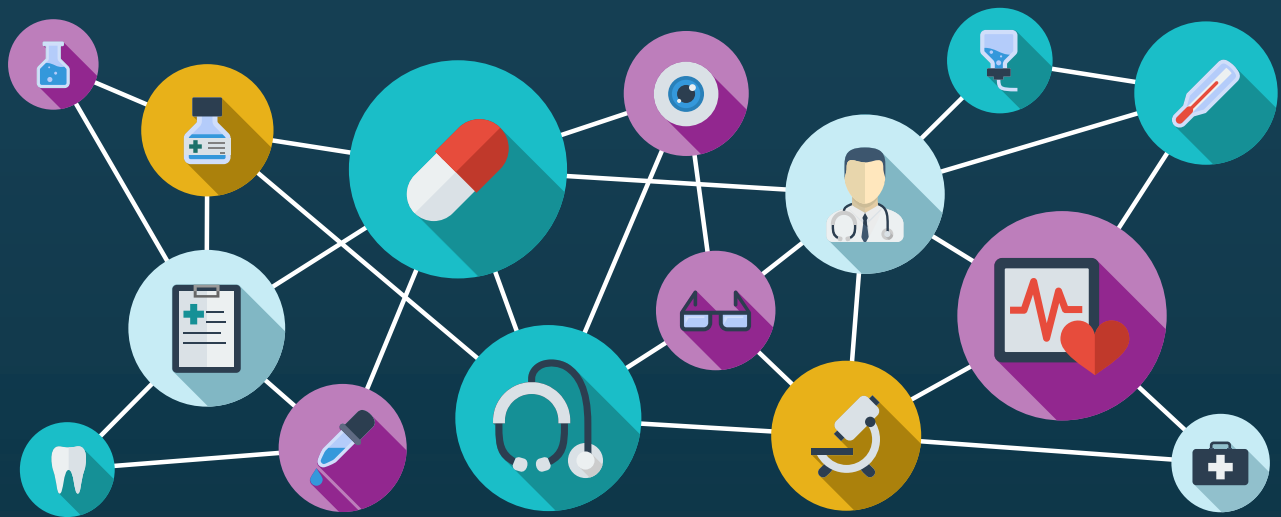


The Future of Medicaid Transformation:

A Practical Guide for States



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How to Use the Toolkit

The toolkit is a guide for states seeking to design and implement statewide transformation of their Medicaid programs, using the federal authorities of either State Plan Amendments or Section 1115 demonstrations (referred to as “Section 1115 waivers”). Specifically, the toolkit identifies the steps that will help states successfully engage with stakeholders and “get to yes” with the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS).¹

The toolkit is not a comprehensive, exhaustive manual for every aspect of statewide health care transformation. Rather, it is intended to highlight the concepts and processes states should consider to create a more efficient path to approval for the states and CMS. The toolkit has been organized into two phases of statewide transformation: developing the building blocks for transformation and preparing, submitting and negotiating a proposal with CMS. Within each phase, we highlight key elements critical to success. Note, however, that these phases are not linear and certain steps may need to occur concurrently. As a result, each state can adapt the process to meet its individual needs.

Implementation and evaluation are critical components to the successful transformation of a state Medicaid program, ensuring that the vision is successfully operationalized and that the state will be able to measure the impact of the reform on its Medicaid recipients and health care expenditures. This toolkit does not focus on the implementation process, but states should consider planning for implementation and evaluation while they are negotiating with CMS for approval.

Although the toolkit addresses certain Medicaid requirements and policies, these requirements can change over time, and subsequent Administrations may interpret them differently. Accordingly, states should consult with their own legal counsel about federal and state requirements throughout their transformation efforts.

We also note that in 2017, the change in presidential Administration may affect states seeking to negotiate Medicaid transformation proposals with CMS and states will need to adjust their negotiations accordingly. The steps in this toolkit, however, address the fundamental building blocks for effectively designing and negotiating Medicaid transformation proposals and can be modified as needed to address new developments at the state or federal level.

¹ The Centers for Medicare & Medicaid Services (CMS) oversees the Medicaid program on behalf of the U.S. Department of Health and Human Services. Therefore, CMS is referenced throughout this document when appropriate.

Overview and Introduction to the Toolkit

Across the country, the cost of health care continues to grow in state Medicaid programs, Children's Health Insurance Programs (CHIP) and state employee and retiree health programs. At the same time, the nation continues to struggle with underperforming health systems and poor health care outcomes. Increasingly, governors are interested in aligning economic incentives across public and private payers that will signal to the health care market a movement away from traditional fee-for-service systems (often incentivizing volume) toward greater value (decreasing the growth in health care costs and increasing the quality of care). Many governors are taking a proactive approach to this national problem and are leading the way by starting this transformation with their Medicaid programs.

A few states have completed statewide plans and received federal approval to transform their Medicaid programs; others are in various stages of transformation planning. Despite public support from federal agencies for system transformation at the state level, the path forward is challenging. States seeking approval for broad changes to their Medicaid programs often face a lengthy, complicated and at times confusing negotiation process with federal officials.

The National Governors Association Center for Best Practices (NGA Center) supports governors in their transformation efforts. In May 2013, in response to a request from governors, NGA launched the Health Care Sustainability Task Force to identify legislative and regulatory actions that the federal government can pursue to reduce barriers to innovation and further support state health care initiatives. Governors identified four principles that serve as the foundation for federal-state efforts:

- Federal support of state health care innovation;
- Medicare–Medicaid enrollees (dual-eligibles);
- Long-term services and support; and
- Payment and delivery system reform.

In February 2014, the governors formally approved the task force report and requested that the NGA Center build a project to put the report's principles into action. As a result, the NGA Center, with the support of the Robert Wood Johnson Foundation, created a technical assistance opportunity called the *Medicaid Transformation Policy Academy (Medicaid Policy Academy)* to help a small, bipartisan cohort of states design and implement transformed Medicaid programs by building a dialogue between states and the federal government. The purpose of the *Medicaid Policy Academy* was to assist the participating states to reach "agreements in concept" with the U.S. Department of Health and Human Services (HHS) for statewide Medicaid transformation.

This toolkit is the end product of the 18-month-long *Medicaid Policy Academy* and provides a guide for how states can design statewide transformation proposals that HHS is likely to approve. Although all the states that participated in the *Medicaid Policy Academy* (**Alabama, Nevada and Washington**) initially pursued Section 1115 waivers, the toolkit focuses on how states can consider building their vision to better inform their proposals for either a Section 1115 waiver or State Plan Amendment (SPA).²

² At the time of publication of this toolkit, Nevada and Washington were continuing to negotiate their proposals with HHS. Alabama's Section 1115 waiver was approved in February 2016. While Alabama initially proposed a Delivery System Reform Incentive Pool – as indicated in materials included in this Toolkit – their approved waiver utilizes other payment mechanisms.

Executive Summary



Executive Summary

A focal point of the NGA Center Health Division's work is to support governors' efforts to transform their Medicaid programs. Transforming a state Medicaid program, however, is a challenging process. Several of the following elements are critical for success:

- **Ensuring gubernatorial support.** Gubernatorial support is vital for any statewide transformation because the governor has a unique platform from which to elevate issues of priority and focus various stakeholders on one shared goal. Vocal and visible support from the governor signals that the state is committed to the proposed transformation, which is essential for engaging stakeholders as well as working with CMS. The governor's involvement and support can also be crucial as the state negotiates with HHS and can help to "reset" the dialogue if parties reach an impasse.
- **Commitment of adequate resources.** The process of designing, submitting and seeking approval for a statewide Medicaid transformation project is time and resource intensive. Depending on the breadth of the project, states may require up to 12 to 24 months to develop a proposal, assemble the critical pieces and obtain approval from CMS (see [Figure 1](#) on page 10). Such projects require consistent, dedicated staff resources; a commitment to and prioritization of this effort over the entire time period; and an investment of time and dollars to develop internal staff capacity to implement and evaluate the transformation after it has been approved.
- **Using data effectively to drive the transformation effort.** A successful transformation effort is data driven, and so repeated data analysis must underpin this project. As a result, states will need to invest in information technology support to address this fundamental need for transformation proposals. Using data, states will be able to create and defend a vision for transformation—for example, by identifying how the proposal will address gaps in health outcomes and by establishing potential savings generated from using a new approach to health care delivery and payment.
- **Gaining early and meaningful stakeholder engagement through an effective communications strategy.** The investment in meaningful stakeholder engagement—early and often—is critical to the ultimate success of the transformation proposal. To be truly transformative, the vision must be communicated effectively to the stakeholders who will implement it, the clients whose care it will affect, the state staff who will be supporting it and federal officials who can approve it. Through effective communications, public officials and policymakers can move a vision beyond a white paper and gain engagement and momentum to build a movement that has broad public support.
- **Preparing for implementation and monitoring.** Although this toolkit does not focus on post-approval implementation, the reality is that implementation planning and monitoring design must begin before the state receives CMS approval. That initial thinking and planning must take place alongside the negotiation process to ensure readiness for implementation on the heels of approval. States should consider building an implementation work plan that identifies key state staff who are responsible for each deliverable, establishes a process to ensure that projects are on track and continues stakeholder discussions to prepare partners for implementation.

FIGURE 1: Medicaid Transformation Timeline: Roadmap At-A-Glance



* States' implementation planning should begin after they have submitted their SPA or Section 1115 waiver.

** Following approval, states will begin implementation and evaluation.

Developing the Building Blocks for a Successful Transformation



Phase 1: Developing the Building Blocks for a Successful Transformation

INTRODUCTION

The path to Medicaid transformation can begin in different ways. In some states it is prompted by legislative directive. Other states might experience an imminent budget crisis that triggers a governor's interest in driving down costs and improving outcomes in the Medicaid program. Still other states may approach transformation because of a desire to preemptively transform the Medicaid program to improve care and reduce costs. Transforming a state's Medicaid program is resource intensive: it requires uprooting a state's existing payment and delivery system and making large-scale changes to the way health care services are delivered and paid for. Given the expansiveness of that effort, a fundamental component of states' success is ensuring that states are both ready and able to take on this work. **Alabama**³ and **Oregon**⁴ are examples of two states that have embarked on statewide transformation of their Medicaid programs.

Initial Assessment

As state leaders initially engage in conversations about Medicaid transformation, it is important that they consider four components fundamental to successful transformation of the system and to obtaining approval of the proposal from CMS: the timing of transformation, the vision for how the reform will improve health while reducing costs, the process for ensuring support from the governor and the method for obtaining the necessary buy-in from key stakeholders. States should consider each component as they conduct an initial assessment of the need to implement Medicaid transformation, including consideration of the following questions:

- Is the need for transformation crisis driven?
- What outcomes are needed to address the crisis or other driving forces?
- What are the opportunities for a return on investment (ROI) for possible transformation models?
- How are state leaders—that is, the governor and the legislature—reacting to the pending crisis?
- Does the governor support the need for transformation?
- How will the state legislature react to transformation?
- What is the upside of transformation?
- What is the downside of not seeking to transform the program?
- If the state does not pursue transformation, what is the alternative?
- Does the state have the capacity and resources to pursue a long-term transformation effort?
- Will the state have initial support from stakeholders, such as managed care plans, providers and consumers?

3 Donald E. Williamson, "State Experiences With Health Care Reform" (presented at a National Governors Association meeting, Salt Lake City, UT, October 1–3, 2015), <http://nga.org/files/live/sites/NGA/files/pdf/2015/1510StateExpHealthWilliamson.pdf> (accessed April 25, 2016).

4 Tina Edlund, "State Experiences With Health Care Reform" (paper presented at the National Governors Association, Salt Lake City, UT, October 1–3, 2015), <http://nga.org/files/live/sites/NGA/files/pdf/2015/1510StateExpHealthEdlund.pdf> (accessed April 25, 2016).

Environmental Scan

In addition to an initial assessment, states should consider completing an environmental scan. The scan includes the following analyses:

- What health reform efforts are already underway in the state? How can these reforms support the current need for transformation?
- What funding is available to support transformation?
- At the federal level, what are the Administration's current views of Medicaid transformation proposals?
 - » How have policies evolved within CMS, particularly in relation to the design, financing and approval of Section 1115 waivers or SPAs?
- How might potential stakeholders react to Medicaid transformation, including affected state agencies, managed care organizations (MCOs), regional care entities, providers, consumers and potential public-private partners?
 - » What initial steps need to occur to begin the dialogue on transformation?
- What is the timeline for designing, submitting and negotiating a Section 1115 waiver or SPA?
- What information technology (IT) infrastructure is in place (for the state, plans, and/or providers) to allow for data collection, sharing and analysis?

Current Federal Policy

Understanding current CMS policy is an important component of the initial process. A negotiating strategy that may produce effective results for the state is to approach CMS with the state's defined transformation vision (including goals and objectives), and then work closely with CMS to determine what types of federal authority might best achieve the desired result. By approaching CMS with the overarching vision, the state can interact with a broader group of CMS leaders—not just staff working on waivers or SPAs—and develop a shared objective of defining legal authorities. This approach also allows for flexibility while designing the program. During the state-federal discussions, however, it is critical that states continue to advocate for their program to ensure that the legal authorities being explored can achieve the state's full vision.

States also can gain a clear understanding of any recent shifts in CMS approvals, particularly concerning the financing, outcomes and quality metrics applied in Section 1115 waivers. This understanding is critical to ensuring that states will be able to negotiate effectively with CMS. For example, recent policy evolutions include the following approaches:

- A reduction in uncompensated care (UC). CMS is currently favoring states' use of Medicaid expansion instead of UC pools and approving only time-limited UC funding pools accompanied by UC and Medicaid rate analyses.
- More rigorous delivery system performance measures, including descriptions of data sources and benchmarks and specific metrics tied to improved health care efficiency. For example, **New York** is applying a metric of a 25 percent reduction in avoidable hospital use, and Oregon has committed to reducing Medicaid cost trend by 2 percent.
- States that have received approval of federal investment for payment transformation are often identifying a clear path to establishing value-based purchasing (VBP) that includes linking payment to quality at the plan and provider levels. For example, New York has a goal that 80 percent to 90 percent of provider payments will qualify as VBP, as defined by the state in its delivery system reform incentive payment VBP roadmap.

- Recent approvals of additional federal investment focus on supporting the establishment of health care systems or networks to achieve transformation rather than individual providers such as hospitals.

Consideration of such parameters during states' initial planning process may help them to better position themselves during negotiations with CMS. States also should understand which requirements CMS may be unable or unwilling to waive and build their proposals accordingly. For example, under Section 1115 waivers, CMS generally has not waived actuarial soundness requirements. As a result, states should consider how to incentivize plans to address non-traditional services that improve quality and reduce costs (for example, evidence-based supportive housing programs) through sound actuarial rates that are sustainable over time.

Establishing a Timeline

States should consider creating a clear timeline for developing the proposal and negotiating it with CMS. Devising a timeline at the start ensures that the state can maintain momentum for getting to yes with CMS. The timeline can create the necessary pressure to prioritize the project for both the state and the federal government, which is critical to ensuring continued progress on the proposal.

The entire transformation process, from the pre-work to approval of an application, could take 12 to 24 months. Thus, the timeline should be strategic and establish achievable milestones based on state capacity (including staffing, expertise and IT infrastructure), gubernatorial and legislative support (including the provision of additional state dollars, if needed) and the support of the state's interested and affected stakeholders.

[Figure 1](#) on page 10 shows a sample timeline for a state's Medicaid transformation proposal and approval process. A state's actual experience will depend on many factors, including the complexity of its proposal, whether the state is seeking federal investment, the state's capacity to produce deliverables and the commitment of leadership at the federal and state levels. Importantly, state efforts to submit and negotiate a series of SPAs can be much shorter (for example, a few months) than for a Section 1115 waiver.

Checklist: Building Blocks for a Successful Transformation

(Note that depending on the project, some of these steps will occur simultaneously.)



Build a core team that includes a transformation champion, a project director, the governor's health policy advisor, the Medicaid director, technical experts and other affected agency heads and senior staff. (See [Step 1](#) on page 17 for details.)

- ▣ Schedule leadership meetings (monthly or more frequently, if needed).



Plan for staffing needs for all project phases, including consultants, if necessary. (See [Step 6](#) on page 35 for details.)

- ▣ Draft requests for proposals (RFPs) and engage in other procurement processes for consultants, if necessary.



Conduct data analysis that will serve as the foundation of the “theory of the case” for the vision and need for reform based on gaps in the current system. (See [Step 2](#) on page 21 for details.)

- ▣ Review the IT and data infrastructure to determine the capability of the state and providers.
- ▣ Analyze the capabilities of the state’s Medicaid Management Information Systems (MMIS) to determine whether updates are needed.



Set the vision for transformation based on the initial data analysis and identified gaps in the current system. (See [Step 3](#) on page 24 for details.)

- ▣ Establish clear goals for the patient population, delivery system and state budget.
- ▣ Identify agencies, affected stakeholders and potential partners.
- ▣ Define the upside of transformation.
- ▣ Define the downside of the status quo.
- ▣ Develop a project work plan.



Determine whether a change in state law is needed to pursue transformation efforts.

- ▣ Align the state timeline with the larger submission timeline goals.
- ▣ Determine whether state investment is needed.

Identify and engage core stakeholders through workgroups and meetings with providers and payers. (See [Step 4](#) on page 27 for details.)

- ▣ Develop an internal communication strategy for affected agencies and state staff.



Develop a statewide communications strategy. (See [Step 5](#) on page 29 for details.)



Develop and submit a concept paper to CMS; develop and execute the state’s plan for communications with CMS. (See [Step 7](#) on page 40 and [Step 8](#) on page 41 for details.)

STEP 1: BUILD THE CORE TEAM

A core team is a fundamental element of a successful transformation effort. The team's members must have the ability to devote the time and resources needed for the term of the project. The exact composition of the team depends on the focus and the scope of the state's transformation efforts, but it should include high-level health care leaders to ensure that stakeholders and the federal government understand the state's commitment to the transformation effort as well as the technical experts necessary to execute the work (see [Figure 2](#) on page 20).

Members of the Team

One of the core team's leaders should be a transformation champion—an individual who will set the vision and make strategic decisions throughout the project. If there is no champion, the Medicaid director, who understands how the program currently operates and how it should operate in the future, could fill this role. The governor's health policy advisor also can play a crucial leadership role because of his or her relationship with the governor and ability to bring gubernatorial attention and support to the effort.

The core team requires a project director—who is responsible for ensuring that the state stays on track for all the different steps during the process, ranging from data analysis to planning stakeholder engagement and preparing and submitting a SPA or waiver application. If possible, the project should be the primary focus of the director's time until its completion, and the state should consider planning its staffing levels accordingly. (See "[Key Members of the Core Team](#)" box on page 18 for details.) Successful state negotiation teams often include a senior member of the state's health informatics and data analytics staff, as well as the state's chief medical officer or senior public health official. The technical expertise of these individuals is critical for responding to the questions CMS may pose during negotiations. Team members likely will vary by state given the structure of state agencies, and each state will have to determine whether individuals can serve in more than one role.

Because of the long-term nature of a transformation effort (spanning 12 to 24 months), states should consider identifying someone within the core team who could easily step into a leadership role if staffing transitions occur. This advanced planning will allow states to maintain momentum as they engage with CMS in the event that the transformation champion or Medicaid director, for example, needs to move on to other priorities or opportunities.

Key Members of the Core Team

Transformation champion:

- Speaks for the governor and has broad decision-making authority;
- Has the respect of the legislature, external stakeholders and federal officials; and
- Understands the transformation the state is planning to undertake and can articulate the vision to various audiences.

Medicaid director:

- Speaks for the Medicaid agency and understands the broad vision for how the agency currently operates and how it should operate in the future;
- Depending on how long the Medicaid director has been with the agency, has an established relationship with CMS leadership that can be helpful during negotiations; and
- Has the technical background needed to guide the transformation.

Governor's health policy advisor:

- Has the ability to bring gubernatorial attention and support to the transformation effort;
- Can use established relationships with other leaders within the governor's inner circle, legislative leaders, business leaders and other key stakeholders;
- Can incentivize cross-agency collaboration; and
- Can help identify opportunities for additional staffing and other resources.

Project director:

- Has the capacity to manage the day-to-day activities that support the reform effort;
- Is a trusted voice of the senior leadership charged with managing the transformation;
- Has an existing relationship with the transformation champion and is familiar with the governor's office, using that relationship when appropriate;
- Understands the high-level vision as well as the operational details of how that vision will be implemented;
- Is empowered to make decisions to maintain momentum and continue to meet milestones; and
- Has project management skills to stay on top of all the moving pieces associated with reform.

Technical staff supporting the project director:

- Data analyst who can analyze available data sources within the state to identify gaps in the current system and key areas of focus;
- Clinical expert who can assist in the development of process and outcome metrics;
- Medicaid operations expert who understand the intricacies of the current Medicaid program, including details of the Section 1115 waiver or SPA approval process;
- Communications expert who can design the stakeholder engagement and communications process throughout the project; and
- Financial expert who understands the financial structure of the Medicaid program and can provide the analysis needed to design and negotiate the proposal.

Because many transformation efforts focus on crossing silos and linking clinical care with the underlying social determinants of health, the core team should consider engaging with a cross-agency group of state officials to facilitate working across agencies, build trust among agencies that might historically have been independent and effectively make decisions to maintain momentum and execute the transformation vision. Depending on the topic of the proposal, such individuals may include officials from the state department of health or human services, state budget office, department of behavioral or mental health, department of corrections or department of housing.

Staffing Strategies

As state officials build the core team, it is important that they be realistic about the broader internal staffing requirements for completing the transformation effort. Transformation, regardless of the scope of the project, is an intense effort and will place burdens on existing staff as they work to balance their "day jobs" with their commitments to the reform effort. The core team will need to find creative ways to limit staff burnout. For example, while Oregon was drafting and implementing its Section 1115 waiver establishing coordinated care organizations (CCOs), the state created teams of individuals who could rotate in and out of high-stress waiver-related roles and their standard work

responsibilities in an effort to alleviate potential burnout from managing both sets of tasks at the same time. In addition, this strategy exposed a broader group of leadership within state agencies to the reform effort, allowing them to contribute to and buy-into it.

While estimating staff and other resource requirements, the core team may identify a need for a consultant to fill any gaps in internal capacity. In choosing a consultant, states should consider several factors, including the availability of financial resources to compensate consultants, defining the appropriate role of consultants (long-term staffing support or short-term assistance at strategic junctures), selection criteria and the timing of any RFPs (if applicable). For more information about how best to use state resources when contracting with consultants, see [Step 6](#) on Page 35.

Core Teams of the *Medicaid Policy Academy* States

Nevada team	Washington team
Chief medical officer (team leader)	Chief policy officer, Washington Health Care Authority (HCA) (team leader)
Governor's health policy advisor	Medicaid director (HCA)
Director, Department of Health and Human Services	Governor's health policy advisor
Deputy director, Programs, Department of Health and Human Services	Director (HCA)
Medicaid director	Senior budget assistant, Human Services Division for the Office of Financial Management
First lady	Director, Research and Data Analysis, Department of Social and Health Services (DSHS)
Deputy administrator, Division of Health Care Financing and Policy	Assistant secretary, Behavioral Health Administration (DSHS)
Program specialists, Division of Health Care Financing and Policy	Assistant secretary, Aging and Long-Term Support Administration (DSHS)
Administrator, Division of Public and Behavioral Health	Medicaid project manager (HCA)

FIGURE 2: Team Model



STEP 2: CONDUCT DATA ANALYSIS

An important initial step is to clearly define and set the vision for how the transformation will result in an improved program. A central component of setting that vision is completing a data analysis of the current Medicaid program. The data analysis begins with the information gathered in the initial assessment and environmental scan completed in [Step 1](#) on Page 17. The analysis should identify the characteristics of the current program, including:

- The features of the current Medicaid population;
- Where the program is excelling;
- Where the gaps are;
- What the cost drivers are;
- How Medicaid consumers are accessing and using the system; and
- The design of the payment and delivery system.

A deeper analysis of the data could provide insights into provider network adequacy and program costs and expenditures, including potential areas for ROI. A thorough literature review of studies documenting ROI for relevant interventions can help inform a state's budget and financial modeling as state officials develop their vision for transformation. This type of data analysis lays the groundwork for building the state's "theory of the case"—that is, why statewide reform of the Medicaid system is needed and what the transformation would achieve (see [Figure 3](#) on Page 23).

Sources of Data

States need to identify the data that are available and reliable and where these data are. A variety of data sources are available to states, and it is helpful if states are strategic about identifying which are priorities to review. Broadly speaking, states may review clinical, administrative or claims data to develop a full picture of their current Medicaid program. More specifically, states should consider the following data sources as they conduct their analysis:

- Medicaid claims or encounter data;
- Publicly available secondary data analysis (for example, county health rankings);
- Clinical records data;
- Records from relevant state agencies (for example, departments of health, departments of behavioral health, or state housing authorities); and
- County system health data.

Measurement of Health Outcomes

States will likely need to run their data several times. The first analysis informs high-level thinking on the challenges the state faces in serving its Medicaid population. Clearly understanding the challenges the state faces in its population's health outcomes, the cost of services and access to services is key to building a long-term vision for health care transformation. That analysis informs the vision, and states can use it during initial conversations to get buy-in from key state leaders, such as the governor and senior state health officials. Additional data runs will help the state further refine its vision, goals and objectives for transformation.

During this step, states should consider thinking about the metrics they will use to monitor progress and evaluate the transformed Medicaid system. CMS requires monitoring and evaluation as part of its approval of a Section 1115 waiver and identifies the specifics, such as quality measures in the Special Terms and Conditions (STC) approved as part of the waiver process. As a result, a state may consider proactively establishing the ultimate goals of its transformation efforts and how best to measure and report on them. In addition, the state might release an RFP for an independent evaluator as part of its evaluation effort (a potentially lengthy process). It is important to plan early and be prepared to work with CMS during negotiations to answer any questions CMS might have about the state's monitoring, evaluation and reporting strategies.

Alabama law required the establishment of a Quality Assurance Committee. The committee analyzed data to identify where improvement was needed and approved 42 quality measures to address gaps in care. The committee expects to use the metrics to evaluate the performance of the newly established provider-based managed care system, with 10 of these metrics forming the basis for receiving incentive payments. The vast majority of the metrics are nationally recognized, which will allow Alabama to compare its performance to other states as well as national benchmarks. The measures include metrics for diabetes, asthma, behavioral health, care coordination and appropriate settings of care.

Required Resources

States must consider the human and IT resources they need to retrieve, aggregate, analyze, manage and share data on an ongoing basis. If a state lacks an adequate data infrastructure, this is the moment to identify needs and build the capacity for data and IT infrastructure—for example:

- Does the state have the appropriate staff in place to analyze data as they are collected? What is the quality of the data being collected?
- Does the state have a memorandum of understanding or signed partnership agreement with a university to enable the university to access data and perform analytics?
- Is there an all-payer claims database that allows state staff to review these data?
- Will the state need to retain consultants to conduct certain data analyses? If so, procuring additional data analytics capacity will require additional time and resources.
- What IT capability will providers require, and how can they develop that capability prior to implementation?

FIGURE 3: Data Foundation for Medicaid Transformation



- ☐ Conduct environmental scan.
- ☐ Establish highest level goals for program potential (improved outcomes, reduced cost).
- ☐ Identify potential stakeholders, including impacted agencies, health plans, providers, consumers/enrollees and potential public-private partners.
- ☐ Identify which data are available, reliable, where they reside (for example, Medicaid claims or encounter data and public health data) and whether you have legal access.
- ☐ Determine human and IT resources to retrieve, aggregate, analyze, manage and share data on an ongoing basis.
- ☐ Run available, useable data to build the “theory of the case” (that is, why the state needs to transform the Medicaid program). Acknowledge any limitations to the data.
- ☐ Set the vision.

STEP 3: SET THE VISION FOR TRANSFORMATION

Before a state undertakes a complete and thorough analysis of its Medicaid data, its governor and legislative leadership must support the transformation effort. Gubernatorial support is vital for any statewide transformation because the governor has a unique platform from which to elevate issues of priority and focus various stakeholders on one shared goal. As a partner to the governor, the support of legislative leadership is also critical. The legislature often must authorize broad changes to the Medicaid program associated with transformation, may need to appropriate additional state dollars to fund a transformed system or may seek to reform the program as one of the state's largest budget line items. Garnering the support of influential legislators is critical throughout the transformation process, both in engaging state stakeholders and in communications with federal officials.

Answering Key Questions

In seeking gubernatorial and legislative support, state officials can use their Medicaid data to establish clear goals for the transformation effort, as described in [Step 2](#) on Page 21. As the state begins to define its transformation vision and goals, it is important to remember the key questions CMS will ask of states as they present transformation visions for approval:

- What is the impact of this transformation on Medicaid consumers and how they access care?
- Why is this effort different and innovative?
- What is the link between payment and quality? How can the state evaluate and measure potential improvements?
- How does this transformation proposal fit in with other state efforts, such as State Innovation Model (SIM) grants? How does this effort leverage those other programs, and how is it distinct?
- Will the model extend to payers beyond Medicaid?
- Does this transformation require federal investment? If so, what about the proposal merits this federal investment? How is the need for funding distinct from other grants already provided to the state? Also, if the state does need new federal investment, what is the state's transition plan to ensure the future sustainability of the program?

The previously undertaken data analyses will have identified gaps in the current Medicaid system, where the cost drivers are, potential areas for focus that could yield an ROI and how Medicaid consumers are using the system, among other useful variables. Based on these data, the core team can define a vision for transformation, determining how the Medicaid program would evolve through transformation to best address its current needs. At this point in the process, states are not constrained by specific authorities or federal Medicaid requirements. Instead, they can think creatively about how best to address the program's current needs and how potential design features can effectively reach this goal.

The vision will be the foundation not only for engaging CMS but also of communicating with stakeholders across the state. Questions states may consider include the following:

- What does a transformed Medicaid program look like in the state? What issues does the state hope to solve? How will the new program positively affect the lives of Medicaid recipients?
- What political or other dynamics at play in the state will influence the type of transformation the state can pursue?

- What milestones must the state meet along the way to ensure that it is on track for implementation?
- What metrics will the state use to measure progress?
- What other payment and delivery system reform efforts, if any, are currently underway in the state that this transformation can build off and support?
- Who are the key stakeholders, and what role will they play in the transformation?
- What financial resources are needed for the transformation, and what are the potential sources of these funds?

See [Figure 4](#) on page 26 for a summary of steps for organizing the vision, goals and objectives of the transformation project.

Defining What Happens Without Transformation

In addition to outlining the state's vision for the future, states can clarify what will happen without transformation. Realistically outlining the alternative to transformation can help energize partners, both internal and external. For the state audience, particularly the governor and the legislature, it is important to highlight which other priority areas within the state, such as education or transportation, might lose funding as more and more state dollars go to Medicaid. External stakeholders will want to hear about actions the state may need to take in lieu of transformation, such as provider payment cuts.

As the state defines its vision, it can identify partner agencies and begin to incorporate them into the conversation early. In addition, the state can begin to reach out to key stakeholders to alert them to the vision; inviting feedback at this stage creates goodwill and increases the likelihood of support from affected groups as the process continues.

Developing a Project Work Plan

As the core team works through developing the vision, goals and objectives of transformation, it should consider developing a high-level timeline that details when each activity needs to occur. A work plan that lays out the overarching goal of the transformation, key milestones, deliverables, due dates and responsible staff is a necessary component for maintaining organization and staying on track throughout this process.

The project work plan will complement the state's vision-setting effort, grounding the vision in attainable milestones and deliverables and assigning responsibility for each task. The outline and work plan lay the groundwork for the transformation effort to come. (See [Appendix A: Sample Work Plan](#) on page 81.)

Figure 4: Pre-Work: Key Elements to Set the Vision for Transformation



STEP 4: ENGAGE CORE STAKEHOLDERS

The investment in meaningful stakeholder engagement—early and often—will strengthen a state’s vision and is critical to the long-term success of transformation (including after the state receives approval). It provides an important opportunity for state officials to validate their expectations among those whom implementation will most likely affect and to find alignment when possible. It builds support and a sense of ownership and investment in the vision that will be valuable when stumbling blocks arise or when implementation begins. It also creates an environment of trust and establishes relationships that will be essential to successful implementation. Finally, it lays the foundation for meeting federal and state public notice requirements associated with Section 1115 waivers or SPAs. (See “[Phase 2: Getting to Yes with CMS](#)” on page 47 for details.)

Building the Conversation

As the state gathers information to share with the governor and legislative leadership, senior staff can begin informal outreach to the core stakeholders whom transition will most likely affect—for example, managed care plans, providers and consumer advocates. Such outreach can build off existing relationships and provide stakeholders with the opportunity to offer their input on the vision the team will present to the governor.

After the governor approves the overall transformation vision, senior staff can engage core stakeholders in a more formalized manner. Through these conversations, state officials can learn more about how the proposed transformation vision will be implemented and where challenges may arise. In some states, these core stakeholders will be true partners in the development of the vision, helping drive the creation of a transformation plan.

In some states, systemwide transformation will require a partnership with managed care plans and/or providers—for example, to build quality metrics and design how they will be held accountable based on those metrics.

In other states, these stakeholders will be an important audience to engage for feedback and reactions as the state drafts a transformation plan. In both instances, it is important that the state establish an appropriate process to include these core stakeholders in the design phase and for the state to be as transparent as possible about the direction it is taking, as well as changes, updates, and other developments that may affect stakeholders.

In **Alabama**, two specific workgroups (one for primary care providers and one for providers and families of individuals with disabilities) were established to facilitate new relationships between Regional Care Organizations and stakeholders. In addition, more than 1200 providers were updated during a statewide series of 16 provider forums.

State officials, however, will need to be strategic about how they incorporate stakeholder feedback into their vision for transformation and eventual submission to CMS. Specifically, state officials must maintain ownership of the overarching vision and critically examine the feedback they receive from stakeholders, who may be motivated to maintain the status quo or elevate their role in a new delivery system.

Defining the Process for Engagement

Establishing a stakeholder workgroup that meets on a regular basis with the state's core team is an effective engagement strategy. Workgroups provide a forum for state staff to update stakeholders on progress and offer an opportunity for stakeholders to provide feedback. When appropriate, one-on-one meetings with the leadership of particular stakeholders (such as managed care plans, provider groups and patient advocacy groups) can allow for both confidential feedback and open conversations.

STEP 5: DEVELOP A COMMUNICATIONS STRATEGY

Patty Wentz wrote this chapter of the toolkit.⁵

A comprehensive communications and outreach campaign is essential to the success of a state's transformation vision. To be truly transformative, the core team must communicate the vision to the stakeholders who will implement it, the individuals whose care it will affect and the staff who will support it. Through effective communications, public officials and policymakers move the vision beyond a white paper and gain engagement and momentum to build broad public support. This communications effort is separate from the formal public notice requirements associated with Section 1115 waivers and certain types of SPAs. (See "[Phase 2: Getting to Yes with CMS](#)" on page 47 for details.)

Building the Plan

1. *Build a strategic communications plan that has clear objectives, timelines, audiences, spokespeople, communications channels, public input opportunities, materials and accountabilities.*

Section 1115 waivers and SPAs are not goals in themselves and typically are not the only activities necessary to support state-based health reforms. For that reason, a state should design its strategic communications and outreach around a larger vision of a transformed system.

Objective. As a state pursues Medicaid transformation, achieving its goal will require uniting the stakeholders that the reform affects. One essential objective of a communications plan is to engage policymakers, the legislature, a potentially siloed state bureaucracy, the physical health care system, the behavioral health care system, local governments, advocates, media and the general public on the state's unified vision of transformation to build support for any actions necessary, such as a Section 1115 waiver, legislation and project implementation.

Timelines. The team should tie communications timelines to the state policymaking calendar, taking into account legislative, budget and federal deadlines. Each is an opportunity to communicate key messages linked to activities relevant to stakeholders.

Audiences. The team should break down audiences by both category and geography. Although core messages stay the same, the team can tailor information in a way that speaks to the needs and concerns of a particular audience. For example, the team can assemble the costs and benefits of Medicaid changes for each county or local jurisdiction, making the data more immediate and real at the community level. In addition, a concurrent and targeted internal communications campaign is necessary to support agency efforts in health system transformation.

Communications channels. A variety of communications channels are available to a state beyond paid media. A successful communications strategy will use each channel as appropriate.

External communications channels include the following:

- **Mass media.** States should develop press kits, plan face-to-face visits with every major newspaper and make several rounds of editorial board visits. This effort could result in news stories in print, television or radio, focusing on the proposed transformation and the efforts

⁵ Patty Wentz is with Strategies 360's Oregon office. Prior to joining Strategies 360, Ms. Wentz was the communications director of the Oregon Health Authority, where she led the multiagency communications and outreach campaign for Oregon's health reform legislation. She also served as communications director for Governor Ted Kulongoski and the Oregon Department of Human Services.

the state is undertaking. It is essential that reporters and editors have a solid grounding in the health reform vision. An educated press can be a critical ally in communicating the state's vision of reform.

- » **Direct communications.** State staff should consider including the agreed-on transformation message in all direct communications. For example, the governor can include focused health reform messages in major speeches, budget documents, legislative priority materials and the executive branch website. The lead agency can use a listserv for regular email newsletters to both internal and external audiences. One tactic is to issue a short weekly email highlighting transformation milestones or examples combined with a monthly email that offers a news round-up and promotes opportunities for public engagement. Newsletters are an opportunity to inform and engage as well as model the core messages. They can also exemplify how leadership is framing all health activities under the health reform umbrella.
- **A dedicated website.** The team should create a dedicated website focused on the state's health reform efforts, with an easy-to-remember name and a clean format that allows people to find current information about reform efforts. Alabama created an easy-to-find series of webpages on the Agency's website⁶ that included background information about its regional care organization (RCO) efforts, frequently asked questions and updates as they occurred.
- **Use all existing opportunities for public engagement, and create new opportunities tied to milestones.** States should take advantage of standing meetings, such as advisory committees, legislative hearings, board meetings or tribal consultations, to maintain a consistent message throughout the Section 1115 waiver process, telling the story of transformation and updating stakeholders. In addition, states can establish public workgroups made up of key stakeholders to provide forums for stakeholders and media to learn first-hand about the opportunities and challenges of the state's health reform work.

Internal communications channels include the following:

- Direct, frequent and interactive communications with agency staff. Such communications are critical to the success of health reform. Staff should get the same reinforcement of core messages as external partners: After all, they are telling the story of health reform every day, with or without direction. Engage them as ambassadors, and make sure that there are opportunities for them to learn how a changing health system affects their work and the agency.
- An internal communications plan should also include messages that reflect leadership's vision of how the agency will support health reform and what the changes will mean for agency operations. Tactics for internal communications include:
 - » Prioritizing health reform in any existing internal communications channels wherever possible;
 - » Ensuring that division and program leadership understand and use the core messages in their communications to staff;
 - » Where possible, engaging the appropriate labor unions in health reform and staff communications;
 - » Creating a dedicated intranet site;
 - » Producing internal presentations, leadership brown bags and email updates; and
 - » Branding health reform internally with materials such as posters and flyers.

6 Alabama Medicaid Agency, "Regional Care Organizations," http://medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx (accessed May 3, 2016).

Spokespeople. Senior state officials and policymakers can make telling the story of the state's health system transformation a top priority. Top messengers include the governor and executive health policy staff, the chief policy officer, the state Medicaid director, the addictions and mental health director, and legislative champions. Whether to rotary clubs, trade associations, health systems, media interviews or keynote speeches to hundreds of people, executive and agency leadership should give their time to lay out the state's vision and answer questions. The core team should prepare spokespeople with:

- A set of key talking points developed for the governor's office and agency leadership so that they can deliver the same core messages (see [Oregon Community Care Organizations Talking Points](#)⁷); and
- Preparatory sessions held before major speeches, presentations, interviews and editorial board visits.

In addition, the team can identify third-party validators such as health care providers in all media markets. Spokespeople should engage these validators, prepare them and ask for their participation in town hall meetings. They will lend support to state health reforms and demonstrate local leadership by discussing the innovations underway in their communities.

Materials. Information spread relies on creating materials that allow partners, stakeholders and the media to share the information and be influencers to their own audiences. These materials include toolkits with simple fact sheets, presentations, videos from the governor's office and agency leadership, talking points and newsletter articles. These materials should be available on the state's transformation website (see [Oregon Community Care Organizations Fact Sheet](#)⁸).

Accountabilities. The team should consider engaging leadership weekly on the progress of communications efforts. It can create a reporting and feedback loop to ensure that communications strategies adjust to meet real-time needs and opportunities.

2. Start early to create a unified vision.

In many instances, state officials discuss and design their transformation efforts well before drafting a Section 1115 waiver and submitting it to CMS for approval. A public outreach and education campaign should also start early in this process to ensure that affected stakeholders are involved and supportive before the state gets too far ahead in its planning. Early input from key stakeholders can identify issues with the health reform plan, making it stronger in the long run.

3. Engage community partners and stakeholders in outreach and communications planning.

Many stakeholders have expertise in the populations they serve. The state can ask for their help in identifying audiences, setting priorities and targeting messages. The team should consider building a formal or informal communications table to solicit feedback and advice on outreach plans and communications materials. It can develop a communications process to serve as a model of the state's transformation efforts: team-based, audience-centered and broadly accountable.

7 Oregon Community Care Organizations Talking Points, <http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1606MedicaidOregonTalkingPoints.pdf>, (accessed June 15, 2016).

8 Oregon Community Care Organizations Fact Sheet, <http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1606MedicaidOregonFactSheet.pdf>, (accessed June 15, 2016).

4. Make the vision tangible, and show what is possible through real-life examples across the state.

The list of problems with the current health care system is long, detailed, complex and so overwhelming that it can seem impossible to make real, sustainable change. It is also likely, however, that examples exist of innovation underway in local and state agencies, in clinics and in communities across the state that point the way toward a transformed health system. The team should take the time to find them and tell their stories—for example:

- Successful emergency department diversion programs that save money and improve health;
- Clinics or health systems that are finding ways to integrate physical and behavioral health and improve outcomes;
- Places that are using community health workers successfully; and
- Programs that are addressing health disparities or complex chronic conditions.

The team can use these stories as examples of what the state is driving for and also as a way to show people that the new approach is not necessarily reinventing the wheel. Rather, health reform builds on local innovation and moves the entire state toward an attainable goal.

5. Create a story bank.

One key tactic for bringing proposed health policy changes into focus is to show the effect on real people in the state. Beneficiaries, providers and community health workers all have a story to tell. It is helpful to have a bank of such stories from around the state on hand to share with stakeholders and media. When written, the stories should be short (less than 300 words), include a photograph and repeat the core messages of health reform. They can be posted on the health reform website as a resource for media and stakeholders. The team can use these stories in news releases, legislative testimony, toolkit materials, presentations, speeches and social media. Each story should be carefully vetted and fact-checked, and subjects should sign a release giving permission for their story to be told.

6. Partner with other agencies, and create a communications and outreach cabinet.

Depending on the state structure, not all health-related activities may be under one agency. In addition, improvements in the Medicaid program will affect human services and other, related agencies, and so staff and stakeholders of those agencies need information about health reform, as well. A joint communications cabinet can build allies, inform the communications plan and create more opportunities for dissemination.

The core team should consider the following message strategies:

- ***Keep language simple, clear and researched.*** If possible, the team should consider working with a local partner to undertake message research to identify the right language to describe the state's vision for health reform in a way that resonates with the public. The most effective messages are not always obvious. When research is not an option, clear language strategies are always more effective. Staff could look to leading national health care messengers who are experts at explaining complex policies in ways that resonate with everyone.
- ***Keep the focus of communications on the people, not the system.*** Good health care is personal; it is about improving people's lives. A state should focus its communications campaign on the human element of health care from the perspective of patients, providers and community leaders. It is also important to show the reach of Medicaid in a way that people can relate to, such as the number of children and families covered locally or the percentage of babies born in the state who are covered. Such information helps reporters understand the reach of the program and how it affects people and local communities.

- ***It is not about the Section 1115 waiver.*** Language about government can be bureaucratic and disengaging. Language about health care is often scientific and confusing. Combined, descriptions of Medicaid Section 1115 waivers are incomprehensible to most audiences. Moreover, the Section 1115 waiver is a tool for health reform, not an end in itself. Instead, the team should consider framing the conversation in terms of the state's health reform vision and goals.
- ***Communications with clients.*** Having information specifically for Medicaid clients available on both the state's reform website and the Medicaid website is helpful. This information should be in plain language and emphasize what will—and will not—be changing for clients. For example, people should know that they will not be losing benefits. Direct communications to clients should wait until policies are changed and should be tied to changes such as getting a new MCO that offers more coordinated care.

The core team should consider the following resources and staffing points:

- There should be a designated communications lead for the health reform campaign who has the authority to direct reform-related activities across agencies. He or she can be part of the health reform leadership team and present for policy and strategy conversations. That said, finding adequate resources for effective communications campaigns can be a challenge. In most health and human services agencies, communications and outreach are understaffed, and what staff there are typically juggle a heavy workload. Ideas for adding temporary capacity for a strategic communications and outreach campaign include:
 - » ***Prioritizing the work of the communications and outreach staff for health reform.*** During the years of policy approval and implementation of health reform or transformation, agency communication staff should be able to prioritize this work above—and sometimes to the exclusion of—ongoing, nonessential duties. Coordinating the plan, creating the materials (including the Web pages and social media presence), responding to opportunities, preparing for presentations and speeches, meeting with stakeholders and updating the public on progress takes a focused and coordinated effort. Such focus means that some aspects of communications work will be postponed or not completed at all. Making transformation the priority will deepen the capacity for the communication and outreach work and ensure that it is sustained throughout the timeline of the campaign.
 - » ***Repurposing staff for a short time.*** Creating short-term positions can provide both career development opportunities for staff who have communications skills but not the title and also fill a need for the agency.
 - » ***Hiring contractors for specific work.*** Contractors can be helpful in crafting communications plans, message grids, presentations and materials for staff to use in the campaign. Adding contractors can be a challenge under many states' contracting rules, but there are often simpler avenues for short-term, focused contracts (see [Step 6](#) on Page 35 for details).
 - » ***Partnering with local foundations or groups on shared communication and outreach goals.*** In Oregon, for example, a local health foundation funded the limited-duration "story banker" position after local stakeholders requested more information and materials about health reform. A partner also funded message research.

Case Study: Oregon

In July 2012, CMS approved a Section 1115 waiver for **Oregon** and invested \$1.9 billion in the state's new coordinated care model. In return, the state agreed to reduce Medicaid cost growth by 2 percentage points and establish both accountability and incentive metrics for the Medicaid coordinated care organizations (CCOs).

Oregon started its public outreach and education campaign more than a year before submitting its Section 1115 waiver, but the state's health reform conversations began even earlier. The Oregon Health Authority was created in 2009, and one of its first actions was to create the Oregon Action Plan for Health, with broad public and stakeholder input. This document laid the foundation for the state's health system transformation and Section 1115 waiver and built public input into the design process from the ground up.

Over the course of the waiver process, there was little conversation about the "waiver." None of the workgroups, task forces, public meetings, town halls, webinars or online surveys were chartered as being about the waiver except in the narrow time when public comment about the application itself was due. (All those moments of public engagement, listed by date and participants, were submitted as part of the waiver as supporting the elements and purpose of the waiver.)

This approach is important because it moved the conversation beyond a limited audience and allowed for broader engagement by the general public. In fact, Oregon media report that from the day the Section 1115 waiver approval was announced, the state did not use the word waiver. Rather, the document was described as federal support and investment in Oregon's vision for health reform, with the state's accountability to the federal government. That made the story about more than Medicaid. It was about everyone, and Oregon worked to create opportunities for everyone to learn about the transformation, whether in person, online or in the press.

This is important because different audiences often have unique concerns. For example, the behavioral health system was concerned about the ways in which a coordinated care model would change its funding streams. The physical health care system, in addition to having concerns about reimbursement rates, needed to know how the new system would hold it accountable and what incentives for improvement would be. Community advocates wanted to know how the new model would affect Medicaid members' access to care. The public health community was eager to participate early and often to affect the upstream conversation, and agency staff were anxious

to understand how their jobs would change to adapt to a new vision for the health care system.

Oregon hosted nine statewide town hall meetings and numerous webinars. Media visits and stakeholder visits with local health systems were scheduled to support those events, and they received strong local media coverage. In all, there were more than 90 public-facing opportunities to learn or comments to the state about health reform over the 13 month period between January 2001 and February 2012. By the time the public comment period opened at CMS for the Section 1115 waiver, interested Oregonians were well-versed on the state's health reform vision.

To make it easy for interested members of the public to find information about transformation in one place and recognizing that not everyone would be able to participate in a town hall or webinar, Oregon created Health.Oregon.gov, and the address was included in the footer of all agency communications, presentations and materials. The state used search engine optimization techniques to ensure that the site ranked high in search engine results when the public and the media sought information about health care reform. The state achieved this in part by developing relationships with other stakeholder sites so that they could include links back to state reform content. To make it even easier, Oregon created a graphic that partners could put on their sites that matched the look and feel of the reform site.

News of the federal approval and investment in Oregon's plan was released at a Portland news conference held in a community health center and attended by hundreds of people who had been involved along the way. The crowd included community members, lawmakers, providers, health system executives and agency staff. For everyone in the room, it was the culmination of a years-long journey to reform Oregon's health care system to meet the triple aim of better health, better care and lower costs.

Oregon timeline:

- 2009: Oregon Health Authority and Oregon Health Policy Board created.
- December 2010: Oregon Health Policy Board releases "Action Plan for Health," laying the foundation for Oregon's health reform work.
- June 2011: State Bill (SB) 580 created CCOs.
- February 2012: SB 3650 (CCO implementation) was approved.
- July 2012: CMS approved the state's Section 1115 waiver.
- August 2012: First CCOs were launched.

STEP 6: DETERMINE THE NEED FOR CONSULTANTS

When designing and seeking approval for a transformative Medicaid project, states may require the assistance of consultants along the way. Consultants can support state officials in various ways, such as providing expertise in niche areas (for example, actuarial services), supplementing resources to allow state officials to produce deliverables in a timely manner (for example, assisting states with drafting a Section 1115 waiver application), and ensuring that state officials design their reforms in a way that will be palatable to CMS (for example, developing communication strategies to ensure that states are on track for federal approval). Consultants are often familiar with current CMS policies and based on that experience can facilitate the design and negotiation process.

Without adequate state planning and management, however, the use of consultants can be ineffective and costly. To avoid this outcome, state officials can strategically use consultants, determining when consultants are necessary for a state to be able to design a transformation that CMS will approve. In considering when and how to use consultants, state officials may consider the following points.

Identifying the Need for Outside Expertise

State officials should carefully evaluate their existing capabilities and resources to determine when external expertise will be critical to developing their transformation proposals. In conducting this needs assessment, the core team should consider breaking the project work plan into pieces to determine when a consultant may be needed and whether the engagement would be a short-term or longer-term engagement.

When this analysis is complete, state officials may determine that outside expertise would be valuable at a “big-picture” level—for example, assisting in the development of the vision and strategy by identifying models from other states that CMS has approved. In this example, state officials should retain control of developing and communicating the vision throughout the project and clearly define deliverables for which the consultants will be accountable. State officials should work with the consultants to develop internal expertise and capacity and not turn over full strategic control to the consultants. This internal capacity will be critical for actively managing and overseeing the consultants’ work over the course of the contract. It also will develop staff capacity for implementation after approval.

State officials also may determine that outside expertise may be needed for specific elements or phases of the transformation development. For example, the core team may not have the actuarial expertise to develop the financial documents necessary to demonstrate budget neutrality (BN) for a Section 1115 waiver proposal. The team may determine that it requires guidance to develop its stakeholder engagement strategies and plans or in the development of how the state will create VBP strategies, including the metrics that form the basis of incentive payments. Similarly, state officials may determine that they need additional resources to prepare and submit a complex SPA or Section 1115 waiver proposal. In these examples, state officials can clearly identify the targeted need, the timeframe within which the state will use consultants, and the potential use of different consultants, depending on the expertise needed.

Identifying Financial Resources Available for Consultant Services

After state officials have identified when and how they will use consultant services, the next question is what resources are available. The answer will dictate what the state will be able to purchase. Consultant services can be costly depending on the nature of the assistance. For example, a one-year consultant agreement to assist in the development of a Section 1115 waiver proposal may range from \$200,000 (for the development and preparation of a concept paper) to \$2 million (for

the provision of hands-on assistance throughout multiple phases of the project). If state officials determine that they need more comprehensive, resource-intensive assistance, including having multiple consultants on site as “staff” for a prolonged period, the state may spend considerably more per year. For example, it is possible for a state to spend \$6 million per year for comprehensive assistance throughout the transformation process (including two to five consultants providing on-site assistance throughout the year). These examples emphasize the need for states to be critical thinkers about the need for consultants and to be proactive managers of the services they purchase.

Given the potential cost of consultant services, state officials should first determine whether technical assistance (TA) opportunities are available at no cost to the state. National associations or other, similar organizations may offer TA related to the development of VBP strategies or models for the integration of physical and behavioral health. In identifying those opportunities, state officials may be able to reduce the state resources needed to obtain an outside consultant. For example, through the *Medicaid Policy Academy*, states were able to receive TA for certain aspects of their projects. This assistance included access to a consultant who could vet questions and provide insight into the Section 1115 waiver submission and approval process.

The state may need an outside consultant, however, who is not available through TA opportunities, so the core team will need to identify the state funds that may be available. Unless the cost of consultant services has been built into an existing Section 1115 waiver, consultant services are generally reimbursed as an administrative expense, allowing for a 50 percent federal match rate for costs incurred. As a result, state officials will need to identify the funds for the non-federal share of these costs.

Process For Selecting Consultants

Once the specific need for outside consultants has been delineated and the state has identified available funds, state officials will need to identify the process by which they will retain the consultants. Given the dollar amount associated with such contracts, state officials may need to develop and issue an RFP. Because the RFP process mandates a timeframe, state officials must ensure that they conduct the RFP process far enough in advance to avoid delaying development of their transformation proposal. In the RFP, state officials can clearly define the specific tasks the consultant will need to complete and the criteria by which selections will be made.

If multiple consultants are necessary, state officials will also have to determine the timing of the different RFPs to ensure that consultant services will be available when needed. If the RFP process becomes a barrier to efficiency and appears likely to delay the state’s timeline, state officials may want to consider using master services agreements, which often provide quicker access to prequalified consultants.

The state of **Washington** has a “convenience pool of consultants” selected through an RFP process. When the state identifies the need for a consultant, it can issue an RFP just to the firms within the pool, which reduces the time and resources needed for the selection process.

Criteria For Selecting Consultants

When choosing a consultant, states should ensure that the consultant will be able to execute the identified tasks successfully. After the state has narrowed the field to a few select individuals, it can

apply the following criteria:

- **Prior state experience.** Consultants should have experience in the precise area for which the state is seeking their assistance. For example, if a state requires assistance with financial models for BN, the consultant should have prior BN experience with other states, such as the approval of Section 1115 waivers, and should identify his or her role, timeframes and cost. State officials can reach out to other state leaders to confirm the quality of the assistance they received.
- **Familiarity with CMS policies and approval process.** Consultants should have intimate knowledge of CMS's expectations for a SPA or Section 1115 waiver. Ideally, the consultant team should include someone who was either a former leader within the Center for Medicaid and CHIP Services (CMCS), a state leader who recently designed and implemented his or her own transformation proposal or individuals who have assisted multiple states to obtain CMS approval of transformation proposals. These individuals can best understand where there is ambiguity in CMS policies and the potential solutions that fit the state's needs. Consultants should also be able to point to their role in other SPAs or waivers to illustrate where they have achieved outcomes that may be desirable for the state.
- **Team members.** Many states have noted that once they enter into a consulting contract, the consulting company changes the team working on the project, or the more experienced members described in the contract are not available for hands-on work. State officials can establish a clear understanding of who the consultant's team leader will be and who the other team members will be and request a commitment for the time each individual will spend throughout the project, with the specific budget associated with that commitment.
- **Relationships with other consultants.** If the state requires the involvement of multiple consultants for different pieces of the project—for example, development of a waiver application and the BN calculations—state officials should consider how the consultants have worked together previously. Consultants who have established relationships from work on similar projects provide an opportunity for the state to leverage that prior experience for a more efficient path to approval.
- **National or local presence.** State officials can be strategic about whether a local or national consulting group better meets their needs. Local firms can bring a deep understanding of the state's current health care marketplace, including knowledge of the various stakeholders and the dynamics that shape their interactions. National firms may be more familiar with current CMS policy through their work with other states, including details of what has worked and what has not. It also can be helpful to a state politically to have an independent, outside expert as part of the team.
- **Cost.** In thinking about cost, there are different ways to structure the contract. A state may opt for a fixed-fee contract, with a clear delineation of the tasks the consultant will perform. Alternatively, a state may choose to reimburse consultants based on hourly rates. In this model, there is a much greater financial risk to the state, so generally such a model is not recommended because it is often difficult to accurately predict the hours required given the many external factors that can delay or complicate the process.

Holding Selected Consultants Accountable

Once the state has selected a consultant, state officials need to manage the consultant and hold him or her accountable for outcomes. The following tasks will help ensure accountability:

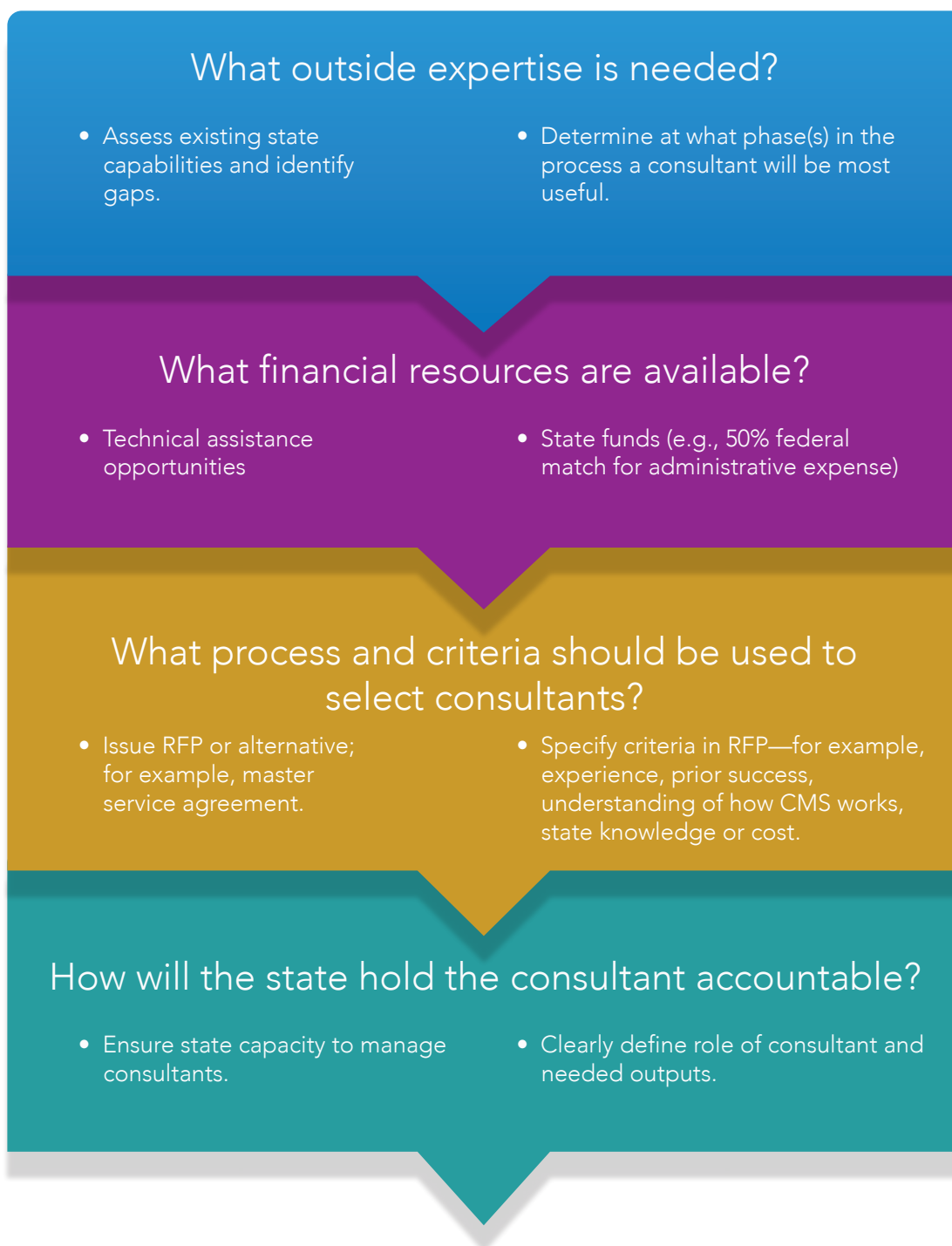
- **Clearly define the role of and oversee consultants.** Through the contract, state officials can clearly define the role of the consultants, with specific deliverables, expectations and timelines. As noted earlier, state officials can identify in the contract who on the consultant

team will provide services and the manner in which they will do so. For example, if the state has engaged a consultant for extensive support for proposal development, state officials can determine whether the consultants must be on-site, how many site visits will be required and the support the consultant will need to provide during those visits. During the course of the project, developing a good relationship with the consultant is important. To that end, for example, the team can include consultants in stakeholder meetings so that they can gain needed context for the work. Other strategies include the consultants' full engagement with team members, such as asking consultants to provide comments on proposals or suggesting alternative strategies. Allowing this type of back and forth will foster a communication stream that allows the state to benefit from the consultant's perspective and prior experience. Of course, state officials must weigh the benefit of such engagement against the cost of this level of involvement.

- ***Hold consultants accountable for outcomes.*** State officials can hold consultants responsible for deliverables and overall outcomes through their contracts, up to and possibly including ensuring that the state receives CMS approval for its proposals. Several factors will determine whether a state achieves approval from CMS, but it is possible to identify a subgroup of factors that consultants' advice and actions directly influence. For example, including clear deliverables in the RFP process and final contract and measuring the consultants against whether those tasks were completed is one way to hold them accountable over the course of the project. If the consultants are not meeting the clearly delineated goals, state officials can identify the tools to address the deficiencies in the contract, such as withholding payment for deliverables or, in the most extreme case, terminating the contract.
- ***Transition planning.*** State officials can build their internal structure to ensure that the state will be able to manage the work after a consultant's contract has ended. Officials will need to take the lead on ensuring knowledge transfer from the consultants to help state officials prepare and plan for the continuing work. One strategy is to have the consultant "train" state staff to ensure they will be able to carry on the work.

[Figure 5](#) on page 39 helps states identify key considerations while determining the need for consultants.

FIGURE 5: Determine Need for Consultants: Key Considerations



Outcome:
Successful partnership that leads to CMS approval

STEP 7: DEVELOP AND SUBMIT THE CONCEPT PAPER TO CMS

Prior to submitting a concept paper, senior state officials can reach out to CMS—specifically, to officials within CMCS—to discuss initial ideas, identify to whom they should send the concept paper and let CMCS officials know when to expect the paper. For example, if state officials think they may need a Section 1115 waiver, they can engage with the director of the CMCS State Demonstrations Group (SDG) and send the concept paper to that individual. The SDG can then engage the other groups within CMCS that may need to be involved in discussions. There are many different groups within CMCS, and states can determine which are relevant for the initial discussions. (See the [CMCS organizational chart](#)).⁹

Through the concept paper, the state will provide CMS with a clear overview of the proposed project. This paper has two main goals: to introduce the state’s thinking to CMS and to get CMS support for the vision and move forward in discussions. If CMS becomes invested in the state’s concept for transformation early in the process, it can be easier for the state to overcome later obstacles and facilitate the negotiation process down the road.

A well-written concept paper—one that is the result of all the work a state has done to identify why transformation is critical—can demonstrate to CMS its level of commitment to pursuing reform. The paper also provides a solid platform from which state officials can begin to engage with CMS on specific elements of the proposal. Note, however, that the concept paper should focus on concepts, not on specific legal authorities (for example, whether the state needs a SPA or waiver). The state can discuss such things after submission.

The concept paper can be short (up to 10 pages) and can follow an outline such as:

- Section I: Introduction—Why Transformation Matters
- Section II: Project Vision and Goals
- Section III: Description of the Target Population
- Section IV: Explanation of the Current System of Care
- Section V: Explanation of the New System of Care
- Section VI: Potential Federal Authorities
- Section VII: Project Financing (including both the federal and nonfederal share)

See [Appendix B: Concept Paper Template](#) on page 93 for further information about what the concept paper can include. The **Washington** core team drafted a concept paper as it embarked on its discussions with stakeholders and CMS, which provides an example of a completed concept paper. (See [Washington concept paper example](#)).¹⁰

As discussed in [Step 5](#) on Page 29, creating and implementing a stakeholder engagement plan is a critical step. So, in addition to using the concept paper to engage CMS, states can post the paper publicly and use it to disseminate information to stakeholders across the state. By engaging stakeholders during this phase, there will be opportunities for their input to shape the design of the proposal that will be described in the SPA or Section 1115 waiver that the state submits to CMS.

⁹ Centers for Medicare & Medicaid Services, “Approved Leadership as of March 1, 2016,” <https://www.medicaid.gov/about-us/organization/cmcs-organizational-chart.pdf> (accessed April 25, 2016).

¹⁰ Washington Health Care Authority Medicaid Transformation Concept Paper, http://www.hca.wa.gov/hw/Documents/1115_waiver_concept%20paper.pdf, (accessed July 20, 2016).

STEP 8: ENGAGE WITH CMS

A key component of getting to yes with CMS on a transformation project is effective and targeted communication aimed at the appropriate CMS staff (see [Figure 8](#) on page 54 for details about CMS's structure and formal review process). After submitting the concept paper, states can develop a communications strategy for how and with what frequency they plan to engage CMS, with the knowledge that early and consistent communication facilitates a smoother application and approval process. Although the specifics of communications strategies may vary depending on the policies and personnel at CMS, the sections that follow provide key strategies.

Establishing a Plan to Engage with CMS Leadership and Staff

Within two weeks of a state submitting its concept paper to CMS, state leaders can follow up with email communications to ensure that CMS received the paper, ask whether CMS has additional questions and confirm the timeline for CMS to engage with the state about the paper's contents. As [Step 7](#) on Page 40 showed, in conducting this outreach, states can identify the relevant directors and groups within CMCS to engage in the conversation. If the state wants to discuss technical aspects of the proposal, state officials can request that CMCS subject matter experts (SMEs) join these meetings. For example, if a question arises about financing, state officials can ask for an expert from the CMCS Financial Management Group to join the meeting. (See the CMCS organizational chart).¹¹

During the course of the conversations, states can ask CMS how many meetings will be needed to ensure that CMS understands the state's vision and goals and to identify a path forward—for example, whether the state should consider a SPA or waiver. When CMS officials receive a concept paper, they generally go through an internal process of review and discussion. Before CMS officials can commit to regularly scheduled calls, such as every one to two weeks, there must be buy-in from CMS leadership on the state's proposal. States can ask CMS where they are in that process and when they can commit to moving to regularly scheduled calls.

One goal at this stage is for the state to reach agreement on next steps. So while it is unlikely CMS will "approve" concepts at this phase, the state and CMS should be able to agree on:

- Where the state has the flexibility to get to approval and which elements are non-starters or challenges;
- Frequency of contact; and
- Timeline for submission of a waiver or SPA.

Content Development for Meetings

While engaging with CMS leadership in these early meetings, states can focus on presenting the high-level vision, goals and objectives of the project. As part of these conversations, the state must be prepared to explain why the current authorities under which it operates its Medicaid program (through either SPAs or existing waivers) do not allow the flexibility to pursue its desired transformation. The state must also be clear about its current environment and how that environment affects its options moving forward. For example, if a state knows that its legislature will not appropriate additional dollars for the project, it must clearly communicate that fact to CMS so that CMS and the state can think creatively about alternative funding options.

¹¹ Ibid.

Format of Meetings and Information Transfer

The state team leader may take the lead when presenting the project to CMS officials and answering any questions during these initial calls. With each call, the state's goal is to facilitate CMS's understanding of the project and the direction the state is headed. States must consider which presentation format would best highlight the vision underlying their concept for transformation. For example, a state may consider building a succinct, clear Microsoft PowerPoint presentation that walks through its project and introduces CMS to its transformation concept as the basis for the phone calls or in-person meetings.

In general, these meetings can be conducted by video conference or conference call, but if a state has the resources available and feels that the phone calls or video conferences have not been productive, members of the core team can plan in-person meetings with CMS leadership. Through the in-person meetings, state officials can underscore the importance of the proposal to the state, signaling its willingness to work collaboratively with CMS on a path forward.

Post-Meeting Follow-Up

Before the meeting ends, the state's core team should clearly understand next steps and when to schedule the next meeting with CMS. After each meeting, state officials can follow up with an email to CMS officials summarizing the decisions made, outstanding questions and next steps. This exercise ensures that both parties are on the same page and that there is a record of what was discussed. States officials can also document which CMS officials were on the call or in the meeting and their roles within CMS.

In many instances, CMS staff will have follow-up questions and areas for which they need more detail. State officials should consider responding to these questions and providing the requested details as quickly as possible—ideally, within two weeks—and keep the answers simple and direct. State officials can keep a log of the questions asked and answered for internal purposes because similar questions may come up later (for example, when there is CMS staff turnover) and the state may need to provide the information again. State officials can also keep track of the “to-dos” on CMS's plate, such as answering questions or scheduling a follow-up call with another CMS SME. State officials can send reminders to relevant individuals to ensure that CMS completes these items.

During these conversations, it is strategically important that states listen carefully to what CMS is communicating to them. The art of negotiation for the states is to understand how to push their vision while addressing concerns that CMS raises and working with CMS to identify alternatives to any stumbling blocks. At the end of this phase, states will not be able to resolve all the outstanding questions or obtain CMS approval, but they can meet certain milestones. These milestones include confirming whether they will pursue a SPA or a waiver (see [“Choose a Path Forward: Prepare and Submit a SPA”](#) on page 47) and whether CMS leadership supports the vision which would, for example, allow the state and CMS to move to regularly scheduled calls on the proposal.

Tips for engaging CMS

States should send presentation slides with any supporting materials at least two business days prior to the call with CMS to allow CMS time to review the material. In addition, states should be prepared to walk the CMS staff through the material and engage their questions. An important note: If a state chooses to send supporting material to CMS, it is advisable not to overwhelm CMS staff with multiple, lengthy documents. Rather, states should be selective in what they send. The goal is to bring CMS along and ensure buy-in to the proposed project, not to confuse or bog down CMS staff with unnecessary paper.

CMS officials are more likely to read 1- or 2-page documents than 50- or 60-page documents. Before the call, the state should assign someone from the state team to be responsible for noting call participants' names, the group or agency they represent and whether they are located in the central office or a regional office. A state participant can also catalogue the items addressed and resolved during the call or meeting, outstanding issues, and responsibilities for next steps. The state can then email this information to everyone on the call or in the meeting—both state and CMS participants—asking for their confirmation of the conversation, decisions made and items outstanding.

Getting to Yes with CMS



Phase 2: Getting to Yes with CMS

States must build a path for getting to yes with CMS. After submission of the concept paper to CMS, states must ensure they can get to an “agreement in concept” with the agency as quickly as possible.

As referenced in [Step 8](#) on Page 41, states will first engage CMS leadership and relevant SMEs to identify which elements of the proposal are “approvable,” where the state has flexibility to get to approval, and which elements may be challenges or “nonstarters.” In the context of these discussions, states and CMS also must determine the authorities needed to achieve the desired outcomes: a SPA or a waiver. A SPA provides permanent authority but requires the state to operate the program in accordance with existing federal requirements. Section 1115 waivers allow states to accomplish Medicaid strategies they may not be able to accomplish under the Medicaid state plan, including “waiving” certain federal regulatory requirements that would otherwise apply and claiming federal financial participation for expenditures that are not otherwise matchable under Title XIX. These waivers, however, are time limited, approved initially for five years, but can be renewed.

Throughout these conversations, CMS will work with states to see if it is possible for a SPA to achieve the desired results. (A SPA has a simpler path to approval and is generally far less resource intensive for states.) In some cases, using a SPA (or other, narrower authority) may be the best path forward for a state. In other cases, states may require the flexibility of a Section 1115 waiver.

The following sections discuss the process states will use to determine the appropriate authority and the path to submission and approval of the formal application.

CHOOSE A PATH FORWARD: PREPARE AND SUBMIT A SPA OR SECTION 1115 WAIVER APPLICATION

As states envision transformation of their Medicaid programs, they will have to work with CMS to determine which authority provides the best path forward to implement their vision.¹² There are many factors that states can consider as they navigate this process:

- The type of transformation envisioned and whether it is possible to achieve through a SPA (or other, narrower authority, such as a Section 1915(b) waiver):
 - » SPAs offer a more straightforward path to approval and do not require the time and resource commitment that Section 1115 waivers require.
 - » Changes proposed in a SPA must comply with federal Medicaid requirements, such as statewideness, comparability (that is, providing the same benefit package across Medicaid populations) and choice of providers. There are exceptions, however, such as health homes and other authorities, that allow states to target certain populations if other requirements are met.
- The timeline the state faces to implement the desired transformation:
 - » Section 1115 waiver negotiations and approval process generally are more complex and time intensive than SPAs, and states will need to take that into consideration in their implementation planning. For example, when a state submits a complete SPA, CMS has 90 days to review and approve it. There is no time limit for negotiating Section 1115 waivers, and approvals have ranged from two months to two years after formal submission of the waiver application.

¹² For purposes of the toolkit, we focus on SPAs or Section 1115 waivers, but states could pursue other types of authorities as vehicles for transformation, such as Section 1915(b) or (c) waivers.

- Whether federal investment is critical to implementing the transformation:
 - » SPAs generally allow states to receive federal matching funds for statutorily defined Medicaid services. Section 1115 waivers, however, allow states to receive federal matching funds for expenditures not otherwise covered under Medicaid. Some states have received significant federal funds through programs such as delivery system reform incentive payment (DSRIP) programs and designated state health programs (DSHP) (see “[Financing Section 1115 Waivers](#)” on page 63 for additional information about DSRIP and DSHP). States must balance the need for additional federal investment and flexibility against the complexity of preparing and negotiating a Section 1115 waiver.
 - » States should consider all possibilities available for funding and work with CMS to determine any opportunities that exist outside the Section 1115 waiver context, such as intergovernmental transfers (IGTs), certified public expenditures (CPEs), provider taxes, and enhanced match rates (such as for health homes and CHIP).
- Sustainability of the transformation over time:
 - » By design, Section 1115 waivers are generally approved for three to five years, with five years being more common. Although most states seek to renew these waivers after their initial approval, for new projects, states will need to identify how they will be able to continue the project when the federal investment ends. States that continue to require the waiver authority or federal investment beyond the initial approval will need to renegotiate the terms of the waiver every three to five years.
 - » In contrast, SPAs create a permanent change to the program that authorizes the program indefinitely, assuming that no significant changes need to be made.

During the pre-application submission period, states should consider giving CMS leadership and other technical staff progress updates on the evolution of the proposal and continue to respond to questions about any outstanding pieces of the proposal that remain unclear or need further explanation. States should consider engaging with CMS every two to three weeks to maintain project momentum. When the state and CMS have a general understanding of the authority needed, the state can begin to develop the necessary application.

PREPARE AND SUBMIT A SPA

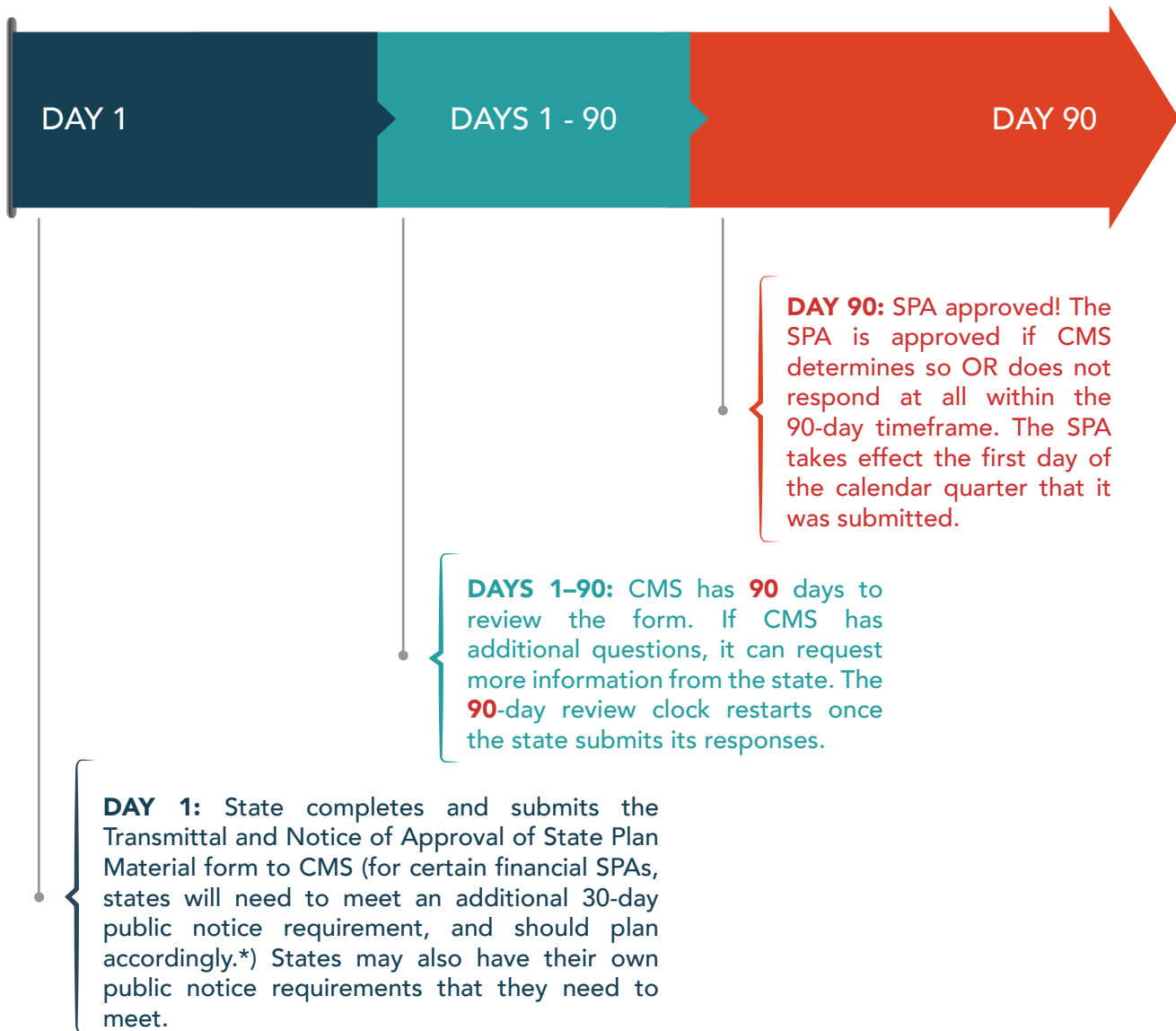
If a state determines that a SPA is the appropriate vehicle for moving forward with transformation, it will complete the SPA template and submit it to CMS. Although generally there are no federal public notice requirements for SPAs, states must comply with state requirements, which may require notice under certain circumstances.¹³ When CMS receives a SPA, it has 90 calendar days to approve or deny it or to send a formal request for additional information letter, which stops the 90-day clock until CMS receives the state’s response. However, CMS also can send questions and feedback to states informally by email or phone, which allows the 90-day clock to continue to run.

If over the course of the review process CMS identifies significant problems with the SPA, a state can withdraw the application. If it chooses to resubmit, a new 90-day clock begins. States can work collaboratively with CMS before submitting a formal SPA and during review to ensure the most expeditious and expansive use of SPAs in implementing Medicaid coverage, benefits and reimbursement strategies. CMS will provide TA to states and often review draft SPAs to ensure that the formal SPA does not run into significant or unexpected delays once submitted formally.

¹³ There are federal notice requirements for SPAs that involve significant changes to payment methodologies. State must provide notice that describes the proposed change, estimates the impact on costs to the Medicaid program, and explains why it is changing methods and standards. See 42 C.F.R. § 447.205 for details, <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec447-205.pdf> (accessed April 25, 2016).

If CMS approves a SPA, the changes can take effect retroactive to the first day of the quarter of the federal fiscal year in which the SPA was submitted. Once approved, a SPA does not expire, but a state can change it through a subsequent SPA. If CMS denies a SPA, the state can appeal the denial through the administrative review process.

FIGURE 6: Timeline for Submitting a SPA



*See 42 CFR 447.205.

PREPARE AND SUBMIT A SECTION 1115 WAIVER APPLICATION

If a state's desired transformation does not comply with current state plan requirements and cannot be implemented through a SPA (or other, narrower authority), the state must request Section 1115 waiver authority to implement the program.

Establishing the Need for a Section 1115 Waiver

A Section 1115 waiver application is typically a much more time- and resource-intensive process than a SPA, both for the state and for CMS. Therefore, the state should have a thorough understanding of the need for this authority to meet its transformation goals before heading down this path. Before preparing a Section 1115 waiver, state officials should demonstrate to CMS:

- Why it is not possible to meet state goals with a SPA (supported by a thorough analysis of the state and why alternatives will not suffice);
- How the state's proposal fits into larger policy goals of the Administration (for example, movement to VBP strategies); and
- An understanding of more recent Section 1115 waivers that CMS has approved and what pieces of the current proposal may be similar.

After determining that a Section 1115 waiver is the appropriate authority to pursue, the state would then begin to draft its formal application. CMS has a template¹⁴ that states must complete to guide their application process. When completing the template, states should be sure to refer to their data and clearly answer the following questions:

- What is the impact of this transformation on Medicaid consumers and how they access care?
- Why is this effort different and innovative?
- Does this transformation require federal investment? If so, why?

States' ability to answer these questions will greatly affect the likelihood of getting to yes with CMS. States can continue to engage informally with CMS leadership on a regular basis, but the formal CMS review process does not begin until the completed application has been submitted.

Preparing a Section 1115 Waiver: Public Notice Process

Before submitting an application for a Section 1115 waiver, a state must comply with federal and state notice requirements. [Table 1](#) on page 51 details the various federal public notice requirements and their timing within the submission process. If a state does not meet these requirements, CMS will not consider its application complete as detailed in federal regulations¹⁵ and described in the April 27, 2012, Dear State Medicaid Director Letter¹⁶ (see [Figure 7](#) on page 52). States should also consider consulting with their legal counsel to ensure that they are meeting all federal and state notice requirements. States can make their application public as part of the state public comment period, and then update it before final submission to CMS based on comments received. They do not need to submit to CMS a draft identical to what they posted for their state public comment period. In fact, the Section 1115 waiver template includes a section in which states indicate the comments received and how or whether they were incorporated into the document submitted

14 Medicaid.gov, "Section 1115 Demonstrations," <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html> (accessed May 15, 2016).

15 Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 C.F.R. § 431.408, "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations," <https://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4354.pdf> (accessed May 15, 2016).

16 Medicaid.gov, State Medicaid Directors Letter, #12-001 (April 27, 2012), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf> (accessed May 3, 2016).

to CMS. The two documents should be similar, with no major changes to the central design of the transformation, but states can update components based on comments received. States can group the comments received by topic and summarize state responses by theme. States can also indicate their responsiveness to the comments by detailing edits or updates made from their initial application to the application submitted to CMS.

Table 1: Federal Public Notice Requirements

Federal Public Notice Requirements (See 42 C.F.R. § 431.408) ¹⁷	Timing
<i>Tribal notification (if applicable).</i> States are required to send written notification to federal tribes of the intent to file a Section 1115 waiver application and engage in a consultation process. States may have their own requirements for notification and consultation with tribes that must be met during this process. (See the “Tribal Notification” box below for details.)	<i>Written notice.</i> At least 60 days before submission to CMS. Tribes are allowed at least 30 days to respond to notification.
<i>State public comment period.</i> The draft application is posted to the state website and otherwise made publicly available.	Thirty days before submission to CMS (can run concurrent to tribal notification, if permitted under state law).
<i>State public hearings.</i> The state must hold at least two public hearings, and at least one must have a webinar or remote participation option.	At least 20 days prior to the state’s submission to CMS.
<i>Federal public comment period.</i> Within 15 days of receiving a state’s application, the federal government will open its public comment period.	Thirty days after CMS considers the submission complete.

Tribal Notification

When submitting an application for a new Section 1115 waiver or an extension for an existing Section 1115 waiver, a state must satisfy requirements of consultation with and seek advice from Native American/Alaska Native tribes, including federally recognized tribes, Indian health programs and urban Indian health organizations. As part of this process, the state must be able to demonstrate to CMS that it has conducted consultation activities with and sought advice from tribes prior to submission of the Section 1115 waiver. This process must be consistent with the July 17, 2001 State Medicaid Director letter¹⁸ or the state’s own consultation requirements, as detailed in its current Medicaid state plan. The American Recovery and Reinvestment Act of 2009 required that states submit a SPA defining their rules for tribal consultation for both SPAs and waivers.¹⁹ States must include documentation of tribal consultation and advice sought in their Section 1115 waiver application and must describe the notification process, the entities involved in the consultations, the dates and locations of the consultations, issues raised, and the potential resolution for such issues. (See 42 C.F.R. § 431.408).²⁰

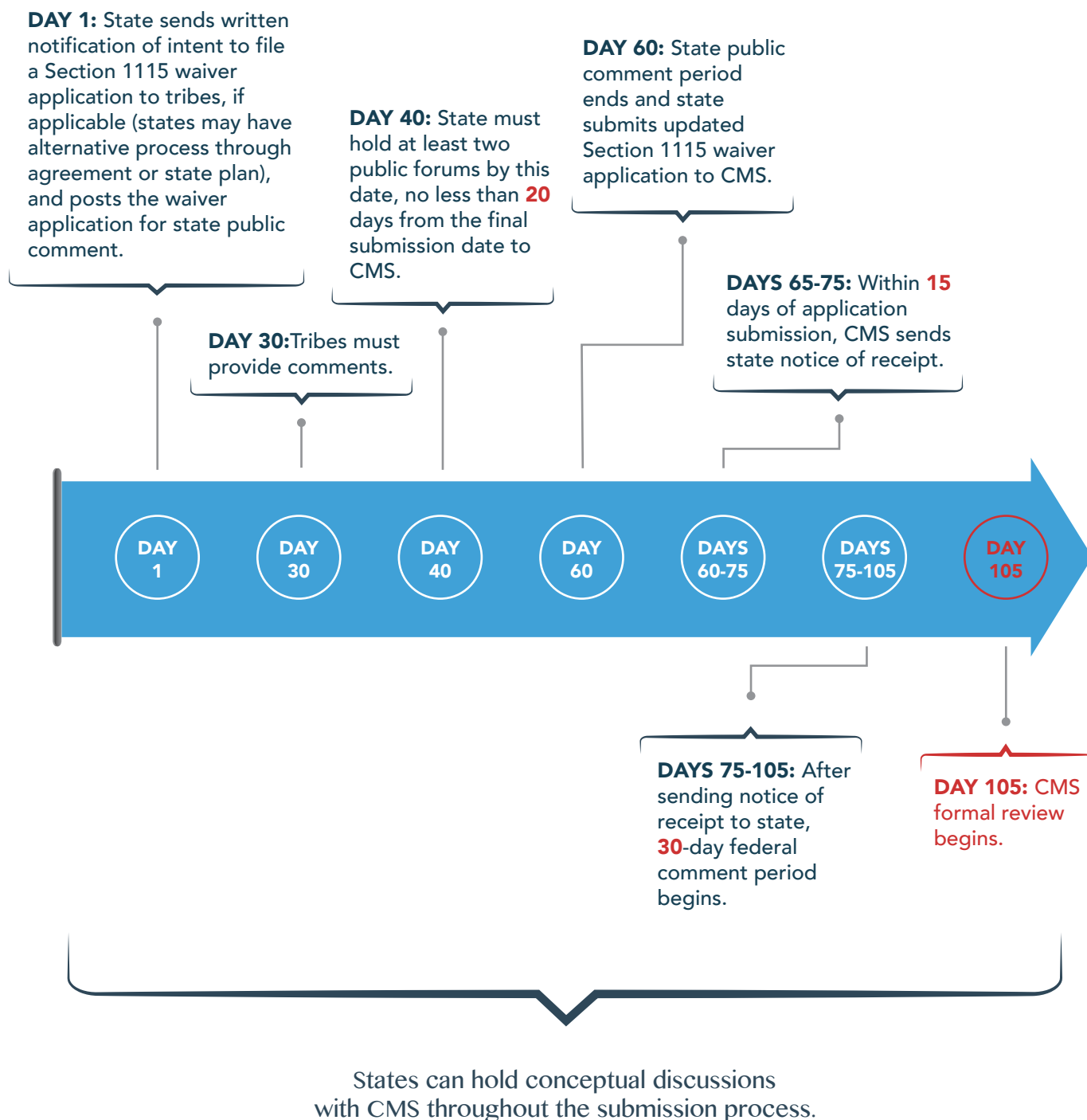
17 42 C.F.R. § 431.408, <https://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec431-408.pdf> (accessed April 25, 2016).

18 Medicaid.gov, State Medicaid Directors Letter, #01-024 (July 17, 2001), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd071701.pdf> (accessed April 25, 2016).

19 American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5006 (Feb 17, 2009), <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Section-5006-Protections-for-Indians-under-Medicaid-and-CHIP.pdf> (accessed April 25, 2016).

20 42 C.F.R. § 431.408. <https://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec431-408.pdf> (accessed April 25, 2016).

FIGURE 7: Section 1115 Waiver Submission Timeline



POST-APPLICATION SUBMISSION: CMS TECHNICAL REVIEW PROCESS

After a state has submitted its Section 1115 waiver, CMS's formal review process begins. The sidebar "Moving from Section 1115 waiver receipt to engagement" outlines the steps involved in this review process. [Figure 8](#) on page 54 provides an overview of the CMS process from the time CMS receives a state's application.

Moving from Section 1115 Waiver Receipt to Engagement

When CMS receives a proposal for a new Section 1115 waiver, it must complete a series of steps to move from receipt of the application to engagement. First, the application (proposal) is assigned to a project officer in the CMS State Demonstrations Group (SDG) who reviews the application for compliance with the Section 1115 Transparency Rule (42 C.F.R. § 431.408²¹). CMS has 15 days to complete its review:

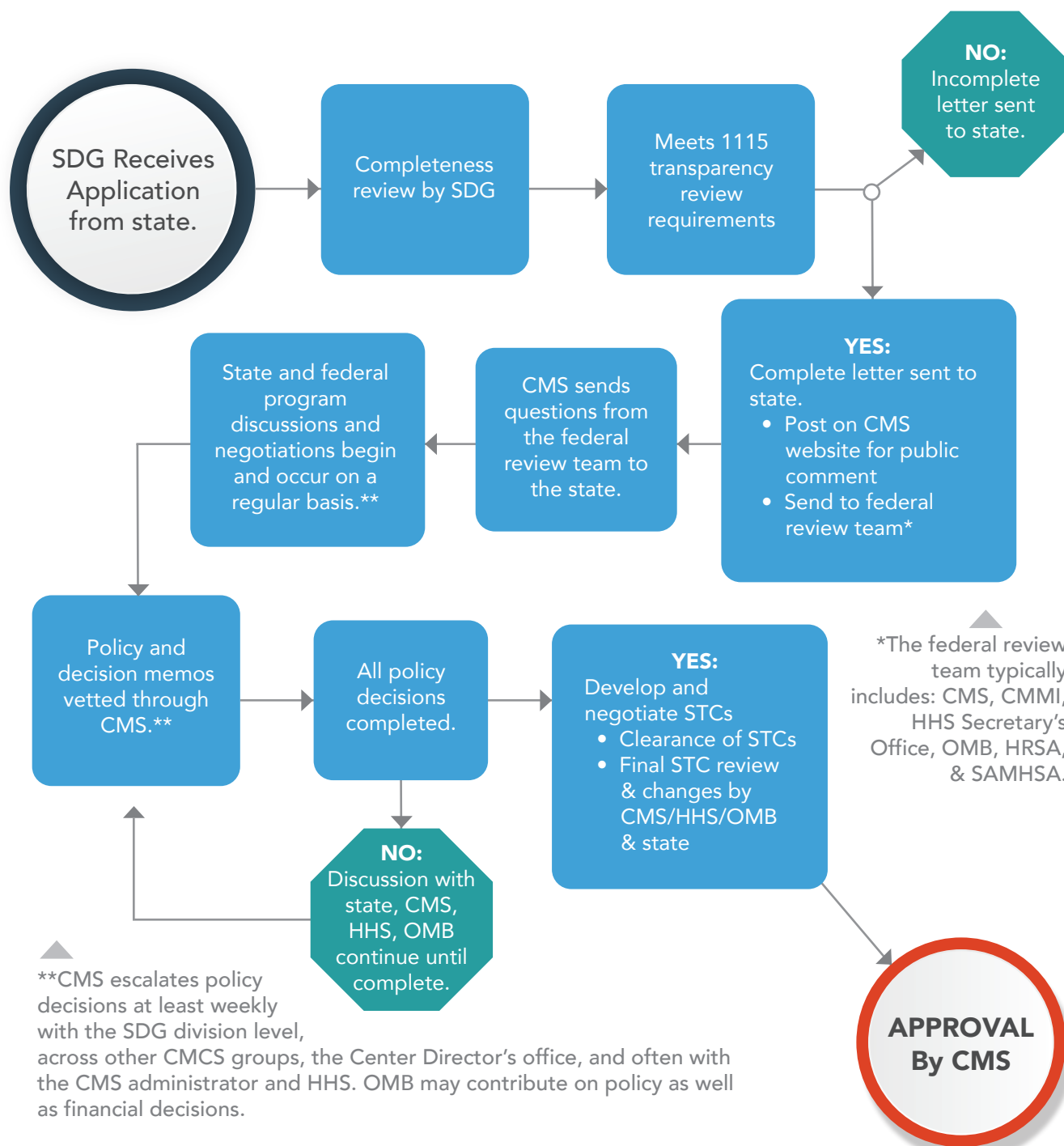
- If all the components of the waiver application are included in the application, the project officer generates a "completeness" letter to inform the state.
- If elements are missing, CMS generates an "incomplete" letter to the state. If time permits, CMS may elect to contact the state to determine whether the missing documents are available to complete the application, but CMS is not required to do so.
- Following a determination of completeness, the application is posted on Medicaid.gov for 30 days of public comment. CMS has a listserv that notifies interested parties that a new waiver

application is available for review and public comment.

- The project officer serves as the liaison among the state, internal CMS stakeholders and the entire federal review team throughout a state's engagement with CMS.
- As CMS receives and discusses responses to the questions, it is the responsibility of the project officer and SDG leadership to identify and escalate any policy issues or policy recommendation papers throughout the entire federal review process. They must also develop all STC language and incorporate CMS, HHS and Office of Management and Budget changes once a package is in final CMS clearance for approval:
 - » For states that have multiple efforts pending with CMS concurrently, it is possible that the Intergovernmental and External Affairs Group would become the coordinating entity for their Section 1115 waiver application, with the State Operations and Technical Assistance structure taking the lead.

21 Ibid.

Figure 8: Internal CMS Process for Review of Section 1115 Waiver Applications



CMMI: Center for Medicare & Medicaid Innovation
 HHS: Health and Human Services
 HRSA: Health Resources and Services Administration
 OMB: Office of Management and Budget
 SAMHSA: Substance Abuse and Mental Health Services Administration
 SDG: State Demonstrations Group

POST-APPLICATION SUBMISSION: STATE AND CMS NEGOTIATIONS

During this phase of the process, the state and CMS will need to reach an agreement on all the critical pieces of the proposal, such as:

- Waivers of Medicaid requirements (providing the state with the flexibility it needs to operate outside of otherwise-applicable Medicaid requirements, such as statewideness or comparability) and expenditure authorities (meaning the authority to claim federal matching funds for costs that Medicaid would not otherwise cover);
- Operational components of the proposal that the STCs will detail;
- How the state will demonstrate BN, ensuring that the costs of the waiver will not exceed the current level of federal spending over five years (see [“Financing Section 1115 Waivers”](#) on page 63 for details);
- How the state will finance the non-federal share of the additional costs of the waiver (see [“Financing Section 1115 Waivers”](#) on page 63 for details); and
- If additional federal investment is needed, the mechanism through which the state will be able to access additional federal funds and the process by which these funds will be distributed (such as through a DSRIIP pool; see [“Financing Section 1115 Waivers”](#) on page 63 for details).

State officials will need to establish a clear plan for negotiating the waiver with CMS. The plan should address the information in the following sections.

Identifying Who Will Be at the Table

As noted in [Step 8](#) on Page 41, it is important that state leadership engage with CMS leadership throughout this process to ensure that CMS understands how much the state is investing in the proposal and to have decision-makers at the table. Relevant members of the state’s core team should be present during all meetings with CMS leadership to provide support on granular details required to reach agreement. When necessary, state officials should consider bringing external SMEs, such as actuaries, to the negotiations to assist in resolving the more technical questions.

There may come a time in the negotiation when it feels like CMS and the state have come to an impasse. In such an instance, it might be necessary for the state to strategically approach its political representatives, including the governor, to advocate on the state’s behalf with CMS and the Administration. In particular, by getting engaged in negotiations, the governor can demonstrate a commitment to reform and a desire to move forward, which can send a powerful signal and possibly reset the conversations. Particularly effective is governor outreach directly to the HHS secretary and the White House. At key moments, governors may decide to travel to Washington, D.C., to request in-person meetings with the President, the HHS secretary, the CMS administrator, or the CMCS agency lead. In addition, the governor can activate congressional delegations to advocate for waiver approval. All these meetings and communications signal the state’s commitment, the importance of the request and the political ramifications of failure. In general, the White House may defer to CMS leadership on approval, but there are examples where the White House has intervened in approval decisions because of a governor’s involvement and tenacity.

Identifying the “Must-Have” Outcomes in the Proposal

During the negotiations, there will be difficult points to negotiate, and the state should be able to articulate its “must-have” outcomes. In these circumstances, CMS may suggest alternatives that require significant changes to the proposal. If state officials remain focused on the final outcome

they want and remain open to alternatives on how to get there, the state may have more success in reaching agreement. For example, Alabama originally proposed a project-based DSRIP in its waiver application (see “[Financing Section 1115 Waivers](#)” on page 63 for details). During negotiations with CMS, state officials reached agreement on an alternative approach using transition pools that met the same goals in supporting the establishment of the new regional care organizations.

State officials can also anticipate the pieces of the negotiation that may take more time and resources. For example, in many cases, a stumbling block during negotiations surrounds BN and how the state is planning to support its transformation vision financially (see “[Financing Section 1115 Waivers](#)” on page 63 for details). State officials should consider having the necessary resources ready to prepare the financial modeling and worksheets and engage in discussions with CMS on this topic.

Identifying a Schedule and Process for Meetings with CMS

State officials should consider confirming a schedule for regular meetings with CMS to discuss the waiver proposal. For example, state officials could establish monthly calls with CMS leadership and biweekly calls with their project officer to maintain momentum on the proposal. State officials should plan for a mixture of in-person meetings and conference calls, to the extent that it is possible. At certain junctures during the negotiation process, relevant members of the state’s core team should plan to travel to CMS for in-person negotiation sessions. This face-to-face time is a vital opportunity to make progress and move the negotiation forward with CMS leadership.

Planning for Follow-up

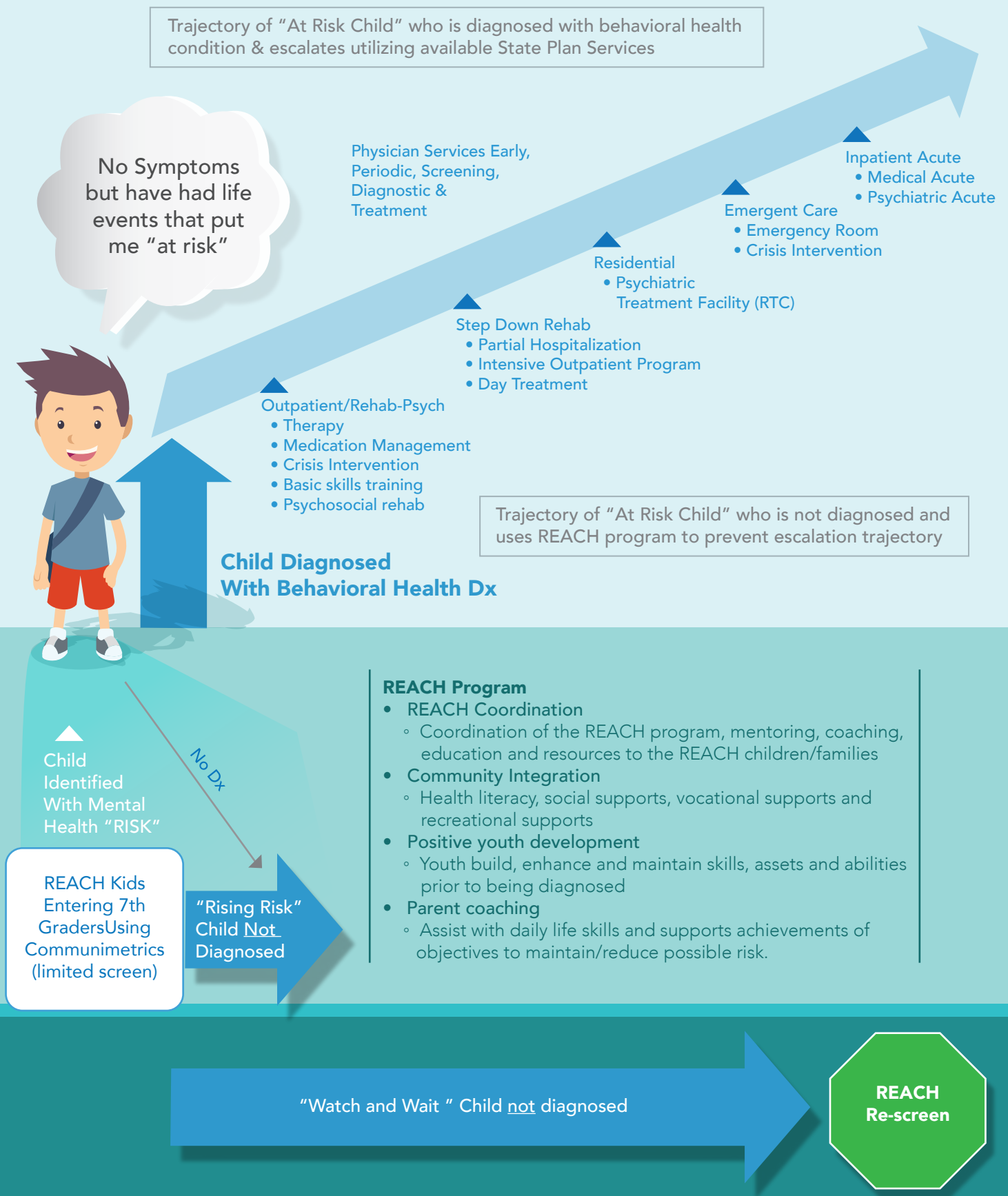
After each meeting, state officials should consider following up with an email to CMS summarizing the decisions made, the outstanding questions and next steps. This exercise ensures that both parties are on the same page and creates a record of what was discussed in case that information is needed later in the negotiations. State officials should also document which CMS officials were on the call or in the meeting and their role within CMS.

In many instances, CMS staff will have follow-up questions and areas for which they need more detail. State officials should respond to these questions and provide details as quickly as possible—ideally, within two weeks—and keep answers simple and direct. State officials should also consider keeping track of the “to-dos” for CMS, such as answering questions or scheduling a follow-up call with another CMS SME. State officials can ensure that CMS completes these items by sending reminders to the relevant individuals. At times the state may need to respond to questions multiple times for different CMS officials. As a result, state officials should keep a record of all information exchanged.

During these meetings, state officials should present information clearly, not just answering CMS questions but also explaining any refinements to the proposal that occur over the course of negotiations. During the Medicaid Policy Academy, states used PowerPoint presentations or visuals to illustrate the state’s vision and specific components of the proposed program. The team at CMS negotiating with the state found the presentations and visuals helpful because the SDG team must be able to explain the state’s vision and how it will get there with other individuals within CMS, within HHS more broadly and with other federal agencies. For example, during Alabama’s negotiations with CMS, state leaders presented why transformation was necessary in the state and how their proposal was designed to improve outcomes while reducing costs (see [Alabama Regional Care Organization Presentation](#)²²).

22 Alabama Medicaid Agency, RCO Presentation to CMS, <http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1606MedicaidAlabamaPresentation.pdf>, (accessed June 15, 2016).

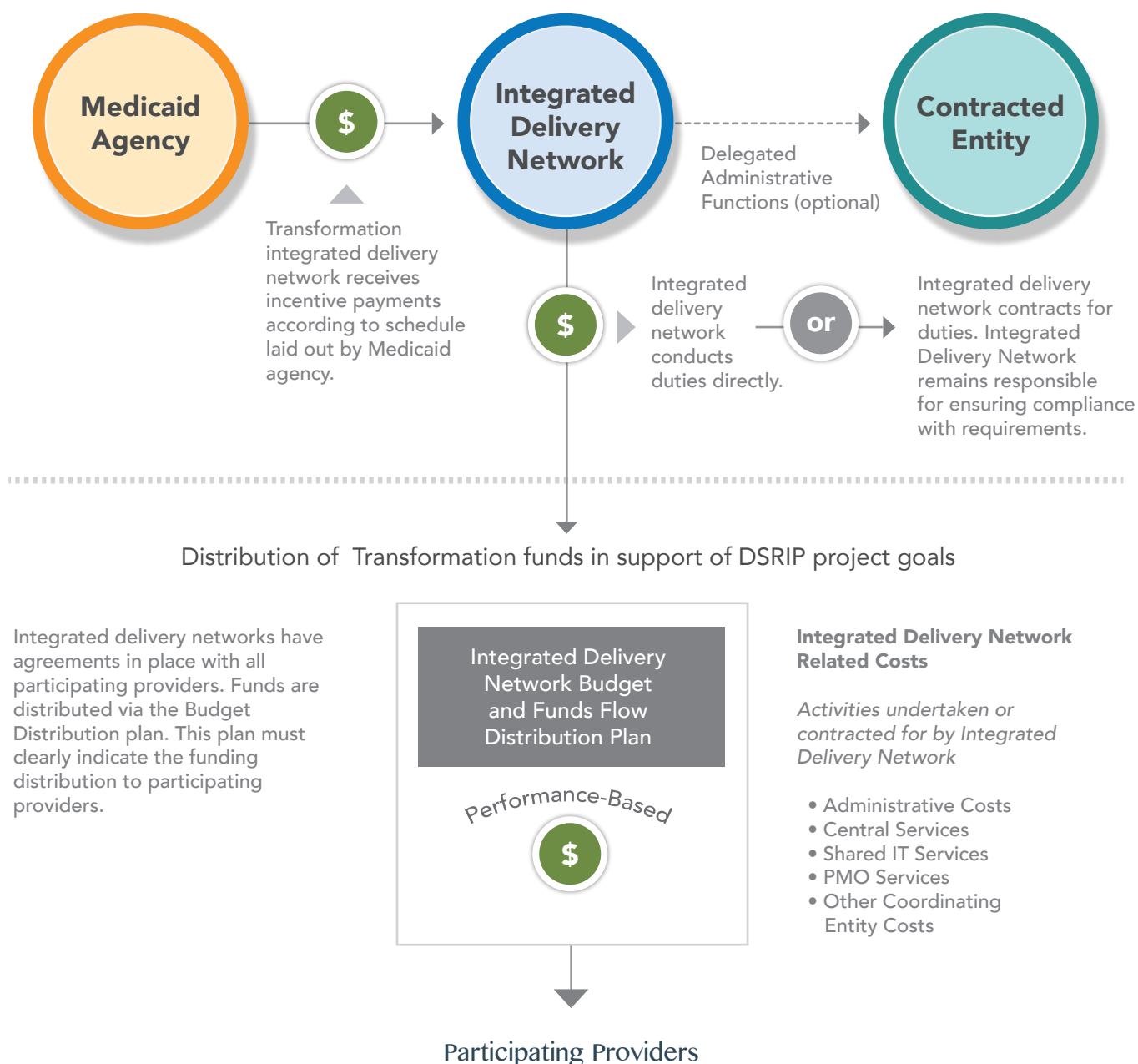
Figure 9: Example of Proposed Delivery of New Benefits



Nevada used a visual to explain its original concept to CMS. [Figure 9](#) on page 57 is based on Nevada’s visual and illustrates how a child in Nevada can access services within the new proposed benefit structure, detailing the various types of interventions available to children who qualify based on the initial discovery tool.²³

States also have used diagrams to illustrate how payments may flow to plans and providers. The diagram in [Figure 10](#) below is an example of how federal dollars could flow through a DSRIP to support a transformed delivery system.

Figure 10: Proposed Flow of Funds through DSRIP

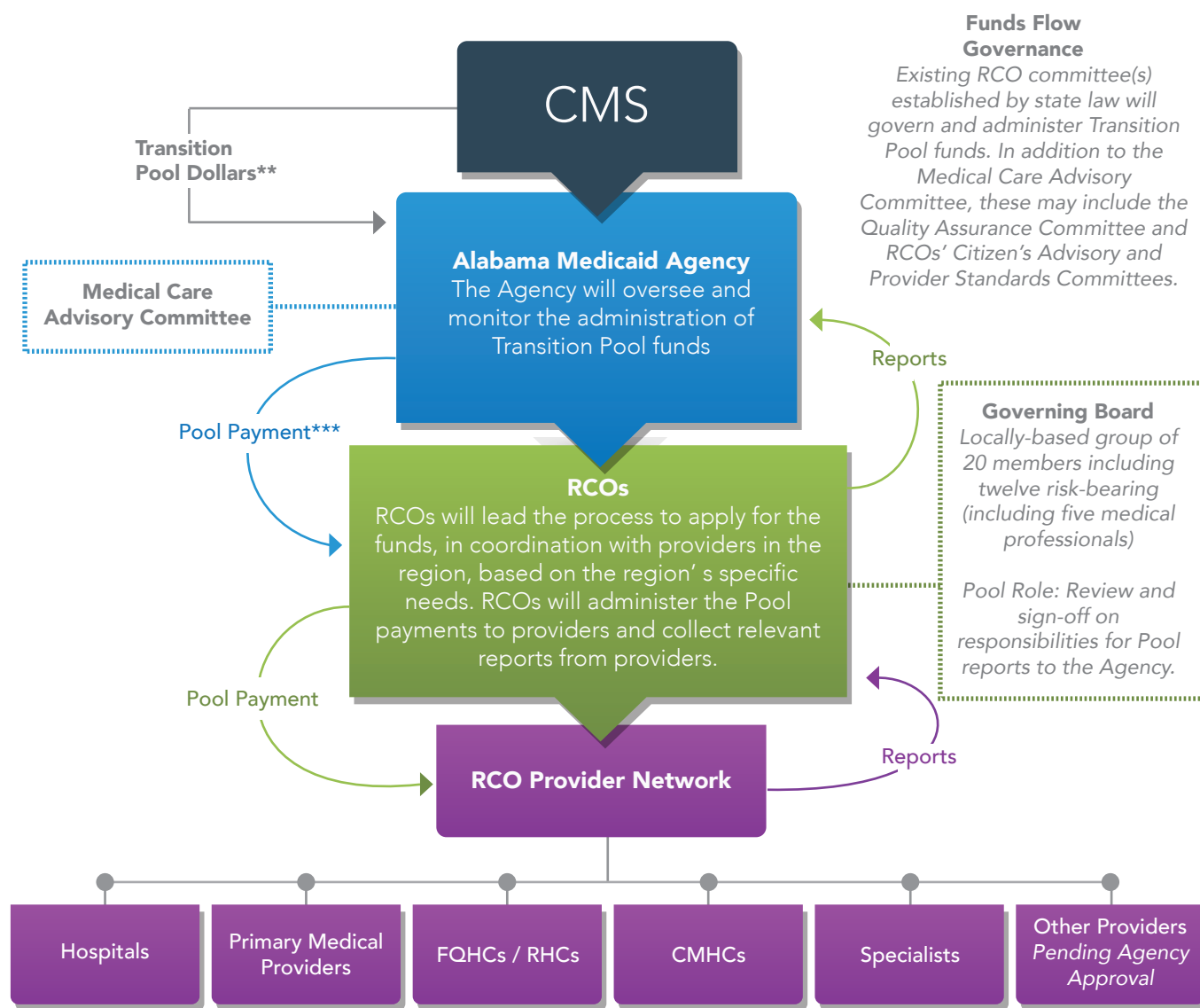


²³ Over the course of Nevada’s negotiations with CMS, details of the program were refined and the visual was updated accordingly.

The diagram in Figure 11 was created by Alabama during their negotiation with CMS to depict the flow of funds associated with their Regional Care Organizations. The visual references DSRIP program funding, which was the financing mechanism being pursued by Alabama at the time of negotiations. The Section 1115 waiver that was approved, however, did not include DSRIP and instead contained transition pools that met the same goals in supporting the establishment of the new RCOs.

Figure 11: Alabama Draft Funds Flow

Alabama Medicaid Agency Regional Care Organization (RCO) Implementation:
Proposed “Developing an Integrated Provider System”^{*}
Organizational Structure



- * Developing an Integrated Provider System is a proposed category of the Transition Pool
- ** Funding is contingent on CMS approval of Alabama's Section 1115 Demonstration Waiver
- *** Funding is contingent on Agency approval and achievement of milestone/outcome requirements

Key:

- CMS Function
- Agency Function
- RCO Function
- Provider Function

Financing Section 1115 Waivers



Financing Section 1115 Waivers

Dianne Heffron and Diane Gerrits wrote this chapter of the toolkit.²⁴

BUDGET NEUTRALITY

One of the most challenging aspects of Section 1115 waivers is establishing that the waivers will be budget neutral. To determine the total amount of funding available under a Section 1115 waiver, CMS developed a budget model known as the budget neutrality (BN) limit. BN is a federal policy applied to Section 1115 waivers, and although not described in statute or regulations, this policy governs the federal expenditure limits in a Section 1115 waiver. The following equation illustrates the requirement:

$$\text{Expected without-waiver expenditures} \leq \text{actual with-waiver expenditures}$$

A Medicaid Section 1115 waiver is considered budget neutral if the total federal Title XIX match or funding the state receives for all waiver expenditures (that is, *with-waiver [WW] expenditures*) does not exceed what the state would have received in the absence of the waiver (that is, *without-waiver [WOW] expenditures*). The BN expenditure limit is included in the waiver's STCs. BN is measured annually but enforced over the lifetime period of the waiver (for example, three or five years), which means that some states have actually spent more than their BN limit in some waiver years but less in others, making the aggregate waiver period budget neutral. States may not receive any federal funds in excess of the waiver BN limit.

Another term associated with WW financing and BN is waiver savings. States that actually spend less than their expected WOW expenditures garner what is generally referred to as waiver savings. *Waiver savings* are considered savings to the state and federal government because waiver programming, once implemented, achieved actual WW spending that was lower than expected without the waiver. Importantly, states often access waiver savings to fund programs that would not otherwise be matchable. Over the years, typical costs not otherwise matchable (CNOM) that states claimed have been non-Medicaid populations, non-Medicaid services (other than housing), uncompensated care payments and DSRIPs (see [DSRIP Programs](#) on page 69 for details.) CMS recently announced a new BN policy that limits how states can accrue waiver savings. See BN Models below.

In addition, states that seek to use DSHPs as a funding mechanism for their waiver must include the total computable value of the state health programs for which they seek federal matching funds. DSHP is a CNOM expenditure under a waiver and must be netted against waiver saving with other CNOM expenditures (see "[Funding Streams for Section 1115 Waivers](#)" on page 71 for details). Over the years, CMS has used the Section 1115 statutory authority for CNOM expenditures to allow states to pursue a variety of innovative and transformative Medicaid programs under Section 1115 waivers that would not have been possible under the Medicaid state plan.

BN MODELS

Over the years, CMS has used a variety of BN models in approved waiver programs. Often, the choice of BN model is determined by the nature of the waiver, with some better suited to specific types of waivers. It is important to note that because BN is a CMS policy, it is subject to change, and some of the models described below have become less common over the years as policy priorities have evolved.

²⁴ Dianne Heffron and Diane Gerrits are with the Mercer Government Human Services Consulting Group, a part of Mercer Health & Benefits LLC (Mercer). Prior to joining Mercer as a principal, Ms. Heffron was the director of the Financial Management Group and the acting director of the Children and Adult Health Program Group at CMS. Prior to joining Mercer as a senior associate, Ms. Gerrits was director of the Division of State Demonstrations and Waivers at CMS.

In May 2016, CMS announced a new BN methodology. (For more details see [CMS Budget Neutrality for Section 1115\(a\) Medicaid Demonstrations–New Adjustments in Methodology presentation](#)).²⁵

Under the revised methodology, CMS made significant changes to its long standing BN policy by limiting the manner in which states may accumulate savings under demonstrations. While this policy change generally does not impact the use of the BN models described below, states that are seeking to extend their section 1115 demonstrations or states that are seeking a new demonstration—but anticipate that the project will extend beyond five years—will need to adjust their assumptions for longer term savings under the new methodology. Under the new policy CMS will:

- Limit the savings that can “roll over” from one demonstration period to another and phase down the savings in each demonstration year;
- Require states to rebase “without waiver” baselines for extensions starting on or after January 2021. The rebasing will require states to calculate per member per month (PMPM) cost estimates using actual PMPM costs from the prior demonstration period; and
- Modify how to calculate available funding from diverting upper payment limit (UPL) payments into demonstration funding pools. States must either rebase UPL estimates based on current levels of fee-for-service utilization or carry-forward UPL estimates without growth at each extension.

Per-Capita Model (Also Known as a Per-Member-Per-Month Model)

The per-member-per-month (PMPM) model is a common model used when a state seeks to broadly modify the way a specific population or populations will receive Medicaid coverage or when the waiver will affect large numbers of people eligible for the state plan. This model defines WOW limits per eligible individual per month. The PMPM model base year costs are developed based on historical state spending by specific Medicaid Eligibility Groups (MEGs). PMPM data are trended forward through the waiver years annually by a negotiated inflation rate. The WOW BN limit is developed by multiplying actual MEG member months in a waiver year by the annual PMPM limit. This calculation—actual member months x PMPM limit—is the basis for developing the aggregate BN spending limit above which federal financial participation (FFP) is not available. In this model, the state will be at risk for increases to the PMPM cost growth but not in the number of member months.

Key model elements are as follows:

- Only individuals eligible under the Medicaid state plan can be used to develop the WOW BN limit;
- CMS relies on five years of historical costs (when available) to develop historical PMPM limits;
- Inflation trends applied to WOW PMPMs are based on the lesser of state historical trends or the President’s budget trend factors. However, this federal policy is subject to negotiation depending on individual state circumstances, such as state recessionary periods in excess of national experience;
- States can earn BN savings only on populations that are Medicaid eligible through their Medicaid state plan. Current CMS policy, however, is to exclude expenditures associated with the new adult Patient Protection and Affordable Care Act (ACA) expansion population from that equation when that population is covered by a waiver; and

²⁵ CMS, “Budget Neutrality for Section 1115(a) Medicaid Demonstrations–New Adjustments in Methodology,” (May 12, 2016), <http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1606MedicaidBudgetNeutralitySavings.pdf> (accessed June 15, 2016).

- States cannot achieve BN savings by reducing benefits available to Medicaid enrollees. Instead, they must achieve savings through programmatic change such as implementing managed care or alternative payment methodologies.

Aggregate Model

The aggregate limit model caps FFP for waiver expenditures. Often referred to as an aggregate cap, the amount of available funding does not depend on enrollment but rather is defined for each year of the waiver. In this model, the state is at risk for increases in expenditures because of increased cost to purchase services and increased enrollment (case load). Although the aggregate cap applies to FFP, it does not mean that the state can limit benefits or coverage available to Medicaid populations that the waiver covers. Rather, it means that the state's access to FFP for the expenditures associated with that covered population is limited. Two common examples of aggregate budget limits are:

- ***Disproportionate share hospital (DSH) diversion.*** In the DSH diversion model, the state diverts all or a portion of its DSH allotment to fund expansion of eligibility or services or to fund defined waiver payments. Some states have used this strategy in conjunction with other BN models. For instance, **Tennessee** and **Hawaii** have included DSH in their waivers since their inception. **California** diverted DSH to its per-capita model in its recent approval. For states using this methodology after 2010, applicable DSH reductions as included in the ACA would apply to the DSH allotment, regardless of whether the state uses that DSH funding in a Section 1115 waiver.
- ***Upper payment limit (UPL) diversion.*** In the UPL diversion model, states identify historical expenditures for UPL payments made to providers under fee-for-service and “divert” that amount to fund waiver activities. States must remove all UPL payments from the state plan by submitting SPAs to remove the authority to make UPL payments. States using this model have generally used hospital UPL programs to fund waiver programs. This model has also been used in conjunction with per-capita models in some states, including California and **Texas**, but this BN model has not been used for new waiver programs in recent years and may be more difficult to effectuate because many states have already moved to managed care. (UPL is associated with FFS payment structures.) CMS's new budget neutrality policy also impacts how the model can be used in waivers that are extended beyond the initial approval period.

This model has two key elements:

- It is typically used to fund explicit expenditures rather than coverage options because there is significant risk of case load growth.
- It has limited use for new waivers where DSH or UPL is the only waiver funding source. Several states have included this as part of a multifaceted funding strategy in combination with a per-capita limit.

Cost Diversion Model

The cost diversion model, or avoidance model, builds on the premise that the interventions under the waiver will reduce Medicaid state plan expenditures that would occur in the absence of the waiver. The amount of the projected Medicaid savings is the source of funding for waiver expenditures. The data used in the budget analysis must show that the cost of the waiver intervention or avoided disease progression is less than the inevitable circumstance of the progression to a full disease state, disability status or facility placement. States often use this model with waiver programs targeting specific populations or specific medical services. Examples of this model include the following:

- ***Averted birth methodology.*** This methodology has historically been used with family planning waivers. It quantifies the historical costs associated with delivery and the first year of providing Medicaid coverage to a newborn. This cost information is combined with fertility and birth rates in a state to determine the Medicaid savings associated with avoiding or delaying births for which Medicaid would be the likely payer. These avoided costs (or savings) are used to fund programs that target reproductive health and planning programs for non-Medicaid populations.
- ***Facility diversion models/disease progression diversion models.*** Like the averted birth methodology, these models use predicted future Medicaid savings directly linked to waiver interventions that reduce, delay or avert progression of a disease or illness. The theory is that by implementing waiver programs such as prevention, care management or other interventions, waiver enrollees are healthier and states avoid increased Medicaid costs in the future. The challenge with this methodology is in identifying appropriate data to develop budget savings.

This model has two key elements:

- BN model development requires data and analysis of disease state and rate of disease progression, which may be difficult to define clearly depending on the targeted disease or population.
- States may find it difficult to implement fulsome programs based solely on diversionary savings.

Hypothetical Model (Also Known as a Pass-Through Model)

States use the hypothetical or pass-through model when they want to provide coverage to a population that could otherwise be covered through the state plan. This budget model is often employed by states seeking to maintain modified coverage for populations either no longer covered or not yet covered through the state plan. Often, states provide modified benefits, enrollment caps or other limitations for such waiver populations. Generally, the model resembles the per-capita model: The state develops PMPM base year costs based on historical state spending by specific MEGs or projected costs. These PMPMs are trended forward through the waiver years annually by a negotiated inflation rate. The WOW BN limit is developed by multiplying actual MEG member months in a waiver year by the annual PMPM limit. As in the per-capita model, aggregate spending above the BN limit is not eligible for FFP. Unlike the per-capita model, states cannot accumulate or access BN savings. States can use this model to develop entire BN waiver components or may apply only it to specific MEGs within a larger waiver framework.

This model has four key elements:

- Only individuals who could be covered under the Medicaid state plan can be used to develop a hypothetical BN limit;
- CMS relies on five years of historical costs (when available) to develop historical PMPM limits;
- Inflation trends applied to WOW PMPMs are based on the lesser of state historical trends or the President's budget trend factors. However, this federal policy is subject to negotiation depending on individual state circumstances, such as state recessionary periods in excess of national experience; and
- States cannot earn BN savings on hypothetical populations.

DETERMINING THE BN LIMIT

Data Requirements

For a new waiver application, CMS requires that a state use five years of historical data (when available) to build the WOW expenditures and develop a historical trend. States must provide at least aggregate financial data with their application. CMS does not use any federally collected data (such as Medicaid Statistical Information System data) in lieu of state historical data. The historical data are typically categorized by major eligibility group (for example, adults, children, Supplemental Security Income, new adult group) or spending category (for example, DSH or UPL payments), but this can vary based on the state's waiver design. Often, the breakdown is done to illustrate appropriate trends for inflation over the lifetime of the waiver in specific population and to develop a base year expenditure amount.

Trend Rates

The future spending projection is based on an extrapolation of past trends. When states develop a trend rate, they must be aware of the federal policy regarding such rates: States generally must use the lower of historical trend (often from the past three years) or the President's budget baseline trend rate. States can negotiate trend rates with CMS that vary from this policy based on extenuating environmental circumstances that may have affected state historical trends or expected future trends. An example of such a circumstance is the impact on state expenditures caused by the recent economic downturn that occurred in many states starting in the mid-2000s. In addition, some states implemented rate reductions over periods in which the state experienced budget contractions. Such actions can have the effect of reducing the appearance of historical cost trends. If a state finds itself in this situation, it is important to document for CMS how and why costs are expected to increase at a higher rate to address rate cuts from prior periods.

Expenditure Projections

The agreed-on trends and historical base cost are used to project WOW PMPM costs by eligibility group through the end of the waiver. If there are additional financing mechanisms such as DSH diversions, the PMPM projections will be added in to develop the WOW BN limit.

With Waiver Calculation

The WW calculations use the projected PMPM costs times actual member months by group plus any other waiver-authorized expenditures, such as uncompensated care pools, service expansions or population coverage. The calculations are on an annual basis and aggregated across the years of the waiver period. The actual spending on the WW side of the equation is compared to the WOW limit. Any amounts that exist between the actual expenditures and the WOW projection are considered "savings."

STATE STRATEGIES

State officials will need to navigate the complex BN process and determine which model will best represent the state's proposal. During this phase of the negotiation, states will need to be prepared to explain the application of the various models, as requested by CMS, and demonstrate why particular aspects require some creativity or flexibility when applied to their state's financial situation. Given the complexity of these discussions, state officials should consider building in adequate time

Figure 12: Budget Neutrality Calculations: A State Example

State Waiver Proposal: Provide Medicaid benefits to Temporary Assistance to Needy Families (TANF) adults and kids through defined networks utilizing alternative payment methodologies. Affected MEGs: TANF Adults (1), Kids 0-19 (2)

Develop PMPM WOW limit:

- For each MEG, develop 5-year historical average expenditures for all services.
- Apply annual trend rate to each MEG, each year.
- Multiply annual MEG PMPM by actual MEG member months experienced (MM).

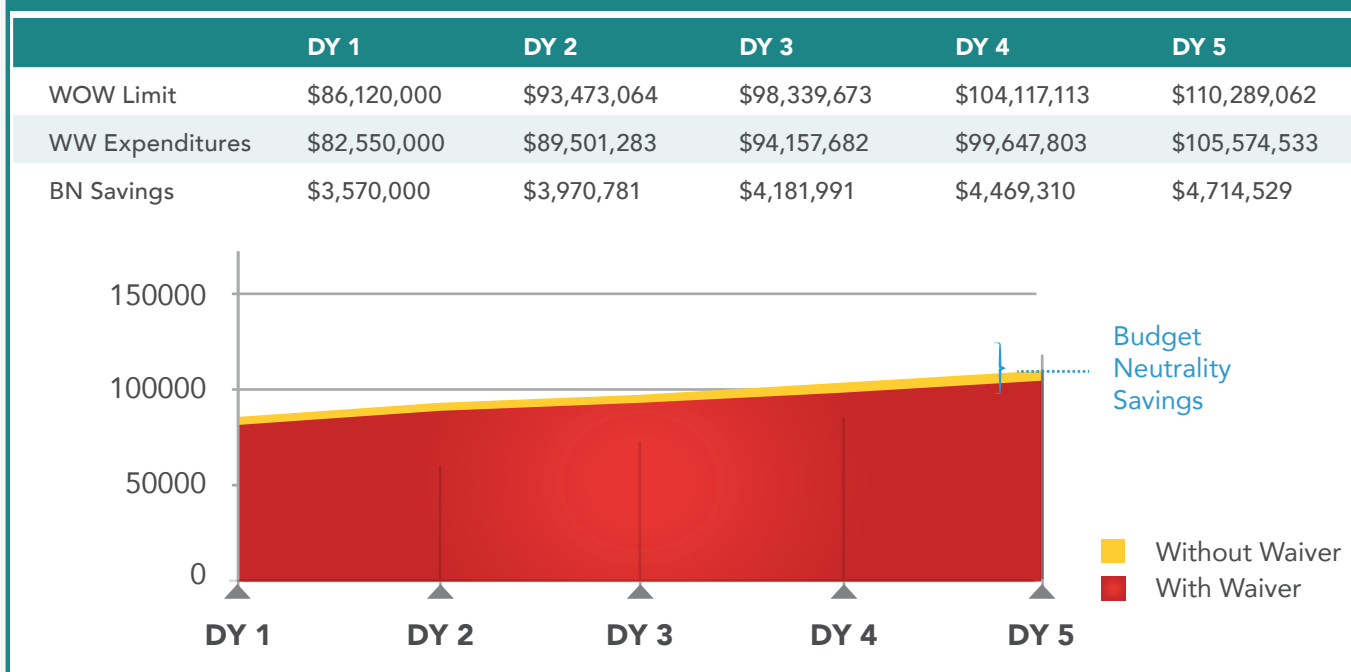
Develop PMPM WW Expenditures

- Show all expenditures for each MEG for each year.

WOW Limit	DY 1	DY 2	DY 3	DY 4	DY 5
MEG 1	\$328.00	\$339.81	\$352.04	\$364.72	\$377.85
Actual MM (1)	100,000	111,000	113,000	118,000	119,500
MEG 2	\$248.00	\$256.93	\$266.18	\$275.76	\$285.69
Actual MM (2)	215,000	217,000	220,000	221,500	228,000
Total WOW Limit	\$86,120,000	\$93,472,064	\$98,339,673	\$104,117,113	\$110,289,062

WW Expenditures	DY 1	DY 2	DY 3	DY 4	DY 5
MEG 1	\$30,520,000	\$35,096,779	\$37,015,403	\$40,044,770	\$42,013,751
MEG 2	\$52,030,000	\$54,404,504	\$57,142,279	\$59,603,033	\$63,560,782
Total WW	\$82,550,000	\$89,501,283	\$94,157,682	\$99,647,803	\$105,574,533

Budget Neutrality Savings is the difference between actual expenditures WW and estimated expenditures WOW. These savings can fund authorized waiver expenditures such as DSRIP Payments.



for this phase of negotiations. [Figure 12](#) on page 68 provides an example of state BN calculations.

In preparing the BN analysis, the state may require the services of a consultant (for example, an actuary) who can prepare multiple runs of the financial data and offer ideas for which financial models will provide the greatest promise for the state (see [Step 6](#) on page 35 for additional information about retaining consultants).

DSRIP PROGRAMS

Starting in 2010, DSRIP programs have become elements in a number of Section 1115 waivers. The first DSRIP program was approved in 2010, and nine states, **Alabama**,²⁶ **California**,²⁷ **Kansas**,²⁸ **Massachusetts**,²⁹ **New Jersey**,³⁰ **New Mexico**,³¹ **New York**,³² **Oregon**³³ and **Texas**,³⁴ have received approval for DSRIP or DSRIP-like programs within their Section 1115 waivers.³⁵ The DSRIP programs use Section 1115 CNOM authority to draw FFP to match incentive payments to the health care system, to providers paid for meeting benchmarks or for metrics measuring progress toward or achievement of transformational activities. These metrics are attached to specific projects or outcomes that directly support the state's waiver goals and objectives.

These programs are appealing to states that are trying to incentivize providers and ignite change because they provide additional funds to support targeted investments that are critical to improving Medicaid systems of care. Many states are beginning to identify providers as well as other social supports across a variety of agencies to develop whole-person care strategies that target populations traditionally difficult to treat effectively. In addition, because the payments are not for services—rather, they are in addition to actual service payments—they give states the ability to truly incentivize change.

States seeking to implement DSRIP programs, however, face several challenges. These programs are complicated, and states must understand how best to incentivize the change they seek and measure that change in an efficient and effective way. In addition, because the programs are relatively new, federal policies around DSRIP are subject to frequent modification. In some states, recent approvals have moved away from DSRIP per se but created transition payments that play a similar role. As such, existing programs can provide only limited guidance. That said, there are emerging themes in approved programs that seem to transcend evolving implementation. CMS has approved DSRIPs from the perspective of “prove to us that this investment is needed and important to the goals of the

26 Medicaid.gov, “Demonstrations & Waivers: Alabama,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Alabama (accessed April 25, 2016).

27 Medicaid.gov, “Demonstrations & Waivers: California,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=California (accessed April 25, 2016).

28 Medicaid.gov, “Demonstrations & Waivers: Kansas,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Kansas (accessed April 25, 2016).

29 Medicaid.gov, “Demonstrations & Waivers: Massachusetts,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Massachusetts (accessed April 25, 2016).

30 Medicaid.gov, “Demonstrations & Waivers: New Jersey,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=New%20Jersey (accessed April 25, 2016).

31 Medicaid.gov, “Demonstrations & Waivers: New Mexico,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=New%20Mexico (accessed April 25, 2016).

32 Medicaid.gov, “Demonstrations & Waivers: New York,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=New%20York (accessed April 25, 2016).

33 Medicaid.gov, “Demonstrations & Waivers: Oregon,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Oregon (accessed April 25, 2016).

34 Medicaid.gov, “Demonstrations & Waivers: Texas,” https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=Texas (accessed April 25, 2016).

35 Melanie Schoenberg et al., *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools* (Washington, DC: National Academy for State Health Policy, 2015), <https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf> (accessed May 4, 2016).

Medicaid program and for Medicaid enrollees.” More specifically, CMS may ask states to consider:

- Clearly identifying the transformation they seek, the providers or populations they seek to affect and the timeframe in which change will occur;
- Using the data and community needs assessments described in [Step 2](#) on Page 21 of the toolkit to further refine the metrics and goals they seek;
- Working collaboratively with providers and other stakeholders to develop projects or outcomes that are most likely to bring about transformation;
- Meaningfully pursuing alternative payment models and provider organization models to facilitate movement away from a fee-for-service system and toward a system that rewards value instead of volume;
- Focusing on data and metrics that are recognized and available for ease of reporting for providers and systems of care and that can be evaluated across systems and even states;
- Identifying metrics throughout the continuum of systems, including payers and the state, to demonstrate the effects of transformation throughout the Medicaid program;
- Planning for sustainability of the program when the waiver is complete, including how alternative payment strategies and VBP methodologies can support transformation after initial goals are met; and
- Understanding the total investment sought and how that investment fits within the BN savings projections.

DSRIP or similar payment reform programs can give states the opportunity to invest in transformational strategies for Medicaid systems of care and are an evolution of how states can reinvest BN savings. State officials, however, must be familiar with the current perspective on DSRIP or similar programs in the future because Administration priorities can change.



Alabama was approved to use transition pools to support new delivery system entities known as RCOs and providers. Payments under this time-limited pool focus on RCO startup costs, payments to providers to support quality and integration strategies to align with RCO efforts.

New York's transformation program includes funding through two funding pools: the Public Hospital Transformation Fund and the Safety Net Performance Provider System Transformation Fund. A unique aspect of the New York DSRIP program is that providers must collaborate to participate in the funding pools, organizing as performing provider systems (PPSs). PPSs must include safety net providers, as defined in the STCs, and must develop project plans that address the goals and objective of the transformation strategy, as defined in DSRIP protocols that describe project menus and metrics. The state has also developed project valuation and patient attribution strategies to assign patients associated with projects and to determine the level of payment available when metrics and milestones are met. New York has also developed a broad array of technical assistance tools to educate providers and support the transformation efforts in the state.

FUNDING STREAMS FOR SECTION 1115 WAIVERS

Generally, states can fund Section 1115 waivers in accordance with standard Title XIX Medicaid funding rules that allow states to use state general funds, including funding derived from provider taxes, IGTs and CPEs, as the source of the non-federal share for these new expenditures.

Section 1115 expenditure authority provides additional funding options not available under the Medicaid state plan. In some instances, states have used programs known as DSHP to leverage federal match for what would otherwise be state-only expenditures that are matched with FFP under Section 1115 authority. DSHP is a targeted and time-limited funding source. Recently approved waivers have used DSHP only for supporting transformations that are novel and significant, often reserving it for statewide transformation efforts involving VBP strategies. DSHPs are state-funded programs (generally, health-related programs that CMS qualifies as eligible for FFP under the waiver), which in turn provides additional state funds that can be used for other waiver payments. Historically, these programs have been health programs funded by the state that provide services to low-income individuals who do not qualify for Medicaid.

The process of identifying potential sources of DSHP dollars is time intensive and involves closely coordinating with other state agencies to identify potential state-funded programs that CMS could approve. Early engagement with sister agencies to alert them to a future need to work together and identify potential DSHP programs is important for maintaining momentum when the time comes to complete the federal DSHP worksheets, which CMS has created to help states identify state spending that is independent of other federal funds and federal funding commitments. In addition to identifying potential DSHP programs, the state must think strategically about how it describes and characterizes these programs to CMS. It must be clear about how the programs are currently funded, whom they serve, and how they will continue to move forward.

Typically, CMS has not allowed states to draw FFP (under DSHP authority) for state expenditures associated with prison health care, Institutions for Mental Disease and housing or non-health care-related state spending. In addition, any program funding that represents federal grant funding (like a Substance Abuse and Mental Health Services Administration grant) or is identified as the maintenance of effort for a federal grant program is not eligible for FFP under a DSHP arrangement. [Table 2](#) on page 72 identifies DSHPs approved in Oregon's Section 1115 waiver, the Oregon Health Plan.³⁶

³⁶ Medicaid.gov, "Centers for Medicare & Medicaid Services Special Terms and Conditions: Oregon Health Plan" (July 7, 2012), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/Health-Plan/or-health-plan2-stc-07052012-06302017-correction-062013.pdf> (accessed May 4, 2016).

Table 2: DSHPs Approved in the Oregon Health Plan**DSHPs**

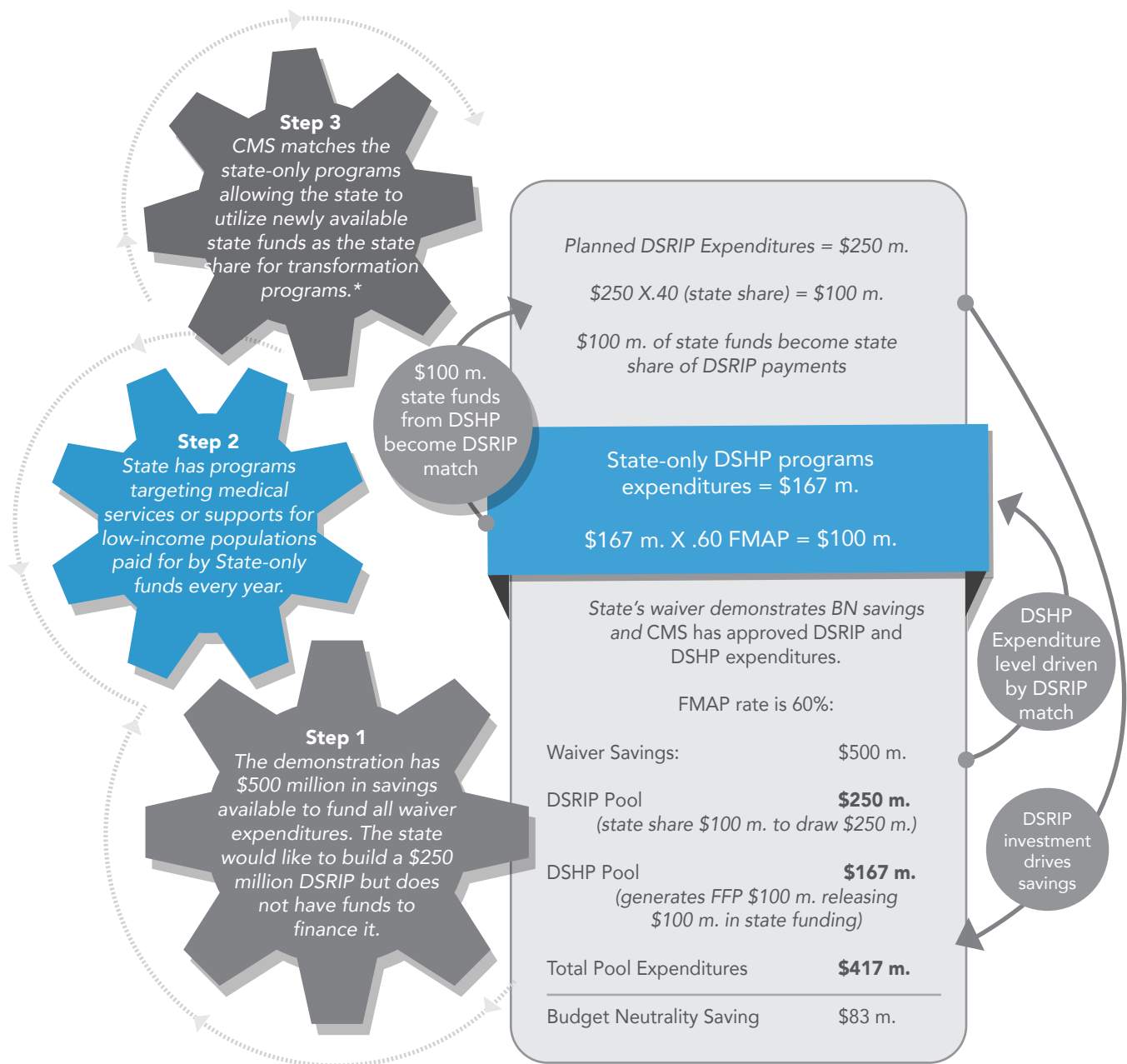
Other	
Non-Residential Adult	Nursing Assessments
Child and Adolescent	Other Medical
Regional Acute Psychiatric Inpatient	IV-E Waiver (Demo Project for Parenting, mentoring, enhanced supervision)
Residential Treatment for Youth	Personal Care
Adult Foster Care	Oregon Project Independence
Older/Disabled Adult	SE #150 Family Support
Special Projects	SE #151 Children Long-Term Support
Community Crisis	Licensing Fee
Support Employment	General Microbiology
Homeless	Virology
Residential Treatment	Chlamydia
Non-Residential Adult (Designated)	Other Test Fees
A & D-Special Projects	State Support for Public Health
A & D Residential Treatment – Adult	(Newborn screening OF is used for match for the MCH block grant)
Continuum of Care	Prescription Drug Monitoring Program
System of Care	HIV Community Services
Community Based Sexual Assault	General Funds–HST
Community Based Domestic Violence	Sexually Transmitted Diseases
Family Based Services	Mental Health Treatment
Foster Care Prevention	Drug and Alcohol
Enhanced Supervision	Formerly Medically Needy (Oregon Transplant) Clients
Workforce Training to Promote Medicaid Provider Participation	State Hospitals (OSH and BMRC)
Undergraduate and graduate health professions education	Gero-Neuro

Source: Centers for Medicare & Medicaid Services Special Terms and Conditions: Oregon Health Plan” (July 7, 2012), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/Health-Plan/or-health-plan2-stc-07052012-06302017-correction-062013.pdf> (accessed May 4, 2016).

It is important to note that DSHP has historically been approved as a component of a larger funding strategy, not as the sole source of state share under a waiver. CMS has developed a template to help states identify potential DSHP programs and the total funding that might be available within them. CMS has used DSHP as an adjunct component of a complex strategy to finance waiver programs rather than as a full replacement of payment strategies available under Medicaid state plans.

States that have received CMS approval for DSRIP or DSRIP-like programs have needed new sources of funding for the non-federal share of the payments made through DSRIP. In some states, new funding made available through DSHPs provided that source. If a state is considering using DSHP in conjunction with a DSRIP, there are a number of challenges and considerations. [Figure 13](#) below highlights how to determine the level of funds needed.

Figure 13: Using DSHP to Support DSRIP Programs in Section 1115 Waivers



*Requires that the payments have already been made by the state prior to drawing federal share. DSHP is often granted for a limited amount, time and/or with performance requirements.

As DSHP is considered a CNOM waiver expenditure, it must be offset against BN savings in the waiver. For example, if a state develops a program projected to save \$120 million (state and federal share) and wants to spend \$60 million on additional waiver CNOMs (such as services that are not covered by Title XIX), the net waiver savings is reduced by \$60 million (state and federal). The state would like to use the \$60 million in savings to create a DSRIP for transformation activities. In this example, the state is limited in its options for financing its share of the \$60 million DSRIP and would like to explore using DSHP. If they use DSHP, the state would be limited to matching DSHP at the remaining level of BN savings (\$60 million in this example). (See [Table 3](#) below).

Table 3: Calculating Budget Neutrality Savings Needed for DSRIP and DSHP

BN Savings (total computable)	CNOM	
	DSRIP expenditures	DSHP expenditures
\$120 million	\$60 million	\$60 million
	(requires \$30 million in state share @ 50% Federal Medical Assistance Percentage [FMAP])	(draws \$30 million in FFP @ 50% FMAP)

CONSIDERATIONS WHEN IDENTIFYING A FUNDING SOURCE

When developing a funding strategy for waiver payments, states should be aware that some of the sources described earlier bring challenges related to developing reimbursement strategies. For instance, CPEs are directly linked to Medicaid-related costs incurred by the governmental entity providing the certification. Although CPEs provide opportunities to use existing costs within the system to draw FFP, the reimbursement strategy associated with CPEs is cost, and therefore limits the state's ability to use that mechanism to fund incentive payments, nonservice payments or alternative payment methodologies that are tied to value rather than cost.

States have often used IGTs from localities and public providers to fund waiver payment streams. IGTs and general-fund revenue (either directly appropriated or derived from provider taxes) create broader opportunities to fund a variety of payment methodologies. These funding sources can support methodologies for particular providers, MCOs, accountable care organizations or other eligible provider entities as well as fee-for-service payments, capitation payments for covered services, value-based alternative payments and incentive payments. The challenge states may face when developing local funding sources is that public providers or local entities may seek to drive payments back to the funding entity. In some instances, such as in risk-based payments, states may find it difficult to ensure that waiver payments are directed to specific entities. The recently released managed care rule also may limit the ability of states to require plans to make certain "passthrough" payments to providers.³⁷

³⁷ For additional information see CMS, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered> (accessed July 15, 2016).

States—in conjunction with the provider community—can use a variety of strategies to develop payment arrangements that support waiver goals and objectives and recognize the need for local funding to support the payments. For example, states can develop funding strategies that target specific providers, services, delivery reform payments or reimbursement strategies that would not otherwise be eligible for FFP. These waiver payment and funding strategies allow for federal investment that would not otherwise be available under the Medicaid state plan. For example, waiver payment methodologies have been developed that are paid to networks of providers based on performance goals. Those networks develop payment distribution strategies that reflect provider metrics and outcomes within the larger system. Some states have developed payments that have been included as incentives associated with managed care contract requirements or paid as a PMPM add-on based on qualitative metrics and achievement of defined waiver goals. Such payments are not pass-through payments targeted at a particular provider or providers but rather are developed as payments to incentivize accountability at both the MCO and provider level.

Many states find that financing is the most challenging aspect of waiver negotiation and they should be prepared to engage with CMS to discuss how waiver funding will transition over time to a self-sustaining model.

The critical element threading throughout these funding and reimbursement strategies is developing methodologies that are appropriate to the program and acceptable to the state, providers and CMS. The BN model is critical to the fiscal feasibility of the entire waiver program, but financing the investments in transformation and sustainability is critical to the longer-range impact of the transformation strategies designed to drive change.

Many funding options are available, and CMS will work with states to develop a mutually agreed-on funding strategy, but a state should consider a period beyond the initial investment and how they may share that vision with CMS.

Transitioning to Implementation

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Transitioning to Implementation

As states negotiate with CMS for final approval, they should consider planning for implementation to ensure that they will be ready on the heels of approval. In some states, a legislative mandate drives the reform and provides a justification for implementation planning before receiving approval. In other states, officials must justify the need to begin implementation planning prior to approval and should ensure that their leadership understands why this planning is necessary and is aware of the extended timelines if planning does not occur beforehand.

The majority of this implementation planning work involves developing a timeline of milestones and deliverables that the state must meet to be in alignment with the requirements agreed to in the STCs. States must provide evidence of implementation progress and be sure to design an early implementation work plan that aligns with these established dates. In addition, most states that obtain approval of a Section 1115 waiver must develop and submit operational protocols that define how the waiver will work. These protocols often include details on incentive payment valuation strategies, funding and reimbursement methodologies and DSRIP project metrics and milestones. This list is not exhaustive, but it focuses on the necessary follow-up work that occurs during the first 60 to 90 days after approval.

To ensure successful implementation, states should consider building an implementation work plan that identifies key state staff who will be responsible for each deliverable, establishing a process to ensure that projects are on track and continuing stakeholder discussions to prepare partners for implementation.

APPENDIX A



MEDICAID TRANSFORMATION WORK PLAN

Getting to Yes:

Planning, Negotiating, and Implementing
a Statewide Medicaid Transformation Plan

STATE OF X

MEDICAID TRANSFORMATION WORK PLAN

1. This document will serve as your state's work plan as you pursue system-wide transformation of your Medicaid program. It has been organized to align with the sections of the Medicaid Transformation Toolkit, in order to support your efforts and achieve success. The milestones in this work plan map to the sections in the toolkit.
2. The work plan is not intended to be a lengthy written document (use bullet points instead of paragraphs). The value in the document lies primarily in the thinking that it will encourage your team to identify clear action steps that will lead you through the transformation process and to success.
3. We have included sample objectives within each milestone, to provide an example of the type of information and level of detail to be included as the state completes its transformation work plan.

Below are examples of Medicaid transformation milestones and the associated objectives and action steps.

MILESTONE 1: BUILD THE CORE TEAM

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Identify Core Team Members	<ul style="list-style-type: none"> Review different agencies and determine which ones have a role in the design and implementation of the proposed transformation Reach out to agency leadership to introduce the transformation to them and get their buy-in Confirm participation in core team by individuals from different agencies 			
2. Schedule weekly core team meetings	<ul style="list-style-type: none"> Coordinate calendars to identify time for weekly, recurring meeting 			

MILESTONE 2: CONDUCT DATA ANALYSIS

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Identify state data sources	<ul style="list-style-type: none"> Check multiple data sources within state and counties (if appropriate) for clinical, administrative, and claims data Flag relevant data sources for further review and analysis 			
2. Identify challenges in current Medicaid program	<ul style="list-style-type: none"> Run data analysis on various data sources to identify gaps or components of the current Medicaid system that are underperforming Create report of that analysis highlighting the potential focus areas for a transformation plan Vet the report with the core team for their approval 			

MILESTONE 3: SET THE VISION FOR TRANSFORMATION

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Define key vision and goals for transformed Medicaid program	<ul style="list-style-type: none"> Review key questions about current program and, using the results of the data analysis, identify potential opportunities for transformation 			
2. Identify partner agencies	<ul style="list-style-type: none"> Based on the data analysis and key questions, select partner agencies who the state team can collaborate with to support transformation effort Begin to reach out to relevant individuals to introduce them to the effort and bring them on-board as partners 			

MILESTONE 4: ENGAGE CORE STAKEHOLDERS

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Identify core stakeholders	<ul style="list-style-type: none"> Based on the data analysis and key questions, identify core stakeholders from provider, payer and consumer communities whom the state team can collaborate with to support transformation effort Schedule meetings with relevant individuals to have informal conversations around their current experiences with the Medicaid program 			
2. Establish a stakeholder workgroup	<ul style="list-style-type: none"> Identify a small group of core stakeholders to participate in workgroup(s) focusing on the transformation Determine an appropriate schedule for regular work group meetings around the transformation plan 			

MILESTONE 5: DEVELOP COMMUNICATIONS AND STRATEGY

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Build a strategic communications plan	<ul style="list-style-type: none"> Define clear objectives, timelines, audiences, spokespeople, communications channels, public input opportunities, materials and accountabilities Create website for external updates Create plan of engagement for internal updates and communications with agency staff 			
2. Engage community partners and stakeholders in outreach and communications planning	<ul style="list-style-type: none"> Work with stakeholders to develop communications plans and strategies that will resonate with their constituents 			

MILESTONE 6: DETERMINE NEED FOR CONSULTANTS

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Based on scope of transformation, determine if state will need to bring in consultants	<ul style="list-style-type: none"> Core team should discuss potential staffing implications associated with proposed transformation vision, and determine if the state has the internal capacity and expertise to successfully design and implement the vision 			
2. Determine the financial costs of consultants	<ul style="list-style-type: none"> Review potential technical assistance opportunities the state could apply for to defray the costs of consultants Scope out potential role of consultants and estimate budget impact Draft Request for Proposals (if required) outlining consultant roles and state budget 			

MILESTONE 7: DEVELOP AND SUBMIT THE CONCEPT PAPER TO CMS

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Inform CMS of transformation work and concept paper	<ul style="list-style-type: none"> Reach out to CMS leadership and state project officer to discuss initial ideas, identify to whom the state should send the concept paper and let CMS officials know when to expect the paper 			
2. Draft concept paper	<ul style="list-style-type: none"> Identify staff people to draft specific sections Establish timeline for drafts Create schedule for the core team to meet to review and discuss drafts 			The concept paper has two main goals: to introduce the state's thinking to CMS; and to get CMS support for the vision and how to move forward in discussions

MILESTONE 8: ENGAGE WITH CMS

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Establish a Plan to Engage with CMS Leadership and Staff	<ul style="list-style-type: none"> After submission of the concept paper: <ul style="list-style-type: none"> » follow-up with email communications to CMS ensuring the paper was received; » ask whether there are any additional questions the concept paper has raised among CMS staff; and » confirm the timeline for CMS to engage with the state around the content of the paper. Establish schedule of calls or in-person meetings with CMS, ensuring the relevant officials are able to participate in the calls 			
2. Develop content for CMS meetings	<ul style="list-style-type: none"> Prepare to answer CMS questions based on the concept paper submission Create presentation or visuals to help walk CMS through the high-level vision of the transformation 			

MILESTONE 9: IDENTIFY AUTHORITY OPTIONS AND CHOOSE A PATH FORWARD

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Explain the need for new authorities from CMS to achieve transformation effort	<ul style="list-style-type: none"> Assign staff to compile list of authorities the state currently operates under, and explanation of why they are insufficient to meet transformation goals 			
2. Establish timeline for transformation	<ul style="list-style-type: none"> Assign staff to create timeline for desired implementation, taking legislative session, gubernatorial and presidential election cycles, state budget environment, etc. 			
3. Determine whether and why federal investment is needed for transformation	<ul style="list-style-type: none"> Identify potential financing sources from within the state (e.g. general revenue, IGTs, CPEs) and whether there is a need for federal financial support 			

MILESTONE 10: PREPARE AND SUBMIT A STATE PLAN AMENDMENT OR SECTION 1115 WAIVER APPLICATION

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Begin to draft SPA or Section 1115 waiver application	<ul style="list-style-type: none"> • Complete SPA or Section 1115 templates • Establish timeline for drafting of application • Schedule meetings for the core team to review drafts of the Section 1115 application • Determine due date for public notice posting • Inform CMS leadership that state is drafting application for submission 			
2. Ensure tribal notification requirements are met (for 1115 waiver application)	<ul style="list-style-type: none"> • Assign staff to review tribal notification requirements • Continue to outreach to tribal leadership around the content of the waiver • Post the waiver to state website • Comply with the state's notification requirements as set forth in the American Recovery and Reinvestment Act (ARRA) 			
3. Ensure public notice requirements are met (for 1115 waiver application)	<ul style="list-style-type: none"> • Build timeline that comports with federal and state notice requirements • Post the waiver to state website • Schedule at least two public hearings within 40 days of posting waiver application online (ensure at least one has virtual participation capability) • Assign staff to compile and review comments received and incorporate them into updated waiver draft 			

MILESTONE 11: DETERMINE FINANCING OF SECTION 1115 WAIVERS

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Identify appropriate budget neutrality model	<ul style="list-style-type: none"> • Conduct analysis of state spending trends from prior 3-5 years to determine the amount of savings needed to be budget neutral • Review different budget neutrality model options and determine which one applies to state efforts • Determine future trend rates both with and without waiver to identify potential budget neutrality savings 			
2. Identify potential financing streams	<ul style="list-style-type: none"> • Review financing options for both federal and non-federal share <ul style="list-style-type: none"> » If pursuing DSHP, convene different state agencies to review potential state-funded programs that can become eligible for DSHP » Coordinate across agencies to complete the DSHP worksheet » Schedule calls with CMS to discuss financing options and help identify potential allowable state-only programs for designated state health programs, if applicable. 			

MILESTONE 12: PLANNING FOR SUCCESSFUL IMPLEMENTATION

Objectives	Action Steps	Due Date	Point Person(s)	Notes
1. Prepare for implementation	<ul style="list-style-type: none"> • Create timeline for implementation milestones before final waiver is approved • Identify key state staff to be responsible for each deliverable • Establish a process to ensure implementation is on-track • Schedule stakeholder communication opportunities to continue to engage during implementation process • Prepare and submit operational protocols for a Section 1115 Waiver 			

APPENDIX B



Concept Paper Template

The concept paper should not exceed 10 pages in length.

SECTION I - INTRODUCTION – WHY TRANSFORMATION MATTERS

Describe why the state needs to transform the Medicaid program. This section tells the story or the “theory of the case” for the underlying need for transforming the Medicaid program. The story should create a sense of urgency, and should be tied to the governors’ agenda for health care transformation. If the state faces a budgetary crisis, or a mental health crisis or a mandate from the legislature, the “theory of the case” should draw on those pending pressures as evidence for needing to transform the state’s Medicaid system to truly drive system change. This theme should be present throughout the concept paper.

This section should be 3-5 paragraphs.

SECTION II – PROJECT VISION AND GOALS

State the vision for your project and the corresponding goals for Medicaid transformation. In determining the state's goals, be clear, concise and think about the specific goals the state is aiming to achieve. The goals should be more specific and targeted than the vision and should address different aspects of the project, such as "Fully integrate primary care and behavioral health care."

The vision statement should be 3-5 sentences. Bullet out the goals for transformation.

SECTION III – DESCRIPTION OF TARGET POPULATION

Describe the target population for the project. The decision to target this population must be based on a thorough analysis of the state's data. This is a fundamental piece of your proposed project. CMS will be specifically looking to see if the state has run its data, and completed a thorough analysis of the data to understand how the current system is functioning, the gaps in the existing Medicaid system, and what population/s will be the focus of the project. A thorough data analysis is crucial to putting together a successful proposal.

This section should be about 3-5 paragraphs, depending on the size and scope of the population/s.

SECTION IV – EXPLANATION OF THE CURRENT SYSTEM OF CARE

The explanation of the current system of care should build on the discussion about the target population and the underlying data analysis. This section should provide a concise and thorough explanation of how the current Medicaid system is operating within the state and should highlight the issue areas and gaps the data analysis identified. This section needs to be focused on the target population and how the current system is working for that population. For example, if the state is focusing its transformation efforts on children between the ages of 10 and 17 who experience behavioral health challenges, this section should explain how the current system provides services to this population. Consider answering the following questions:

- How do beneficiaries access care?
- Where do beneficiaries access care?
- What services/treatment are currently available to this population?
- What are the current referral pathways (if applicable)?
- Describe the current gaps in care delivery?
- What types of providers and health workforce deliver services?
- Is the health workforce adequate?

At the end of this section, the reader should clearly understand how the current system is operating and the areas that need to be transformed.

This section should be between 1-2 pages.

SECTION V – EXPLANATION OF THE NEW SYSTEM OF CARE

Describe how the new system of care will operate under the proposed project. This section of the concept paper should be a methodical explanation of how the proposed new system of care will operate. For the purposes of the concept paper, do not get bogged down in the details, instead focus on the conceptual changes to the way the new system of care will solve for the issues you discussed in the previous section. Consider answer the following questions:

- How do beneficiaries access care in the new system?
- Where do beneficiaries access care in the new system?
- What services/treatment will be available to this population in the new system?
- Will there be a new referral pathways (if applicable)?
- How will the new system address the gaps in service delivery?
- Will there be new providers added to the workforce? Or will existing providers, deliver new services?

This section should aim to be between 1-2 pages.

SECTION VI – POTENTIAL FEDERAL AUTHORITIES

Describe the state’s thinking around federal authority options for the proposed project. The state should describe its preliminary thinking around the possible federal authorities that might be needed to undergo Medicaid transformation. The frame and tone of this section should be more exploratory, rather than declaratory. Show CMS that the state has done some thinking around the different authorities such as what is permissible under the State Plan and why the state may need additional federal authority to accomplish its goals. This section should also explain the challenges and opportunities the state might face with each authority. If the state thinks that their transformation efforts cannot be done with a state plan amendment, present the opportunities the state plan amendment would provide, and also the challenges, or limitations it presents to truly transform the Medicaid program.

This section should be about 3-5 paragraphs in length.

SECTION V – PROJECT FINANCING

If applicable, describe the state’s need for potential federal investment in the project. This section should be fairly short. At a high level, describe how the state envisions financing the project and how the project will be sustained overtime from a financing perspective. It is important to clarify whether the state is able to invest state dollars into the project and the potential sources of those dollars. If the state may need potential federal investment to undergo Medicaid transformation, dedicate a few sentences to explain that the state may be in a position of seeking potential federal investment for its transformation efforts.

As a cautionary note: states should tread lightly around any conversation about federal investment. Federal investment should be viewed as a last resort and should be tied to true transformation of the state’s Medicaid program. If a state leads any conversation with CMS with needing federal dollars, or frames the conversation around federal investment in a way that is perceived as “just wanting the money” the state will not get very far in its transformation efforts.

This section should be 1 short paragraph.



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