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THE VOICE FOR HEALTH CARE CONSUMERS

Financial Support for Safety Net and Small Community Providers to Participate in Delivery System Reform: Medicaid-Based Options for States

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There has been an important and ongoing effort over the past decade to address the failures of the health care system by changing how providers are paid and organized, to reward value and not volume. However, transformation efforts have largely ignored one of our system's most fundamental problems: persistent racial, ethnic, and geographic health and health care inequities.

These health and health care disparities are costly to the health care system and the larger national economy. Considering this high cost, as well as the increasing proportion of communities of color as a share of the U.S. population,[1] solving for equity must be central to health care payment and delivery reform.

There is a strong case for financial support to safety net and small community providers to enable them to participate in alternative payment methodologies and associated new care delivery models.[2] Delivery system reform and integrated provider financing involve significant new expenses for healthcare providers.[3] These expenses can include, among other things, new staff and new training of existing staff particularly around community-based interventions, new information systems and training on how to use them, and physical modifications to clinical space. Although these costs affect all providers, the upfront costs associated with reforming provider organization and payment are likely to be larger and less discretionary for clinicians working with low-income people. At the same time, these clinicians typically have more limited financial ability to make the investments required than providers outside of the safety net. The providers affected by these costly barriers to entry into health care delivery and payment transformation and in need of financial support include public hospitals and other larger safety net providers, smaller rural hospitals, and small, independent community providers.

Furthermore, while health system transformation presents a valuable opportunity to accelerate the reduction of health inequities, it also poses risks for those communities that have been most affected by them and that have been historically underresourced. As new delivery and payment models are implemented, changing financial incentives and the shifting of financial risk could endanger historically underfunded health care providers and organizations, particularly if they have not been financially able to

prepare for the transition. Low-income communities depend on and trust these providers and organizations, many of which have long track records of providing culturally centered care that effectively addresses the many barriers these communities face. The loss of these providers, many of which serve health professional shortage areas, would likely undermine access to care for communities already struggling with health care access issues.

Earlier this year, we released (as part of a larger policy options document) several national-level policy options for funding safety net providers to participate in delivery system reform.[4] Notably, each of those options would require a federal policy change through either legislation or administrative action. We anticipate a future issue brief further developing a federal agenda on this issue. This issue brief is focused on options for state policymakers and advocates under existing federal policy to support safety net providers' upfront costs in participating in transformed care delivery and payment.

The Need to Consider Alternatives to DSRIP

One mechanism in place since 2010 to fund these expenses has been a type of Medicaid waiver called a "Delivery System Reform Incentive Payment, or DSRIP. The DSRIP program involved over $40 billion in federal and state funding commitments over seven years across 12 states.[5] They involve Medicaid payments to providers structured as incentives to set up new types of care delivery. In some states, DSRIP incentives have been more directly tied to the formation of accountable care organizations (ACOs) or other new payment mechanisms.

However, it appears that the federal government is moving away from the DSRIP model. The Centers for Medicare & Medicaid Services (CMS) has not approved any new DSRIPs since the Trump administration took office in January 2017. And in December 2017, CMS established a phaseout for the Texas DSRIP, the first to come up for renewal under this administration. Furthermore, most state DSRIPs have been driven in part by a specific Medicaid funding context involving public hospitals and the shift to Medicaid managed care that inherently limits their applicability to all states, even were CMS to once again embrace the DSRIP model.[6]

Medicaid-Based Funding Mechanisms

Several states have initiated ambitious changes to provider organization and payment focused on Medicaid-funded services.[7] Not all of these states relied on DSRIP funding to support provider transitional costs. While the below channels are not likely to generate funds on the scale of DSRIP programs, they can be significant channels of funding for highly targeted provider needs.

A. Medicaid Health Homes

The State Option to Provide Health Homes for Enrollees with Chronic Conditions allows states to fund a variety of care coordination and community-based support services for people with chronic conditions. Health Homes does not include more traditional direct medical treatment that is payable under conventional Medicaid claims.[8] New Health Homes programs receive 90 percent federal Medicaid matching funds for their first two years.

- New York leveraged Health Homes funding to help build out intensive, community-based care manager capacity at designated providers.[9] These providers are required to coordinate with Medicaid managed care plans and are assigned patients based on claims history or provider referral. New York developed a diagnosis-based reimbursement structure, taking into account both physical and behavioral health intensiveness of care management need. In New York, there was a separate set of Health Homes implementation grants made available with Medicaid administrative funds in the 2013-2014 state budget. New York also paid a rate specific to a six-month "case finding period" for newly assigned patients.
- Vermont leveraged the Medicaid Health Homes option to build an innovative statewide infrastructure of "hub and spoke" supports for substance use treatment in primary care settings.[10] The Vermont Hub and Spoke program has been a critical component of its relatively successful approach to addiction services as well as its broader multipayer statewide ACO initiative.

Note that Health Homes funding supports direct service delivery, not infrastructure or upfront program development as such. But both of the above states were able to build a rate structure under Health Homes that could incorporate a level of program development expense, and CMS has stated explicitly that service overhead costs are a permissible component of rates.[11] As noted above, New York also made available a separate set of Health Homes implementation grants early in program operations.

B. Managed Care Payments

In general, managed care plans pay providers for covered benefits based on negotiated rates, with additional benefits or payments limited to narrow categories by federal statute and regulation. This means that plans generally cannot make nonclaims payments to providers on their own, and state Medicaid agencies have little ability to incorporate special payments to providers into plan capitation rates beyond the benefit package.[12] However, CMS has laid out an explicit regulatory exception allowing states direct managed care plan payment as part of state implementation of "value-based purchasing models" or "delivery system reform or performance improvement initiatives."[13] This flexibility has been used to route delivery system reform implementation incentives and upfront funds through managed care plans.

- Rhode Island is implementing statewide Medicaid Accountable Entities (similar to Accountable Care Organizations) under managed care.[14] These new provider organizations are largely comprised of and led by safety net and community providers with high proportions of Medicaid reimbursement, including behavioral health and long-term supports and services providers. In order to support "building the capacity and tools required for effective system transformation"—and particularly readiness for taking more medical risk and managing community-based and social services—Rhode Island created a Medicaid Infrastructure Incentive Program that is routed through managed care plans.[15] Rhode Island leveraged the flexibility in Medicaid regulations described above to direct managed care plans to administer a state-funded infrastructure investment program via incentives to the providers who are establishing new provider organizations. These providers will, over several years, shift their managed care plan contracts from claims-based contracting to alternative payment methodologies.

C. Direct Supplemental Medicaid Payments to Providers Who Receive Fee-for-Service Payment

Unlike the managed care regulatory framework, states that pay providers directly on a fee-for-service basis have broad flexibility to direct lump sum payments to providers that are in addition to regular claims.[16] This flexibility—often called supplemental payments—has historically been a way for states to close a gap between regular Medicaid rates and hospital costs for safety net hospitals. But the flexibility states have around fee-for-service payment also has the potential to serve a role in supporting implementation of alternative payment methodologies.[17]

A major constraint on this option for most states is that they engage in limited direct fee-for-service payment overall, as many states have moved service delivery into managed care arrangements. States cannot legally mix direct provider payment—whether fee-for-service or lump sum—and managed care capitation for the same service. Furthermore, under the "Upper Payment Limit" in Medicaid statute, states are barred from paying a class of providers—such as public hospitals, private hospitals, or physicians—more than what Medicare would have paid in direct payments (combining fee-for-service and additional direct payments) for a given service. States that have shifted most populations into managed care have only so much "room" to make additional lump sum payments to providers. That "room" is defined by the populations that are not in managed care and how much revenue providers are receiving for those populations relative to the Upper Payment Limit defined by what Medicare would have paid for them.

During the 2010-2017 period, states pursuing system transformation implementation support to safety net providers could request DSRIP section 1115 waiver authority, which (when approved) often effectively waived the Upper Payment Limit rules for Medicaid managed care states. In an environment in which new federal DSRIP approvals are not forthcoming, states without capitated Medicaid managed care will be in a particularly flexible position regarding direct lump sum payment to providers tied to upfront costs to participate in alternative payment structures.

D. Non-DSRIP Section 1115 Waivers

In our policy options paper published in June 2018,[18] we proposed that "CMS could establish a more modest, and therefore more easily replicated, Medicaid waiver program to fund DSRIP-style safety net and small community provider support." Medicaid waiver policy is often established in response to state proposals. There may be room for federal consideration of clearly time-limited and highly targeted funding tied to specific provider costs associated with a specific new payment model.

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One of the key potential roles for state Medicaid agencies is to enable safety net providers to participate in new payment and delivery models by funding upfront costs that would otherwise be beyond their reach, along with facilitating the technical assistance they need to achieve it.

State Innovation Models—A Once and Future Option for States?

Minnesota and Vermont have implemented ACO transitions statewide, focusing on Medicaid in Minnesota and putting a multipayer model that includes Medicaid in Vermont. Each state leveraged federal State Innovation Model (SIM) funding of about $10 million per year over several years to fund statewide interoperable information technology among other provider supports. SIM is an initiative of the federal Center for Medicare & Medicaid Innovation (CMMI).[19] While SIM does not fund providers directly, it supported statewide data infrastructure and training that effectively supplanted key provider implementation costs in Vermont and Minnesota.[20]

However, the status of future rounds of SIM funding is currently unclear. After issuing two rounds of funding in 2013 and 2015, CMS has not made a formal announcement regarding a third round of SIM funding.

Conclusion

The existing system of organizing providers and paying for health care has failed communities of color and other disadvantaged communities. Changing care delivery and payment offers a valuable path to improving long-standing health inequities. State policy is central to fulfilling the potential of system transformation to address health inequity. One of the key potential roles for state Medicaid agencies is to enable safety net providers to participate in new payment and delivery models by funding upfront costs that would otherwise be beyond their reach, along with facilitating the technical assistance they need to achieve it. Even as the Trump administration appears to have pulled back on Delivery System Reform Incentive Payment programs, states have concrete options under current authorities to catalyze reforms to Medicaid care delivery with provider implementation funding that will be crucial in ensuring that communities of color, rural communities, and other vulnerable populations are not left behind.

Endnotes

[1] See Ani Turner, *A Business Case for Equity: A Strategy for Growth* (Battle Creek, MI: W.K. Kellogg Foundation, 2018), available online at http://www.businesscaseforracialequity.org/resources.

[2] See our publication, Sinsi Hernández-Cancio, Ellen Albritton, Eliot Fishman, Sophia Tripoli, and Andrea Callow, *A Health Equity and Value Framework for Action: Delivery and Payment Transformation Policy Options to Reduce Health Disparities* (Washington, DC: Families USA, June 2018), available online at https://familiesusa.org/product/health-equity-and-value-framework-action-delivery-and-payment-transformation-policy-options.

[3] Rachael Matulis and Jim Lloyd, *The History, Evolution, and Future of Medicaid Accountable Care Organizations* (Hamilton, NJ: Center for Health Care Strategies, February 2018), available online at http://www.chcs.org/media/ACO-Policy-Paper_022718.pdf.

[4] Hernández-Cancio, et al., *op. cit.*, Option 2, p. 25 ff.

[5] For a summary, see *Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Programs* (Portland, ME: National Academy of State Health Policy, August 2017), available online at https://www.macpac.gov/publication/exploration-of-the-evolving-federal-and-state-promise-of-delivery-system-reform-incentive-payment-dsrip-and-similar-programs/.

[6] Ben Finder and Robert Nelb, *Delivery System Reform Incentive Payment (DSRIP) Programs* (Washington, DC: Medicaid and CHIP Payment and Access Commission, March 2015), available online at https://www.macpac.gov/wp-content/uploads/2015/03/01_Delivery-System-Reform-Incentive-Payment-DSRIP-Programs1.pdf.

[7] See Matulis and Lloyd, *op. cit.*, Exhibit 4.

[8] For an overview, see Alicia Smith and Eliot Fishman, *Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions* (Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions, April, 2013), available online at https://www.integration.samhsa.gov/about-us/Financing_HHs_Webinar_Presentation.pdf.

[9] Center for Health Care Strategies (CHCS) & State Health Access Data Assistance Center (SHADAC), "Community Care Teams: An Overview of State Approaches" (Washington, DC: CHCS & SHADAC, March 2016), available online at https://www.chcs.org/media/Community-Care-Teams-An-Overview-of-State-Approaches-030316.pdf and http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm.

[10] State of Vermont, "Blueprint for Health" (Waterbury, VT: State of Vermont, 2018), available online at http://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke.

[11] Centers for Medicare & Medicaid Services (CMS), "Health Homes Frequently Asked Questions, Series II, (Washington, DC: CMS, December 2015), available online at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/health-home-faq-1-21.pdf.

[12] Deborah Bachrach, Jocelyn Guyer, Sarah Meier, John Meerschaert, and Shelly Brandel, E*nabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools* (New York, NY: Commonwealth Fund, January 2018), available online at https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review.

[13] 42 CFR 438.6(c)(1), and Brian Neale, *CMCS Informational Bulletin: Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts* (Baltimore, MD: CMS, November 2, 2017), available online at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf. States and stakeholders interested in pursuing this flexibility should monitor potential changes to managed care regulations anticipated in late 2018.

[14] Executive Office of Health and Human Services for the State of Rhode Island, "Accountable Entities" (Cranston, RI: EOHHS, 2018), available online at www.eohhs.ri.gov/initiatives/accountableentities.aspx.

[15] See Executive Office of Health and Human Services for the State of Rhode Island, "EOHHS Medicaid Infrastructure Incentive Program: Attachment L2: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities" (Cranston, RI: EOHHS, September 29, 2017).

[16] Medicaid and CHIP Payment and Access Commission, Report to Congress, March 2014, Chapter 6.

[17] For analysis regarding how to shift large existing Medicaid supplemental payment programs toward system transformation efforts, see Cindy Mann and Deborah Bachrach, *Integrating Medicaid Supplemental Payments into Value-Based Purchasing* (New York, NY: Commonwealth Fund, November 2016), available online at https://www.commonwealthfund.org/publications/fund-reports/2016/nov/integrating-medicaid-supplemental-payments-value-based.

[18] Hernández-Cancio, et al. *op. cit.*

[19] Centers for Medicare & Medicaid Services, "State Innovation Models Initiatives: General Information" (Baltimore, MD: CMS, 2018), available online at https://innovation.cms.gov/initiatives/state-innovations/.

[20] Sharon Silow-Carroll, Jennifer N. Edwards, and Diana Rodin, "Aligning Incentives in Medicaid: How Colorado, Minnesota, and Vermont Are Reforming Care Delivery and Payment to Improve Health and Lower Costs" (New York, NY: Commonwealth Fund, March 2013), available online at https://www.commonwealthfund.org/publications/case-study/2013/mar/aligning-incentives-medicaid-how-colorado-minnesota-and-vermont.

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