

MEDICAID INCENTIVE PROGRAMS: HOSPITAL PERSPECTIVES FROM THREE STATES

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KEY FINDINGS

- Section 1115 Medicaid waiver incentive programs provide essential hospitals with vital resources for initiating delivery system transformation.
- Engaged leadership is crucial to navigating culture change, promoting the importance of waiver programs across the organization, and laying the groundwork for ongoing improvement efforts.
- Collaboration among clinicians and community-based organizations is critical to the success of DSRIP/DSTI programs.
- Despite the challenges of having to report on new metrics, DSRIP/DSTI programs have encouraged hospitals to better integrate their data systems.
- Delivery system transformation can be accelerated by leveraging existing infrastructure to create new systems and processes.
- Waiver transformation often transcends specific projects to further the overall improvement of system processes and patient care.

BUILDING A WAIVERS PROGRAM

Shortly following the implementation of the Affordable Care Act in 2010, California, Texas, and Massachusetts each implemented a Section 1115 Medicaid waiver, launching what has become a new era of waivers and delivery system transformation. In response, America's Essential Hospitals developed a comprehensive waivers program based in policy, research, and education (see Our Waivers Work for more details).

As part of this program, we developed a quarterly webinar series around waiver-based quality improvement (see Research Methods for more on this series). Throughout the series, members from California, Massachusetts, and Texas discussed their experiences in this area. With several years of waiver work behind them, members in these states are providing the examples being built upon by health care leaders nationwide.

The webinar series allowed us to gain in-depth perspectives from three essential hospitals in these states: Boston Medical Center (BMC), Santa Clara Valley Medical Center, and UT Health Northeast. This brief summarizes their thoughts and experiences, as discussed during the webinar series.

Research Methods

Essential Hospitals Institute conducted a webinar series over the course of six months. Each webinar included a presentation from administrative and clinical leadership at selected hospitals.

- [Santa Clara Valley Medical Center in San Jose, California](#)
- [Boston Medical Center in Boston, Massachusetts](#)
- [UT Health Northeast in Tyler, Texas](#)

Webinar speakers were provided with a list of questions regarding their waiver experience, which guided their presentations. The presentations were transcribed and qualitatively analyzed to identify the key successes and challenges related to DSRIP/DSTI programs. The questions included the following:

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WAIVERS ARE JUMPSTARTING TRANSFORMATION

All three waivers include an incentive program for delivery system transformation—delivery system reform incentive payment (DSRIP) programs in California and Texas and delivery system transformation initiatives (DSTIs) in Massachusetts. The DSRIPs and DSTIs provide participating hospitals with funding that is tied to their work on projects to improve care, increase efficiency, and reduce costs.

An anticipated outcome of the DSRIP/DSTI programs was a jumpstart to transformation. For each of the three hospitals, this expectation has come to fruition. Essential hospitals are dedicated to serving the uninsured and those covered by public programs. As a result, they often do not have the financial means for systemwide transformation. DSRIP/DSTI funding is, therefore, boosting transformation by providing resources for otherwise unfunded or underfunded hospital projects. See Table 1 for more on these projects.

“Putting the money behind [the projects] really forced more clarity in terms of what we were going to do and the timelines for getting it all done.”

—Charles Williams, MD, vice chair for clinical affairs and quality at BMC

Leaders at BMC described this funding as “absolutely critically important.” With the DSTI funding available, the hospital could hone in on specific aims such as transforming its primary care practices into patient-centered medical homes (PCMHs) accredited by the National Committee

for Quality Assurance and improving its flu vaccination rates, which are now well above the 50th percentile. DSTI funding also allowed BMC to lay the foundation for creating an accountable care organization (ACO) and alternative payment methodologies, such as global payments that will align payment and system transformation.

Hospital leaders report the DSTI has provided hospitals in Massachusetts with the financial resources and incentives to focus on important projects that may have been previously put on hold due to lack of funding. “Putting the money behind [the projects] really forced more clarity in terms of what we were going to do and the timelines for getting it all done,” said Charles Williams, MD, vice chair for clinical affairs and quality at BMC. As BMC prepares for the upcoming renewal of its DSTI, the hospital has proposed projects that will build upon the foundation that was laid in the first round of DSTI programs.

At UT Health, DSRIP funding provides support for improving the local population’s health through community-specific projects, such as establishing a new primary care clinic to increase access for an underserved community of Smith County. Daniel Deslatte, associate vice president of planning and public policy for UT Health, said, “We’ve known this data for some time, but of course, as it is with many states and communities, there wasn’t really a funding mechanism to help us address these real population health needs that were out there.” The waiver funds represent an opportunity and an incentive to drive down costs and encourage innovation.

At Santa Clara, the waiver funds provided a critical incentive for

1. How are you measuring outcomes and to what extent are you measuring results that go beyond the measures requested by the Centers for Medicare & Medicaid Services?
2. What factors have facilitated waiver implementation in your hospital/health system?
3. What barriers did your team face over the course of the project? How did you overcome them?
4. In your opinion, what should hospitals consider in the early stages of DSRIP/DSTI implementation to help ensure their success?
5. What implications has the waiver had on other areas of your hospital? For example, have there been any spillover effects or unanticipated consequences, either positive or negative?
6. What practices have you put in place to ensure the sustainability of your achievements?

driving organizational changes in care delivery, many of which required additional resources and support. For example, the funds helped create an interdisciplinary sepsis team, policies and protocols, education, and a sepsis resource nurse position, which have resulted in a significant reduction in sepsis mortality.

LEADERS PROMOTE WAIVER IMPORTANCE

Engaged leadership plays a key role in implementation as well as sustainability. Medical leadership at Santa Clara serve as project sponsors and team leaders for both inpatient and outpatient initiatives. In this role, they ensure each team has sufficient support and direction to achieve goals and objectives. To help sustain DSRIP transformation, Santa Clara leaders emphasize the benefits of the DSRIP, particularly for patients. Slogans such as “Who Gives a Rip about DSRIP?” generate organization-wide awareness. These strategies ensure everyone in the organization recognizes the value and importance of waiver work, which enhances the pace of transformation.

“It is really impossible to overcommunicate the importance of these projects to frontline staff.”

—Charles Williams, MD, vice chair for clinical affairs and quality at BMC

Recognizing the importance of widespread commitment to DSRIP projects, leaders at UT Health have created an atmosphere of dedication to DSRIP across all disciplines and departments. BMC has incorporated its DSTI projects into its overall strategic plan, ensuring all staff view them as a priority. “It is really impossible to overcommunicate the importance of these projects to frontline staff,” Williams said.

COLLABORATION IS CRUCIAL FOR SUCCESS

Enhanced collaboration, whether among hospital teams or external

Our Waivers Work

America’s Essential Hospitals is strengthening its focus on Medicaid waiver research, education, and policy. This brief is the third in a series of waiver-related publications:

- *Delivery System Transformation: Section 1115 Medicaid Waiver Demonstration Projects in California, Massachusetts, and Texas*—a research brief that introduces the waiver agreements in these states
- *Medicaid Incentive Programs: Extending the Reach of Health Care Transformation*—a policy brief that provides a more in-depth look at how waiver-based incentive programs support essential hospitals’ delivery system reform

Our education programming began with an [introductory waiver webinar in December 2013](#), which provided a policy overview of existing delivery system reform incentive programs and similar models. We followed that webinar with the quarterly series on which this brief is based (see Research Methods).

To augment the distance learning, our [Leadership Summit on State Medicaid Waivers](#) has brought national leaders together to discuss current trends in Medicaid waiver design and various perspectives on the waiver process.

partners, has emerged as a key factor for successful project implementation. In many cases, collaboration has been about sharing ideas and experiences. Massachusetts, for instance, created a learning collaborative with six participating waiver hospitals. Facilitated by Essential Hospitals Institute, the collaborative allowed the hospitals to share their DSTI experiences with each other and learn new best practices from national experts. As Williams noted, “[The collaborative] has been wonderful and one of the most valuable resource-sharing places in this whole three-year project. As DSTI hospitals, we are struggling with the same issues and are learning from others across the country who are doing the same

things. We have taken many nuggets from the various presentations and immediately put them into play.”

“Transformation in isolation is not transformation. ... Collaboration means sharing—even among competitors—best practices to improve patient care.”

—Jeffrey Levin, MD, MSPH, senior vice president for clinical and academic affairs at UT Health

UT Health identified collaboration among internal and external players as one of its “key areas of success.” The Texas waiver is unique in that hospitals across the state are divided into 20 regions, with an anchor hospital in each region. As the anchor for the northeast region, UT Health coordinates the five-year regional health plan with 17 hospitals, 6 local mental health authorities, 2 public health departments, and 1 academic medical center. “Transformation in isolation is not transformation. ... Collaboration means sharing—even among competitors—best practices

to improve patient care,” said Jeffrey Levin, MD, MSPH, senior vice president for clinical and academic affairs at UT Health.

Among internal clinical teams, collaboration has been especially successful, as each hospital noted the culture of partnership and increased cohesion that has developed due to the waiver. At Santa Clara, cooperation among clinical leaders has led to rapid transformations and increased staff morale and buy-in. DSRIP projects there are carried out by interdisciplinary teams composed of a physician, nurse

manager, frontline staff, analysts, and quality coordinators. This teamwork has aided transformation and offered a new mechanism for ownership of patient care processes at the unit level. BMC noted that teamwork has improved significantly among its primary care providers. “We started working ... and it was the first meaningful time that the primary care practices—or at least the majority of them—got together in the same room,” Williams said. As a result, BMC realized the various strengths each physician possessed and the value of pooling those strengths for the sake of larger

TABLE 1 SECTION 1115 WAIVER DETAILS IN CALIFORNIA, MASSACHUSETTS, AND TEXAS

TRANSFORMATION OVERVIEW

Each state’s specific transformation categories and projects are unique, yet they all focus on integrating care delivery, expanding primary care capacity, improving health care quality, and improving population health.

	CALIFORNIA DSRIP (21 hospitals)	MASSACHUSETTS DSTI (7 hospitals)	TEXAS DSRIP (300 hospitals)
Demonstration Term	November 1, 2010– October 31, 2015	December 20, 2011– June 30, 2014	December 12, 2011– September 30, 2016
Transformation Categories	<ol style="list-style-type: none"> 1. Infrastructure Development 2. Innovation and Redesign 3. Population-Focused Improvement 4. Urgent Improvement of Care 5. HIV Transition–Improvements in Infrastructure and Program Design 	<ol style="list-style-type: none"> 1. Development of a Fully Integrated Delivery System 2. Improved Health Outcomes and Quality 3. Ability to Respond to Statewide Transformation to Value-Based Purchasing and to Accept Alternatives to Fee-for-Service Payments 4. Population-Focused Improvements 	<ol style="list-style-type: none"> 1. Infrastructure Development 2. Program Innovation and Redesign 3. Quality Improvements 4. Population-Focused Improvement
Example Projects	<ol style="list-style-type: none"> 1. Expand Chronic Care Management Models (Category 2) 2. Severe Sepsis Detection and Management (Category 4) 3. Empanel Patients into Medical Homes with HIV Expertise (Category 5) 	<ol style="list-style-type: none"> 1. PCMH Development and Implementation (Category 1) 2. Rapid Diabetes Referral and Follow-Up (Category 2) 3. ACO Development (Category 3) 	<ol style="list-style-type: none"> 1. Behavioral Health Integration (Category 1) 2. Congestive Heart Failure Quality Improvement (Category 3) 3. Creating the North Tyler Clinic (Category 4)

organizational goals. UT Health has focused strongly on integrating teams and clinical practices, shying away from isolated groups. In fact, the organization has created a physical headquarters, the Center for Rural Community Health, for all projects.

However, collaboration does have its challenges. Of the three states, Massachusetts is the only one to directly address payment transformation in its DSTI (see Table 1). BMC noted some issues around working with community health centers (CHCs) to establish ACOs. Specifically, some of the CHCs' financial systems and analysis differ from BMC's, making it difficult to model the ACOs' predicted financial flow. In addition, many of the CHCs in BMC's community operate independently and have their own boards, which lengthens the approval process for various actions.

METRICS AREN'T EASY, BUT ARE NECESSARY

Collecting data has been a major challenge for hospitals for several reasons. First, the DSRIP/DSTI programs have heavy reporting requirements. Providers also face the usual challenges of collecting accurate and complete data from vulnerable patients who are often transient or simply weary of providing personal information. In some instances, however, the new reporting activities brought on by these programs have encouraged hospitals to better integrate their data systems. As Carolyn Brown, RN, MS, director of quality and safety at Santa Clara, noted, "Our organization is rich in data. However, the data lived in silos. To see transformation, we had to bridge those gaps to gain true insight into our operations."

BMC discussed the importance of information technology (IT) leadership encouraging project teams to be very specific in the early stages of the project about their analytics needs. Williams said, "There was a new level of rigor that was brought by both new IT leadership and the structure of the project. [It] really improved the overall care of our patients and taught clinical leaders about the precision needed to build and use IT analytics."

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For UT Health, DSRIP success hinges on satisfying metrics in an all-or-nothing fashion. According to the Texas waiver agreement, milestone-specific funding is withheld for metrics that are not fully met. As Levin stated, "Partial achievement is essentially failure." Some expressed the difficulties of collecting and verifying these metrics in real time, even though they drive the system's transformation. Yet, overall, UT Health describes this accountability with metrics as a key factor for the success of its transformation thus far.

Metrics can also be used to help hospitals determine whether they are achieving cost savings through their projects, though, again, it is often difficult to do. For example, reducing

readmissions is one straightforward way of achieving cost savings. But with overlapping initiatives in any given hospital focusing on reducing readmissions, it is hard to attribute the reductions to any particular initiative.

CHANGING THE CULTURE OF PEOPLE AND PROCESSES

The major cultural changes that generally accompany transformation have proven challenging for all three sites, especially in the beginning stages. For example, hospitals have encountered staff resistance and shortages. Williams stated, "There was not only push back from the personal level of, 'I don't know how to do that,' but also from the union of, 'That's not in the job description.' So it required negotiation with the union, which ended up being a good partnership and a good learning lesson for us." BMC also noted the challenges of engaging a large number of primary care practices in transformation projects and changing the behavior of clinicians. As a rural health system, UT Health hospital leaders had a difficult time recruiting providers at all levels and disciplines for their transformation projects as well as recruiting individuals to train as community health workers.

Leveraging infrastructure, utilizing preexisting quality improvement projects, and reaching out to partners can facilitate project uptake and buy-in.

Culture change also involves revising long-time processes and systems. One critical element of many DSRIP/DSTI programs is the redesign or creation of new care delivery models—such as PCMHs and ACOs. Such models are designed to change the way patients flow through the health care system—driving patients to receive care in the most appropriate setting, increasing the use of preventive and primary care, avoiding unnecessary hospitalization, and improving transitions from the hospital to other settings. While hospitals recognize the added benefit of these models for patients, creating these new delivery models is a challenge, especially when the payment system has not evolved to support the hospitals’ investments to improve care.

Under a fee-for-service system that pays based on volume of services delivered, even when the hospital is successful with PCMH/ACO projects, it may ultimately lose revenue because fewer services are provided within the hospital. Creating new care delivery models, therefore, often requires physicians and staff to work toward reducing hospital utilization and, in a fee-for-service system, driving down hospital revenues—a significant cultural shift for organizations traditionally paid more to do more. Williams stated, “[Our payment system] is at odds with what the PCMH and ACO are designed to do as far as taking care of patients and then optimally reducing hospitalization costs and total medical expenses.” This has led the state of Massachusetts and its participating DSTI providers to pursue as part of the improvement program the additional challenge of developing alternative payment systems.

One way to minimize the disruption that accompanies hospital transformation is to leverage existing

infrastructure (i.e., from previous quality improvement activities) to create new systems and processes. As Brown mentioned, “DSRIP can sometimes feel like its own island, so we approach it as a systemic quality improvement effort.” Hospitals expect this integrative approach to implementing waiver projects will improve their likelihood of long-term sustainability.

TRANSFORMATION IS TRANSCENDING WAIVER PROJECTS

DSRIP/DSTI projects have had positive spillover effects in other areas of the hospitals. UT Health leaders are thinking ahead about fully integrating project resources into health care operations and leveraging preexisting systems. Santa Clara intends to develop a transition strategy that positions DSRIP infrastructure as the hub for future quality improvement initiatives. The organization believes DSRIP can serve as a model for improvement work going forward.

“The success in DSRIP areas has informed our approach in non-DSRIP-funded areas, so the hospital is getting more than it paid for.”

—Carolyn Brown, RN, MS, director of quality and safety at Santa Clara

Hospitals have also observed positive spillover effects on their staff and patients. BMC notes the unforeseen benefit of its waiver work on an improved culture of collaboration throughout all of its primary care sites. Similarly, Santa Clara noticed that its team approach has motivated staff to look for opportunities for improvement—not necessarily

related to the DSRIP—and to take ownership of these opportunities by proposing solutions. Brown said, “The success in DSRIP areas has informed our approach in non-DSRIP-funded areas, so the hospital is getting more than it paid for.” UT Health has seen spillover effects in prevention efforts. The organization believes the transformation has driven care upstream along the prevention continuum and has had positive effects on patient well-being and preventive medicine.

The hospitals attribute these positive spillover effects to their executive leaders, who have successfully promoted culture change, encouraged innovation, supported their staff, and recognized successes along the way. When, in the course of participating in DSRIP/DSTI projects, leaders instill a new level of discipline and rigor across the organization, they lay the groundwork for ongoing improvement efforts. However, it is the committed team that makes all the difference.

IMPLICATIONS FOR OTHER ESSENTIAL HOSPITALS

One of the most important considerations for essential hospitals as they approach Section 1115 Medicaid waiver work is anticipating the iterative process of transformation projects. Several leaders highlighted the need to start projects immediately rather than seeking to perfect processes from the start. This may be uncomfortable territory for many clinicians who prefer to get it right the first time around. But instilling the plan–do–study–act cycle creates an ongoing feedback loop that allows work processes to improve on a continuous basis—and ultimately ensures precious time is not wasted.

Aligning waiver projects with the organization's needs is critical to implementing and sustaining transformation.

Given that health care reform will be unfolding rapidly over the next several years, it can be challenging to anticipate a hospital's needs four to five years down the road. A great deal of uncertainty exists around the impacts of payment reform, Medicaid expansion/non-expansion, and other major changes. Essential hospitals should prepare for a highly dynamic environment with regard to transformation projects and plan to integrate flexible strategies.

Aligning waiver projects with the organization's needs is critical to implementing and sustaining transformation, especially in essential hospitals that often face unique circumstances regarding patient populations and resource availability. With large transformation projects, these concerns could be barriers to success, but taking these realities into consideration early on in the implementation process can help mitigate these challenges. Leveraging infrastructure, utilizing preexisting quality improvement projects, and reaching out to partners can facilitate project uptake and buy-in. All three hospital sites noted these lessons learned and expect these ideas to greatly support the sustainability of their projects.

Section 1115 Medicaid waivers and, specifically, incentivized delivery system transformation programs provide ample tools for essential hospitals to initiate change within their organization. Taking a closer look at three hospitals from established 1115 waiver states provides greater insight into their experiences as essential hospitals. Each has identified a number of facilitators and barriers to the success and sustainability of transformation efforts, as well as the true value of the waiver funding. As these waivers continue to gain traction across the country, these shared experiences and lessons learned can be vital resources for essential hospitals nationwide.