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COPE Monthly Digest

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Thought Leadership, Visionary Transformation

What Every Health Care Leader Should Know About Medicaid Waivers

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The Medicaid and uninsured populations don't have to be an economic burden for hospitals and health systems if they are managed well. The key is to focus on managing risk and outcomes in these patient groups in many of the same ways health care executives manage commercial or Medicare populations.

Houston-based Texas Children's Hospital established a patient-centered medical home for children who suffered from chronic conditions and were not receiving the care they needed. As a result of the program, Texas Children's Hospital added new Medicaid patients, standardized its referral process to eliminate access barriers, educated community providers on caring for complex patients and worked with disease-specific clinics to develop a transition plan.

Similarly, Round Rock, Texas-based Bluebonnet Trails Community Services, which provides mental health and disability services, worked with Guadalupe Regional Medical Center in Seguin, Texas to implement a patient navigation project for patients who frequent the emergency department (ED) due to behavioral health disorders in order to provide rapid triage and alternate service options.

These are just a few of the types of interventions that can lead to reduced hospital readmissions and provide better care for Medicaid and uninsured patients. These projects were also established through a program that many health care executives are not familiar with—The Medicaid 1115 Waiver. Below are answers to the most frequently asked questions about Medicaid 1115 Waivers and how these programs are helping health care providers transform patient care.

1. **What is a Medicaid 1115 Waiver?** First of all, it is not part of the Affordable Care Act (ACA). While these programs are influenced by the ACA, they are not driven by it. The waivers are meant to transform how care is provided to the Medicaid and uninsured populations by achieving the Triple Aim—a concept introduced by former Center for Medicare & Medicaid Services (CMS) Administrator Donald Berwick aimed at improving population health, improving

the patient experience and outcomes and reducing costs of care. Think of 1115 waivers as accountable care organizations (ACO) for the Medicaid and uninsured population. The focus of the waivers is to use innovative demonstration projects to better manage and treat patients in the Medicaid and Children's Health Insurance programs. The demonstrations typically focus on increasing enrollment, providing services not typically covered and using innovative service delivery systems to improve care and reduce costs.

2. **How innovative do the projects have to be?** Innovation has two connotations. First, create something brand new that never existed and see if it works. This type of innovation is more the exception than the norm for many 1115 waivers. The second type of innovation involves looking at a practice that has been successful when applied to another population or location and applying those practices to your location or population in order to garner a better result. This is the type of innovation that most of the waivers are centered around. The 1115 waiver is about embracing Medicaid and uncompensated care patients and focusing on interventions to improve care. For example, implementing a clinical or care management protocol for diabetes screening.

3. **Why focus on these payer groups?** Contrary to what many people believe, the Medicaid population can be an economically productive payer group for most health systems if managed well. Most health systems or medical groups would rather focus on the commercial and Medicare population. The 1115 waiver is a way to leverage many of the same approaches providers use with the commercial population for Medicaid patients. The waiver helps complement what providers are already doing as part of their risk-based strategy. However, providers should not treat the 1115 waiver as a long-term program. The funding, which lasts for five to eight years, is only meant to help providers build the necessary infrastructure to transition to a point where the intervention is self-sustaining and the providers are receiving risk-based payments for their success. It's not meant to be a long-lasting funding source.

Additional Resources

- Medicaid 1115 Waivers
- New York Medicaid 1115 Waiver
- Texas Medicaid 1115 Waiver
- Healthy Indiana Plan 2.0

4. **How do the 1115 waivers work?** The Delivery System Reform Incentive Payment (DSRIP) waivers employ a regionalization approach. A state is broken into regions and the providers in a specific region form partnerships together to manage projects aimed at achieving specific outcomes. For example, in New York there are 25 different regions called Performing Provider Systems (PPS). In each PPS there can be as many as 200 or more entities, including hospitals, health systems, academic medical centers, physicians groups, home health agencies, hospice organizations and long-term care facilities, among others. Next, the regional partners decide on 10 projects to focus on based on the needs of the Medicaid and uninsured populations in that region. Lastly, the provider groups identify specific interventions, tailored for the patients served, for each of the 10 projects that are designed to improve the health of the population, the patient experience and reduce cost. The state of New York is using the waiver with the goal that all the PPS's focus on reducing unnecessary ED visits and 30-day hospital readmissions.

5. **How do we earn the money from 1115 waivers?** First of all, DSRIP payments are separate incentive payments that exist in addition to the fee-for-service (FFS) payment for Medicaid patients from the state or managed care organization. Also, FFS payments are not impacted directly by DSRIP. The only impact would be that by reducing unnecessary ED visits, the FFS payment would be lost because the patient is not coming to the hospital, for example. But DSRIP is an add-on payment providers can receive if the requirements for the project are met. For every DSRIP project there are two types of indicators that drive payment.

1. **Milestone.** This would be an activity that helps providers achieve an outcome. For instance, it might be expanding hours in a primary-care facility so there is better access to care. Many waivers focus on improving mental health services, so hiring staff like psychiatrists to work in a primary-care setting would be a milestone.

2. **Defined metrics.** The second way that providers receive payment is by meeting metric goals for defined outcomes, such as reduced ED visits or reduced 30-day hospital readmissions. Each project has its own identified measures.

The second area of economic benefit involves the participation of the PPS in some form of risk-based payment. This payment is meant to support the success of the intervention for the long term after DSRIP funds are exhausted. In New York, if the reduced ED and hospital admission targets are achieved, the PPS and its providers will reap risk-based incentive rewards as a result of the cost savings attributed to the reduced utilization. These value-based payments can be achieved in several ways including, but not limited to, shared savings with upside potential only, care bundles with outcome based payments, subsidies for risk sharing based on total cost of care and full capitation.

6. **How do you receive the money?** The waivers are funded through what's called a "pool" approach. CMS and the state agree on a set amount of money—for New York it is roughly $8 billion. Then the money is placed into different types of pools through which the state can draw down funds. The challenge for states is that these programs are funded through the federal matching grant program, which means the state has to find someone able and willing to put that money up initially in order to receive the matching funds. For example, a state with a 50% match rate has to find a way to put up 50 cents as an intergovernmental transfer (IGT) and then the federal government will send back $1. Most states rely on public hospitals to put up the money because they receive money from taxes that qualify as an IGT. The way the funding cascades down to the provider level is that once the state receives money back from the federal government, allocates the money to each region, then providers in each region are evaluated to see if they achieved either their milestone or outcome metric. If the provider achieved those goals, it would receive payment for performance out of the pool.

The 1115 waivers are another important pool of funds that every state should consider to transform care and improve value. The process may be complicated, but the waivers can have a significant impact on the health care delivery system for patients—especially the Medicaid and uncompensated care populations. There are many other uses for waivers, aside from the DSRIP program, to consider. The state of Indiana through its Healthy Indiana Plan 2.0 has used the waiver to expand its Medicaid population with a model that places more accountability on the patient. Patients have a copay and fund a medical spending account, and patients can earn other services like dental and eye coverage for accessing preventive care services. Health care providers, community health organizations and government leaders, among others should research the many creative ways that a Medicaid 1115 Waiver can be used in their community and state to enhance care for Medicaid and uncompensated care populations.

For more information on Medicaid 1115 Waivers, please contact: COPE@copehealthsolutions.org.