

Snapshot of Medicaid 1115 Waiver and Other State-Based Delivery System Transformations

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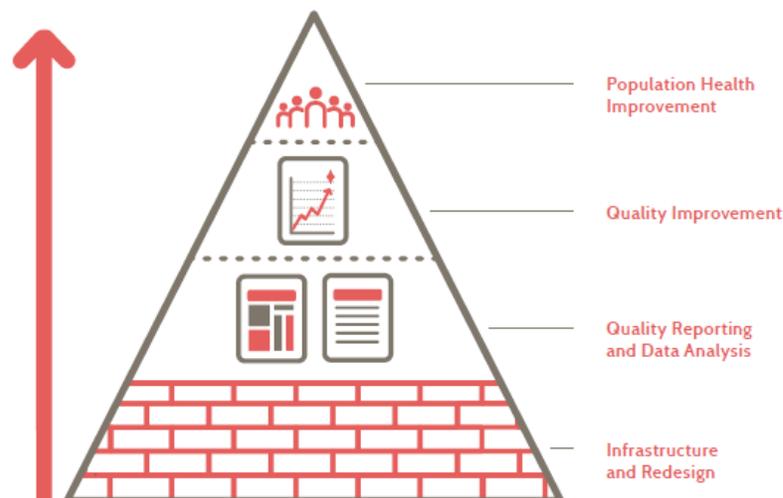
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Introduction

The concept for the Delivery System Reform Incentive Payment (DSRIP) program was developed in California as part of the state's 1115 "Bridge to Reform" Medicaid waiver approved in 2010, and DSRIP programs have since started in other states to transform health care delivery and funding methods for safety-net systems. DSRIP and other similar programs with varying names pay incentive payments to hospitals and other safety-net providers for reaching pre-established milestones that improve quality and cost of care. Milestones are organized into phases that generally include infrastructure development, program innovations and data analysis, quality improvements, and population-focused improvements, with infrastructure being the foundation that must happen first (see Figure 1).

The purpose of this review is to provide a snapshot of programs incentivizing delivery system transformation as part of Medicaid 1115 waivers to inform California as well as other states as they work to renew their waivers and related systems transformation programs. To this end, this review documents the varying approaches, outcomes, and lessons learned from existing DSRIP and related programs to serve as a reference point for states to both compare and contrast their efforts, as well as to draw on emerging innovations. This report complements and adds dimension to materials emerging in the context of California's DSRIP renewal discussions¹ by providing experiences, lessons, and early outcomes from similar programs across the country.

Figure 1. DSRIP Model for Transforming Health Care



Source: America's Essential Hospitals, "Medicaid Incentive Programs: Extending the Reach of Health Care Transformation (June 2014, p. 4), online at http://essentialhospitals.org/wp-content/uploads/2014/06/AEH_Waiver_Paper_PolicyBrief_PrintReady1.pdf.

Setting the Context

The California DSRIP program, set to expire at the end of October 2015, involves 21 public hospital systems with 17 DSRIP plans, since several are partnering together. The hospital systems chose transformation projects from five categories concerning infrastructure development, innovation and redesign, population-focused improvements, urgent improvement in care, and later HIV transition projects. In the third year of the waiver (called demonstration year or DY 8, since the original waiver started in 2005), hospital systems achieved 98.1% of their goals, or 1,291 milestones.²

States with DSRIP and Similar Programs

After the first DSRIP program was approved for California, several other states added similar programs as part of their 1115 waivers, though there are differences among them due to state needs and the evolving concerns of the Centers for Medicare and Medicaid Services (CMS). States with DSRIP programs in their waivers include:

- California (started in 2010);
- Texas (started in 2011);
- New York (started in spring 2014; first year is dedicated to planning, with projects starting in second year);
- New Jersey (started fall 2013 after delay, plans approved in spring 2014);
- Kansas (delayed until 2015); and
- Rhode Island (terms approved in January 2014 but have not started program as yet).

States with waiver programs similar to DSRIP include:

- Massachusetts (Delivery System Transformation Initiatives, or DSTI, started in 2011 and renewed in 2014);
- Florida (Low Income Pool, or LIP, started in 2005, renewed in 2011, covers uncompensated care and includes milestones for innovative projects);
- Arizona (Health System Improvement Pool, or HSIP, started in 2012); and
- New Mexico (Hospital Quality Improvement Incentive Pool, or HQII, started in 2014, projects start in 2015).

Several other states plan to implement DSRIP programs in the next few years including Alabama, Illinois, and New Hampshire.³

Funding for state DSRIP-related programs varies greatly, with \$29 million approved for New Mexico and \$628 million for Massachusetts, to the three most populous states obtaining funding in the billions: a little under \$7 billion each in California and New York, and \$11.4 billion in Texas over the five years of the program.⁴ States may or may not have a Safety Net Care Pool (SNCP) in addition to incentive payments as a financing mechanism to draw down matching funds for uncompensated care.

CMS Waiver Approval Trends

CMS has not issued guidance on DSRIP programs, so insight must be gleaned from other states' experiences. Other states' waivers and what CMS wants to see in incentive payment programs have evolved since California last submitted a waiver renewal. As such, future waivers will likely need to take into account these changes while still incentivizing projects that work towards the Triple Aim. CMS trends in waiver approvals include the following:

- Newer approved waivers such as in Texas and New York include non-hospital partners collaborating with safety-net hospitals, including clinics, public health departments, nursing homes, and behavioral health providers, forming regional partnerships that work to address community needs.
- After California hospitals created their own DSRIP projects and Texas providers could choose from a list of hundreds of projects, CMS is asking for smaller lists of projects to choose from and for predetermined metrics for each project (this helps projects compare themselves to peers).
- CMS has required that states direct providers to set goals that are a “stretch” and not too easily achievable, especially as in some cases, California was able to more readily achieve its goals.
- CMS has worked to help states value projects more formally than initially done in California and to award DSRIP funding in a fair and equitable way depending on population size and other factors.
- Recently approved waivers have statewide goals that tie into some of the DSRIP funding, such as New York’s goal of lowering preventable hospitalizations by 25 percent in the state.⁵

Methods

Our review focused on two sets of states: first, those that have Medicaid 1115 waivers with explicit DSRIP programs; and secondly, other states that have built into their waivers a focus on safety-net systems transformation or other provider incentive programs. Our review of these programs focused on identifying goals, related initiatives, and

outcomes to date as identified through a review of existing peer-reviewed articles, publications, and informational interviews and follow-up with policy experts. To ground our review and inform California’s waiver renewal process explicitly, we also reviewed various materials emerging from the state.

We note that as distilling and analyzing programs from all states with Medicaid waivers was beyond the scope of this study, our review strategically focused on six states: the three in addition to California that are farthest along with DSRIP-type programs (Massachusetts, Texas, and New York), and three states that have experience with other related payment and delivery system reforms (Oregon, Vermont, and Colorado). We also reviewed a subset of federal and multi-state models to further inform California’s waiver renewal process.

Findings

In this section, we present findings from our review of waiver and other state programs focused on systems transformation from Massachusetts, Texas, New York, Oregon, Vermont, and Colorado, as well as several federal and multi-state initiatives and models. For each selected state, we present the overall scope and goals of the program and share initial outcomes and lessons learned. For the federal and multi-state models, we describe the initiatives and provide citations with links to tools and other resources that offer additional information and guidance on these topics.

Massachusetts

MassHealth, Massachusetts’ 1115 waiver, includes a Delivery System Transformation Initiatives (DSTI) component that is similar to DSRIP. The waiver was first funded in 1994

and has been renewed five times, with the last renewal approved on October 30, 2014.^{6,7} The 2011 waiver extension allowed Massachusetts to restructure the Safety Net Care Pool (SNCP) to support improvements including DSTIs to provide incentive payments for progress related to the Triple Aim. Seven hospitals are participating and receive payments for projects under four categories:

- Development of a fully integrated delivery system;
- Improved health outcomes and quality;
- Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments; and
- Population-focused improvements.

The state submitted a master DSTI plan to CMS when DSTI was first approved, and participating hospitals each have their own plans describing the new initiatives they developed, which must include all four categories (the categories remain the same in the 2014 renewal). Hospitals must also participate in a learning collaborative to share best practices and get timely information from outside experts.⁸

The 2014 waiver renewal maintains the goals of universal coverage and person-centered health care, and “focuses on gaining federal authority and support to pave the way for the next phase of health care reform in Massachusetts, with a focus on sustainability of the health care system, payment reform and cost containment.”⁹ It sought and gained the authority to implement shared savings/shared risk payment arrangements that will support Primary Care Payment Reform and future plans such as contracting with Accountable Care Organizations. The waiver also sought to modify the Safety Net Care Pool to eliminate the provider sub-cap that is

tied to the state’s Disproportionate Share Hospital allocation, but this was not approved.^{10,11} The 1115 waiver was approved for four years and 8 months (through June 30, 2019), with the DSTI portion funded for the first three years. The state will work with CMS to redesign the Safety Net Care Pool for the fourth and fifth years to develop payment methods to support low-income care and transformation efforts.¹²

Outcomes and lessons learned in

Massachusetts: An interim evaluation of the DSTI portion of the MassHealth waiver states that as outcomes are intended to be long-term, it is somewhat premature to evaluate outcomes from the first year (2011-2012) which was focused on foundational work. However, the evaluation does report on progress in implementing programs across the seven participating hospitals, finding that implementation is on track with 95% of project metrics being achieved in year 1 across the hospitals.¹³ Some lessons learned are that a five-year waiver instead of a three-year term is important for continuity; that the incentive funds are not new additional funding but are partial replacements of previous funds, which means that hospitals need to align their activities with the strategic plan of the institution so they do not do inconsistent work; and that the Medicaid waiver funding is central to supporting safety-net hospitals in systems transformation.

Texas

Texas is one of the few states in addition to California with some experience with a DSRIP program, since most of the other approved programs are just starting. The Texas Healthcare Transformation and Quality Improvement Program was approved in 2011 and is funded through September 2016. This

1115 waiver provides for expanding Medicaid managed care, setting up an uncompensated care pool to pay hospitals for uncompensated care, and establishing a DSRIP pool to provide incentive payments to hospitals and other providers that increase quality and cost-effectiveness.

Hospitals must participate in a regional healthcare partnership (RHP) along with other safety-net providers such as clinics and public health departments in order to be eligible for payments from the pools. RHPs must develop a regional plan and have one main entity for contact and coordination.

“Regional Healthcare Partnerships should promote system transformation (improved access, quality, cost-effectiveness, and coordination). Delivery systems should be developed based on geographic proximity and an ability to efficiently deliver care to regional residents. Specialized providers ... can and should be included based on delivery system functional needs, even if outside the area’s geographical boundaries.”

– *Texas DSRIP Regional Healthcare Partnership Principles*¹⁴

The four categories of DSRIP projects, much like California, are:

- Infrastructure development;
- Program innovation and redesign;
- Quality improvements; and
- Population-focused improvements.¹⁵

All current projects fall within the first two categories, as infrastructure and redesign need to come first, and projects for the last two years of the waiver are being finalized and approved. DSRIP participants in Texas participate in regional learning collaboratives as well as a statewide collaborative. Texas’ DSRIP (as well as California’s) focuses on

delivery system reform more than payment reform, while Massachusetts’ waiver has more payment reform models.¹⁶

As of October 2014, there were 300 providers and over 1,400 DSRIP projects within the 20 RHPs.¹⁷ The most common types of projects are focused on expanding “access to primary and specialty care, behavioral health interventions to prevent unnecessary use of services in certain settings (e.g. emergency department, jail), and programs to help targeted patients navigate the healthcare system.”¹⁸

Outcomes and lessons learned in Texas:

Projects report milestones twice a year, and most metrics have been met so far, with about \$2.1 billion in incentive payments distributed in years 1 and 2 as of January 2014. Examples of successful outcomes in different regions include integrated primary care and substance abuse services at several behavioral healthcare clinics, and integrated mental health services in outpatient obstetrics offices to provide increased access to treatment for postpartum depression. Future broad goals of the program are to “reflect a unified quality strategy for Texas Medicaid managed care and DSRIP, and establish shared incentives within regions to make improvements in healthcare delivery and population health indicators.”¹⁹ The Texas Health and Human Services Commission contracted with Texas A&M University’s Center for Rural and Public Health to evaluate outcomes from the DSRIP projects, and may contract with others as well. This evaluation is currently ongoing, and the state’s interim report to CMS is due in December 2015. The waiver expires September 30, 2016, and a renewal must be submitted by September 30, 2015.

New York

New York's Medicaid Redesign Team Waiver amendment includes a DSRIP program that was finalized in 2014, with projects starting in 2015 (the original 1115 waiver has been in place since 1997, with several renewals). The Medicaid Redesign Team (MRT) was a group created by the governor in 2011 to bring together stakeholders to improve New York's Medicaid program and reduce costs, and the 1115 waiver amendment enables the state to reinvest some of the savings produced by the reforms. The DSRIP program focuses on community health improvement projects led by provider collaborations called Performing Provider Systems (PPS), as well as an overarching goal of reducing avoidable hospital admissions by 25% over the period of the waiver.²⁰

PPSs are comprised of public hospitals (or other qualifying hospitals) in partnership with safety-net providers in the same community. PPSs develop at least two clinical improvement priorities (behavioral health, HIV/AIDS, diabetes care, and other options) plus one population-based project.²¹ The groups receive incentive payments for reaching milestones, which they distribute internally according to an approved plan, and are encouraged to use value-based payments instead of fee-for-service reimbursements within their organizations. To determine the types of DSRIP projects to undertake, each PPS is required to perform a community needs assessment and evaluation of available data to ascertain existing resources and health-related priorities in their areas.²²

New York had experience before DSRIP with cost containment and payment and delivery reforms in the Medicaid program, including the Medicaid Statewide Patient-Centered

Medical Home Incentive Program,²³ and the aforementioned MRT.²⁴ The MRT effort involved extensive stakeholder meetings in the state, which led to an agreement to establish a global spending cap in Medicaid that is tied to the long-term medical Consumer Price Index. Medicaid spending is closely monitored and if it appears that it may exceed the global cap, actions such as a possible reduction in reimbursement rates could take place to control spending levels, creating an incentive for providers to innovate and keep spending in check.²⁵ Besides the spending cap, the MRT action plan also includes other reform measures such as Care Management for All, which works to change payment methods to capitated or bundled, and Health Homes, which works to move patients to coordinated care, especially high-need patients.²⁶ It also includes supportive housing for high-need patients, which became a reality starting in 2013 with affordable housing provided for 5,000 Medicaid beneficiaries.²⁷

Outcomes and lessons learned in New York:

Results are not in at this time for New York's DSRIP program since it started in 2014, but the state plans for a variety of monitoring activities in addition to what is required by CMS. It will have learning collaboratives, quarterly reports on PPSs, semi-annual reports on project achievements, operational reports on DSRIP performance, and reports for consumers on provider activities.²⁸ DSRIP chartbooks and dashboards will be available online for participants and other stakeholders to use to monitor performance.²⁹ The Medicaid Analytics Performance Portal (MAPP) is available online for PPSs to monitor networks and performance.³⁰ An independent evaluator will prepare interim and final statewide evaluations of the DSRIP program.³¹

Regarding MRT activities, the global spending cap has reduced costs, with Medicaid spending decreasing \$4 billion in the first year (fiscal year 2011-12). In the first year spending was \$14 million under the cap and in year 2 it was \$200 million under, while the number of beneficiaries increased during this period. The spending reductions were produced by such actions as shifting non-emergency patients from emergency rooms to ambulatory settings, transferring from fee-for-service to Medicaid managed care, and pilot programs that help to control health care utilization and spending. Stakeholders have been an important part of designing the Medicaid cost containment measures, leading to buy-in and limited opposition, and the successes of the programs so far are attributed to stakeholder collaboration and a shared view among public and private sector health care systems and settings that these activities are necessary to the survival of Medicaid in the state.³²

Oregon

Oregon's Medicaid program received approval for an 1115 waiver amendment in 2012, after several years of development and stakeholder input, to implement the Coordinated Care Model (CCM), which is intended to reduce costs and improve care coordination. The state contracts with 16 local, risk-bearing entities called Coordinated Care Organizations (CCOs) to provide a comprehensive set of services (medical, behavioral, dental, and vision, but not long-term care), and uses global payments that include a capitated amount, payment for optional services, and incentive payments for meeting goals. CCOs develop innovative transformation plans for their communities such as integrating physical and mental health care, implementing medical homes,

and working with community health workers to help patients with chronic conditions and to reduce emergency department use. The state created a Transformation Center to provide technical assistance to CCOs and manage learning collaboratives to share best practices.³³

The amount paid to CCOs grows each year, but at a smaller rate than expected in the Medicaid program, thus creating a mechanism to control costs (and leaving CCOs at risk for extra expenditures). The state must demonstrate a 2% decrease in the Medicaid per capita growth rate and show \$330 million in savings over the five years of the waiver, or risk significant penalties of several hundred million dollars. Performance is tracked using 33 metrics that measure access to care, quality of care, and patient satisfaction, 17 of which count toward the provider earning incentive payments.³⁴

Outcomes and lessons learned in Oregon: In the first full year of operation (2013), the CCM met the 2% reduction commitment and avoided a penalty, while also reducing ED use and reducing hospitalization for certain chronic conditions. Other achievements included increasing developmental screening for young children and increasing primary care visits and enrollment in patient-centered primary care homes. Identified areas for improvement included drug and alcohol screening and adequate access to care. Funds were distributed from the first annual quality pool (\$47 million, which is 2% of the 2013 CCO payments) and the challenge pool (funds remaining unused from the quality pool, which were \$2.4 million) according to progress on the 17 incentive metrics, and the CCOs earned anywhere from 84% to 107% of their share as would be allotted by number of members.³⁵

Strong leadership (including Governor John Kitzhaber who is a physician) as well as many meetings with stakeholders helped forge a shared vision in the state and helped with the process of passing legislation on the CCM and then implementing it through the Medicaid waiver. With the global budget, all providers are accountable and at risk, which incentivizes collaboration and finding efficiencies. If the program ultimately proves successful, Oregon may expand it to the state public employee’s purchasing pool and small businesses.³⁶

Vermont

Vermont has a history of progressive healthcare legislation, including the Blueprint for Health,³⁷ the initiative on integrated care passed in 2006, and the Vermont Health Reform Law of 2011 (Act 48), that calls for a single-payer system in the state and creates a board to oversee changes to the state’s healthcare system. The Blueprint for Health combines Advanced Primary Care Practices (providing medical homes) with community health teams (providing care coordination), and a majority of Medicaid recipients now participate in these medical homes.³⁸ Act 48 also created the state marketplace under the Affordable Care Act (ACA) as an interim step until an ACA State Innovation waiver can be sought (effective in 2017 at the earliest) to implement a public-private single-payer system to provide coverage for all Vermont residents.³⁹ Vermont’s 2005 “Global Commitment to Health” 1115 Medicaid waiver was extended in 2013 for three additional years to establish capitated payments paid by the state per member per month for Medicaid beneficiaries, and give the state flexibility to change benefit packages for non-mandatory populations.⁴⁰

Planning for financing of the single-payer system has been delayed due to implementation work for the marketplace, but other related health reforms are proceeding, such as planning under Vermont’s State Innovation Model grant from CMS that allows the state’s Medicaid and commercial payers to test three Medicare models—bundled payments, shared savings ACOs, and pay for performance. Three ACO pilots are currently underway, including one with federally qualified health centers, one with independent physicians, and a statewide initiative with 13 hospitals and 2,000 physicians.⁴¹

“Ultimately, the success of any health system is more likely if the underpinnings include the best possible foundation of primary care, close integration of medical and social support services, and community providers operating in more cohesive networks.” – *State of Vermont*⁴²

Outcomes and lessons learned in Vermont:

The Green Mountain Care Board, which oversees health reforms in the state, will determine outcome measures for reform efforts—providers would like to see fewer measures, while some advocates wish to have more measures for different populations. The state plans to “collect and report data on a variety of access, population health, cost, and financing measures. Potential measures include the percent of residents in a medical home, rates of obesity and smoking, the adequacy of provider supply, rate of growth in Vermont health care expenditures, and passage of legislation authorizing financing for and receiving a federal waiver for a single payer plan.”⁴³ The state has experienced strong leadership of the administration and legislature that has helped reform efforts to

be accepted and implemented, as well as substantial involvement of stakeholders and consumers. Comprehensive reform is also less complicated in Vermont than some other states due to its relatively smaller size.⁴⁴

A recent report to the legislature highlights the successes of Vermont's Blueprint for Health. It notes in particular the formation of multidisciplinary health teams and medical homes as well as reduced costs. However, challenges have also surfaced. First, providers are increasingly feeling that incentive payments are too low to support the program's standards (especially after current grants end). Secondly, there is concern that the emergence of a Medicare coordinated care program that will provide higher reimbursements may encourage practices to switch to this program even though it will only cover Medicare patients.⁴⁵ The report offers several options for the state to sustain the Blueprint for Health model, including:

1. Adjusting the proportion of the costs that each insurer contributes to the community health teams to make it more in line with their proportion of beneficiaries served by medical homes;
2. Increasing the per person per month payments to the multidisciplinary community health teams that are a hallmark of the state's medical home model, in order to increase their effectiveness and capacity for coordinated care;
3. Increasing the per person per month payments to the primary care practices that serve as medical homes to assist them in meeting NCQA medical home standards;
4. Increasing the per person per month payments to both the medical homes

and the community health teams at the same time (Blueprint for Health has two separate capitated payments, one for the administration of the community health teams and one for the practices that serve as medical homes, and both components are seen as essential for the model to succeed); and

5. Exploring the option to establish Medicaid Health Homes, which include an enhanced federal matching rate of 90/10, but funding is only available for two years.⁴⁶

Colorado

The Medicaid Accountable Care Collaborative (ACC) legislation was passed in 2009 and implemented in 2012 to coordinate care and to reform payments to reward providers for outcomes rather than volume. Related state legislation was passed in 2012 to implement payment reform pilots such as global payments.

In the ACC program, the state was divided into seven regions, and the Medicaid program contracts with a regional care collaborative organization (RCCO) in each region. The RCCOs contract with networks of primary care medical providers (PCMP) including group practices, FQHCs, rural health centers, and others, to provide primary care, to implement medical homes, and to coordinate with specialists to meet beneficiaries' needs. Medicaid pays a total of \$20 per member per month, with \$13 originally allocated to each RCCO, \$4 to each PCMP, and \$3 to the data analytics vendor; this was later modified to have \$1 withheld from the monthly portions to the RCCOs and PCMPs to fund an incentive pool to reward decreased hospital readmissions and emergency department usage, and high-cost imaging.⁴⁷

Colorado Medicaid is also working on several other relevant initiatives as follows:

- The state received a federal State Innovation Model design grant that will assist with integrating behavioral health and primary care in the ACC program and with private payers.
- Participation in the federal Comprehensive Primary Care Initiative where payers give care coordination payments to primary care provider networks, and any savings can be shared between the participants.
- Two health information exchanges in the state allow practice transformation teams to work with providers.
- Development of an all-payer claims database (APCD) to show utilization and spending trends, starting with Medicaid and commercial insurance and eventually including all claims; this effort will help in evaluating payment reforms.⁴⁸

Outcomes and lessons learned in Colorado:

In fiscal year 2013, the ACC program noted an average of 15-20% reduction in 30-day hospital readmissions from expected rates (goal was 5% reduction), while ER visits varied between higher and lower than the benchmark (goal was also 5% reduction). Reductions in use of high-cost imaging were 20-25%. The program saw a \$44 million gross reduction and \$6 million net reduction in total cost of care (through cost avoidance) for the 729,000 Medicaid beneficiaries in the ACC program.⁴⁹ The program has widespread support because the state engaged stakeholders early. The RCCOs have flexibility to customize reforms to meet regional needs. However, provider contracting and health information technology infrastructure were more complicated and took longer than expected. Constituents also acknowledge the

need to develop a strong focus on data collection to evaluate the initiatives and establish accountability.⁵⁰

Federal and Multi-State Models

In addition to DSRIP, there are numerous other payment and delivery reform innovations and pilot programs taking place around the nation, including multi-state initiatives and federally supported programs. These are testing and advancing evidence-based methods for implementing reforms that could be included in Medicaid waivers and other policies, and will be useful to monitor in the future once more results and best practices are available. Several relevant initiatives are described below.

Comprehensive Primary Care Initiative (CPC):

Colorado is participating in this federal program as mentioned above, as well as seven other states. It consists of 481 primary care sites, over 2,000 providers, and about 2.5 million patients, some of which are covered by Medicaid and Medicare. The program is testing a comprehensive primary care delivery model as well as a payment model involving a monthly capitated fee and shared savings in years 2-4.⁵¹

Medicaid Innovation Accelerator Program (IAP):

This new CMS program announced in 2014 assists states in improving the health of Medicaid recipients and reducing costs by providing technical assistance for states' service delivery and payment reforms. The program will work with states and providers to offer resources and lessons learned from reform efforts to accelerate innovations in the Medicaid program.⁵² Its initial main functions are to 1) identify and advance new models, 2) leverage new data sources and analytics, 3) improve quality measurement,

and 4) improve dissemination of best practices and evaluations.⁵³

State Innovation Model grants (SIM): This CMS program has awarded almost \$300 million to 25 states (including California) to test or design state-based payment and delivery models to improve their health care systems. CMS announced in 2014 that up to \$730 million will be available in round two for existing SIM states and new states to participate.⁵⁴ Details on various innovation models, participants, and results can be found on the CMS website.⁵⁵ SIM will coordinate with IAP mentioned above to disseminate information.

Primary Care Extension Program (PCEP): The PCEP was authorized by the ACA and the Agency for Healthcare Research and Quality (AHRQ) was directed to create this program. Since no funding was allocated, AHRQ used existing appropriations to start a pilot program in four states called IMPaCT, or Infrastructure for Maintaining Primary Care Transformation, in 2011.⁵⁶ Each participating state disseminates information to three additional states. The PCEP borrows the model of the U.S. Department of Agriculture's successful Cooperative Extension program to send community-based Health Extension Agents to help primary care providers establish patient-centered medical homes.⁵⁷ AHRQ created the Health Extension Toolkit for Primary Care Transformation to share experiences with the extension model.⁵⁸ The Safety Net Medical Home Initiative also has tools online for creating patient-centered medical homes.⁵⁹

Multi-Payer Advanced Primary Care Practice (MAPCP): Eight states are participating in this CMS program to test reform initiatives to expand advanced primary care practices.⁶⁰

Participating practices receive extra payments for transforming to medical homes and providing additional services not covered under traditional Medicare. Medicaid and private insurers participate as well as Medicare. CMS chose sites for MAPCP that did not overlap with sites in the CPC program mentioned above.⁶¹ The demonstration projects will end in 2015 and 2016. The Patient-Centered Primary Care Collaborative has a webpage where interested practitioners and policymakers can search for this program and other primary care innovations by state.⁶²

Multi-Payer Medical Home Learning Collaborative: The National Academy for State Health Policy (NASHP) and The Commonwealth Fund have supported a series of learning collaboratives for states seeking to implement medical homes in Medicaid and CHIP, including the current initiative with four states.⁶³ NASHP developed the Multi-Payer Resource Center to gather resources and share lessons learned in these collaboratives to support states in five main priorities of focus in developing multi-payer medical homes: 1) stakeholder engagement and pilot convening, 2) developing infrastructure and community linkages, 3) payments, 4) attribution and enrollment, and 5) evaluation.⁶⁴

Patient-Centered Outcomes Research Institute (PCORI): Established by the ACA, PCORI is a nonprofit organization with the mandate "to improve the quality and relevance of evidence available to help patients, caregivers, clinicians, employers, insurers, and policy makers make informed health decisions."⁶⁵ This focus on evidence-based outcomes and the emerging results of funded studies could help guide states and providers in determining what DSRIP projects would be most useful to undertake. Target

populations for PCORI research are racially and ethnically diverse populations, low-income and rural populations, older adults, and children.⁶⁶

Discussion

Continually rising costs in Medicaid are unsustainable for states, leading many to explore alternative options and to obtain Medicaid waivers to test new delivery system and payment reforms such as in DSRIP programs. The approaches, experiences, and lessons from emerging delivery and payment reforms may be helpful in informing states such as California as they work to renew their Medicaid waivers.

Our review suggests that programs that have shown success across most states share a common set of elements, including a focus on patient-centered medical homes, primary care and behavioral health integration, collecting and sharing data, moving ambulatory care out of the emergency departments and into clinical and community-based settings, and efforts that support transitioning away from the fee-for-service model toward capitated or value-based approaches such as bundled or global payments. State experiences also reflect that in order to be successful, cost-cutting or performance incentives need to be more meaningful and substantive than they have been—especially in improving population health outcomes. Additionally, efforts to coordinate care need to be structured in ways that do not incentivize providers to stop accepting Medicaid patients.

Our review also reinforces that simply initiating reform does not necessarily yield success in terms of achieving the Triple Aim. Instead, given the wide proliferation of

payment and delivery demonstrations occurring across the country—largely spurred by investments in the ACA—there are many opportunities for states to draw on and build upon emerging evidenced-based strategies and lessons. For example, a 2011 study from Massachusetts showed that doctors paid under global payments did not cost less and in some cases cost more than doctors paid fee-for-service, though some stakeholders said it would take more than one year of data to show cost savings.⁶⁷ The ambitious coordinated care program in Oregon has been called risky, as some of the models have not been proven to reduce costs, especially in smaller provider networks, and there are millions of dollars in penalties on the line.⁶⁸ Colorado's 2013 annual ACC report showed that while emergency room visits decreased in some months, they increased in other months. Given these early experiences, reforms need to be carefully designed and build on emerging experiences and evidence as much as possible, with monitoring over a period of time that is sufficient to determine program efficacy.

Despite such early experiences in some states, promising delivery system and payment reforms are emerging in a number of state programs. For example, in Colorado, Oklahoma, and Vermont, Medicaid medical homes were shown to reduce costs and increase access using methods such as implementing quality standards (such as NCQA) and modifying payment strategies.⁶⁹ A 2012 study showed that global payments in the Massachusetts Blue Cross Blue Shield Alternative Quality Contract saved 1.9% in year 1 and 3.3% in year 2 compared to non-participating physician groups, with savings achieved through means such as moving tests and procedures to lower-priced providers; quality of care improved through these

initiatives as well.⁷⁰ States, especially California as it works to renew its DSRIP program, along with safety-net systems generally may benefit from lessons learned through these models and others mentioned in the federal and multi-state resources above to help refine future demonstration projects in these areas.

In addition to our review and snapshot of state-based payment and delivery reforms, major national organizations have also reflected on promising elements and strategies for advancing systems transformation. For example, The Commonwealth Fund’s report on delivery and payment reform initiatives in Vermont, Colorado, and Minnesota, and the National Academy for State Health Policy’s (NASHP) review of multi-payer medical home initiatives suggest that there are common strategies that may help to position states and providers in undertaking systems transformation.^{71,72} In fact, both groups report common lessons that other states can draw on as they initiate and renew reform efforts. For example, both found that it is important to consider **community characteristics and dynamics in crafting reforms**, and to this end, allow for **regional or local flexibility in implementation**, especially in efforts to assure that critical health, social services, behavioral, and other community providers are a part of delivery and payment transformations.

The **importance of data** was also reinforced, especially in DSRIP states to measure performance and outcomes overall as well as for specific population subgroups. **Breaking down silos** was also a common theme, and as lessons from Vermont suggest, states can and should have different departments share resources and divide responsibilities in efforts

to achieve a common transformation goal and vision.

States found success when **engaging and involving a breadth of stakeholders** representing a range of sectors that can address the underlying causes in many cases for costly, inefficient delivery through multiple strategies—e.g., lack of transportation resulting in no-shows, unemployment and uninsurance generating avoidable emergency department visits and hospitalizations, or cultural and linguistic barriers associated with delayed access to care. Such input can especially help to better tailor programs for vulnerable, high-risk, and complex patients through solutions generated by members from within communities.

Furthermore, states need not approach reform as an effort to “reinvent the wheel” or start from ground zero. Instead, **many building blocks already exist that can be built upon further for reform**—e.g., patient-centered medical homes, health information technology especially spurred by “Meaningful Use,” and community health teams among other initiatives are all stepping stones for moving toward more accountable care arrangements at the community or population level. This can be particularly important in states in which a fee-for-service model is still highly prevalent, and where states may continue to find themselves in a “two-canoe” situation balancing both fee-for-service and capitated arrangements.

Coordination across a spectrum of services is also an important precursor to extensive delivery and payment transformation, and while many have uncovered innovative ways to bridge and coordinate primary and specialty care especially through ranging

medical home models, these efforts will need to be expanded upon in many states to better integrate behavioral health in all care.

Once medical home models are established and initial milestones have been reached, it is vital to ***promote continuous improvement*** in the model with tiered quality standards and other methods. To this end, leaders and stakeholders should also determine long-term plans and goals for medical home initiatives as they become more established. It is also important for states to understand that most reform measures do not yield short-term results. The point and focus of meaningful reform should be about ***long-term transformation***, and while this can be difficult to digest by stakeholders (and especially those supporting and funding such efforts), it is important to include in managing expectations and delivering outcome information. Also, if health reform regarding safety-net hospitals will truly result in an improvement for population health, it is vital to ***align reform across other state programs***. An example of this alignment was in Vermont that incorporated all payers including Medicaid in its Blueprint for Health and its unified health care budget.

Finally, ***ongoing financing and leadership*** are key to transformation. To this end, stakeholders will need to leverage as well as seek out both traditional and other financial resources to assure initiative continuity, to sustain reforms, and to realize their potential. Payment systems as well as services must eventually be fully integrated, and participants and funders must remember that these efforts are a marathon (not a sprint) and that savings and health outcomes may take multiple years to show evidence of benefits.

Conclusion

California has made much progress in health care transformation, and a renewal of the 1115 waiver and DSRIP program will help the state continue on this path. California will need to continue to explore cost containment strategies while strengthening medical homes and modifying payment arrangements in order to increase care coordination, incentivize quality instead of quantity, and improve health outcomes.

Models and lessons from other states with Medicaid reform successes in these areas such as Vermont, Colorado, and New York could help with this process. Controlling health care costs while improving quality, efficiency, and coordination is a complex task with no easy solutions, but states must seek to reward value instead of volume and continue to try to find reforms that benefit their beneficiaries as well as their budgets.

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About Texas Health Institute

The Texas Health Institute is an independent, nonpartisan, nonprofit organization with the mission of improving the health of communities in Texas and nationally. To find this report online, as well as our other reports on health care reform and health equity, please visit www.texashealthinstitute.org/health-care-reform.html.

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