

# Medicaid 1115 Transformation Waiver

May 10, 2016



# Caveats and Disclaimers


- CMS has expressed high level support for Initiative 3 approach, **but...**
- Many details are subject to change based on final investment level and negotiations on Standard Terms and Conditions (STCs).
- Current groundwork is based on addressing anticipated needs once waiver is approved and STCs are signed.



# Supportive Housing—Eligible Services

- Housing transition services that provide direct support to help individuals obtain housing, including:
  - Housing assessment and development of a plan to address barriers.
  - Assistance with applications, community resources, and outreach to landlords.
- Housing tenancy sustaining services that help individuals maintain their housing, including:
  - Education, training, coaching, resolving disputes, and advocacy.
- Activities that help providers identify and secure housing resources.

*Supportive housing services **do not** include funds for room and board or the development of housing.*



# Populations most likely to benefit from supportive housing services

- Chronically Homeless
- Individuals with frequent or lengthy institutional contacts
- Individuals with frequent or lengthy adult residential care stays
- Individuals with frequent turnover of in-home caregivers
- Those at highest risk for expensive care and negative outcomes—PRISM Risk Score of 1.5 or above



## Putting Initiative 3 in perspective

- The 1115 Waiver is a five-year demonstration.
- Sustainability of waiver benefits beyond five years depends on an effective demonstration of their value and impact.
- **Failure to meet expectations during the demonstration will significantly limit the long-term viability of supportive housing and supported employment benefits through Medicaid.**



# Supportive Housing Proposed Phasing

1. Chronically Homeless (HUD Definition)
  - BHO and FIMC
  - Full BHO/MCO benefit
2. Frequent/Lengthy Institutional Contact
3. Frequent/Lengthy Adult Residential Care Stays
4. PRISM Score 1.5+

## Why phasing?

- Housing stock
- Delivery system and provider capacity build
- Assessment of demand



# Supportive Housing & Supported Employment Criteria

## Medical Necessity Criteria – *for MCO benefit*

- Inability to live in an independent or family setting without support
- At risk of serious harm to self or others
- Dysfunction in role performance
- Risk of deterioration

*BHO benefit will still use Access to Care Standards.  
ALISA benefit will use CARE criteria.*



## Enrolling those currently housed and receiving services

- Potentially allowable, but limited.
- Limitations to consider:
  - Time
  - Population
  - Budget
- Initiative 3 benefits are meant to *enhance*, not replace, existing services.





# Housing stock needs

- Services must be connected to housing in order to achieve desired outcomes.
- The current availability of housing stock is limited.
- Opportunities:
  - Phasing in populations
  - Redirection of flexible dollars (philanthropic, some HUD)
  - Pay for Success model (possibly)
  - Limited access to the benefit for those currently receiving services

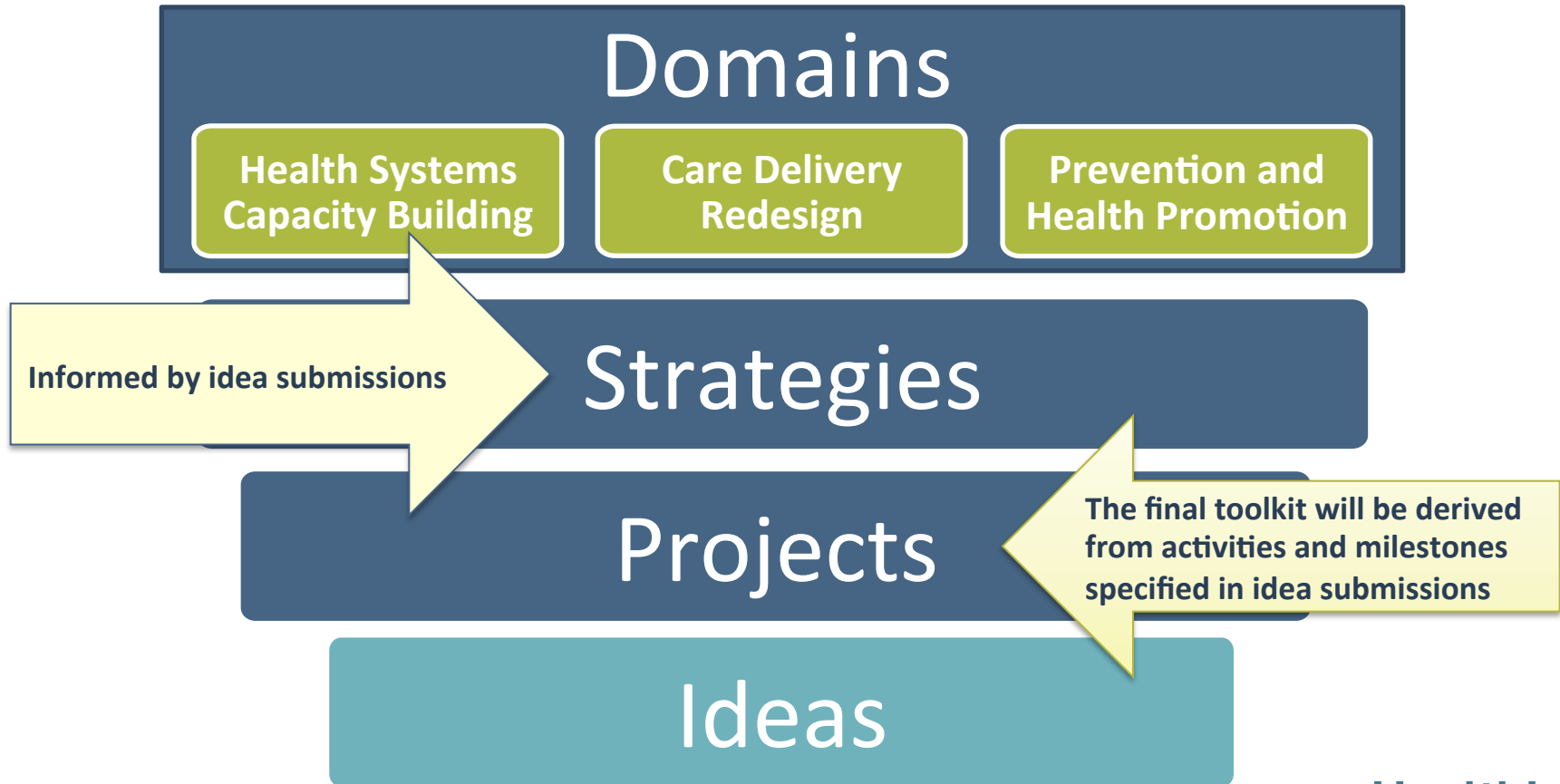


# ACH Transformation Project opportunities

- Each region, through its ACH, will be able to pursue projects that will transform the Medicaid delivery system.
- The only way to engage in this process is through participating in your ACH.

# Transformation Framework

The framework is a high-level overview of the strategies necessary to achieve the desired outcomes under each domain.





# Domain 1: Health Systems Capacity Building

## Projects and key strategies:

- Primary care models
- Workforce and non-conventional service sites
- Data collection and analytic capacity



## Domain 2: Care Delivery Redesign

Projects and key strategies:

- Bi-directional integration of care
- Care coordination
- Care transitions



## Domain 3: Prevention and Health Promotion

### Projects and key strategies

- Chronic disease prevention and management
- Maternal and child health

# Transformation Toolkit Example

**Domain:** Care Delivery Redesign

**Project title:** Care Transitions

## **Objectives:**

- Improve referral pathways to housing providers so those in need of medical respite are connected to permanent supportive housing.
- Improve providers' ability to effectively hand off health care responsibly to the appropriate provider.

## **Core components:**

- Hospitals and PSH providers collaborate to identify and refer individuals in need of housing upon discharge.
- On site, post-discharge supports are made available to individuals until care needs are addressed.
- Individual housing needs are maintained after medical needs are met.

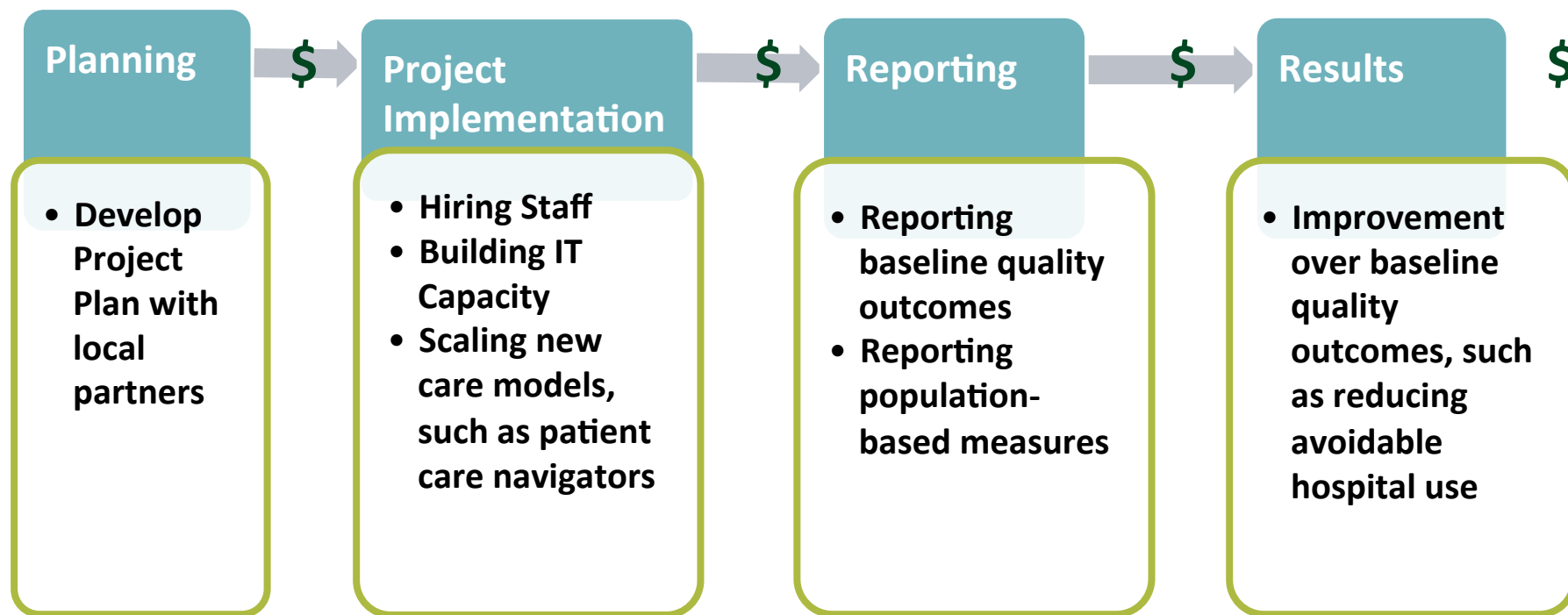
## **Metrics:**

- Consistency with statewide common measures.

To be specified  
in final toolkit

# Examples of Incentive Payment Milestones

Types of milestones and system-level improvements hypothetically eligible for incentive-based payments.



Initially, payments focus on more process oriented changes; focus later shifts to more outcome based measures.





# Where to find more information

[http://www.hca.wa.gov/hw/Pages/medicaid\\_transformation.aspx](http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx)

## Resources available:

- Draft Project Toolkit Framework
- Updated FAQ and Fact Sheets
- Waiver Application
- Previous webinar presentations (slides & recordings)
- Updates on workgroup activities

## Workgroups

- Chronic Homelessness Policy Academy
- Olmstead Policy Academy

Send questions and comments to:  
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Questions?

For more information, contact:

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