MEDICAID INCENTIVE PROGRAMS: EXTENDING THE REACH OF HEALTH CARE TRANSFORMATION

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KEY FINDINGS

- Medicaid demonstration programs give essential providers the ability to lead delivery system reform by providing incentives to them to achieve system reform milestones.
- Waiver programs encourage investments that track and improve population health and enable providers to identify issues beyond the hospital that impact their patients' health.
- Waiver programs require data and other infrastructure improvements—a challenging up-front investment for essential hospitals.
- Quality improvement milestones that are built on existing measures help hospitals understand their own performance, resulting in better patient care.
- To ensure states and providers are able to promote achievable reform, funding for incentive programs must be in addition to existing core hospital funding.

America's health care system is embarking on an extraordinary period of change. In search of better value for dollars spent, insurers, employers, governments, providers, and consumers are individually and collectively engaged in the challenge of reforming a massive and complex system. And some parts of the system are more difficult to reform than others. Providers who serve predominantly low-income, medically vulnerable patients can struggle to find the resources to change the way they deliver care. Yet these providers are essential to the viability of the health care system as a whole—their patients are the sickest and most expensive to treat, and the unreimbursed cost of their care is often borne by others.

In the face of this reality, several states have taken steps in recent years to promote and support these essential providers' transformation through Section 1115 Medicaid waiver demonstration programs that incentivize and reward delivery system reform. Such programs are unprecedented in their nature and scope. They use Medicaid dollars in a budget-neutral fashion to invest in long-term system transformation, the full impact of which will not be felt for many years to come. It is precisely this long-term investment that makes these programs so promising.

Members of America's Essential Hospitals have partnered with their states and the Centers for Medicare & Medicaid Services (CMS) to lead development and participation in these programs. As a result, many are now intensively engaged in improving care with a level of focus and resource commitment that has never before been possible.

WHAT ARE WAIVER-BASED INCENTIVE PROGRAMS?

Through Section 1115 Medicaid waivers, states are increasingly implementing programs to incentivize systematic changes in care delivery, particularly among essential hospitals, which are the predominant providers of care to the Medicaid and uninsured population. These programs are unique because they offer payments to providers for achieving predetermined milestones in delivery system reform, rather than using Medicaid funds to reimburse providers for services. Providers are not paid if they do not successfully achieve the milestones. As a result, these programs focus attention and resources on transformation at a record level. For resource-strapped essential providers, the risk involved in these programs—and the consequences of not meeting the targets—are substantial.

California[1] was the first state to implement one of these incentive programs, named the Delivery System Reform Incentive Program (DSRIP). The California DSRIP was approved in concept by CMS in late 2010, and by late 2011, each of the 17 participating hospitals had an approved DSRIP plan. Thus, DSRIP work has been under way in earnest for two years in California.

Other states—Massachusetts, Texas, Kansas, New Jersey, New Mexico, and New York—have since received approval for similar incentive programs. Additional states have proposals under development or pending approval by CMS. The structure and goals of the programs are evolving with lessons learned from early efforts, and states are increasingly promoting statewide policy goals through these programs.

ESSENTIAL HOSPITALS NEED SUPPORT FOR DELIVERY SYSTEM REFORM

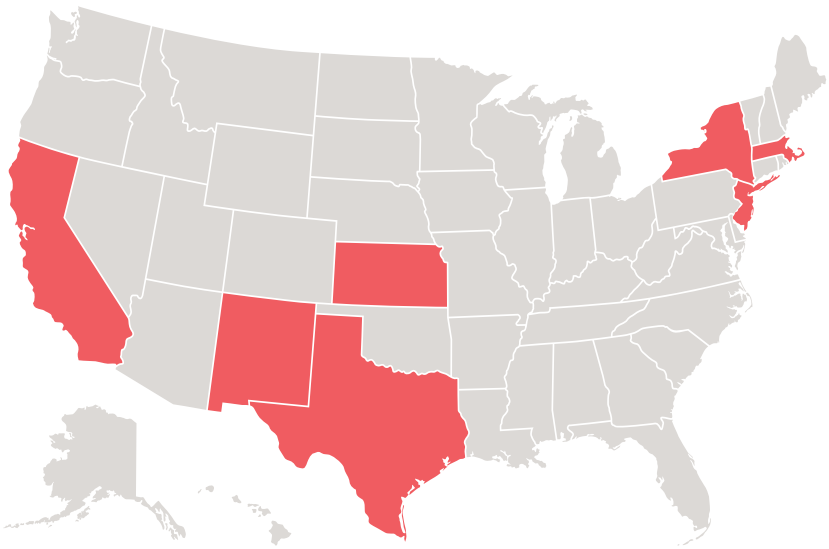
Many of these waiver-based incentive programs are targeted at essential hospitals that provide much-needed access to care for Medicaid and uninsured patients. These hospitals also provide high-level specialty, tertiary, and often quaternary services; meet public health needs; train the next generation of health care professionals; and serve as medical homes for the chronically ill. They fill a critical need in their communities but are often under-resourced because of the high volumes of care they provide that is either uncompensated or covered by government-sponsored health insurance.

At the same time, essential hospitals, like other providers, are dealing with significant regulatory and reimbursement changes mandated by the Affordable Care Act. And they are working hard to meet the ever-increasing quality standards set by both public and private payers. As a result, many of these hospitals are struggling to cover the cost of the care they currently provide and do not have available revenue to invest in long-term reform. Moreover, many cannot participate in Medicare demonstration projects or commercial alternative payment mechanisms intended to promote reform because they do not have enough Medicare and commercially insured patients to warrant the required up-front investments.

Properly structured, Medicaid incentive programs have the potential to drive change for essential hospitals, which serve the nation's poorest and most vulnerable patients.

Essential hospitals' unique role in their communities may create unique barriers to engaging in meaningful delivery system reform without additional support. Properly structured, Medicaid incentive programs have the potential to drive change for essential hospitals, which serve the nation's poorest and most vulnerable patients.

APPROVED MEDICAID INCENTIVE WAIVERS



Approved DSRIPs as of June 2014

INCENTIVE PROGRAMS HELP ACHIEVE STATE AND FEDERAL REFORM GOALS

If successful, Medicaid incentive programs can drive infrastructure development and operational changes, engage hospital staff at all levels, and instill a culture of data-driven accountability within hospitals, all of which provide the foundation necessary for measurable transformations in patient care. While these programs are still in their infancy, early reports show promise in their ability to effectively incentivize and support providers working to create this foundation. This kind of systemic change in the way providers approach care delivery is central to state and federal health care reform efforts.

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At the heart of waiver-based incentive programs are concrete, hospital-specific projects—including periodic milestones—designed and developed in conjunction with the state and CMS. States release payments per milestone if and when the milestone is achieved. As New Jersey has put it, incentive payments are "earned, not guaranteed."[2]

Recently, states have been increasingly focusing these projects on statewide goals. As a result, project incentives drive hospitals to focus on the metrics the state and CMS believe are most critical, which is crucial in a health care environment that has so many competing priorities.

For example, Massachusetts[3] tailored its Delivery System Transformation Initiatives (DSTI) Program to support the ambitious payment reform goals adopted by the state legislature as part of its health reform efforts. Among other projects, all participating DSTI hospitals must undertake at least one initiative to enhance their ability to respond to a statewide shift to value-based purchasing and to accept alternatives to fee-for-service payments. Incentivized by this component of the DSTI, hospitals are developing the necessary infrastructures and capabilities to undertake increasing levels of risk, including obtaining National Committee for Quality Assurance (NCQA) certification for their patient-centered medical homes, developing accountable care organizations (ACOs) and other models that integrate hospitals and other providers, learning to stratify risk among identified patient subpopulations, working with community-based partners to reduce readmissions, and developing information systems to aggregate patient data across independent physician groups to facilitate care coordination.

Kansas designed its DSRIP to support the goals of Healthy Kansans 2020, based on the federal Healthy People initiative. The program focuses on three of the state's overall goals: healthy living, healthy communities, and access to services. DSRIP projects address specific barriers to achieving these goals. For example, because cardiovascular disease is the leading cause of death in Kansas, some projects seek to improve adherence to evidence-based guidelines for treatment of coronary heart disease and heart failure.

Similarly, New Jersey developed its program to create statewide incentives to support the Healthy New Jersey 2020 vision. Because Healthy New Jersey 2020 aims to reduce chronic illness, the state's DSRIP requires hospitals to select from a menu of projects to improve chronic care services.

"Our safety net hospitals have done a brilliant job of controlling healthcare costs without sacrificing quality and this investment will keep them innovating through delivery reforms and new payment models."

—Former Massachusetts senator and current U.S. Secretary of State John Kerry[4]

Texas[5] developed its incentive program to advance regional health care goals. Providers participate through geographically based regional health care partnerships (RHPs), each of which is required to perform a community needs assessment that identifies key health challenges specific to the RHP's area. Each individual project is then tied to those specific identified community needs. Projects must focus on improving areas of poor performance and disparity in the region.

INCENTIVE PAYMENT PROGRAMS DRIVE FOUNDATIONAL INVESTMENTS IN INFRASTRUCTURE AND REDESIGN

Almost all of the programs tie early milestones to infrastructure and redesign investments that are foundational to transformation. This design recognizes these tools are necessary for success in later stages of the DSRIP, when milestones begin emphasizing quality reporting and performance improvement.

California providers have already significantly improved their infrastructures. Progress reports reveal the following:

- expanded primary and specialty care capacity through additional staff, space, and service hours
- implementation and use of a disease management registry, which is a critical building block for population management
- enhanced performance improvement and reporting capacity through lean/Six Sigma staff training, quality dashboard development and regular leadership review, and quality improvement data systems and collection and reporting capabilities

These building blocks will be key to realizing more extensive outcomes-based improvements in later years, particularly as the DSRIP begins to focus more heavily on population health and urgent improvements in care.

California providers have also invested in innovation and redesign through the following:

- expanding medical homes, hiring dedicated staff to empanel patients and manage those panels, and defining care delivery team roles
- redesigning primary care delivery, including redesigning clinic space to expand access and enhance efficiency and developing a system for protocol-driven automatic patient reminders
- expanding a care transitions program by adding more case management staff to the emergency department and modifying an electronic health record (EHR) system to identify high-risk patients

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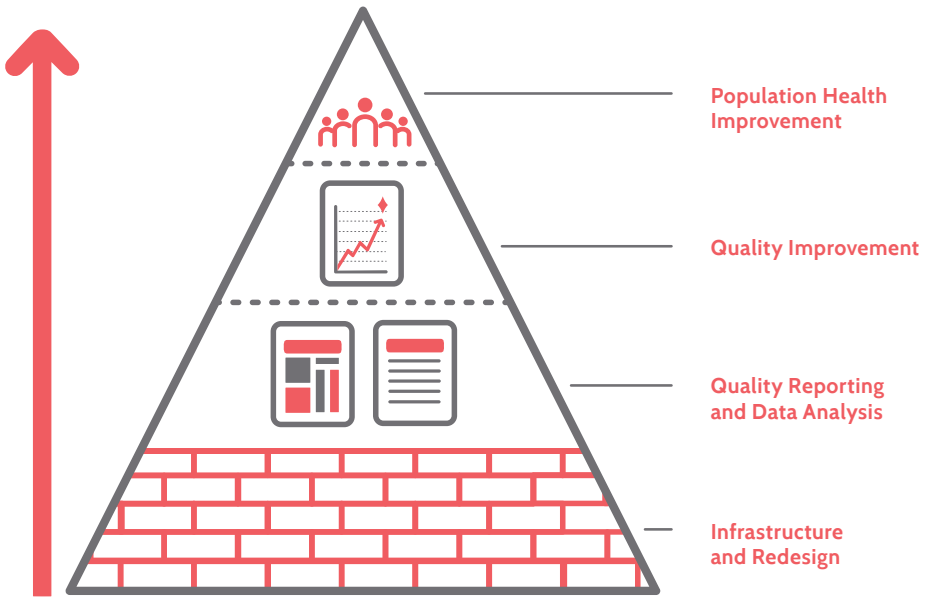
Such investments continue in the newer DSRIP models. New Jersey is supporting investment in infrastructure and redesign geared toward enabling progress on particular chronic disease focus areas. For example, a hospital that selects asthma as its focus area and pediatric asthma case management as its project would begin with the following types of foundational steps:

- developing a risk stratification tool to assess the varying complexity of the project's patient population

DSRIP MODEL FOR TRANSFORMING HEALTH CARE



- procuring existing and new staff for a medical and support team dedicated to the project
- procuring physical space, supplies, and technological resources
- addressing data needs and staff training

In the second stage, the hospital would focus on the following:

- redesigning and managing systems and processes (e.g., determining discharge planning interventions, case management/care coordination needs, a medical home model, and a plan for home visits)
- conducting a pilot test
- modifying and implementing the full project
- tracking and reporting on progress

With these investments in infrastructure and redesign, the hospital should have the capacity to shift its focus in the third and fourth stages to reporting and pay-for-performance on asthma-specific quality measures and population-focused metrics.[6]

The ability to collect, report, and analyze data is foundational to any evidence-based improvement.

Across the states with existing models, these hallmark early investments in infrastructure and redesign are substantial and significant, especially in those states where hospitals are undertaking multiple projects in different areas of their delivery system.

The kind of focused attention necessary to undertake these activities successfully often is not possible without the resources and incentives made available through these incentive payment programs.

INCENTIVE PROGRAMS GROW DATA CAPABILITIES THAT ENABLE QUALITY REPORTING AND PERFORMANCE IMPROVEMENT

The ability to collect, report, and analyze data is foundational to any evidence-based improvement. In some instances, however, gaps exist even in the infrastructure necessary to collect performance data. Incentive programs reward providers for creating, broadening, and accelerating efforts to implement and tailor EHRs and other information systems. They also reward efforts to identify and understand the landscape of available data sources, hire and train staff to collect and manage data, and conduct ongoing analysis.

In Massachusetts, hospitals are designing, implementing, and evaluating projects using increasingly sophisticated data analytics. They are incorporating data analysis into their daily operations in the following ways:

- creating and implementing dashboards to measure DSTI progress
- analyzing claims data to identify high-risk populations that need intensive care management

California Data Registries Create the Basis for Intervention and Measurement

- Initial DSRIP infrastructure projects in many hospitals in California involved investing in a data registry. Over the course of a year, participating hospitals entered more than one million patients into disease registry information technology (IT) systems and trained nearly 400 staff to use these registries. Such investments foster a culture of data-driven improvement, which leads to quality-focused improvement such as chronic care management and population health management within medical homes.
- San Mateo Medical Center streamlined the collection of race, ethnicity, and language (REAL) data through the use of its EHR system, providing a comprehensive data set upon which to target specific improvements in care.

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- closely monitoring and analyzing readmissions data to appropriately target, evaluate, and expand discharge and postdischarge interventions
- collecting and using baseline data to measure the effectiveness of various interventions and determine when adjustments are warranted
- acquiring and implementing population health analytic tools

Incentive programs can make a marked and substantial contribution to improving care for the nation's most vulnerable patients by spreading the use of such analytics.

Existing DSRIP programs have already led to considerable progress in the creation of disease registries to produce foundational knowledge about patient populations, identify and track community health needs, and target improvements.

In California, many program participants have not only developed functional disease registries, but are also using registries to enable real improvements in care delivery. (See sidebar: California Data Registries Create the Basis for Intervention and Measurement.[7])

The up-front investments required to implement and use these data systems are costly and can present a significant barrier to under-resourced hospitals. But the ability to use reliable, relevant data to design, implement, measure, and refine care improvement activities is critical. Incentive programs can make a marked and substantial contribution to improving care for the nation's most vulnerable patients by spreading the use of such analytics.

INCENTIVE PROGRAMS DRIVE QUALITY IMPROVEMENT

Accountability for quality reporting and improving patient outcomes is a significant component of all of the incentive programs. Milestone achievement is generally based on measures already in use and developed by recognized entities such as the NCQA, the National Quality Forum, and the federal Health Resources and Services Administration.

A key feature of these waiver programs is the assessment of each provider's progress measured against the provider's own historical performance. This strategy pushes all participants to stretch without discouraging participation among the providers (and patients) who might benefit the most.

The various efforts to provide patient-centered care and collect and monitor data on patients' experience of that care are helping hospitals focus on quality and satisfaction at an unprecedented level.

In New Jersey, for example, hospitals will only receive payment for quality performance if they make measurable improvement. The state will measure such improvement against each hospital's own baseline performance—requiring hospitals to achieve 10 percent improvement to be eligible for improvement payments. New Jersey hospitals cannot just select performance measures they are guaranteed to meet. Rather, hospitals must show "[t]he project selection is grounded in a demonstrated need for improvement at the time the project is submitted."[8]

California Data Registries Create the Basis for Intervention and Measurement, continued

- San Joaquin General Hospital used the registry for outreach efforts to people with diabetes. Clinic staff identified all diabetic patients in need of a foot exam and contacted those patients to schedule services. More than 300 foot exams were completed within seven days.
- University of California, Los Angeles (UCLA) developed a decision-support infrastructure through registries to measure cost, access, and quality and demonstrate improvement. UCLA now has patient registries in place, and its acute care facilities use these data for all payers on a daily basis, reducing the gap in generating timely and effective data. ■

While results are limited at this point, as the waivers ramp up, participating providers are already expanding access, integrating care, and improving their patients' experience.

In California, participating hospitals have assigned more than 300,000 patients to a medical home and/or primary care provider. These results were driven by milestones aimed at building, improving, and spreading medical homes; developing patient panels using registries; and restructuring clinic care models to identify and treat high-risk patients.[9] The various efforts to provide patient-centered care and collect and monitor data on patients' experience of that care are helping hospitals focus on quality and satisfaction at an unprecedented level.

INCENTIVE PROGRAMS ENCOURAGE INVESTMENTS THAT TRACK AND IMPROVE POPULATION HEALTH

Across all programs so far, the final stage of quality-based achievement incentivizes the collection and reporting of population health-related metrics. For example, New Jersey's incentive program will require hospitals to report a range of information, including use of mental health services, patient performance on diabetes and high blood pressure control measures, cancer screening, admissions rates for certain chronic diseases, tobacco cessation interventions, and engagement in alcohol and other drug treatment.

Hospitals in most of the states have not yet reached this stage of the program. However, the early stage infrastructure investments will enable providers to broaden their focus and consider the issues impacting their patients' health and potential interventions beyond the hospital. Improvements related to data systems and collection/analysis capabilities in particular offer invaluable new information to providers looking to better understand their patients and communities.

Moreover, these early stage activities should actually improve community health and ultimately the population health outcomes on which the hospitals will report. The potential for this result can be seen in the work participating hospitals are already doing to manage population health. Disease registry development and use to target patients, such as the efforts in California, is one such example.

Also in California, the Santa Clara Valley Health & Hospital System (SCVHHS) and its partner organization the Santa Clara Mental Health Department are creating the delivery infrastructure to better care for their shared patients. They created a new entity, the Division of Integrated Behavioral Health, within the mental health department and a new staff position solely to work with SCVHHS ambulatory care service providers to improve the integration of behavioral health in primary care clinics.[10]

In Massachusetts, one of the participating hospitals hired bilingual community health workers to operate as patient navigators, working with patients entering the hospital through the emergency department to help them obtain regular primary and preventive care. The hospital has "successfully connected hundreds" of such patients and "succeeded in bridging gaps regarding follow-up care, rescheduled appointments, and changes in insurance."[11]

California Hospitals Share Lessons for Transforming Care in the Safety Net

"For many public health care systems, the daunting journey of evolving primary care clinics into medical homes has been made less arduous and more expedient by sharing experiences and best practices with one another. For example, throughout 2012 and 2013, Bay Area public health care system ambulatory leaders have met regularly in conversations facilitated by CAPH's improvement affiliate, the California Health Care Safety Net Institute (SNI). This group has shared their experiences—and spread best practices—about care team optimization, standing orders, physician wellness and primary care capacity post EHR implementation, among other highly relevant medical home issues. They have also discussed how to streamline their processes in order to increase primary care capacity. For example, clinic leaders in the San Francisco Department of Public Health plan to pilot a successful telephone consultation clinic developed at Contra Costa Regional Medical Center as a novel model of improving access.

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INCENTIVE PROGRAMS DRIVE ONGOING IMPROVEMENT THROUGH ORGANIZATIONAL AND CULTURAL CHANGE

While incentive programs are designed to achieve specific reforms, their impact extends far beyond the immediate milestones laid out in each hospital's plan. Hospitals are finding the organizational and cultural changes necessary to successfully earn incentive payments have the potential to benefit the health care system for years to come.

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For example, many participants report their organization is building a culture of collaboration. Improving efficiency and quality of care requires true coordination within hospital systems and with other providers in the community. As one California hospital put it, the DSRIP has made the concept of collaboration across the system more automatic, breaking down the "inertia of silos." (See sidebar: California Hospitals Share Lessons for Transforming Care in the Safety Net.[12])

In Massachusetts, hospitals are working extensively to align physicians to provide more integrated care, particularly within those hospitals with dispersed community physicians. Such alignment is a critical step to reform but would not have occurred without the DSTI. Hospitals are collaborating with affiliated physician groups to form ACOs and integrated care organizations, develop health information exchanges with physician offices, support physician recruitment efforts, and provide support for physician EHR systems. This collaboration should facilitate cooperation and integration in the best interest of patients, well beyond the intended scope of the waiver program.

Hospitals participating in incentive programs are sowing the foundational seeds for improvement well beyond the completion of individual improvement projects.

Hospitals participating in these programs are also collaborating with each other. Many programs require participants to join a learning collaborative—whether with fellow program participants or separately with other hospitals (based on a particular project focus). In Texas, the RHPs' structure fosters collaboration and shared learning among participants as they work together to meet regional community needs. The state of Texas is encouraging more statewide collaboration by urging providers to form a "community of communities" to share their learning.[13]

In Massachusetts, the DSTI hospitals have formed a learning collaborative through which they are sharing best practices, learning from national experts, and developing a culture of improvement that can be a model for other essential providers across the country. Hospitals in the collaborative have built relationships with each other that will continue beyond the end of the formal network.

Beyond collaboration, participating hospitals also have implemented organizational and managerial changes. For example, Alameda Health System (AHS) in California established a System Transformation Center (STC) within the organization that is responsible for oversight and accountability. The STC serves as a central clearinghouse for all significant reform-related

California Hospitals Share Lessons for Transforming Care in the Safety Net, continued

SNI facilitated DSRIP learning sessions and other convening opportunities have identified common practices, key drivers of success, and have spurred peer to peer problem solving. For instance, eight public health care systems are implementing Lean, a set of management principles and practices that drive greater efficiencies and reduced waste. Through close collaboration, half of these systems are planning primary care and medical home improvement Lean 'events' in the upcoming DSRIP demonstration year, which will undoubtedly accelerate transformation to more sophisticated medical homes."

—California Association of Public Hospitals and Health Systems and California Health Care Safety Net Institute ■

projects, enabling the hospital to prioritize among multiple DSRIP initiatives, ensure alignment with systemwide goals, and track and hold accountable those charged with implementation. With this structure in place, AHS can continue to engage in meaningful and successful improvement activities well beyond the confines of the DSRIP and can extend successful DSRIP-related approaches to non-DSRIP work throughout the health system.

Parkland Health & Hospital System in Dallas is making similar organizational changes through one of its improvement projects, the Quality Through Transformation Initiative (QTTI). Through the QTTI, Parkland is creating an infrastructure to provide governance and integrated oversight for all of its DSRIP projects. In addition, the QTTI will provide leadership and consultative support for the delivery system reform work undertaken by providers regionwide.

Hospitals participating in incentive programs are sowing the foundational seeds for improvement well beyond the completion of individual improvement projects. Their use of data, their accountability structures, their team-based approach to project implementation, their willingness to learn from mistakes, and their collaboration across silos are just some of the ways these hospitals are driving continuous improvement through organizational and cultural change.

INCENTIVE PROGRAMS ARE A PROMISING DRIVER OF CHANGE BUT NO SUBSTITUTE FOR ADEQUATE PAYMENT

The incentive program concept—offering additional Medicaid funding to hospitals that achieve meaningful, sequential steps toward delivery system reform—holds great promise for producing the kind of transformation that will reverberate across the health care system. But these programs present peril as well. Some of them simply redirect existing core hospital funding to an incentive-based structure, effectively risking reimbursement that is needed to cover the cost of providing services. This approach defeats the purpose of enabling and incentivizing true transformation. When current funding is simply redirected to an incentive pool, states and providers have more difficulty adopting milestones that require providers to stretch because both parties recognize putting core funding at too much risk jeopardizes patient care.

Incentive programs must be designed with sufficient flexibility so the incentives align with local hospital and community needs as well as the state's needs.

Without new funding, essential providers find themselves where they started—lacking the resources necessary to invest in meaningful transformation. The foundation of a successful incentive program is a base of adequate Medicaid payments that cover the cost of care. Then the incentive funding can be invested in needed reform efforts instead of paying for services. Essential hospitals are facing unprecedented threats to the core sources of Medicaid funding that for years have supported the many roles they fill. Massive impending cuts to disproportionate share hospital funding are on the horizon.

Waiver Programs: Driving Positive Change

In general, accountability associated with incentive programs fosters organizational capacity and discipline that can translate into success in many other endeavors.

"The knowledge that there is a state and national focus on our performance, the partnership with other public hospitals, and the concreteness of the milestones [have] been a driver for change…"

—Alameda County Medical Center DSRIP Annual Report, DY7[14]

"UCLA's participation in [the] DSRIP has resulted in a fundamental and revolutionary change in our approach to quality management. The discipline that was established by our participation in [the] DSRIP… has enabled us to substantially reorganize our quality efforts."

—UCLA DSRIP Annual Report, DY7[15] ■

Other targeted Medicaid support payments are being lost as states expand managed care programs. And evolving CMS policies disfavor certain types of funding streams. Incentive programs should not be used to fill those gaps.

Nor should incentive programs be expected to result in overnight transformation. Section 1115 Medicaid demonstrations generally last for three to five years before they must be renewed. True transformation, especially among essential hospitals with their unique challenges, takes much longer. Delivery system reform is a process. While incentive programs can lay the groundwork for a successful journey, there will always be additional work ahead.

Ensuring adequate base funding will help hospitals avoid diverting focus and resources from other urgent priorities as they work on incentive program projects.

As with many value-based payment systems, incentive programs run the risk of overemphasizing the importance of the chosen projects because funding is tied to them. This tendency could deter competing—and possibly more urgent—hospital priorities.

Incentive programs must be designed with sufficient flexibility so the incentives align with local hospital and community needs as well as the state's needs.

Ensuring adequate base funding will help hospitals avoid diverting focus and resources from other urgent priorities as they work on incentive program projects.

Ultimately, Medicaid waiver-based incentive programs could prove to be a critical tool for achieving a high-performing, high-value health system available to all Americans. However, to accomplish this goal, CMS must resist the temptation to fund incentive programs from existing funding streams, and states and providers must structure programs to promote achievable reform. ■

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