State of Illinois 1115 Medicaid Waiver Update and Summary
February 19, 2014

The state of Illinois released its 1115 Medicaid waiver application on February 10, 2014, with a goal of submitting the application to the Centers for Medicare and Medicaid (CMS) on March 12. The waiver proposes an increase in federal funding for the state’s Medicaid program of approximately $5.2 billion over five years. Once the state submits the application, CMS will begin its evaluation and engage the state in what are anticipated to be very lengthy negotiations that may result in changes to the funding amounts and distribution as well as specific initiatives that have been proposed in the application.

An 1115 Waiver Recognizes the Central Role of Hospitals

Under Section 1115 of the Social Security Act, the federal government has authority to waive certain Medicaid requirements, giving states flexibility in the operation of their Medicaid program and allowing states to improve care as well as obtain federal funding to assist in transforming the underfunded Medicaid system. As hospitals continue to broaden their service offerings and take on a central role as care coordinators, the waiver presents opportunities to support these care coordination activities.

Having served their communities in many cases for over 100 years, Illinois’ hospitals and health systems know that it takes much more than “traditional” medical care to achieve healthy communities. The predominant model of health care delivery for IHA members has evolved to support enhanced quality of life for communities by identifying and addressing health and social needs. Hospitals and health systems provide a broad range of services – not just “traditional” emergency, trauma, inpatient/acute and surgical care – and not just within the walls of their buildings – but well beyond those walls, all across their communities. Hospitals and health systems currently provide the following services: extensive preventive and primary care services, post-acute services, (including skilled nursing, rehabilitation, long-term care, home health, palliative and hospice care), and mental health and substance abuse programs. Illinois’ hospitals and health systems also provide free and subsidized health services, wellness programs, support groups, medical research, and neighborhood revitalization projects.

In addition, our hospitals and health systems are training the next generation of physicians and other critically needed health care professionals to meet the workforce needs of the state’s health care delivery system, often within training programs where the costs exceed the financial support for training. Hospitals and health systems are truly the cornerstones of their communities and the state’s health care delivery system are the key mechanism to integrate various providers to form an integrated delivery system (IDS) and provide care across the continuum. Typically, it is the hospital that has the necessary infrastructure to bring together a wide range of providers to ensure patients receive the full range of care in the right setting at the right time.
What Will the Waiver do for Illinois?

Through a Section 1115 waiver, the state aims to obtain approximately $5.2 billion in new federal funding that will benefit providers and patients in various ways such as by strengthening the community-based behavioral health system, providing incentives for delivery system innovations, increasing access to community-based care options and positively impacting the social determinants of health.

The waiver includes a request for approximately $1.3 billion over five years in funding specifically for hospitals and health systems in performance incentives, Graduate Medical Education (GME) incentives, loan repayment programs, and incentive payments for public health systems to implement specific quality and delivery system initiatives. Additional opportunities may also exist for hospitals and health systems in other provisions of the waiver, such as behavioral health and community-based services. These waiver projects are designed to improve and integrate systems of health care delivery, including providing more comprehensive and coordinated care for the state’s most vulnerable populations.

Over the past few years, the state of Illinois has taken major steps to reform its Medicaid program, including enactment of the Save Medicaid Access and Resources Together (SMART) Act. This will substantially reduce costs and other legislation to improve the program, by moving substantial numbers of patients into care coordination and establishing provider-sponsored integrated delivery systems.

An 1115 waiver will enable the state to complete the transformation of its Medicaid program through innovative and flexible approaches, ensuring that the program is viable and sustainable in the long-term to provide the highest quality care at the lowest costs. An inherent element of a waiver is the ability to obtain additional federal funding to allow providers to make the necessary investments to transform the health care delivery system. This is especially relevant for Illinois because Illinois ranks at the bottom of state rankings of Medicaid spending per beneficiary. Additional funding is essential so that hospitals and health systems can make the necessary investments and develop partnerships to provide care across the continuum. These waiver incentive funds will be the main mechanism for the state to transform the delivery system and realize savings achieved from enhanced care coordination.

Overall, the state’s draft application is consistent with IHA’s Path to Transformation principles and those waiver components that the IHA Board has determined to be a high priority. The state will now need to demonstrate to CMS the rationale for the funding request and enter into what is predicted to be lengthy negotiations, which will determine the final scope of the waiver. Therefore, many of the implementation details will not be developed until the application is reviewed and refined by CMS.

For example, the waiver describes a general framework for a hospital integration and incentive pool including the plan to solicit input on the selection of measures. But the final measures and thresholds for achieving the funding are not contained in the waiver
application. IHA will be closely monitoring those provisions of greatest interest to hospitals and will keep members informed as more details are released during the review process.

**Summary of Draft State Waiver Application**

The Illinois waiver application is divided into four “pathways” for transforming the health care delivery system. The four pathways are:

1) Transform the Health Care Delivery System;
2) Build Capacity of the Health Care System for Population Health Management;
3) 21st Century Workforce; and
4) Long-Term Services and Supports (LTSS) Infrastructure, Choice, and Coordination.

**Pathway 1 - Transform the Health Care Delivery System**

IHA has advocated for two hospital and health system incentive funds that would be funded by the overall waiver financing. The application includes both of these funds, a $100 million Health System Integration and Transformation Performance Program and a $25 million Institution Transition Fund for hospitals and other providers.

The funding for the integration and performance program is divided into two pools of funding: one for safety net hospitals and critical access hospitals and another pool for all other hospitals. A limited number of performance metrics will be used to determine funding distribution. A committee with representatives from hospitals and health systems, including Accountable Care Entities (ACEs), will make recommendations of the final performance measures and several examples are contained in the application. It is envisioned that three to five measures would be used for this pool including a measure that will be based on level of integration among different providers, including use of health information technology. Illinois hospitals and health systems are committed to the type of transformation described in the application and the integration and performance pool will provide incentive funding for hospitals to continue their transformation and build integrated delivery systems.

Another pool that IHA supports would provide incentive funding for hospitals that commit to redesigning, downsizing or closing some of their facilities. The application allocates $25 million a year for this initiative for institutions, which would include hospitals, nursing homes, and possibly other providers that have not yet been defined. In some instances, a community no longer needs traditional inpatient hospital beds, as more care is being provided in the outpatient setting. However, it is often challenging to close or convert that inpatient facility to the type of facility that is needed to meet the community’s health care needs in today’s environment. Consequently, a hospital conversion program would serve as a catalyst and provide funding to support hospitals that are facing this situation so that the hospital (and the community it serves) can thoughtfully consider and develop a strategy to transition to a use that would continue to meet the health needs of the community.
Delivery System Reform Incentive Payments to Transform Public Providers
The waiver application proposes a delivery system reform incentive program for the University of Illinois Hospital and Health Science System and Cook County Health and Hospitals System (CCHHS). These two public health and hospital systems are able to participate in a waiver program referred to as delivery system reform incentive program (DSRIP), which is typically used in waivers to fund a variety of incentive projects for public hospitals.

The waiver application contains a number of proposed DSRIP projects and these will be finalized, including funding amounts and program metrics during the CMS review process. Examples of projects proposed by CCHHS include development of a community health worker residency program and collaboration on other training programs to address workforce shortages. In collaboration with Malcolm X College of the City Colleges of Chicago, CCHHS will develop a residency program to train community health worker students in a supervised direct practice community setting. CCHHS also proposes a project to integrate behavioral health and primary care by implementing a population screening measure that allows better identification of patients with mild to moderate depression and related behavioral health disorders (e.g., anxiety, grief, substance use).

The University of Illinois Hospital and Health Science System has also proposed a range of projects. Some of the proposals include a project to build medication therapy management by identifying Medicaid beneficiaries that are not assigned to a coordinated care network and/or who are in rural areas in need of medication therapy management services. Also included is the creation of a specialty Patient-Centered Medical Home (PCMH) for Individuals with Sickle Cell as one way to manage a high cost population that would benefit from intensive, specialized services. The goal of the project would be to reduce inpatient admissions by improving health literacy through specialized care coordination.

Access Assurance Pool
An access assurance pool is included in the application as a mechanism for allowing the state to preserve the current level of federal funding financed by the current Hospital Assessment Programs. Such a mechanism is needed since federal Medicaid requirements (i.e., the Upper Payment Limit) will reduce the amount that can be paid directly to hospitals by the State as more Medicaid patients are moved into capitated managed care arrangements. An access assurance pool is an option that would allow the state to continue to pay all or a portion of the hospital assessment payments directly to hospitals based on their uncompensated care costs. To assure stability as the State moves to managed care and implements the new hospital Medicaid rate system, we have suggested that the payments under the current assessment program could be extended for the first two years of the waiver, at which time the program would transition to the new allocation methodology under the access assurance program. IHA will be issuing a more detailed description of the access assurance pool as one option for preserving assessment funding.
Innovation and Transformation Resource Center (ITRC)
The new provider driven models of care coordination entities and accountable care entities are listed in the application as potential recipients of technical assistance provided by the new Innovation and Transformation Resource Center within the newly created Office of Health Innovation and Transformation. Examples of assistance include:

- Project management, network organization and governance structure support;
- Assistance with design of tracking and reporting systems, including the use of EHR technology for all providers within a network;
- Assistance with data collection, reporting, claims analysis and data analytics to track outcomes, performance and cost savings; and
- Support for training programs for staff involved in care coordination, client record monitoring, reporting and technology use.

The state has requested $40 million annually in waiver funding to support the ITRC. In addition to support for ACEs and Care Coordination Entities (CCEs), the waiver lists the following possible examples of technical assistance:

- Accelerate implementation of health homes;
- Assist in front-line performance improvement – transform physician office, use a registry, team-work;
- Assist in establishing payment methodologies within IDSs to facilitate delivery system transformation;
- Disseminate best practices in models of care (particularly for specific populations)
- Share and spread best practices to maximize the number of people benefitting from the innovations and accelerate the pace of positive change;
- Support the Multidisciplinary Team-based Care Learning Collaborative and promote team-based care across the IDSs; and
- Provide technical assistance for adoption of tele-health and other emerging technologies to optimize efficient use of resources.

Pathway 2 - Build Capacity of the Health Care System for Population Health Management

This pathway aims to build linkages between public health and health care delivery systems, by creating a premium add-on payment for health plans that agree to use the funds to develop population health interventions in conjunction with newly created Regional Public Health Hubs. It is unclear why health plans would be the only entities to receive payments to develop population health interventions in conjunction with the newly created regional public health hubs.

IHA has requested that hospitals also be eligible for such payments and be allowed to shape the activities that would be performed in return for the incentive financing. Hospitals will play a key role in such activities and in some instances are already working closely with public health departments. Interjecting the health plans in this process might
needlessly diffuse scarce resources away from the providers who are already developing community needs assessments and would be in the best position to work with the regional hubs. The application is silent on what activities the health plans would perform in return for this additional funding or how they would be held accountable.

The waiver application also refers to the creation of regional public health hubs to collaborate with local hospitals to share data obtained through the community needs assessment. Such voluntary collaboration has potential to align efforts to address the highest priority needs within communities. The health of our communities is an issue that hospitals are uniquely suited to address as a convener of a wide range of providers and social service agencies. We recognize that the waiver can play an important role in improving population health that will benefit communities throughout the state.

**Pathway 3 - 21st Century Health Care Workforce**

This pathway seeks to increase the supply of primary care physicians and increase use of non-physician providers. A portion of the program would incentivize primary care GME programs to train residents in team-based, patient-centered medical home settings. Also, a state loan repayment program for physicians and other health care professionals would be designed to expand primary care capacity in underserved areas. Investments in training other health care providers such as community health care workers, in-home specialized personal attendants, care coordinators as well as team based care training for nurses, physician assistants and physicians are potential workforce initiatives.

**Graduate Medical Education (GME) Incentive Funding**

The GME funding will consist of two programs, both designed to increase the number of physicians practicing in underserved areas.

First, the application contains $10 million annually for a program the mirrors the current Teaching Health Center Graduate Medical Education Program that was created by the Affordable Care Act. The waiver funding would fund the existing Illinois program, which is expected to run out of funding in 2015. Also, other GME programs would apply for the waiver funding under the existing criteria for the THC program. The program encourages partnerships among GME accredited institutions and community-based ambulatory patient care settings such as federally-qualified health centers, community mental health centers and rural health clinics. But given that the criteria for the program are so stringent, we will be recommending that the state allow other types of primary care residency programs to apply for funding.

The second GME program will consist of $26 million annually in incentive based payments to GME programs in designated medical specialties. While IHA shares the goal of increasing the number of primary care providers in Illinois, especially those practicing in underserved communities, we remain concerned that the GME proposal is overly restrictive in terms of the criteria for receiving funding. The proposal is to provide incentive funding for GME programs to provide community-based training serving
underserved populations. Programs in the specialties of Family Medicine, Internal Medicine, Pediatrics and Internal Medicine-Pediatrics, Obstetrics and Gynecology, Psychiatry, General Surgery, General Dentistry, Pediatric Dentistry and Geriatrics are eligible.

We appreciate that this version of the application removed the criteria for year five of the program. However, the inference is that the criteria in year five would be more stringent than in years three and four, which already are too rigorous. The proposal outlined in the application is based too heavily on holding GME programs fully accountable for physician practice location choices that are outside the control of the program. By basing 50% of funding of physician practice decisions, GME programs considering this waiver program may decide that the additional burdens imposed exceed any potential gain and jeopardize participation. We are not opposed to having some of the funding based on physician practice decisions as one outcome measure, but such funding should not exceed 25%. Holding programs fully accountable for physician practice location decisions overlooks the complexity of such decisions. Levels above that amount not only might unfairly penalize program participants but may create too much uncertainty and serve as a disincentive from participating in this worthwhile and much needed program.

**Health Care Workforce Loan Repayment**
The health care workforce loan repayment programs described in the application hold promise for increasing the workforce serving the Medicaid population. The application includes $10 million annually to fund existing loan repayment programs for family medicine, psychiatry, nursing, allied health professions, and dental, which have not been funded since 2009. The state may also include additional professions such as social workers and mental health and substance use disorder professionals.

In addition, the state proposes to create a bonus payment pool of $20 million annually for safety net and critical access hospitals that have their own loan repayment programs. The program would be designed to incentivize these hospitals to create their own loan repayment programs based on their specific workforce needs.

**Pathway 4 – Long-Term Services and Supports (LTSS) Infrastructure, Choice, and Coordination**
The waiver application contains a variety of initiatives with the overall goal of providing individuals with the right level of long-term services and supports so that they can remain in the home and community settings as well as better coordinate behavioral health with physical health for this population and other populations. The state proposes to allocate a majority of the waiver funding on these two goals with funding of more than $500 million annually. The state anticipates that improving community supports and moving some individuals out of institutional settings into the community will provide considerable cost savings. But up-front funding to build those community supports is needed.
Most significantly, the state intends to redesign nine existing Section 1915 Home and Community Based Services (HCBS) waivers that are currently based on an individual’s primary disability. The state would like to consolidate the waivers and achieve some uniformity in an assessment instrument and therefore provide services based more on needs rather than the specific disability. As part of the waiver consolidation, the waiver recipients would be offered a wider range of community based LTSS options. In addition, the waiver consolidation would seek additional support for development and expansion of community-based options. Additional funding will be sought to reducing the Developmental Disabilities waitlist.

Behavioral health expansion and integration is another goal of the state. The application recognizes how care coordination for the Medicaid population with comorbidities of mental illness cannot be effective without enhancing behavioral health community-based services, including support for patient centered behavioral health homes. This will involve creating health homes for individuals with serious mental illnesses (SMI) as well as requiring Medicaid managed care entities to promote increased coordination of care between physical health and mental health and substance use disorders. The waiver also seeks to expand supportive housing services for vulnerable populations with chronic conditions and behavioral health conditions.

The state will also use the waiver to provide alternatives to institutional care. Among the LTSS services that would be supported by a waiver are those of Specialized Mental Health Rehabilitation Facilities (SMHRFs), a new hybrid facility created exclusively in 2013 for the former IMD nursing facilities that are required to transition their residents to more community integrated settings pursuant to two court consent decrees.

The waiver also will increase access to community-based services by providing $9 million annually for Assertive Community Treatment (ACT) teams and Community Support Teams (CST). ACT and CST are team-based services provided under the Medicaid Community Mental Health System (Rule 132) that historically has been limited to community mental health providers funded by Department of Human Services Division of Mental Health.

CST consists of mental health rehabilitation services and supports delivered by a team to children, adolescents, families and adults with moderate to severe mental illnesses. The service consists of interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources.

ACT is an intensive integrated rehabilitative crisis, treatment and rehabilitative support service for adults provided by an interdisciplinary team to individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. The service is intended to promote symptom stability and appropriate use of psychotropic medications, as well as restore personal care, community living and social skills.
Budget Neutrality

While the waiver application is consistent with IHA priorities in many respects, such as increased support for behavioral health, a hospital performance incentive pool, and an access assurance pool, the ultimate funding available for IHA priorities will depend on achieving CMS and Office of Management and Budget (OMB) approval of the state’s budget analysis. The state will have to demonstrate to CMS and OMB that although the state will receive increased federal funding, overall federal funding for the state’s Medicaid program will not be more than without the waiver. In other words, the waiver funding will need to produce savings in the later years of the waiver. To achieve this budget neutrality, the state is requesting a baseline spending increase projection of 4.85% a year, which is the Medicare equivalent spending projection. The state then is predicting that the waiver will lead to a 1.5% savings or annual spending growth rate of 3.35%.

Part of this financial analysis includes identifying the waiver provisions that will have the largest returns on investment within the five-year waiver period. The application states that the waiver:

- Includes a significant investment in strengthening HCBS services, as well as mental health and substance use disorder services. The waiver also proposes the development of a statewide tele-health network to improve access to specialty care and behavioral health services in hard-to-reach rural areas. These provisions will directly impact the use of hospital Emergency Departments, inpatient utilization including readmissions, and utilization of institutional care.

- Includes incentives for plans and providers to address critical social determinants of health, including stable housing for populations with severe mental illness and/or substance use disorders. A substantial and growing base of evidence indicates that stable housing for this target group can significantly improve treatment compliance, reduce the need for institutionalization, and significantly reduce overall costs;

- Provides a transition path for hospitals to incentivize them to move more quickly to appropriate managed care vehicles and integrated delivery systems; and

- Keeps critical providers and their employees stable during this rapid evolution, through creation of an Access Assurance Pool.

IHA will be closely following the waiver application process and will be providing members with updates, as well as periodic issue briefs on particular waiver topics that are of interest to members.

For more information IHA members should contact Patrick Gallagher at 630-276-5496 or pgallagher@ihastaff.org.