.

Each DSRIP plan must also include a comprehensive workforce strategy that identifies all workforce implications, including employment levels, wages and benefits, distribution of skills, and how workers will be deployed to meet patient needs in the new delivery system.

Under the DSRIP program, most Medicaid beneficiaries will be attributed to a Performing Provider System and each beneficiary will be attributed to only one Performing Provider System. The State will prospectively attribute beneficiaries in the first year of the program based on the beneficiary's current utilization patterns (referred to as "loyalty"), their assigned primary care provider, and the geographical appropriateness of that System. The State, through managed care plans, will make adjustments every year to account for changes in the Medicaid population.

Once the State receives a DSRIP project plan and application, the State will use a valuation formula to calculate the maximum amount that a Performing Provider System can be paid; this valuation is based, in part, on the beneficiaries attributed to the System. Providers participating in Performing Provider Systems will be evaluated by a

[2] The lists of State-identified eligible safety net providers are available here (and include a number of health centers): http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_safety_net_definition.htm

state-selected independent evaluator on performance on DSRIP milestones – both collectively, and as a single entity. The State will require providers to submit data to support such evaluations. The State itself will also be required to meet statewide performance goals or will be subject to funding reductions. Performing Provider Systems payments may be adjusted if they fail to meet the requisite metrics or if DSRIP funding is reduced because the State does not meet its statewide goals. If DSRIP funding is reduced, all Performing Provider Systems' funding will be reduced by an equal proportion.

Outside of the DSRIP program, other funding provided by the larger MRT Waiver will support ongoing state Medicaid reform initiatives, including: (i) Health Home sustainability; (ii) investments in workforce for Medicaid Long-Term Care plans ("MLTCs"); and (iii) the transition of individuals with mental health and substance abuse diagnoses into Medicaid managed care plans.

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