

# An Overview of Emerging State Health Care Purchasing Trends

PREFACE





## An Overview of Emerging State Health Care Purchasing Trends

By *Tricia McGinnis and Rob Houston, Center for Health Care Strategies*

### INTRODUCTION

This *Overview of Emerging State Health Care Purchasing Trends* serves as a supplement to the *Medicaid Health Care Purchasing Compendium* (Compendium), highlighting emerging opportunities in health care purchasing. Trends of note fall into the following categories: delivery system and payment reforms, proposed Medicaid managed care regulations, population-specific reforms, data improvements, and opportunities for federal investment and support.

### DELIVERY SYSTEM AND PAYMENT REFORMS

With continued fiscal pressures in both the private and public health care sectors and new delivery system and payment approaches authorized in the Affordable Care Act (ACA), there has been a growing focus among policymakers to improve the quality and efficiency of the health care system. Emerging trends in this area include: alternative payment models, re-designed managed care payments, multi-payer alignment efforts, and strategies to curb high-cost drug spending.

#### ALTERNATIVE PAYMENT MODELS

Alternative payment models (APMs) are value-based payment methods that move beyond the fee-for-service (FFS) payment model, which many experts believe is a major driver of high-volume care, to incentivize care that is high-quality and cost-effective. The U.S. Department of Health and Human Services (HHS) has set a goal of shifting 30 percent of Medicare fee-for-service payments to APMs by 2016 and 50 percent by 2018, signaling an increased federal effort toward achieving these types of payment reforms.<sup>1</sup> Several states already have begun to expand beyond traditional pay-for-performance programs by shifting from paying their providers on a FFS basis toward arrangements such as shared savings/risk models and bundled payments. In some instances states do this directly with providers and in other instances states require their contracted health plans to pass risk for cost and quality on to their provider networks. These models will likely become more sophisticated in the future.

<sup>1</sup> Centers for Medicare and Medicaid Services, "Better Care, Smarter Spending, Healthier People: Paying Providers for Value, Not Volume," January 26, 2015, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html> (accessed July 22, 2015).

A growing number of states are implementing total cost of care (TCOC) models, which hold a risk-bearing entity (such as a provider-led accountable care organization [ACO]) responsible for the totality of a patient's care, in terms of both outcomes and costs. As of mid-2015, states are generally pursuing two types of TCOC models:

- **Shared savings/risk model** – In this model, FFS payments remain in place but the accountable provider entity is eligible for a portion of savings achieved, or is at risk for any increase in costs, relative to the projected total cost of care; and
- **Capitated per member per month (PMPM) or global payment model** -- In this model, the accountable provider entity receives upfront lump sum payments intended to cover the risk-adjusted projected TCOC.

TCOC models range in complexity. Most TCOC approaches currently in place include only physical health services, while some also cover behavioral health services, long-term supports and services (LTSS), or dental services. Some states also are exploring the inclusion of select social services in TCOC calculations, recognizing that social determinants are a driver of health care costs. Examples of TCOC models include: Oregon's Coordinated Care Organization (CCO) model,<sup>2</sup> which pays for physical health, behavioral health, and dental services through a global payment;

<sup>2</sup> Oregon Health Policy Board, "Coordinated care: the Oregon difference," Oregon Health Authority, <http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx> (accessed July 22, 2015).

Medicaid ACO programs in Maine<sup>3</sup> and Minnesota,<sup>4</sup> which transition from shared savings to symmetrical risk programs; and projects within New York’s Delivery System Reform Incentive Payment (DSRIP) model,<sup>5</sup> which measures population-based costs and outcomes.

### RE-DESIGNING MANAGED CARE PAYMENTS

States with Medicaid managed care are leveraging their contracts with managed care organizations (MCOs) to implement APMs by including requirements around: developing pilot projects (for example, New Mexico is implementing payment pilots proposed by its four MCOs); linking a percentage of medical expenditures to value-based payment approaches (for example, Arizona required that 5 percent of provider payments transition to value-based payments in 2014, which will increase to 50 percent by October 2017); and adopting specific payment models (for example, Tennessee is requiring MCOs to participate in its episodes-of-care program). Central to all of these initiatives are states’ efforts to ensure that some portion of the risk for providing value (measured through cost and quality) is being passed on to providers (such as hospitals, physician groups, and primary care practices).

### MULTI-PAYER ALIGNMENT

To create a stronger economic signal that supports migration from FFS payment systems toward value-based payment systems and to make it easier for providers to participate in APM arrangements, states are seeking to align key parameters of their delivery system and payment reform programs with Medicare and commercial counterparts. For example, states pursuing ACOs and episodes-of-care models for Medicaid are incorporating payment methodologies, including attribution models and quality metrics that are similar to those used in the Medicare Shared Savings Program and commercial programs. First, such alignment allows value-based payment systems to be more viable for provider organizations by allowing the organizations to capture a larger portion of the revenue lost when decreasing volume and orienting toward value. In addition, standardizing requirements, where possible, helps reduce the burden on providers, thereby facilitating provider buy-in. One challenge to creating alignment across these parameters is addressing the unique services provided and populations served in Medicaid, which vary significantly from Medicare and commercial plans. There are several federally funded multi-payer alignment initiatives underway, such the State Innovation Models (SIM) initiative,<sup>6</sup> Financial Alignment Initiative for Medicare-Medicaid Enrollees,<sup>7</sup> Comprehensive Primary Care Initiative,<sup>8</sup> and the Health Care Payment Learning and Action Network,<sup>9</sup> providing even greater impetus for this industry-wide shift.

### CURBING HIGH-COST DRUG SPENDING

Especially challenging for state purchasers are the effective but very expensive new breakthrough therapy drugs, such as Sovaldi which treats Hepatitis C, that have limited or no market competition.<sup>10</sup> Sovaldi, in particular, creates a dilemma for Medicaid budgets because of the disproportionate prevalence of Hepatitis

- 3 MaineCare Services, “Accountable Communities Initiative,” Maine Department of Health and Human Services, <http://www.maine.gov/dhhs/oms/vbp/accountable.html> (accessed July 22, 2015).
- 4 Minnesota Department of Human Services, “Integrated Health Partnerships (IHP) Overview,” [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_161441](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441) (accessed July 22, 2015).
- 5 New York State Department of Health, “Delivery System Reform Incentive Payment (DSRIP) Program,” [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/) (accessed July 22, 2015).
- 6 Center for Medicare and Medicaid Innovation, “State Innovation Models Initiative: General Information,” Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/state-innovations/> (accessed July 22, 2015).
- 7 Center for Medicare and Medicaid Innovation, “Financial Alignment Initiative for Medicare-Medicaid Enrollees,” Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/Financial-Alignment/> (accessed July 22, 2015).
- 8 Center for Medicare and Medicaid Innovation, “Comprehensive Primary Care Initiative,” Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/> (accessed July 22, 2015).
- 9 Center for Medicare and Medicaid Innovation, “Health Care Payment Learning and Action Network,” Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/> (accessed July 22, 2015).
- 10 “Health Policy Brief: Breakthrough Therapy Designation,” Health Affairs, May 15, 2014, [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=115](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=115) (accessed July 22, 2015).

C among Medicaid beneficiaries, including those in the Medicaid expansion population (in those states that have chosen to expand as authorized under the ACA).<sup>11</sup> Similarly, the expense of this drug places considerable pressure on state corrections' budgets because of the high incidence of Hepatitis C among incarcerated populations.<sup>12</sup> Adding to the concern in this area is the growth of genetically based therapies, also expected to have much higher costs than the typical pharmacological therapies of today.<sup>13</sup> Additionally, the underlying cost of generic drugs has gone up in recent years, putting more pressure on state purchasers.<sup>14</sup> Moving forward, state purchasers are negotiating with MCOs to determine how to bear the risk of these high-cost drugs. It is critical that states and Medicaid MCOs carefully monitor the drug pipeline to anticipate and prepare for new, breakthrough entrants. Options for states include developing new utilization management strategies around specialty drugs to target approved usage more effectively (such as adopting prior authorization requirements or readiness for treatment criteria).<sup>15</sup>

## PROPOSED MEDICAID MANAGED CARE REGULATIONS

The Centers for Medicare and Medicaid Services' (CMS) proposed Medicaid managed care regulations, published in May 2015, represent the first significant update to Medicaid managed care regulations in over a decade. Key regulatory changes that will affect Medicaid purchasing strategies include: proposed mandatory 14-day plan selection period for new enrollees; increased standardization in rate setting/actuarial certification; establishment of a federal medical loss ratio standard for Medicaid; new minimum provider credentialing standards; expanded plan responsibilities for program integrity/monitoring fraud and abuse; enhanced requirements for standardized, timely, and complete encounter data submission; more rigorous network adequacy standards; new uniform quality rating system, using a common set of metrics similar to those already used in Medicare Advantage and the health insurance marketplaces; and adoption of a clear definition and principles for LTSS.<sup>16</sup>

The proposed Medicaid managed care regulations also support the states' use of MCOs to implement APMs. For example, if finalized, the proposed regulations would enable states to: continue to use MCO contracts to require the adoption of APMs and have MCOs participate in broad-ranging delivery system and performance improvement initiatives.<sup>17</sup>

## POPULATION-SPECIFIC REFORMS

In tandem with system-wide reforms around paying for care, Medicaid agencies also are pursuing strategies for targeted opportunities to improve how care is delivered and reduce the associated costs. This section explores some emerging trends in population-focused reforms, including: integration of physical and behavioral health, complex care patient programs, and population health integration models that aim to integrate health care with social services and community supports.

11 Michael Ollove, "Could New Hepatitis C Drugs Bust State Budgets?," The Pew Charitable Trusts, Stateline, February 28, 2014, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/02/28/could-new-hepatitis-c-drugs-bust-state-budgets> (accessed July 22, 2015); and National Alliance of State & Territorial AIDS Directors, "The Affordable Care Act and the Silent Epidemic: Increasing the Viral Hepatitis Response Through Health Reform," March 2013, <http://nastad.org/sites/default/files/Primer-ACA-Hepatitis-March-2013.pdf> (accessed July 22, 2015).

12 Centers for Disease Control and Prevention, Hepatitis C & Incarceration (Atlanta, GA, October 2013), <http://www.cdc.gov/hepatitis/HCV/PDFs/HepCIncarcerationFactSheet.pdf> (accessed July 22, 2015).

13 Ron Leuty, "Gene therapy: How much for a magic bullet?," San Francisco Business Times, April 25, 2014, <http://www.bizjournals.com/sanfrancisco/print-edition/2014/04/25/gene-therapy-magic-bullet-randy-curtis-gilead.html> (accessed July 22, 2015).

14 Ed Silverman, "Generic Drug Prices Keep Rising, but is a Slowdown Coming?," Wall Street Journal, April 22, 2015, <http://blogs.wsj.com/pharmalot/2015/04/22/generic-drug-prices-keep-rising-but-is-a-slowdown-coming/> (accessed July 22, 2015).

15 Sandra Wilkniss, Sophia Tripoli, and Frederick Isasi, New Hepatitis C Treatments: Considerations and Potential Strategies for States (Washington, D.C.: National Governors Association Center for Best Practices, February 25, 2015), <http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1502NewHepCTreatments.pdf> (accessed July 22, 2015).

16 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, Proposed Rule, 80 Fed. Reg. 31097 (June 1, 2015), <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicoid-managed-care-chip-delivered> (accessed July 22, 2015).

17 Ibid.

### INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

The siloed nature of the traditional financing and delivery of behavioral and physical health services (such as behavioral health carve-outs) creates disincentives for coordinated and efficient care. While states use various arrangements to pay for and provide Medicaid behavioral health services, there is a general trend of moving toward managed systems of care to integrate physical and behavioral health services. For example, during the last two years, Arizona, Florida, Kansas, and Texas have carved Medicaid specialty behavioral health services (for some or all Medicaid enrollees) into comprehensive managed care contracts that also cover physical health services. Other states, such as New York, plan to implement a similar model in 2015. Meanwhile, a number of states have opted to preserve a carve-out of behavioral health services, in favor of maintaining a specialty system of care for individuals with serious behavioral health needs. Among these states, which include Idaho and Louisiana among others, the general trend has similarly been toward managed care and risk-based contracting.

Likewise, there are several efforts underway in states to promote integration at both the systems level and the point of care. States are requiring payers or providers to report process and outcome measures that are jointly impacted by physical and behavioral health services for individuals with behavioral health conditions. Examples of these measures include emergency department utilization rates, rates of avoidable hospitalizations, and medication adherence for both physical and behavioral health treatments. For example, the Serious Mental Illness Innovations Project in Pennsylvania expanded requirements for coordination across health plans and local county agencies to provide seamless access to physical and behavioral health services. Results included decreases in mental health hospitalizations, all-cause readmissions, and emergency room use for individuals who used those specialty services.<sup>18</sup>

Nineteen states plus the District of Columbia have implemented Medicaid health homes to improve integration across physical health, behavioral health, and LTSS for individuals with serious mental illness or chronic medical conditions (as defined by the state). Health homes offer states an opportunity to pay for difficult-to-reimburse services that are important for this population (such as care management and care coordination) and provide an enhanced federal match for the first two years of implementation.

### COMPLEX CARE PATIENT PROGRAMS

Medicaid patients using a large volume of hospital services, often referred to as high-cost and complex-care patients, tend to have inadequate ambulatory care, poor continuity of care between care settings, co-occurring behavioral health conditions, and a variety of social barriers that contribute to overall poor health. Recognizing that 5 percent of the highest-cost Medicaid patients generate more than 50 percent of program costs, several states are pursuing focused programs to address avoidable costs and improve the health of this high-need population.<sup>19</sup>

Many of these programs were inspired by the work of innovators such as the Camden Coalition of Healthcare Providers in Camden, New Jersey<sup>20</sup> and CareOregon.<sup>21</sup> These models combine an array of interventions to address the complex medical, behavioral health, and social services needs of high-cost patients.<sup>22</sup> Generally speaking, complex care patient programs are structured to identify patients and deploy multi-disciplinary

18 Jung Y. Kim et al., SMI Innovations Project in Pennsylvania: Final Evaluation Report (Hamilton, NJ): Center for Health Care Strategies, October 1, 2012), <http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/> (accessed July 22, 2015).

19 Steven B. Cohen and William Yu, Statistical Brief, no. 354: The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008–2009 (Rockville, MD: Agency for Healthcare Research and Quality, January 2012), [http://meps.ahrq.gov/mepsweb/data\\_files/publications/st354/stat354.shtml](http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml) (accessed July 22, 2015).

20 For more information, visit <http://www.camdenhealth.org/> (accessed July 22, 2015).

21 For more information, visit <http://www.careoregon.org/LearningAndInnovation.aspx> (accessed July 22, 2015).

22 Center for Health Care Strategies, "Fact Sheet: Programs Focusing on High-Need, High-Cost Populations," March 2015, [http://www.chcs.org/media/SU-Fact-Sheet\\_41715\\_Final.pdf](http://www.chcs.org/media/SU-Fact-Sheet_41715_Final.pdf) (accessed July 22, 2015).

care teams that have the expertise to connect patients with the appropriate clinical staff, including both primary care and specialty care, provide access to necessary social supports, and empower patients to achieve their own health goals. The care teams draw on a range of health professionals including nurses, care managers, social workers, community health workers, and care navigators. They also tap into a range of care delivery models including integrated mental health and substance use disorder services, housing support, and trauma-informed care. Some states, including Minnesota through its county-based Hennepin Health<sup>23</sup> model, are using ACOs to provide new incentives for providers to share in savings they generate by providing higher quality and more integrated care for high-need populations. These shared savings opportunities create new incentives for providers to invest in care coordinators for high-need populations to help deliver those savings.

#### POPULATION HEALTH INTEGRATION MODELS

Some states are exploring opportunities to strengthen linkages to complementary state and local investments in public health and social services. The idea is to create a multi-sector infrastructure to better integrate clinical interventions with community-based health efforts, thereby maximizing the return on investment in related state and local programs. Given the impact that communities have on population health, states are seeking to create the necessary linkages and partnerships between clinical care and the community, while also establishing a shared sense of accountability.

There are a few nascent models underway. For example, as part of their SIM initiatives, Minnesota, Michigan, Vermont, and Washington are all pursuing accountable communities for health models. Minnesota and Washington were awarded grants to select communities to pursue specific local health improvement projects while building the necessary community governance structures, decision-making processes, engagement strategies, and administrative support functions.

#### DATA IMPROVEMENTS

For states to successfully advance health care purchasing initiatives, it is critical to improve both the flow of data within the system (interoperability) and the analytics available to surface insights from the data. In many instances, such efforts require high-level support such as the leadership of governors' offices. States are engaged in an array of efforts to improve access to and analysis of data, including: investments in health information technology, such as health information exchanges (HIEs), adoption of electronic health records (EHRs), and analytic tools to ensure timely and accurate data access across providers and state agencies. Current trends in data management include: developing HIEs, developing all-payer claims databases, linking and analyzing data across agencies and organizations and the anticipated 2015 release of the Transformed Medicaid Statistical Information System (T-MSIS).

#### HEALTH INFORMATION EXCHANGES

Using SIM grant funds and other federal sources, many states are developing cohesive HIEs to transmit patient data between providers. In implementing HIEs, states face challenges with reliable and timely access to data, ensuring interoperability between EHRs and record-keeping systems, addressing privacy concerns, and providing a sustainable funding source for these efforts. States are increasingly looking to partner to form multi-state or regional HIEs, such as the Chesapeake Regional Information System for our Patients,<sup>24</sup> a nonprofit membership-based HIE that exchanges data between entities in Maryland and Washington, D.C., and provides additional services such as an encounter notification, direct messaging, and a prescription drug monitoring program.

<sup>23</sup> For more information, visit <http://www.mhp4life.org/about-us/about-hennepin-health> (accessed July 22, 2015).

<sup>24</sup> For more information, visit <https://crisphealth.org/> (accessed July 22, 2015).



### ALL-PAYER CLAIMS DATABASES

All-payer claims databases (APCDs), a rising trend among states, offer the capability to aggregate multi-payer data to better understand cost, quality, and utilization patterns. As of June 2015, 15 states have operational APCDs, including 12 states with APCDs where data submission by carriers is mandated by state law and three states with APCDs where data is provided on a voluntary basis.<sup>25</sup> Six additional states are in active design and implementation of APCDs, and many other states have expressed interest or are pursuing legislation.

APCDs typically integrate enrollee demographics, claims information, and provider information from public and private insurers for all publicly and privately insured residents in a state. Because APCDs collect multi-payer data, the information provides a valuable repository of information about a provider's total insured panel of patients. As performance-based contracting moves from performance incentives at an MCO level to performance incentives at a provider level, APCDs can provide a risk-adjusted profile of a provider's entire insured patient panel, their health care use over time, and health care costs. This information is critical for multi-payer performance-based purchasing efforts involving provider-level incentives. While there are many important considerations when developing an APCD,<sup>26</sup> there are benefits from having these data handy for in-depth analysis across payers and populations to help focus and drive public policy initiatives.

### LINKING AND ANALYZING DATA ACROSS AGENCIES AND ORGANIZATIONS

Data also play a critical role in addressing the social factors that influence health outcomes. Linking and analyzing data across state agencies and organizations creates opportunities to improve program analysis, development, and care coordination. States have begun to work along this vein, including Washington State's Predictive Risk Intelligence System (PRISM),<sup>27</sup> which is made up of an integrated client database linking 16 state agency databases including Medicaid, social services, corrections, and public health. PRISM also features a predictive modeling tool that can generate valuable reports across departments.<sup>28</sup> Similar connections have been made through contracting across providers and organizations, such as Minnesota's Hennepin Health,<sup>29</sup> which involves collaboration across public health and social service agencies, the corrections department, hospitals, Federally Qualified Health Centers, a health plan, and community organizations.

### T-MSIS

CMS is developing T-MSIS,<sup>30</sup> which will allow the federal government and states to report, analyze, and monitor aggregate clinical and cost data at the state and national levels. The system aims to streamline and standardize reporting procedures and data feeds. States should monitor the roll-out of T-MSIS as they may be expected to provide specific data once the system is operational. While it will likely take some time for the system's analytic capabilities to become fully functional, it could present a new opportunity to analyze data both within and across states and programs. T-MSIS roll-out by CMS is slated to begin sometime in 2015.

## OPPORTUNITIES FOR FEDERAL INVESTMENT AND SUPPORT

States must often seek federal approval in order to implement payment and care delivery initiatives. States also face the challenge of financing these initiatives, which often require upfront investment to implement changes to systems that may ultimately lead to improved care and reduced costs. As discussed below, states have been able to receive additional federal Medicaid funds through the use of certain models.

25 For more information, visit <http://www.apcdouncil.org/state/map> (accessed July 22, 2015).

26 Jo Porter et al., *The Basics of All-Payer Claims Databases: A Primer for States* (Durham, NH: APCD Council, 2014) [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2014/rwjf409988](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988) (accessed July 22, 2015).

27 Milbank, "PRISM: The Predictive Risk Intelligence System," [http://www.milbank.org/our-work-with-states/reforming-states-group/resource-library?view=download&file=f72ef75067656985207cccd274a5cac0.pdf&name=prism:\\_the\\_predictive\\_risk\\_intelligence\\_system\\_](http://www.milbank.org/our-work-with-states/reforming-states-group/resource-library?view=download&file=f72ef75067656985207cccd274a5cac0.pdf&name=prism:_the_predictive_risk_intelligence_system_) (accessed July 22, 2015).

28 Services and Enterprise Support Administration, "Research and Data Analysis," Washington State Department of Social and Health Services, <https://www.dshs.wa.gov/sesa/research-and-data-analysis> (accessed July 22, 2015).

29 For more information, visit <http://www.mhp4life.org/about-us/about-hennepin-health> (accessed July 22, 2015).

30 Center for Medicaid and CHIP Services, "RE: Transformed Medicaid Statistical Information System (T-MSIS) Data," Centers for Medicare and Medicaid Services, <http://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-004.pdf> (accessed July 22, 2015).



### 1115 WAIVERS/DELIVERY SYSTEM REFORM INCENTIVE PROGRAM/DESIGNATED STATE HEALTH PROGRAMS

Some states have received approval from HHS for Medicaid Section 1115 demonstrations that have provided states with the authority to make sweeping changes to their Medicaid programs while receiving additional funding from the federal government. For example, states have Section 1115 demonstrations that allow them to implement large-scale delivery system and payment reform efforts and to receive additional federal funds through the DSRIP, which states have used to make additional payments to providers and other entities, and Designated State Health Programs (DSHP), which are state-funded programs that would not otherwise be eligible for federal Medicaid matching funds. Since the first DSRIP program was approved in California in 2010, seven additional states (Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas) have received approval from HHS for DSRIP programs and several of these states have extended their programs. Early DSRIP programs provided federal funding for payments to hospitals, and particularly safety net hospitals, with metrics tied to the success of individual projects. More recent DSRIP programs provide federal funding for payments to integrated delivery networks linking hospitals to other providers and social service agencies, with metrics tied to system transformation. Significantly, in more recent waivers, both the integrated delivery networks receiving DSRIP funds and the state are at risk based on quality and cost measures – meaning that a failure to achieve these metrics results in reductions of DSRIP funds.

New York is using its DSRIP to invest in 25 Performing Provider Systems, each of which must include a network of acute, long-term care, and behavioral health providers with linkages to community-based social services organizations. Providers must form partnerships to implement innovative projects focusing on system transformation, clinical improvement, and population health improvement. DSRIP funds are used to reward performance linked to achievement of specific project milestones associated with specific projects. One keystone of New York’s demonstration is the link between DSRIP funds and demonstrable metrics with an overarching goal of reducing avoidable hospitalizations by 25 percent over five years.<sup>31</sup>

Oregon is using its Section 1115 demonstration waiver to implement its CCO program. Under this demonstration, Oregon obtained a significant level of federal matching funds to support CCO implementation. The state used DSHP funds to invest in a Transformation Center, innovator agents, learning collaboratives, and other technical supports, which are part of the quality strategy that Oregon developed to meet its program goals. DSHP is tied closely to specific terms and conditions pertaining to the annual expenditure reduction in spending targets and quality and access standards. For example, CMS is authorized to reduce DSHP funding if Oregon does not meet those terms.

### 1332 STATE INNOVATION WAIVERS

Under Section 1332 of the ACA, which takes effect in 2017, states may seek waivers to the law’s coverage design requirements (otherwise known as state innovation waivers).<sup>32</sup> States can waive the following requirements for innovation programs: imposition of penalties for the health insurance mandate for individuals, imposition of penalties for the health insurance mandate for employers, essential health benefit requirements and tax subsidies and certain marketplace and qualified health plan requirements. A 1332 waiver must satisfy certain criteria to be approved, including providing coverage to at least as many people as would be covered without the waiver, maintaining minimum coverage requirements, maintaining affordability of coverage and care, and ensuring federal budget neutrality.

To date, HHS has published only preliminary regulations on the process states must use to secure the

31 New York State Department of Health, “Redesigning New York’s Medicaid Program,” [https://www.health.ny.gov/health\\_care/medicaid/redesign/](https://www.health.ny.gov/health_care/medicaid/redesign/) (accessed July 22, 2015).

32 Deborah Bachrach, Joel Ario, and Hailey Davis, *Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform* (Washington, D.C. and Princeton, NJ: The Commonwealth Fund and The Robert Wood Johnson Foundation, April 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/apr/innovation-waivers-and-health-reform> (accessed July 22, 2015).

waiver, but has not addressed how the approval criteria described above will be defined or met by states.<sup>33</sup> Regardless, a number of states have expressed interest in Section 1332 waivers. For example, Vermont initially sought to implement a universal, statewide single-payer system using a 1332 waiver, but has decided not to pursue that plan at this time. Hawaii's legislature formed a State Innovation Task Force in 2014, which has been considering a 1332 waiver to maintain Hawaii's longstanding statewide employer mandate.<sup>34</sup>

Section 1332 waivers can be coordinated with Medicaid Section 1115 demonstrations to provide states the opportunity to coordinate and eliminate some of the differences between Medicaid and Marketplace coverage. Minnesota is reportedly considering seeking a Section 1332 waiver to streamline the continuum of eligibility, coverage, and enrollment between Medicaid and the state marketplace, building on its existing Basic Health Plan.<sup>35</sup> Arkansas is considering building on its existing Section 1115 demonstration through a Section 1332 waiver, which could provide a combined Medicaid and Marketplace budget neutrality agreement while allowing the state to enroll Medicaid-eligible individuals into private coverage.<sup>36</sup> Oregon may consider a Section 1332 waiver to expand on its CCOs with incentives to improve health outcomes, or to harmonize value-based purchasing standards in contracts with Medicaid MCOs, state employee plans, and state-based marketplace plans.<sup>37</sup>

The number of states interested in exploring 1332 waiver opportunities continues to grow. Recently, for example, a legislative task force was proposed in New Mexico to consider a 1332 waiver to investigate how the state may be able to use its federal tax subsidy funds differently in order to improve access and quality of health care.<sup>38</sup>

#### INNOVATIONS THROUGH STATE PLAN AMENDMENTS

States pursuing payment reforms to drive quality improvement are increasingly using State Plan Amendments (SPAs) to do so as an alternative to a waiver. In 2012, CMS released guidance on how states can use SPAs to implement integrated care models such as ACOs and Medicaid health homes, which seek to incentivize quality improvement in FFS models without a waiver.<sup>39</sup> Since that guidance was issued, Arkansas has received CMS approval of a SPA to implement its episodes-of-care payments, while Minnesota and Maine received CMS approval of SPAs to implement shared savings/risk models that are part of their Integrated Health Partnership programs.<sup>40</sup> CMS also has published regulations in which the agency explains how states may reimburse new models of non-licensed health care workers through Medicaid to provide community-based services.<sup>41</sup>

33 Application, Review, and Reporting Process for Waivers for State Innovation, Final Rule, 77 Fed. Reg. 11700 (Feb. 27, 2012), <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf> (accessed July 22, 2015).

34 Jessica Schubel and Sarah Lueck, "Understanding The Affordable Care Act's State Innovation ("1332") Waivers," Center on Budget and Policy Priorities, February 5, 2015, <http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers> (accessed July 22, 2015).

35 Heather Howard and Galen Benshoof, "Section 1332 Waivers and The Future of State Health Reform," Health Affairs, December 5, 2014, <http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/> (accessed July 22, 2015).

36 Ibid.

37 Laura Dunn et al., 2017 and Beyond: Using the ACA Innovation Waiver to Reach Minnesota's Triple Aim (Princeton, NJ: Woodrow Wilson School of Public & International Affairs, Princeton University, January 2015), <http://www.princeton.edu/sites/default/files/content/2017%20and%20Beyond%20-%20Minnesota%20and%20the%201332%20Waiver%20-%203.15%20Final.pdf> (accessed July 22, 2015).

38 Jessica Schubel and Sarah Lueck, "Understanding The Affordable Care Act's State Innovation ("1332") Waivers," Center on Budget and Policy Priorities, February 5, 2015, <http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers> (accessed July 22, 2015).

39 CMS, State Medicaid Directors Letters, Policy Considerations for Integrated Care Models, #1 and #2 (July 10, 2012), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf>, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf> and <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf> (accessed July 22, 2015).

40 Health Care Payment Improvement Initiative, "Episodes of Care," Arkansas Center for Health Improvement, <http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx> (accessed August 12, 2015); Centers for Medicare and Medicaid Services, "Minnesota – Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy: Integrated Care Models (FFS Primary Care Case Management)," <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-11-031-Att.pdf> (accessed August 12, 2015); and Maine Department of Health and Human Services, "State Plan Title XIX of the Social Security Act: Integrated Care Model," [http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/AC/Reimbursement\\_Section4\\_9%20AC\\_SPA%205%2012%20.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Reimbursement_Section4_9%20AC_SPA%205%2012%20.pdf) (accessed August 12, 2015).

41 Medicaid and CHIP, Final Rule, 78 Fed. Reg. 42160 (July 15, 2013), <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf> (accessed July 23, 2015).

**CONCLUSION**

The health care purchasing trends outlined in this overview are at various stages of development but all are poised to influence the Medicaid landscape in the near future. While some of the topics discussed in this supplement will be touched on in greater detail in the Compendium, others will be incorporated into the Compendium over time.