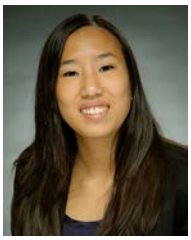
# Lessons for Washington 1115 Waiver Participants

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The Washington State 1115 Waiver application and concept paper is a system transformation initiative that will significantly change the way care is delivered to low-income patients. Medicaid patients are entitled to accessible, coordinated and quality health care that is supported by robust community support services. This multi-faceted approach to patient care and wellness lays the foundation for CMS-driven payment reform, such as value-based purchasing.

There are some crucial lessons learned from other states' experiences in implementing such significant system transformation as the Delivery System Reform Incentive Payment program (DSRIP). Our comments are related specifically to Initiative 1: Transformation through Accountable Communities of Health (ACHs).

**Empower your ACH leads in the waiver administration:**

ACHs are designed to align priorities, actions and investments to facilitate and support their memberships to develop and sustain more accountable and integrated care delivery. The role of an ACH/DSRIP coordinating entity is a heavy lift – the manpower required to properly administer transformational change at the regional level can be significant. Designated ACHs should prepare themselves to perform the multitude of DSRIP coordinating activities and to develop core infrastructure to set a foundation for success. This includes:

1. Education of provider staff
2. Stakeholder and public education on 1115 Waiver
3. Funds flow development
4. Performing contracting and other legal administration
5. Project implementation and management
6. Lead steering, clinical, IT and other workgroups
7. Assess and build IT infrastructure needs for the region to implement 1115 projects. Develop timely, accurate, and actionable reports that can be analyzed for rapid process improvement.
8. Lead the region in developing clinical priorities and selecting appropriate activities
9. Fund new services designed to reduce unnecessary intensive services consistent with the Triple Aim

**Projects should be designed for multiple provider types with clear expectations:**

The regional approach for implementing transformation is a critical piece of DSRIP. By requiring activities across many providers, the necessary collaboration and coordination is encouraged to create an integrated delivery system. This approach, however, also comes with its own challenges in developing measurable milestones for DSRIP payments.

Regions implementing projects should consider the variety of providers who will be participating, with an understanding of the role that each provider will play. For example, a care transitions project should reward primary care providers for achieving different milestones than a nursing home. The primary care provider, for instance, would receive funds for properly implementing a patient centered medical home that provides, coordinates and integrates a spectrum of services designed to meet the goals and objectives of the 1115 Waiver.

One of the largest challenges in the New York DSRIP has been intentionally designing, agreeing upon and ensuring the correct financial incentives for the role of every single provider in DSRIP, from the hospital to the single primary care provider to the patient navigator and the LTSS delivery system. Many or all of these providers will likely be eager to participate in DSRIP but may be unclear on their expectations if there is limited guidance on how they specifically will be paid based on their role, activities and outcomes. We recommend establishing clear payment/reimbursement methodology guidelines upfront to advance and sustain the 1115 Waiver objectives.

**DSRIP funds should advance, support and align with outcomes/care improvement metrics:**

It is no secret that CMS has begun encouraging providers toward value-based purchasing, especially for Medicaid members. New York State has partnered with CMS to set very aggressive and time-bound goals for this activity – establishing a new bar for other states. Providers must prepare for this shift, which may arrive more rapidly than they expected and have planned for. To this end, funds should flow to the regions based on outcomes and care improvement metrics in the latter years of the waiver.

In the initial years, DSRIP payments are usually given for achieving process milestones: providers are rewarded for opening new clinics, implementing care transitions programs, community outreach programs, expanding specialty care, hiring providers, etc. Linking funds to infrastructure development and capacity building in the beginning of the waiver enables providers to build the structures necessary to begin improving clinical outcomes.

The Texas DSRIP waiver has a fairly even split between process and outcome milestones, whilethe New York waiver places more emphasis on outcomes, as the state is closer to value-based purchasing and payment reform.

**Data presents opportunities but can be a significant blocker**

Much of the DSRIP design and payment in Texas and New York hinges on the availability of data.

In Texas, limited access to Medicaid data and a severe lack of HIT infrastructure in the state has led to stunted reporting capabilities by providers; data availability often dictated the selection of clinical outcomes by providers, even though they may not have been the most appropriate metrics to choose from. Providers do not have access to statewide claims data and must rely on their own internal data systems to report on many population measures. This limited data reduces the ability of the state to measure the impact of DSRIP because reported data is not standardized across providers.

In New York, much of the DSRIP project design and funds flow is dependent on data availability. Medicaid members are attributed to the performing provider systems (for waiver purposes only at this time). The number of lives attributed to a PPS impacts the scale of the milestone goals, and the number of lives also affects the valuation of the projects. However, much of the data integral to planning the projects comes from state claims data, which is on a year-plus delay. In addition, much of the data analysis is being done by the state and is a large administrative burden that causes further delays in information disseminated to providers. This will cause significant obstacles in timely reporting of clinical outcomes for payment.

Washington state must consider 1) what data is available to providers as part of the DSRIP planning and measurement phases; 2) what data will need to be made available to providers; 3) what level of analytics and support will need to be given to providers; and 4) how claims data delays may impact DSRIP.

**Anti-trust issues must be dealt with early**

The purpose of creating a regional transformation plan under the 1115 Waiver is to encourage collaboration, care coordination and continuity for patients. In New York, several managed care organizations have raised concerns that DSRIP may lead to anti-trust activities, particularly with relation to Commercial lines of business. New York State has taken some regulatory steps toward addressing this issue, but much remains to be seen. Clarifying antitrust risks up front and developing clear guidance to the ACHs, providers and health plans in advance, to the extent possible, will reduce distractions during the design, implementation and transition process.

**COPE Health Solutions**

Our team has extensive experience with the 1115 Waivers, including the California Coverage Initiative and the DSRIP waivers in California, Texas and New York. We would be happy to share our lessons learned and best practices from our hands-on work in planning, implementing and measuring 1115 Waiver transformation programs. We look forward to supporting your transformation. *For more information please contact us at dsrip@copehealthsolutions.org.*