Putting New York DSRIP in Context: What We Can Learn from Other States?

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The Commonwealth Fund
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Why We Need Payment and Delivery System Reform

- Patients experience poor access to care
- Patients experience poor coordination of care
- Patients and providers report inefficient, wasteful health care system
- Providers report widespread dissatisfaction

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Health Care Spending as a Percentage of GDP, 1980–2012

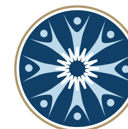
Percent

18
16
14
12
10
8
6
4
2
0

1980 1983 1986 1989 1992 1995 1998 2001 2004 2007 2010

US (16.9%)
NETH (12.1%)*
FR (11.6%)
SWIZ (11.4%)
GER (11.3%)
DEN (11.0%)
CAN (10.9%)
JPN (10.3%)
NZ (10.0%)*
SWE (9.6%)
NOR (9.3%)
UK (9.3%)
AUS (9.1%)*

* 2011.
GDP refers to gross domestic product.
Source: OECD Health Data 2014.



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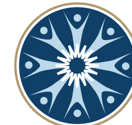
Consensus on Ways to Improve Outcomes, Lower Costs

Wide array of bipartisan and expert groups recommend the following:

- **Provider payment reform**. Discarding current fee-for-service payment models in favor of arrangements such as capitation or partial capitation, global budgeting, or risk-sharing arrangements such as shared savings.
- **Reforming the delivery system**. Strengthening three areas, in particular: the usability of HIT, care coordination for the sickest and most expensive patients, and strengthening primary care.
- **Engaging consumers in making better health care choices**. With better information and incentives, patients should be rewarded for choosing providers that have better outcomes and lower costs of care.
- **Making health care data more available**. Patients should have better information about the prices providers charge as well as the quality and safety of their care.
- **Reducing administrative expenses**: While standardization of billing and claims forms and processes has begun under the ACA, much more needs to be done.

D. Cutler, D. Blumenthal, K. Stremikis. New England Journal of Medicine, 2014.



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DSRIP Defined

- **Goal** = transformation of the Medicaid payment and delivery system to achieve measureable improvements in quality of care and overall population health
- DSRIP initiatives are part of broader 1115 Waiver programs that allow states to reward providers for implementing successful delivery system and payment reform projects
- Initially, states used DSRIP funding to support public hospitals and other safety net providers (e.g., CA, TX)
- Recently, states have been more strategic – articulating a vision, creating projects in support of the vision, establishing benchmarks

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Delivery System Reform Incentive Pool (DSRIP)

- No clear rules or official CMS guidance on how states may structure DSRIP waivers
- States have flexibility to design their programs to address the unique challenges facing their delivery system and Medicaid population
- Bar has been raised from state to state as DSRIP waivers evolve

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Evolution of DSRIP Waivers

California:
Bridge to
Reform Waiver
(2010-2015)

Texas:
Transformation &
Quality Improvement
Waiver
(2012-2016)

Kansas:
KanCare Waiver
(2014-2017)
New York:
Medicaid Reform
Transformation Waiver
(2014-2019)

2010 **2011** **2012** **2014**

Massachusetts:
MassHealth
(2011-2014 w/
extension pending)

New Jersey:
Comprehensive Medicaid Waiver
(2014-2017)
New Mexico:
(2014-2018)

Source: Manatt, Phelps & Phillips

Considerable Variation

State	Years	Funding	Eligible Providers
California	2010-2015	$6.67 billion	Public hospital systems
Kansas	2013-2017	$60 million	Large public children's hospitals, or border city children's hospitals
Massachusetts	2011-2014	$628 million	Hospitals with high Medicaid volume
New Jersey	2014-2017	$583.1 million	All acute care hospitals
New Mexico	2014-2018	$29 million	Sole community providers, state teaching hospitals
New York	2014-2019	$6.92 billion (FFP only)	Safety net providers that have formed a PPS
Texas	2012-2016	$11.4 billion	Providers participating in an RHP (led by a public hospital or other public entity)

Source: National Association of Medicaid Directors, Issue Brief, June 2014

Overview of DSRIP and Medicaid Activity

5 Overlap States Implementing Medicaid Expansion and DSRIP Programs

- States expanding Medicaid, including variants (27 total states + DC)
- States with DSRIP programs (7 total states)
- Expansion states with DSRIP programs (5 states)

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Sources: The Advisory Board Company; New York Academy of Medicine.

Background of DSRIP Waivers

Figure 1

DSRIP waivers generally focus on 4 main areas with an increasing focus on clinical and population improvements over time.

Infrastructure Development (Process)

System Redesign (Process)

Clinical Outcome Improvements (Outcomes)

Population Focused Improvements (Outcomes)

CA includes HIV Transition Projects as a 5th category of DSRIP projects.

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Source: Kaiser Family Foundation, Issue Brief 2014

Emerging Themes from Recent Waivers (NY, NJ)

Themes		State Examples
Clear Vision	▪ States must articulate a clear vision in waiver applications. ▪ Recent DSRIP states have defined, concrete visions and established metrics to monitor progress	▪ **NY:** Overall waiver goal is to reduce avoidable hospital utilization.
Defined Pathways	▪ Some early DSRIP states provided flexibility to eligible providers to choose projects and define performance metrics ▪ More recent DSRIP states have created a menu of defined projects and metrics	▪ **NJ:** Providers select from menu of 17 projects to address 1 of 8 chronic conditions. ▪ **NY:** Providers select from menu of 44 projects across four domains established by the state

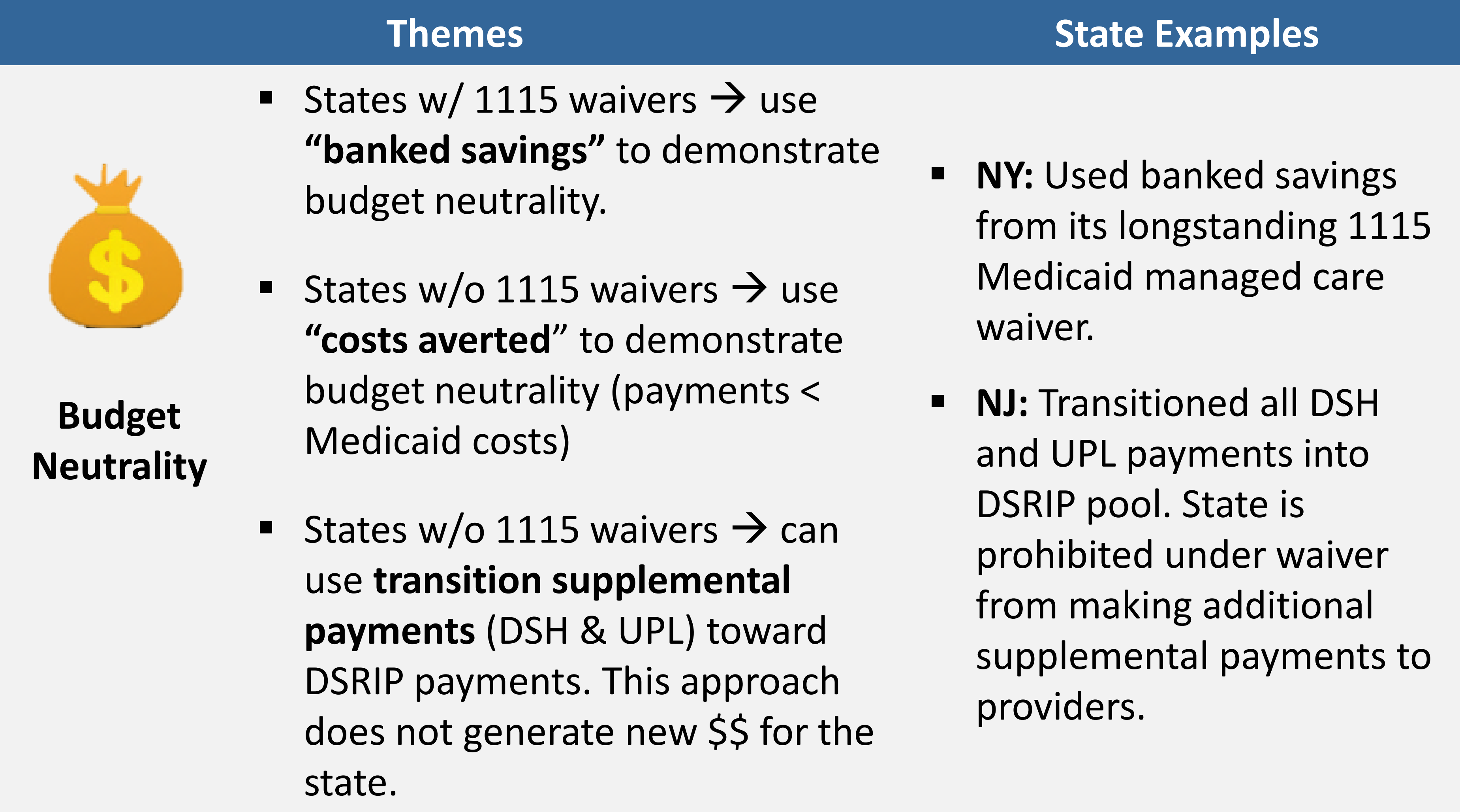
Source: Manatt, Phelps & Phillips

Emerging Themes from Recent Waivers (NY, NJ)

Themes		State Examples
State and Provider Performance Metrics	▪ Statewide performance metrics to measure progress, may be tied to CMS waiver funding ▪ Recent DSRIP states established provider performance metrics that are tied to ongoing support payments	▪ **NY:** State must meet statewide DSR goals and metrics, including reducing inpatient admissions by 25% statewide. ▪ **NJ and NY:** Each project has defined outcome measures for providers (e.g., reduced admissions and ED visits, improved care processes) tied to payments
Transition Payments	▪ DSRIP states generally provide transition payments to support and stabilize transition to new delivery models.	▪ **NJ:** Payments may be used for infrastructure expenses, including investments in "technology, tools, and human resources."

Source: Manatt, Phelps & Phillips

Emerging Themes from Recent Waivers (NY, NJ)



	Themes	State Examples
Budget Neutrality	▪ States w/ 1115 waivers → use **“banked savings”** to demonstrate budget neutrality. ▪ States w/o 1115 waivers → use **“costs averted**” to demonstrate budget neutrality (payments < Medicaid costs) ▪ States w/o 1115 waivers → can use **transition supplemental payments** (DSH & UPL) toward DSRIP payments. This approach does not generate new $$ for the state.	▪ **NY:** Used banked savings from its longstanding 1115 Medicaid managed care waiver. ▪ **NJ:** Transitioned all DSH and UPL payments into DSRIP pool. State is prohibited under waiver from making additional supplemental payments to providers.

Source: Manatt, Phelps & Phillips

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Key Issues

- Lessons Oregon
- Moving Toward Value Based Payment
- Attribution
- Shared Savings

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Learning from Oregon

COORDINATED CARE ORGANIZATION

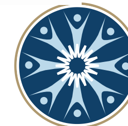
Local accountability for health and resource allocation

Standards for safe and effective care

Integration and coordination of benefits and services

Global budget indexed to sustainable growth

PATIENT CENTERED PRIMARY CARE HOME



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Oregon's Coordinated Care Organizations

- 16 CCOs serve 90% of Medicaid members; Medicaid serves approx. 1 in 4 Oregonians since ACA expansion
- Provide coordinated physical, mental and dental health care benefits to Medicaid members
- Receive funds through a global budget that grows at a fixed rate
- Responsible for health outcomes and paid for performance on 17 quality measures; state reports to CMS on additional measures
- Required to develop agreements with local public health authorities

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Role of Health Plans in Oregon CCOs

- CCOs are new companies, each one is unique
- Only one managed care plan was close to fitting the CCO requirements, as they had to change their governance board
- Most plans needed to partner with behavioral health managed care plans, and then fold in dental.
- CareOregon is a partner in 5 different CCOs and their role varies by CCO
- PacificSource, a domestic commercial carrier & Medicare Advantage plan, is a prominent lead in 2 CCOs
- MODA, also a commercial plan, a public employees plan & Med Advantage is very prominent in 1 CCO that covers 12 rural counties

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What Oregon is Seeing So Far

- Every CCO is living within their global budget.
- The state is meeting its commitment to reduce Medicaid spending trend on a per person basis by 2 percentage points
- Recent survey of low-income Oregonians shows that everyone insured by Medicaid reported better access to care, better quality and fewer ED visits
- Adjusting for insurance, CCO members reported greater improvements in access to medical care than non-CCO/FFS
- CCO members reported slightly better improvements in mental health access than non-CCO/FFS, but not significant
- CCO members more likely to have had a visit with PCP in past 6 months than non-CCO/FFS
- CCO members reported fewer ED visits than non-CCO/FFS Medicaid, but not significant

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J. Smith, 2014; B. Wright, 2014

Moving to Value-Based Payment

Continuum of Payment Bundling

Risk-adjusted global fee with risk mitigation (e.g., reinusrance)

Global amb-ulatory care fees & bundled acute case rates

Global primary care fees & bundled acute case rates

Global primary care fees

Blended FFS and medical home fees

Less Feasible

More Feasible

Quality bonuses for patient outcomes; large % of shared savings, some shared risk

Quality bonuses of care co-ordination and intermediate outcome measures; moderate % of shared savings

Quality bonuses for preventive care; management of chronic conditions; small % of shared savings

Continuum of Quality Bonuses and Shared Savings

Patient-centered medical home networks

Multi-specialty physician group practices

Integrated ambulatory and inpatient systems

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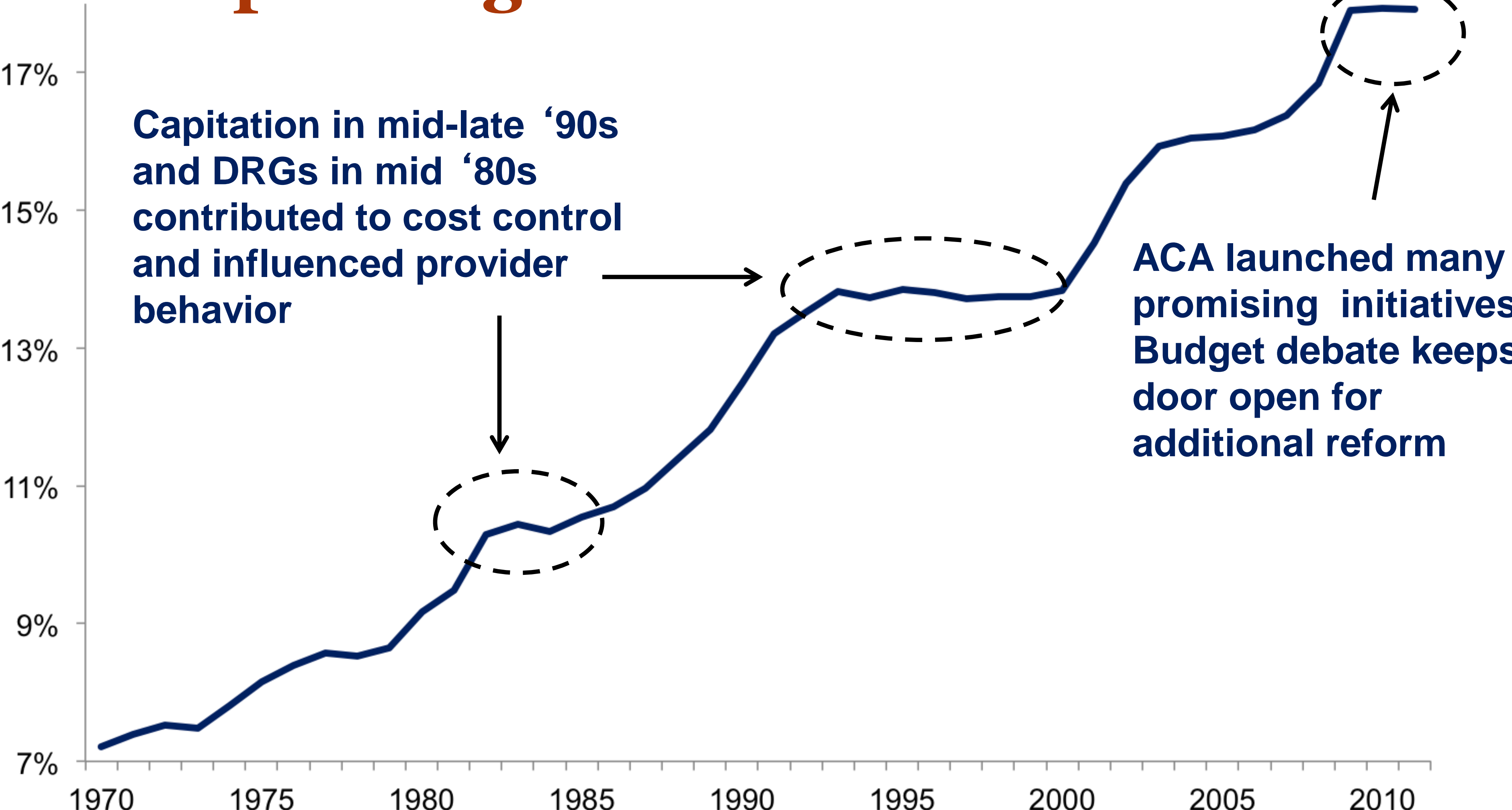
Evidence Payment Reform can Slow Spending



Source: Centers for Medicare & Medicaid Services

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However . . .

- P4P evidence is actually not so clear, particularly when:
  - Smaller proportion of payments involved
  - Payments linked to quality only
- Better evidence for changing productivity and profit gains
- Hard to disentangle impact of financial incentives from delivery reform

Sources: Flodgren G, Eccles MP, Shepperd S, Scott A, Parmelli E, Beyer FR. An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes. Cochrane Database Syst Rev 6(7):CD009255; Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behaviour of primary care physicians: a systematic review. Journal of Health Services Research & Policy, 2001;6(1), 44-55

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What Else Have We Learned From Payment Reform Studies?

Some early, positive results from medical homes, ACOs, hospital readmission reduction

Change takes time

- Best performers often started years prior to launch
  - Requires culture change
  - Bundled payment and ACOs take major investment in legal, technical, and clinical infrastructure

Health care redesign is local

- ACOs, medical homes, bundled payments – can be complimentary and reinforcing

Alignment is essential

- Across payers and payment reform programs

Providers need to remain financially viable

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Shared Savings: Design Principles For Implementation

- Practice transformation difficult. New programs should give greater weight to ensuring incentives result in desired outcomes instead of focusing on risk protection
- Quality-based criteria essential
- Make sure payments are high enough to support transformation
- Target the appropriate unit (larger numbers help pool risk and ensure savings are real)
- Incentive model needs to be transparent
- Payers should pool data
- Risk adjustment important
- Exclude rare, costly events

J. Weissman, M. Bailit, M. Rosenthal. Health Affairs, September 2012.

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Attribution: Key Considerations

- No empirical evidence of best method
- Providers tend to value consistency in number of patients over accuracy of assigned panel
- As initiatives evolve, may want to adjust assignment method
- Medicare ACOs
  - Pioneer ACOs preferred prospective attribution (assign patients based on prior year's use)
  - MSSP regulations propose hybrid approach

V. Lewis et al. Health Affairs, March 2013; R. Yalowich, NASHP, 2014.

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Goals, Themes

- From national perspective, DSRIP encourages stakeholders to work together
- A way to incentive delivery system reform for low-income beneficiaries
- An approach to achieving the Triple Aim
- Evolving process

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Thank you!

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Health Care Spending per Capita by Source of Funding, 2012

Adjusted for Differences in Cost of Living

Dollars ($US)

Country	Public spending	Private spending	Out-of-pocket spending	Total
US	4,160	3,540	1,045	8,745
SWIZ	4,001	497	1,582	6,080
GER	3,691	493	627	4,811
DEN	4,029	85	584	4,698
CAN	3,224	688	690	4,602
FR	3,317	651	320	4,288
SWE	3,336	92	678	4,106
AUS*	2,733	533	731	3,997
UK	2,762	230	297	3,289
NZ*	2,623	202	347	3,172

* 2011.

Source: OECD Health Data 2014.

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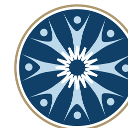
Estimated ACO Covered Lives, by Hospital Referral Region

% ACO lives
- >15%
- 10-15%
- 5-10%
- 3-5%
- 1-3%
- .5-1%
- .1-.5%
- 0-.1%

Total of 606 accountable care entities in the U.S.

- **366 Medicare ACOs (23 “Pioneer ACOs”, 343 MSSP)**
- **240 Non-Medicare ACOs**

Note: Data as of January 2014.
Source: D. Muhlestein, “Accountable Care Growth in 2014: A Look Ahead,” *Health Affairs* Blog, January 29, 2014.



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More Good News:
Medicare accountable care organizations (ACOs)

- **Over 360 Medicare ACOs serving up to 5.3 million people**
- **Costs for beneficiaries aligned to "Pioneer ACOs" increased 0.3 percent in 2012 vs. 0.8 percent for other beneficiaries.**
- **Over $380 million in savings have been generated by Medicare ACOs and Pioneer ACOs.**
- **9 out of 23 Pioneer ACOs produced gross savings of $147 million in their first year (though 9 ACOs also dropped out).**

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Source: Centers for Medicare & Medicaid Services.

Substantial Variation among CCOs

Corporate Form	Total Partners	Board Engagement	Community Engagement
Private IPA/MCO	1	Basic	High
Private/LLC	3	High	Moderate
Nonprofit/LLC	2	High	High
Nonprofit/LLC	2	High	Moderate
Nonprofit/LLC	9	Moderate	High
Nonprofit/LLC	2	High	Basic
Nonprofit/LLC	4	Moderate	Basic
Nonprofit/LLC	18	Moderate	Basic
Nonprofit/LLC	13	Moderate	Basic
Nonprofit/MCO	1	Basic	Basic
Nonprofit/MCO	10	Moderate	Moderate
Nonprofit/PBC	11	High	Moderate
Nonprofit/PBC	13	High	Basic