AMERICA'S ESSENTIAL HOSPITALS

Medicaid Payments to Incentivize Delivery System Reform

Webinar

Dec. 17, 2013

2:00 – 3:00 pm ET

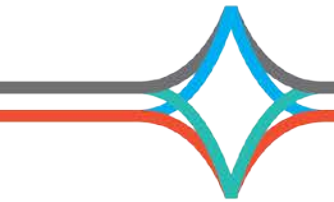
TODAY'S SPEAKERS:

- **Beth Feldpush, DrPH**
  Senior Vice President for Policy and Advocacy,
  America's Essential Hospitals

- **Barbara Eyman, JD**
  General Counsel,
  America's Essential Hospitals

- **Sarah Mutinsky, JD**
  Deputy General Counsel,
  America's Essential Hospitals

INTRODUCTION



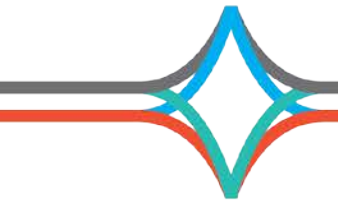
OVERVIEW

- Waiver Background
- Waiver-Based Supplemental Funding Arrangements
- Current Delivery System Reform Incentive Payment Programs
- Looking Ahead

WAIVER BASICS

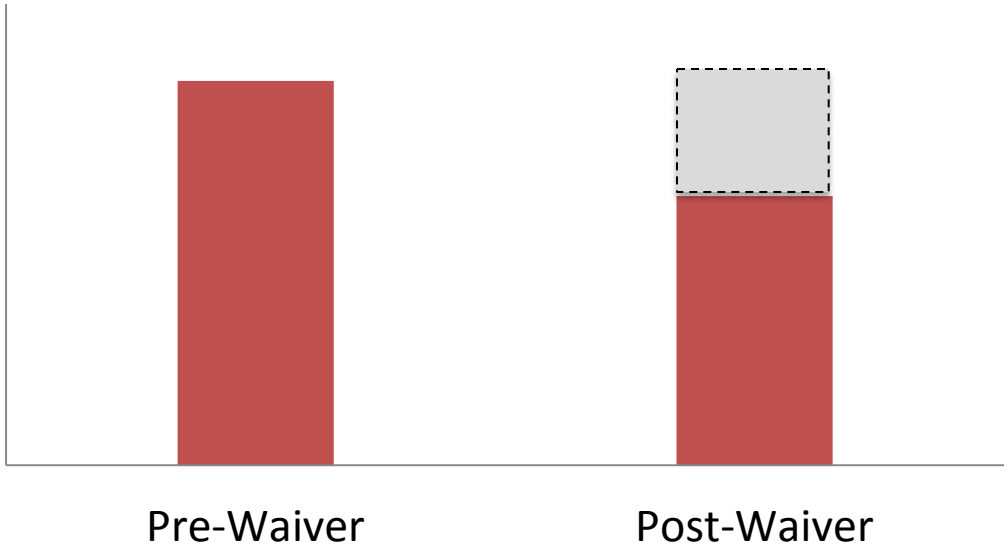
- **Section 1115 of the Social Security Act**
- **Broad flexibility for CMS to:**
  - » Waive requirements of the Medicaid Act
    - *"Waiver authority"*
  - » Provide federal match for otherwise unmatchable expenditures
    - *"Expenditure authority"*

CMS
CENTERS for MEDICARE & MEDICAID SERVICES



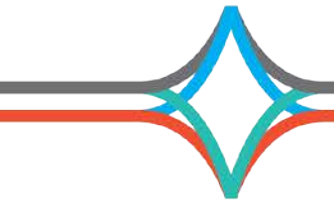
BUDGET NEUTRALITY

- **Federal government cannot spend more *with* the waiver than *without* the waiver**
  - » Flip side: federal government *can* spend *up to* the amount it would have otherwise spent



THE CONTEXT: GROWING RELIANCE ON MEDICAID SUPPLEMENTAL PAYMENTS

- Below-cost Medicaid rates in most states
- Increasing reliance on supplemental payments
  - » $32 billion nationwide in 2010
- Expanding managed care threatening supplemental payments
- CMS distrustful of supplemental payments
  - » Esp. when no state GR dollars involved
- Growing use of waivers for supplemental payment arrangements

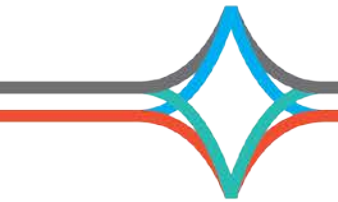


WAIVER-BASED SUPPLEMENTAL FUNDING ARRANGEMENTS

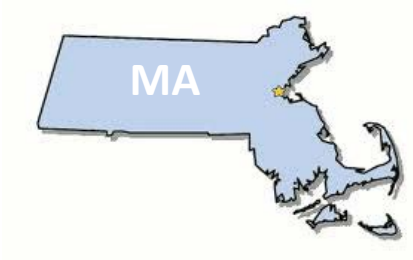
- **Uncompensated care pools** (Safety Net Care Pools, Low Income Pools)
  - » CMS disfavoring
- **Localized coverage expansions** with limited provider network
  - » Used primarily pre-2014
- **Delivery System Reform Incentive Pools** – "DSRIPs"

WHAT IS A DSRIP?

- **Medicaid incentive payments to hospitals and health systems that undertake intensive delivery system reform**
- **State makes payments based on achievement of milestones**
- **Non-federal share may be financed by public hospitals or other public entities**
- **Not considered payment for services**
  - » Does not count towards DSH, UPL
  - » Implemented through 1115 waiver



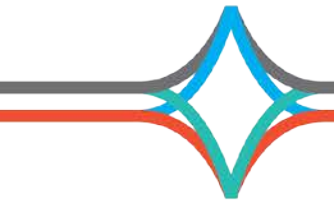
EXISTING DELIVERY SYSTEM REFORM INCENTIVE PAYMENT MODELS



PURPOSE AS DESCRIBED BY CMS

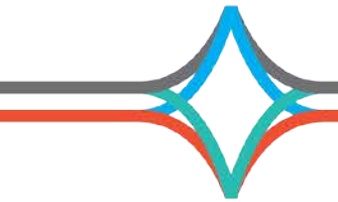
DSRIP funds a program of activity that is "foundational, ambitious, sustainable and directly sensitive to the needs and characteristics of an individual hospital's population, and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement."

Cindy Mann, CMS
Dec. 31, 2012, Letter to California



DSRIP STRUCTURE AND PAYMENTS

- Waiver ***terms & conditions*** lay out overall structure and focus
- State develops ***planning and funding protocols*** to govern hospital-specific plans
- Each hospital system develops a ***hospital DSRIP plan***
- Plan lays out project specifics and ***milestones***
- Funding released annually for each milestone achieved

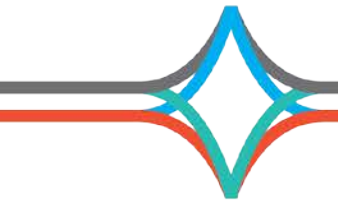


VARYING SCOPE OF PARTICIPATION

- **KS**: State university hospital and border children's hospital
- **CA**: County hospitals and some UC hospitals (17 total)
- **MA**: 7 safety net hospitals (1 public, 5 private non-profit, 1 for-profit)
- **NM**: Sole community hospitals and state university hospital
- **NJ**: Any hospital in state (can opt out)
- **TX**: 20 regional healthcare partnerships (RHPs) of public and private providers across the state
  - » ›300 private, nonprofit hospitals, some public health departments, and 38 local mental health authorities

VARYING LEVELS OF FUNDING

CA	$6.5 billion	5 years (2010-2015)	New/Existing
TX	$11.4 billion	5 years (2011-2016)	New/Existing
MA	$628 million	3 years (2011-2014)	Existing
NJ	$611 million	5 years (2012-2017)	Existing (transition)
KS	$100 million	5 years (2013-2017)	Existing (transition) (DSRIP now starts 2015)
NM	$30 million	5 years (2014-2018)	Existing (transition) (QI incentives start 2015)

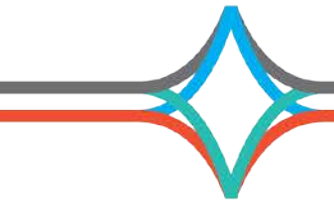


RANGE OF DSRIP STRUCTURES

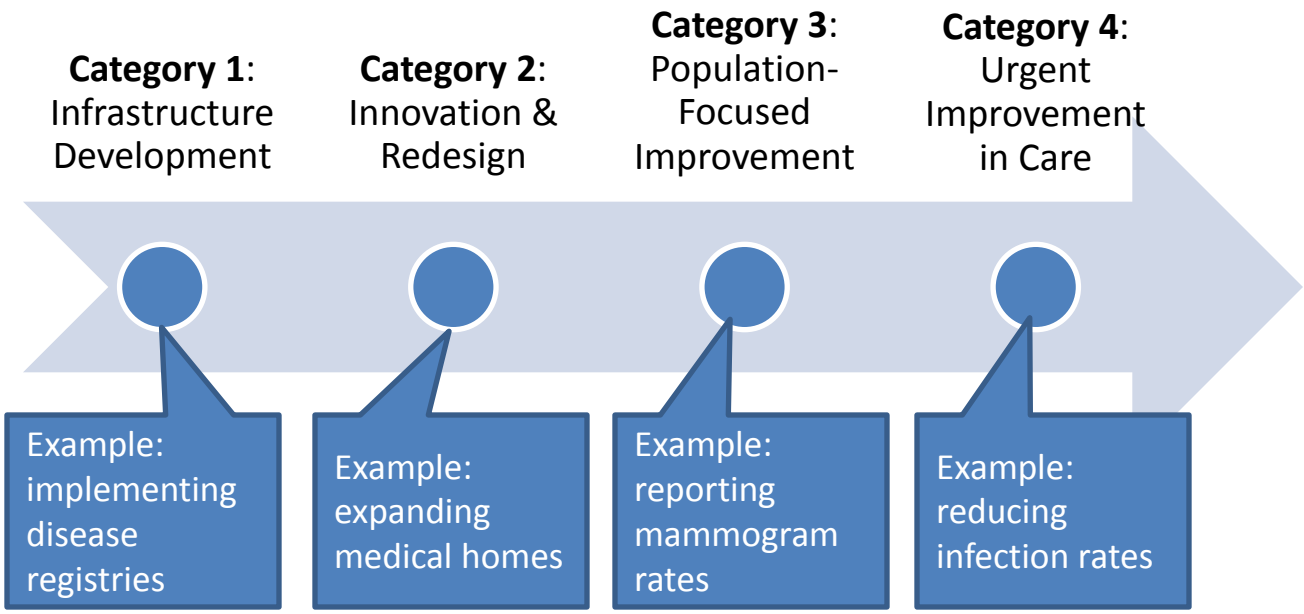
State	Project Structure	Relationship of Payments to Milestones
CA	Select from 54 projects and measures in 4 categories (avg. 15 projects per hospital simultaneously; avg 217 milestones over 5 yrs)	• Payment tied to process improvements • Reporting on clinical measures, not directly tied to projects
TX	RHPs select from 59 projects and measures in 4 categories (min. 4-20 projects; hospitals 1)	• Payment tied to process improvements • Projects linked to clinical outcome measures (pay for performance in later years)
MA	Select from 37 projects and measures in 4 categories (min. 5 projects)	• Payment tied to process improvements • Projects linked to clinical outcome measures (pay for reporting)
NJ	Select 1 of 17 projects in 8 disease-related focus areas; report milestones in 4 stages	• Payment tried to process improvements • Projects linked to clinical outcome measures (pay for performance in later years)
KS	Select min. 2 projects from state selection and report milestones in 4 categories	• Payment tied to process measures in first two years; quality and outcomes and population outcomes in later years
NM	Outcome measures within 2 domains	Hospitals will report on clinical outcome measures (pay for performance in later years)

EXAMPLE: CALIFORNIA DSRIP STRUCTURE

- Hospital plans must address all 4 DSRIP categories
- Include a minimum number of projects within each category
  - » Individually-tailored by/to hospitals
- On average, each hospital is involved in 15 concurrent projects
- Numerous individually-tailored measures for each project
  - » Overall, hundreds of project milestones in five categories
  - » Estimate average of over 200 milestones per hospital over waiver term



CALIFORNIA DSRIP PROGRAM CATEGORIES



Source: California Association of Public Hospitals & Health Systems

EXAMPLE: NJ DSRIP STRUCTURE

- One overarching "project" from one of nine focus areas
  - » Permits unique hospital focus, but extra scrutiny
- Select from 17 pre-defined CMS-approved quality projects across the focus areas
- Unique Focus Area or Off-menu Project requires higher justification and CMS approval

NJ DSRIP 9 FOCUS AREAS AND PROJECTS

Asthma 1. Hospital-Based Educators Teach Optimal Asthma Care 2. Pediatric Asthma Case Management and Home Evaluation	**Behavioral Health** 1. Integrated Health Home for the Seriously Mentally Ill (SMI) 2. Day Program and School Support Expansion 3. Electronic Self-Assessment Decision Support Tool	**Cardiac Care** 1. Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions 2. Extensive Patient CHF-Focused Multi-Therapeutic Model 3. The Congestive Heart Failure Transition Program (CHF-TP)
Chemical Addiction/Substance Abuse 1. Hospital-Wide Screening for Substance Use Disorder 2. Hospital Partners with Residential Treatment Facility to Alternative Setting to Intoxicated Patients	**Diabetes** 1. Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension 2. Diabetes Group Visits for Patients and Community Educators 3. Develop Intensive Case Management for Medically Complex High Cost Patients	**HIV/ AIDS** 1. Patient Centered Medical Home for Patients with HIV/AIDS
Obesity 1. After-School Obesity Program 2. Wellness Program for Parents and Preschoolers	**Pneumonia** 1. Patients Receive Recommended Care for Community-Acquired Pneumonia	**Unique to Hospital** Greater levels of justification and examination will occur.

NJ DSRIP STRUCTURE

- "Project" consists of a series of activities selected from State's predetermined menu
- Activities grouped according to 4 Project Stages

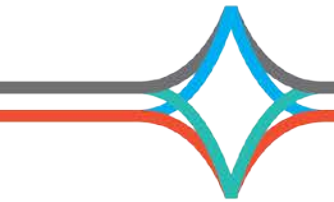
  Stage 1: **Infrastructure Development**

  Stage 2: **Chronic Medical Condition Redesign and Management**

  Stage 3: **Quality Improvements**

  Stage 4: **Population Focused Improvements**

- Performance metrics for each activity in Hospital DSRIP plan



NJ FOCUS OF FUNDS ACROSS YEARS AND STAGES

Stages	Payment Mechanism	DY2	DY3	DY4	DY5
Stages 1 & 2 Project Activities	Pay for Achievement	90%	75%	50%	25%
Stage 3 Measures	Pay for Reporting	5%	15%		
	Pay for Performance			35%	50%
Stage 4 Measures	Pay for Reporting	5%	10%	15%	25%

Source: NJDOH Presentation, July 17, 2013
http://dsrip.nj.gov/documents/07-17-2013%20NJ%20DSRIP%20Education_Session%201.pdf

SAMPLE NJ PROJECT TEMPLATE

Condition	**Asthma**
Project Count	**2**
Project Title	Pediatric Asthma Case Management and Home Evaluations[3]
Project Objective	
To implement Case Management and Home Evaluations in an effort to reduce admissions, Emergency Department visits and missed school days related to Asthma	
Project Methodology	

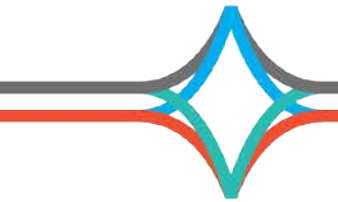
Hospital develops (utilizes national asthma guidelines) asthma education program. Hospital electronic data system identifies children who had an inpatient admission or emergency department visit for asthma or asthma-related symptoms and generates a list. This list is sent to a Nurse Case Manager or Asthma Educator who may perform any the following services:
 	
• Complete a patient needs assessment using a standardized questionnaire (may be performed while patient is inpatient or at home)
• Perform allergy testing if deemed appropriate by the physician
• Conduct Home visits which may include:
  o Asthma medication education
  o Development of a asthma action plan (includes information regarding symptoms and appropriate treatment for symptoms)
  o Assessment of environmental triggers
  o Removal of environmental triggers as appropriate (e.g. extermination services)
  o Providing equipment (e.g. garbage can with lids, air conditioning units, vacuum cleaners) and supplies (cleaning supplies etc.)
  o Education on available community resources and specialty care services
• Communication with primary care physicians on patient care and referrals as needed
• Perform educational workshops at various locations within the community
• Advocacy for public policy asthma care issues
 	
Hospital may consider having a number of parents of children who have participated in the program participate on a board to offer input on the program and plan community forums.	

SAMPLE NJ PROJECT TEMPLATE

Project Outcomes		
1. Reduce admissions 2. Reduce emergency department visits 3. Improve medication management 4. Reduce missed school days 5. Improve care processes		
Project Specific Metrics	**P4P**	**Measure Steward**
1. *CAC-1: Relievers for Inpatient Asthma*: Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.	No	The Joint Commission
2. *CAC-2 systemic corticosteroids for Inpatient Asthma*: Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.	No	The Joint Commission
3. *Use of Appropriate Medications for People with Asthma:* The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	No	NCQA
4. *Medication Management for People with Asthma:* The percentage of members (patients) 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. ***The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.***	P4P	NCQA
5. The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
6. The percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.	P4P	HRSA
7. *Adult Asthma Admission Rate:* This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

TRENDS FROM EARLY TO LATER DSRIPS

- Transitions existing supplemental funds rather than new funding
- Structural changes
- Incorporation of wider state goals
  - » Ex. Massachusetts payment reform
  - » Ex. NJ focus from Healthy New Jersey chronic disease reduction effort

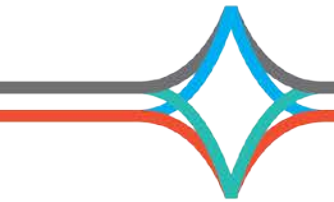


LESSONS FROM NEGOTIATION WITH CMS

- Intensive work and negotiation between providers, state and CMS
- Upfront investment required
- CMS emphasis on data collection and ability to report on achievement metrics and benchmarks
  - » Can require additional training and resources
- CMS wants to see providers stretching and movement on clinical outcomes
- Challenges to showing impact within artificial time period of Medicaid waiver
- Must link to larger state health care goals

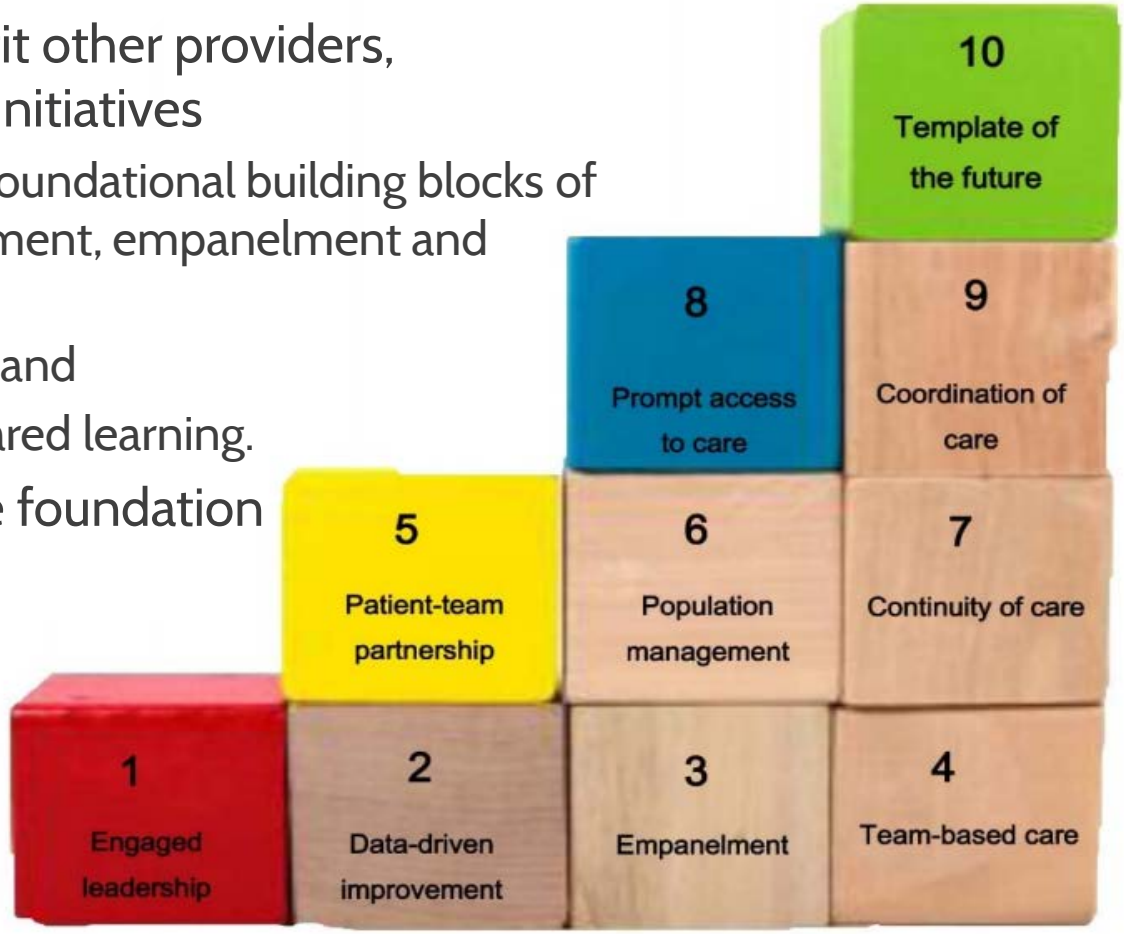
EARLY DSRIP RESULTS-CALIFORNIA

- CAPH report highlights building and spreading medical homes
  - » Initial years effort focused on infrastructure
  - » Culture shift towards outcomes driven work and measurement
  - » Provided an opportunity for systems to expand upon their existing quality improvement efforts and make them large-scale
  - » Medical home efforts include:
    - Implementing disease registries
    - Designing systems where patients are assigned to care teams
    - Using teams to expand level of care provided to patients



EARLY DSRIP RESULTS-CALIFORNIA

- Lessons that will benefit other providers, including in other P4P initiatives
  - » 1) investment in the foundational building blocks of data-driven improvement, empanelment and team-based care;
  - » 2) staff engagement; and
  - » 3) spread through shared learning.
- DSRIP support lays the foundation



Source: California Association of Public Hospitals & Health Systems
Graphic from UCSF Center for Excellence in Primary Care

WHAT CA HOSPITALS ARE SAYING

- Driver for change and not just a revenue stream
- Impetus for culture shift
- Driver of collaboration

Motivation provided by the DSRIP milestones has helped us to rise above the "tyranny of the urgent" to address larger system goals

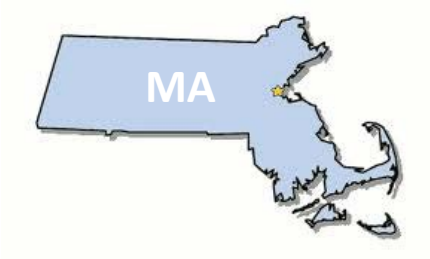
In practical terms, the DSRIP program led to the establishment of an accountability structure that included an executive-level oversight committee, category and project leads, and regular reporting calendar that has helped to maintain focus on accomplishing the milestones

The DSRIP initiative has …brought focus, alignment, and accountability for key projects which are improving, and will continue to improve, the experience and outcomes for the patients we are privileged to serve.

DSRIP and others—have cross campus and/or cross-department participation. Looking for connections between different parts of the system is becoming more automatic.

With its emphasis on measureable results, DSRIP has sharpened the focus on regular use of valid data to guide improvements and measure success

DSRIP 2.0?



2010-2014

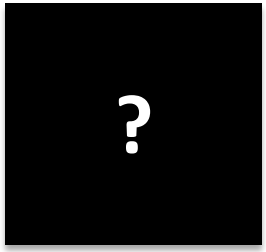
2011-2015

2011-2016

2012-2017

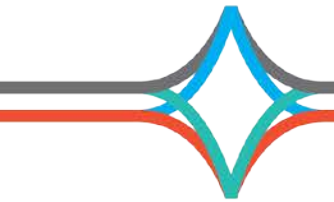
2013-2017

2014-2018



LOOKING AHEAD

- Florida Low Income Pool
  - » CMS increasingly tying funding to "accountable" mechanisms
- Oregon Transformation Plan
  - » Uses Oregon Coordinated Care Organizations under comprehensive 1115 waiver
  - » 7 different categories; each CCO developed own milestones/benchmarks for 2014 and 2015
- Massachusetts negotiations
- Continued evolution of ongoing DSRIPs
- Additional states continue to propose DSRIP programs
- CMS staff turnover



QUESTIONS?

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