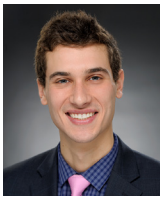
COPE HEALTH SOLUTIONS

Section 1115 Waivers: An Overview and State by State Comparison

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Abstract
Health care reform has evolved over the past few decades, but one constant in this transformation has been Section 1115 waivers. These waivers broadly permit states to conduct "Medicaid research and development" programs to better meet the health care needs of their unique populations. Thus, the onus of health care reform is shifted to the states, accelerating innovation and transformation.

Origin and Overview

Section 1115 waivers have their genesis in Section 1115 of the Social Security Act, which grants the Department of Health and Human Services (HHS) the authority to approve demonstration programs that promote Medicaid and/or the Children's Health Insurance Program (CHIP). Downstream of this HHS authority, states across the US have submitted demonstration program applications in the form of Section 1115 waivers. The waivers span a broad range of health care focus areas, including coverage and eligibility, the care delivery system and reimbursement. Some waivers even target specific disease groups or services, like HIV/AIDS and family-planning.[1]

Key Guidelines

The common thread of 1115 waivers is the enablement of states to pilot innovative and experimental approaches, granted they align with the mission and vision of Medicaid and/or CHIP. This alignment is formally evaluated by HHS to ensure operations under the waiver improve care and do not lessen coverage. More specific evaluation criteria include the promotion of coverage for low-income individuals, increased access to care, increased efficiency and quality of care and improved health outcomes (as measured by quality measures). Evaluation of waivers occurs not only at waiver application submission, but regularly throughout the demonstration period to measure impacts and outcomes of the program.

[1] Kaiser Family Foundation: Five Key Questions & Answers About Section 1115 Medicaid Demonstration Waivers http://kff.org/health-reform/issue-brief/five-key-questions-and-answers-about-section/

In addition, since waiver programs are jointly funded by a federal and state match, waiver operations must be budget neutral to the federal government, meaning the cost of operations under a waiver cannot exceed the projected Medicaid spend without the waiver.

Unique Approaches to Health Care Reform through 1115 Waivers

Within the broad focus areas of health care reform, some of the most common approaches pursued by states in their 1115 waivers include:[2]

- Expanding eligibility to individuals not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid

The final point above, delivery system reform, is particularly interesting due to its ability drive larger health system transformation. A subset of states that have submitted 1115 waivers have a component to address this issue, generally coined the Delivery System Reform Incentive Payment (DSRIP) program. In this brief, the focus will be on state programs that COPE Health Solutions has worked extensively with, specifically California, New York, Texas and Washington[3], but with a nod to other states with approved past and current DSRIP programs, including Alabama, Arizona, Massachusetts and New Jersey.

DSRIP programs provide states with funding to incentivize hospitals and other provider types to provide better and more cost-effective care to Medicaid beneficiaries. By definition, DSRIP is an incentive-based funding program, thus participants draw down dollars from the state by meeting predetermined implementation milestones and clinical outcomes, as outlined in “projects” that guide the work.

Although trending towards similar goals, DSRIP has been approached differently state by state, especially as the programs have evolved and adapted learnings from other states. Of the states explored in this brief, California was the first DSRIP program approved, followed by Texas, New York and then Washington, correlating roughly to the intricacy of each program. The key differences among these programs fall into four major buckets: timeframe, regional structure and organizational authority, eligible participants and funding.

Timeframe

Most waivers are approved for an initial five-year period, after which states can apply for a renewal (typically three years) to continue operations. The ACA allows five-year renewals when the state-focus is on dual-eligibles. See Table 1 for state-specific details on DSRIP timeframes.

Table 1

	Timeframe
California	- Initial demonstration period: 2005-2010 - Five-year waiver renewals granted in both 2010 and 2015 - DSRIP program began in 2010 waiver
New York	- Initial demonstration period: 2015-2020 - 1115 waiver extension granted in 2016 for non-DSRIP components and to continue DSRIP
Texas	- Initial demonstration period: 2011-2016 - 15-month extension granted (through end of 2017) - In the process of requesting an additional 21-month extension (through September 2019), but awaiting CMS response
Washington	- Initial demonstration period: 2017-2021

[2] https://www.medicaid.gov/medicaid/section-1115-demo/index.html

[3] COPE Health Solutions: Section 1115 Medicaid Waiver – Select State Comparison Placemat

Regional Structure and Organizational Authority

Within each state's DSRIP program, the regional structure and organizational authority varies greatly, from individual hospital systems to complex networks of clinical and community-based providers. Table 2 details some of the key differentiators in each state.

	Regional structure	Organizational authority
California[4]	- DSRIP entities are hospital systems - No additional regional structure - 21 public hospital systems and 58 district and municipal hospital systems participating as DSRIP entities	- No additional organizational authority outside of hospital system structure - Hospital systems are the entities that interface with the state and lead administration and implementation of projects - Hospital systems can contract with MCOs
New York[5]	- DSRIP entities are Performing Provider Systems (PPS) - PPSs are arbitrary regions across the state, based on providers and attribution - PPSs overlap in densely populated areas (e.g., NYC) - 25 PPSs participating as DSRIP entities	- PPSs are the entities that interface with the state and lead administration and implementation of projects - Each PPS consists of a lead entity (generally an anchor hospital), associated clinics and a number of other clinical and community-based providers - The state encourages both inter- and intra-PPS collaboration, especially in densely populated areas - PPS cannot contract with MCOs for value-based contracts
Texas[6]	- DSRIP entities are Regional Health Partnerships (RHP) - RHPs align to geographic boundaries across the state - 20 RHPs participating as DSRIP entities	- RHPs are the entities that interface with the state and lead administration and collaboration within their region - Each RHP consists of a public, county, or district hospital that coordinates as the lead entity (anchor) and a number of other clinical providers - The state encourages regional collaboration - RHPs can contract with MCOs
Washington[7,8,9]	- DSRIP entities are pre-existing Accountable Communities of Health (ACH) - ACHs align to Medicaid regional service areas across the state - 9 ACHs participating as DSRIP entities	- ACHs are the entities that interface with the state and lead administration and implementation of projects - Each ACH consists of a lead entity and a number of other clinical, community-based and tribal providers - ACHs cannot contract with MCOs for value-based contracts

Eligible Participants

Just as the regional/organizational structures of DSRIP entities vary state-by-state, so too do the eligible participants that can partake in DSRIP projects and receive funding, the details of which are discussed in Table 3. Applicable participants were designated by each state to best meet the needs of their target populations, including Medicaid beneficiaries in all cases, but also varying degrees of dual-eligibles, uninsured and even Medicare beneficiaries.

[4] COPE Health Solutions: Section 1115 Medicaid Waiver – Select State Comparison Placemat
[5] ibid.
[6] ibid.
[7] http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach
[8] Washington State Medicaid Transformation Project Special Terms and Conditions
[9] COPE Health Solutions: Key Special Terms and Conditions of the Washington Waiver

	Eligible Participants
California	- 21 public hospital systems - 58 district and municipal hospital systems
New York	- All safety net and vital access providers - Non-safety net providers can participate, but have funding restrictions - Around 65,000 providers, including: hospitals, clinics, physicians, medical groups, mental health providers, substance use providers, Health Home/care management agencies, skilled nursing facilities, nursing homes and other community-based organizations that provide social and wraparound services - Providers can participate in multiple PPSs
Texas	- Around 300 Medicaid providers, including: hospitals, medical schools, mental health providers, public health agencies and physician groups
Washington	- All ACHs and their partner organizations, including: public health agencies, insurance providers/MCOs, social services organizations, legal services organizations and state mandated tribal providers (tribal collaboration is a required element of WA DSRIP) - ACH partners include any organizations that have responsibility for the clinical or social health of the community

DSRIP Funding

Upon approval of an 1115 waiver, the state is issued an award letter which displays the total funds available for DSRIP program implementation. The mechanisms by which a state values and provides funds to each DSRIP entity vary state-by-state, but all require some degree of regular reporting on milestones and metrics by the DSRIP entities to earn dollars, in addition to state-collected claims data on clinical outcome measures. Reporting on implementation progress, thus, plays a role as a payment driver alongside actual performance on clinical outcome measures. Most DSRIP programs have a breakdown of P4R (pay-for-reporting) and P4P (pay-for-performance) components tied to varying dollar amounts. These components are critical as DSRIP funds are performance-based incentive dollars, not guaranteed grants. Also diverse is the process by which the lead/anchor organization of a DSRIP entity flows funds from the state to the other providers within the entity. Table 4 details some of these key differences.

	Funding

California	- $7.5 billion award letter
	  o District Municipal Public Hospitals (DMPH): valuation of each DSRIP entity based on attribution and size (e.g., bed count) of hospital system
	  o District Public Hospitals (DPH): Valuation of each DSRIP entity based on a project-selection adjusted metric value and a proportional allotment factor which takes into account the number of Medi-Cal beneficiaries treated at the hospital system
	- After earning funds, each IGT-eligible* provider puts up a ~50% match via IGT
	- Federal match funds are subsequently drawn down and flowed directly to the organization
	- Hospitals may have partnerships with local contributors but there is no formal requirement to share funds with contributing partners

New York	- $6.4 billion award letter - Five funding sources make up the total valuation of a PPS: Net Project Valuation, Equity Infrastructure Program (EIP), Equity Performance Program (EPP), High Performance Fund (HPF) and Additional High Performance Program (AHPP) - Net project valuation of each PPS based on attribution, DSRIP project selection and quality of waiver application - EIP and EPP are state equity programs that focus on crucial DSRIP components, with EIP focusing on implementation and EPP on clinical outcome measures - HPF and AHPP are additional funding pools available for high-performance on certain clinical outcome measures - Funds flow from PPS to providers based on methodology defined by each PPS (only regulation is that 95% of funds must go to safety net providers)
Texas[10]	- $11.4 billion award letter - Valuation of each RHP is based on its percent share of statewide low-income population (including % of low-income individuals in a region, % of total and acute care safety net payments in a region) - After earning funds, each IGT-eligible provider in the RHP puts up a ~50% match via IGT - For non-IGT organizations, the RHP lead entity puts up the matching funds - Federal match funds are subsequently drawn down and flowed to every provider (both IGT-eligible and non-IGT organizations) directly
Washington	- $1.5 billion award letter - DSRIP funding for each ACH is not yet determined, as the Program Funding and Mechanics is still in development - Since ACHs are pre-existing entities, they also receive funding from other sources, including the Washington State Health Care Authority

About COPE Health Solutions

COPE Health Solutions is a national health care consulting firm with extensive experience in health care and population health strategy, including Medicaid waivers and DSRIP. With corporate offices in Los Angeles, New York and Seattle, the COPE Health Solutions team is filled with a diverse range of subject matter experts that can assist hospitals and health care systems be successful in value-based payment environments. For more information, please contact info@copehealthsolutions.com.

[10] Texas Transformation and Quality Improvement Waiver DSRIP Special Terms and Conditions, Attachment J: Program Funding and Mechanics Protocol

* Intergovernmental Transfer