

## ***The Path to Transformation:***

### **Concept Paper for an 1115 Waiver for Illinois Medicaid**

#### **EXECUTIVE SUMMARY**

The Illinois Medicaid Program is applying to the Centers for Medicare and Medicaid Services (CMS) for a comprehensive waiver granted under authority of Section 1115 of the Social Security Act. The *Path to Transformation* waiver will include all spending in the Illinois Medicaid Program and will cover all populations who are currently eligible for Medicaid and who may become eligible after ACA implementation. The proposal will result in tangible savings for both the state and federal governments, which will be used to reinvest in an integrated, rational and efficient healthcare delivery system. The waiver will demonstrate that by spending Medicaid dollars differently, we will have better health outcomes for our Medicaid clients at or below the same costs.

The *Path to Transformation* waiver will accomplish this goal through four important “pathways”:

- *HCBS infrastructure, choice and coordination.* Illinois will rebuild and expand its home and community-based infrastructure, especially for those with complex health and behavioral health needs. We will expand access to and choice of HCBS services for our beneficiaries and ensure that services are based on individual needs and preferences rather than disability.
- *Delivery system transformation.* Illinois’ healthcare delivery system will be built off of integrated delivery systems (IDS) -- centered around patient-centered health homes -- that are built based on the needs of the patient population. Integrated delivery systems have the ability to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, and provide performance reports and counseling to individual doctors and practices. IDSs will be held accountable for the health outcomes of individual patients within their networks as well as for their overall patient population. The goal is for IDSs to reduce costs and improve quality through management of care and care transitions and aligned incentives to ensure the right care at the right time in the most appropriate setting.
- *Population health.* Illinois will expand the capacity of the healthcare delivery system to take responsibility for the health of a population, with a focus on prevention, primary care and wellness. Population health can also be addressed by helping delivery systems focus on the health of their individual patients as well as on the health of the panel of patients they serve.

- *Workforce.* Illinois will build a 21<sup>st</sup> century health care workforce that that is ready to practice in integrated, team-based settings in geographies and disciplines that are in the greatest demand, including the ability to utilize community health workers and ensure all health professions are able to assume responsibility to the full extent of their education and training.

As a key component of the waiver application process, and then in management of the waiver itself, there will be numerous opportunities for input and collaboration by and among community stakeholders, providers, local government and state agency partners to design and then implement an improved Medicaid delivery system that reflects the priorities set forth in the waiver. This collaborative design process, which was begun under the state’s Health Reform Implementation Council and continued and expanded under the State Health Care Innovation Plan process, will itself play a significant role in the transformation of the Illinois Medicaid Program.

## **BACKGROUND**

The Illinois Medicaid Program is undergoing significant healthcare transformation. Illinois is among the last of the major states with an unsustainable fee-for-service Medicaid system. Consequently, service delivery is often fragmented and uncoordinated. This is rapidly changing, however. Pursuant to P.A. 96-1501 (“Medicaid Reform”), signed into law in January 2011, Illinois must enroll at least 50% of its Medicaid clients into some form of risk-based coordinated care by January 1, 2015. Under Medicaid Reform, care coordination is defined broadly to include both traditional managed care organizations as well as alternative payment methodologies such as risk- based direct provider payments from HFS.

HFS currently manages two capitated Medicaid managed care programs and an early expansion waiver program for individuals residing in Cook County. The first is a voluntary program for children and parents (with enrollment of approximately 247,000) in 18 counties.<sup>1</sup> The second program, known as the “Integrated Care Program” (ICP), is a mandatory program for non-dual seniors and persons with disabilities (SPDs). The program began in 2010 for individuals residing in the Chicago suburbs and collar counties surrounding Chicago and has an enrollment of approximately 39,500.<sup>2</sup> Four additional regions were recently added to the ICP and are not reflected in this enrollment figure. Long-term services and supports (LTSS) were also recently added to the ICP, making Illinois one of just a handful of states with an integrated managed acute and long-term care program. In early 2013, the State, in collaboration

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<sup>1</sup> Illinois Department of Healthcare and Family Services, enrollment as of August 2013 (<http://www2.illinois.gov/hfs/ManagedCare/Pages/Enrollment.aspx>)

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with the Cook County Board and the Cook County Health and Hospital System (CCHHS) received an 1115 waiver to early-enroll approximately 115,000 individuals who will become eligible for Medicaid services in 2014. Under the “CountyCare” program, “newly eligible” are served by a provider network that includes both CCHHS and contracted network providers.

In order to provide options for care coordination services, Illinois has recently implemented innovative, alternate models of care in addition to the traditional managed care organizations. The alternative models of care – “care coordination entities” (CCEs) and “accountable care entities” (ACEs) – are organized and managed by hospitals, physician groups, Federally Qualified Health Centers, or social service organizations and are required to provide a full continuum of services, including behavioral health. CCEs were created under Medicaid Reform to provide an organized system of care for the most complex and vulnerable individuals, including the severely mentally ill, homeless, complex children and other high-cost, high-need groups. As of October 1, 2013, client enrollment has started in one of the CCEs and the State is in the process of finalizing implementation for the remaining CCEs.

ACEs were created by statute in the spring of 2013 and were informed by the early experience of preparing CCEs to become operational, the lack of progress toward developing integrated delivery systems under the State’s existing managed care programs, as well as the findings and recommendations from the Alliance planning process on the structure and components of integrated delivery systems. Whereas CCEs are primarily focused on highly targeted sub-populations (e.g., homeless) and, therefore, will have fairly small enrollment, ACEs are focused on the full Family Health Plan and newly eligible populations. Both CCEs and ACEs are paid a PMPM care coordination fee, with fee-for-service reimbursement and shared savings potential initially; ACEs are required (and CCEs are encouraged) to begin moving to a risk-based arrangement after 18 months.

As the state moves ahead rapidly with expansion of coordinated care models, we – like many states -- continue to face an extremely challenging budget environment. Only one year ago, in 2012, the Medicaid Program was in crisis, on the brink of collapse, with a \$2.7 billion budget hole for FY2013 and \$1.9 billion in unpaid Medicaid-related bills. Through a combination of spending reductions, utilization controls and new revenues, Illinois addressed the urgent budget shortfall, primarily through the SMART Act (“Save Medicaid Access and Resources Together”). Similarly, the state was forced to make significant reductions in its mental health budget in recent years, cutting \$114 million in general revenue funding for mental health services between 2009 and 2011. These cuts were necessary to ensure that services were scaled to existing appropriations, but they have also left the state and many of our

providers unable to invest in the kinds of systemic change needed to drive long-term cost savings, improved outcomes and improved patient care.

This waiver represents the culmination of multiple coordinated efforts by the State of Illinois to plan for full implementation of the Affordable Care Act and reform our health care delivery system around the vision of the Triple Aim. These efforts include:

- *Illinois Health Care Reform Implementation Council* On July 29, 2010 Governor Pat Quinn signed Executive Order #10-12 to create the Illinois Health Care Reform Implementation Council, an inter-agency subcabinet that has been charting Illinois' multi-dimensional path toward ACA implementation.
- *Illinois Health Insurance Marketplace*. For the first year after ACA implementation, the Marketplace will be operated in partnership with the federal government. Federal grant dollars are helping the State to build an integrated eligibility system for Medicaid, SNAP and TANF initially (and for other public programs later), and for an Illinois-based Marketplace.
- *The Alliance for Health*. In early 2013, Illinois was awarded a Model Design grant from the Center for Medicare & Medicaid Innovations (CMMI) for the development of a State Health Care Innovation Plan (SHCIP). The State convened a broad group of payers, providers, state agencies, consumers and other stakeholders -- collectively known as the Alliance for Health -- to design new service delivery models and multi-payer strategies for payment reforms, as well as population health and workforce measures designed to achieve improved health, more effective health care delivery, and lower costs. The Alliance completed the SHCIP in late October, and many of the SHCIP components and innovations are included in this concept paper. The State has committed to continuing the Alliance through an Executive Order to ensure that the reforms outlined in the SHCIP move forward.

#### **PROPOSED 1115 REFORM WAIVER: *THE PATH TO TRANSFORMATION***

The Illinois Medicaid Program is poised for transformation, and the ability to secure federal investments for new priorities will support our next steps toward Medicaid reform and full ACA implementation. Our proposed approach identifies new priorities that are essential to a highly functioning Medicaid Program, with the flexibility in service design afforded by an 1115 waiver.

The *Path to Transformation* waiver will accomplish this goal through four important “pathways”:

- *HCBS infrastructure, choice and coordination.* Illinois will rebuild and expand its home and community-based service infrastructure, especially for those with complex health and behavioral health needs. We will expand access to and choice of HCBS services for our beneficiaries.
- *Delivery system transformation.* Illinois' healthcare delivery system will be built off of integrated delivery systems -- centered around patient-centered health homes -- that are built based on the needs of the patient population. Integrated delivery systems will have the ability to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, and provide performance reports and counseling to individual doctors and practices.
- *Population management.* Illinois will expand the capacity of the healthcare delivery system to take responsibility for the health of a population, with a focus on prevention, primary care and wellness.
- *Workforce.* Illinois will build a 21<sup>st</sup> century health care workforce that that is ready to practice in integrated, team-based settings in geographies and disciplines that are in the greatest demand. Illinois will ensure all health professions are able to assume responsibility to the full extent of their education and training.

**Pathway #1: Home and Community Based Infrastructure, Coordination and Choice** -- It is not possible to deliver on the promise of the right care in the right setting, at the right time, without ensuring that supportive services exist in the home and community to assist clients with achieving their highest level of independent functioning and quality of life. Illinois is in the midst of implementing consent decrees related to three Olmstead-related class action lawsuits, by helping residents of nursing homes and other institutions to transition to the community. We have learned through the early implementation of these consent decrees, as well as implementation of the "Money Follows the Person Program", that our existing community infrastructure needs to be strengthened through the addition of community-based services that will enable individuals to remain in their own community post-transition and avoid re-institutionalization.

We also want to emphasize that for our clients who live in poverty, it is the social, cultural, environmental, economic and other factors that are the major causes of rates of illness and the magnitude of health disparities. Illinois Medicaid needs to reposition itself to directly tackle these multiple, challenging causes of ill health associated with poverty, with a renewed emphasis on the social determinants of health throughout all of our programs, services, policies and reform initiatives.

**1A. COMBINE AND MODERNIZE HCBS WAIVERS.** HCBS "waiver providers" provide an important Medicaid service to Seniors and Persons with Disabilities (SPD) by helping them to remain in their own home or to live in a community setting.

In Illinois, home and community-based services in Home and Community Based Services (HCBS) waivers, currently approved under Section 1915 (c) of the Social Security Act, are compartmentalized under nine separate waivers, three departments and numerous divisions within departments. The current waivers are for adults with developmental disabilities; children and young adults with developmental disabilities; elderly; medically fragile/technology dependent children; persons with brain injury; persons with disabilities; persons with HIV or AIDS; supportive living facilities; and a support waiver for children and young adults with developmental disabilities.

These separate waivers provide services based on an individual's primary disability rather than identification of service needs across disability. However, Illinois is in the process of incentivizing the coordination of care for the SPD population, intended to break through the silos which do not effectively address the holistic needs of clients with multiple disabilities and conditions. The current waiver structure makes it difficult for healthcare providers and community organizations as they face steep challenges in their efforts to work together and coordinate care. This structure, with nine HCBS waivers, is not consistent with the State's approach, moving forward.

The *Path to Transformation* waiver will assist the State in developing and implementing, across disabilities and across agencies, a uniform assessment instrument and a consolidated waiver structure. In addition, the State recently received funding under the Balancing Incentive Program (BIP) and plans to use the enhanced matching funds through that program to achieve additional expansion of capacity in the community. The waiver will provide the flexibility needed to deliver appropriate and essential HCBS waiver services, also referred to as "long-term supports and services" (LTSS), in a coordinated fashion through managed care entities and their provider networks. In addition, the state is in the process of developing a universal assessment tool (UAT) for SPD populations that will support efforts to tie services to the needs of the beneficiary. Specifically, Illinois seeks to accomplish the following through the *Path to Transformation*:

- Rationalize service arrays and choices so that they are based on beneficiary needs and preferences to remain as independent as possible, rather than disability or condition;
- Increase flexibility and choice for beneficiaries;
- Support development and expansion of community based options;

- Reduce waiting lists for waiver services;
- Develop outcome-based reimbursement strategies that emphasize quality of care and align payments with the goals of the program;
- Reduce administrative complexity and cost inherent in managing nine separate waivers.

The state also requests CMS feedback on the feasibility of implementing a provider assessment on waiver providers to support access to HCBS services and counteract the additional incentive toward institutionalization that is inherent in the state's current nursing facility assessment.

**1B. BEHAVIORAL HEALTH EXPANSION AND INTEGRATION** -- As home- and community-based services have experienced continuous budget cuts, it has become nearly impossible in Illinois to provide the depth and breadth of long-term supports and services that are needed by the Medicaid population with co-morbidities, including mental illness, substance use disorders and chronic health conditions. We believe that we cannot produce the desired health outcomes – while bending the cost curve for these most expensive clients – without enhancing these community-based services.

The *Path to Transformation waiver* will invest in the transition to an integrated system, including behavioral healthcare, with the following:

- Development, implementation and training on evidence-based recovery models, community crisis supports, step-down and transitional living programs, patient-centered behavioral health homes, and systems of care;
- Development, implementation of and training on discharge planning policies to create seamless care transitions between psychiatric or detoxification services in acute or sub-acute care settings, to community-based services for persons with mental illness and substance use disorders;
- Training for staff of state agencies and community providers to assess and assist clients, across disabilities, with co-morbidities and multiple conditions;
- Development and use of health information technology (HIT) for behavioral health programs, to make necessary seamless exchange of clinical data possible with primary care and hospital providers.

**1C. STABLE LIVING THROUGH SUPPORTIVE HOUSING** -- The ACA offers a paradigm shift to assist low-income adults with complex health and behavioral health needs who will have access to health coverage under

Medicaid, for the first time, by reason of income -- even if they do not qualify for Medicaid as a permanently disabled person. It is possible to aid in recovery of these adults by offering the essential healthcare services and supports.

A recovery-oriented model must consider the healthcare value of providing supportive housing and employment for these vulnerable populations in Illinois. Not only can supportive housing prevent individuals from unnecessarily living in costlier institutional settings, but a growing body of research suggests that stable and affordable housing may help individuals living with chronic diseases and behavioral health conditions maintain their treatment regimens and achieve better health outcomes at a lower cost.<sup>3</sup> Supported employment likewise promotes stability, dignity and self-respect to further the recovery process and achieve independence in the community.

Through the *Path to Transformation* waiver Illinois seeks to expand access to supportive housing through capital funding for supportive housing projects and by expanding supportive housing services. In lieu of direct funding for these programs, the State may also explore the creation of a DSRIP program for behavioral health providers that incentivizes the creation of more supportive housing and supportive housing services.

## **Pathway #2: Delivery System Transformation**

**2A. IMPLEMENT AND EXPAND INNOVATIVE MANAGED CARE MODELS** – As described above, Illinois is in the midst of a rapid and significant shift from a largely fee-for-service model to a risk-based managed care model that includes both traditional MCOs as well as new, provider-driven models (i.e., Coordinated Care Entities and Accountable Care Entities). CCEs and ACEs will establish integrated delivery systems centered around Patient-Centered Health Homes. They will develop multi-disciplinary teams, robust care coordination capabilities, and a high level of integration among primary care, hospital and behavioral health providers. They will be linked by connective technology for tracking of clients and timely transmission of patient clinical data between provider partners. The providers within the network will agree to manage care transitions and deliver care in the most appropriate settings.

These new models of integrated service delivery will also demonstrate how Medicaid can reduce the rate of growth to sustainable levels by piloting payment reforms, including financial incentives that reflect value-based purchasing policies and Illinois requirements for risk-based payments in care

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<sup>3</sup> See, for example, Culhane, et al., *Public Service Reductions Associated with Supportive Housing*, Housing Policy Debates, Volume 13, Issue 1, 2002, pages 107-163; and Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

coordination systems. These payment reforms will incorporate multi-payer strategies being developed through the Illinois State Innovation Model Design grant. While CCEs and ACEs will contract directly with the state, they will also have the ability to contract with traditional MCOs, driving higher levels of integration and accountability throughout the Medicaid program. These new models will enable people covered by Medicaid to remain with their providers if they shift from Medicaid to premium subsidy. With tens of thousands of people newly eligible for Medicaid likely to shift between Medicaid and premium subsidy as wages and hours change it becomes even more important for the state's providers to care for people in their community regardless of the payer. Given the importance of these new models to system redesign efforts, the *Path to Transformation* waiver will invest in their design, start-up, and implementation, including:

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

**2B. TRANSFORM PUBLIC PROVIDERS** – Illinois is home to two large public health and hospital systems – the University of Illinois Hospital and Health System and Cook County Health and Hospitals System. These systems play a vital role in the state's health care delivery system, including the provision of trauma and burn services, transplant services, and sub-specialty care. CCHHS is a major safety net provider for the underserved of Cook County and is one of the largest and most comprehensive public health and hospital systems in the country. The U of I system includes a 495-bed tertiary hospital with nationally recognized transplant programs, an outpatient facility, and 19 neighborhood clinics serving communities throughout the near west, south and southwest sides of Chicago. Both of these systems were active participants in the Illinois Alliance for Health and are committed to the transformation outlined in the State Health Care Innovation Plan.

Illinois will continue to rely on its public providers throughout the implementation of the ACA and beyond. However, we also recognize that large public providers face numerous unique barriers to transformation that extend beyond those faced by other providers. These include cost-based reimbursement methodologies that haven't incentivized efficiency, legal and political barriers that can inhibit integration with other providers, and multiple layers of oversight that can slow the pace of

change. For these reasons, and consistent with the goals of the Alliance for Health, Illinois proposes a Delivery System Reform Incentive Program (DSRIP) to create strong incentives for transformation within these vital providers. DSRIP funds will be contingent on public systems meeting aggressive milestones with respect to integrated care delivery and improved patient outcomes.

**2c. HOSPITAL/HEALTH SYSTEM TRANSFORMATION** – Much of healthcare reform is focused on reducing hospital admissions/readmissions and the use of emergency rooms for primary care, which will positively impact health outcomes and the quality of care but may also negatively impact hospitals' bottom lines. The *Path to Transformation* waiver will invest in hospitals that are committed to transitioning to a modern service delivery model through:

- Development and implementation of one or more incentive-based pools to drive transformation of systems, including, but not limited to:
  - Primary care development, quality care improvements, and regional collaborations on state public health initiatives and community needs;
  - Development of integrated delivery systems, including HIT/HIE infrastructure, governance and care models;
  - Development, implementation and training on effective transitions of care models;
- Technical assistance to support the development of integrated delivery systems that are capable of assuming responsibility for the health care of a defined population;
- An access assurance pool for hospitals and health systems to cover uninsured and unreimbursed Medicaid costs to assure access and preserve the “safety net”; Development and implementation of a pool to support debt relief or capital investments for hospitals that commit to redesigning, downsizing or closing some or all of their facilities, including transformation of rural systems to potentially create rural “hubs” that are not built around inpatient care.

**2c. NURSING FACILITY TRANSFORMATION** – Illinois has approximately 1,200 long-term care facilities serving more than 100,000 residents, from the young to the elderly.<sup>4</sup> The state ranks in the top quintile nationally on the number of licensed nursing home beds per thousand persons aged 65 years and older.<sup>5</sup> Illinois has made substantial progress in recent years toward rebalancing its long-term services and supports and offering community-based alternatives. Specifically, Illinois has implemented the Pathways/Money Follows the Person (MFP) Demonstration Program, which has assisted hundreds of

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<sup>4</sup> Illinois Department of Public Health

<sup>5</sup> Center for Medicare and Medicaid Services, Nursing Home Data Compendium 2012 Edition

individuals with transitioning to the community. Earlier this year Illinois received federal approval for its Balancing Incentive Program (BIP) application, which commits the state to balancing its spending on home and community based services with its spending on institutional services. As Illinois works to rebalance its long-term care system while looking ahead to the health needs of the advancing baby-boomer generation, the State is working with the nursing home providers and community advocates. The *Path to Transformation* waiver will invest in nursing facilities transitioning to the modern service delivery system through:

- Development and implementation of an incentive-based pool for nursing facilities to drive transformation, including, but not limited to:
  - Quality of care improvements;
  - Participation in integrated delivery systems with capacity to assume responsibility for patient care across the full continuum of preventive, acute and long-term care services;
  - Development, implementation and training on effective transitions of care models between nursing facilities, home and community-based care and hospitals;
- Debt relief or capital investments for nursing facilities that commit to redesigning, downsizing or closing some or all of their facilities, including technical assistance in developing new business models to retool facilities to meet the needs of emerging populations;
- Flexibility to develop and fund additional supportive housing and employment options for those populations in need of long term care, at the appropriate levels.

**Pathway #3: Build Capacity of the Health Care System for Population Health Management** -- By 2017, Illinois expects that an additional 500,000 Medicaid clients will be enrolled under the Affordable Care Act, a combination of "newly eligible" adults and "already eligible" clients under current Medicaid rules. In addition, another 500,000+ people will shop for private health insurance in the Health Insurance Marketplace. The health status of these currently uninsured populations is varied — many of the formerly uninsured will be young, relatively healthy adults, but there is evidence to suggest that many will have pent-up demand for health care. With this influx of enrollees into healthcare systems, the Healthcare Reform Implementation Council and the Alliance for Health have focused substantial attention on the need to build linkages between public health and health care delivery systems and to expand the capacity of the system and the skills it will need to manage the health of a defined population.

The new community needs assessment mandate offers opportunities for the state and local health departments to collaborate with local hospitals and community health centers to share data and

analyses and assure that as much attention as possible is directed to fulfilling the identified needs. Establishing and certifying a new category of worker, community health workers, will also help bridge the gap between personal and public health. These workers, who originate in and serve their local communities in linguistic and culturally sensitive ways, are essential to team with providers to educate and motivate consumers to actively participate in improving their own health.

**3A. WELLNESS STRATEGIES** – Providing health coverage to more people also requires a focus on front-end strategies to deflect individuals from costlier back-end care. The *Path to Transformation* waiver will leverage health and other public health dollars by investing in evidence-based prevention and wellness-focused strategies for Medicaid clients, such as tobacco cessation, obesity prevention, diabetes self management, nutrition counseling, fall prevention, physical fitness, and other non-traditional services that assist in improving the health of our clients. We will test payment reforms for wellness programs and integration of public health services that may provide direct incentives for clients or address socioeconomic circumstances of families, with the goal to lower costs of traditional medical services. We also will seek to bring in additional Medicaid funds to fund the public health system, including enhancing the funding pool for local government provided services to improve the ability of these local systems to support the health of their communities in a cost effective manner.

**Pathway #4: 21<sup>st</sup> Century Health Care Workforce** -- Illinois ranks near the middle among states on the total number of active physicians and active primary care physicians per 100,000 population. However, the supply of providers does not necessarily match the demand in certain areas of the state and for some populations. For example, only 64.9% of Illinois physicians reported that they were accepting new Medicaid patients in 2011, compared to a national median of 76.4%.<sup>6</sup> Similarly, 28.5% of Illinois residents live in an area that has been designated as a primary care Health Professional Shortage Area (HPSA), compared to a national median of 18.6%.<sup>7</sup> Even in areas where supply is currently sufficient, concerns exist about capacity for an expanded insured population when Marketplace and expanded Medicaid coverage begin in 2014. In addition, Illinois falls well below the national median in its use of non-physician providers. Illinois has 20.2 physician assistants and 35.3 nurse practitioners per 100,000 people, compared the national median of 33.5 and 62.1, respectively.

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<sup>6</sup> NCHS analysis of NAMCS Electronic Medical Records Supplement from Decker, S. "In 2011 Nearly 1/3 of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help." *Health Affairs*, 31, no. 8, 2012. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

<sup>7</sup> HPSA information from the Health Resources and Services Administration (HRSA); population data from ACS. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

While it is not possible to rapidly increase the pipeline of physicians, the State must invest in training and retraining the types of providers that are needed within the Medicaid program. Similarly, we must invest in a workforce that includes healthcare professionals who can provide and/or assist with primary and preventative healthcare for our clients.

**4A. GRADUATE MEDICAL EDUCATION** – Illinois is currently one of a handful of states that does not have a Medicaid Graduate Medical Education program. In order to align the provider workforce with the needs and goals of the state, we propose to develop a Graduate Medical Education (GME) pilot program with the following goals:

- Increase the number of primary care providers in Illinois.
- Increase the number of primary care providers working in medically underserved areas, including rural areas.
- Increase the number of providers who are trained to practice in a, team-based, patient-centered medical home setting within an integrated delivery system.

The program would incentivize primary care GME programs in Illinois to address state workforce goals through payments for performance on specific GME program metrics. We propose that the GME pilot be a five-year graduated program design with the details and parameters to be developed during the waiver planning process.

**4B. LOAN REPAYMENT** -- Consistent with the recommendations of the Illinois Alliance for Health, Illinois will expand primary care capacity by reinstating a State Loan Repayment program across a broad range of professionals (including physicians, advanced practice nurses, psychologists, and other health care professionals) in underserved areas.

**4C. OTHER WORKFORCE TRAINING** -- The *Path to Transformation* waiver will invest in training and preparing healthcare providers, such as community health care workers, in-home specialized personal attendants, care coordinators, nurses of all specialties, physician assistants/nurse practitioners and physicians to work on primary care provider teams to assure that overall health improvement goals are achieved in addition to providing appropriate clinical care. Education in healthcare across the lifespan and disabilities is essential for our workforce to be prepared for the rapid growth of aging adults and people with disabilities. This workforce training will be implemented in cooperation with community colleges and other certification programs.

#### **Financing/Budget Neutrality**

By implementing the *Path to Transformation*, Illinois expects to achieve significant savings, including the following:

*Future managed care savings.* Our with-waiver baseline will include projected savings under the state's planned managed care expansions, including the following:

- *Family Health Plan mandatory managed care* – Beginning on July 1, 2014, Illinois will begin mandatory managed care enrollment (ACEs, MCOs or MCCNs) for the Family Health Plan population in five regions of the state (Greater Chicago, Rockford, Quad Cities, Central Illinois, Metro East).
  
- *Newly eligible mandatory managed care* – Beginning on July 1, 2014, Illinois will begin mandatory managed care enrollment (ACEs, MCOs or MCCNs) for the Newly Eligible Medicaid adult population in the same five regions of the state.

*Savings resulting from waiver innovations.* Many of the innovations outlined in this concept paper are investments that will help to “bend the cost curve” by eliminating unnecessary costs, reducing rates of institutionalization, and focusing on health and wellness, which will yield a return within the five-year budget window. We will be working with our actuaries to identify and quantify these anticipated savings.

*Previous managed care savings.* Illinois requests “credit” for the savings achieved under our existing managed care programs (implemented under state plan authority), that would have not been achieved in the absence of these programs. These include our voluntary Healthy Families program as well as the mandatory Integrated Care Program (ICP) for the SPD population.

As described above, Illinois has taken significant action to address a looming Medicaid budget crisis. These actions were necessary to prevent collapse of the Medicaid program, but they are not sustainable. Illinois recognizes that it must invest now to ensure access for the uninsured population that will gain Medicaid or Exchange coverage beginning in 2014. We must also invest now to build a modern, integrated delivery system that can achieve better outcomes at less cost. Failing to make these investments now may result in short-term savings but longer-term costs in the form of high emergency department and inpatient admissions and poorer health outcomes and population health. To ensure that Illinois is able to make these investments, we are requesting to use a without-waiver trend that is reflective of the national rate of cost growth.

Illinois proposes to reinvest a portion of these savings into reforming its health care infrastructure, including the programs outlined above and a number of state-only funded programs that may qualify as “Designated State Health Programs” for purposes of federal matching payments. Below is a preliminary list of DSHPs. We are in the process of identifying a complete list of programs that would be eligible for federal matching funds as Designated State Health Programs (DSHPs).

- Department of Public Health targeted prevention and screening programs
- Department of Children and Family Services assessment services
- Illinois State Board of Education early intervention and treatment services for children with mental health/behavior disorders
- Department of Human Services substance abuse prevention services, health education/promotion services

Illinois will maintain budget neutrality over the five-year life of the *Path to Transformation* Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver. We are not, however, proposing to establish a global cap on federal Medicaid expenditures for Illinois. In partnership with the federal government, and with the flexibility afforded by the *Path to Transformation* waiver, Illinois Medicaid will be transformed to a high quality healthcare delivery system, producing positive health outcomes for our Medicaid populations while reducing costs and creating a significant return on investment.