CHCS Center for Health Care Strategies, Inc.
Improving the quality and cost-effectiveness of publicly financed health care

Payment Reform Efforts in Medicaid: A National Perspective

Western New York DSRIP meeting
May 22, 2014

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CHCS Center for Health Care Strategies, Inc.

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CHCS Center for Health Care Strategies, Inc.

A non-profit health policy resource center dedicated to improving services for Americans receiving publicly financed care

- **Priorities**: (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.

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Relevant CHCS Initiatives

- State Innovation Models (SIM) Initiative
- Medicaid ACO Learning Collaborative
- Complex Care Innovation Lab
- Medicaid Leadership Institute
- NYS Health Homes Learning Collaborative

Agenda

I. **DSRIP Projects in California and Texas**

II. **Medicaid ACOs: A National Perspective**

III. **ACO Case Studies: FUHN and Hennepin Health**

California DSRIP: Overview

- $3.4 B in funds over three years to 21 public hospital systems via 1115 waiver (2010)
  - Hospitals submitted plan outlining specific projects and milestones
- Hospitals must perform projects in four categories:
  - Infrastructure development
  - Innovation and redesign
  - Population-focused improvement
  - Urgent improvement in care
- Funding dependent upon achieving yearly quality improvement milestones

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California DSRIP: Lessons Learned

- **Governance Structure**
  - Existing safety-net hospital corporate structure
- **Lessons Learned**
  - Timely and uniform infrastructure/HIT improvements can help facilitate quality reporting
  - Tackling multiple projects at once may lead to provider fatigue
    - Public hospitals are typically carrying out 15 project s at once
    - Average of 217 milestones per hospital system

Source: California Health Care Safety Net Institute Annual DSRIP Report for DY7. March 2013

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Texas DSRIP: Overview

- Established through 1115 waiver in 2011
- Funding available to enhance access to care, quality of care, and patient health in public hospitals
- Funds available for Regional Health Partnerships (RHPs)
  - 20 RHPs each created a regional plan that:
    - Improves access, quality, cost-effectiveness and collaboration
    - Identifies transformation programs, performance metrics, and incentive payments for participating hospitals

Texas DSRIP: Governance

- RHPs must be financially "anchored" by a public hospital or county
- Must serve a specified geographic region
- Must reflect "broad inclusion" of stakeholders including county medical associations, local government, children's hospitals, academic health centers, regional public health directors, and hospitals that serve Medicaid patients
- No specific corporate structure required
- "Federation"-type models:
  - Loosely-developed groups, led by designated chair/committee
  - Each entity has own projects and funding but come together to develop a cohesive plan for the community
  - DSRIP payments to performing providers within RHP
  - Anchor can claim administrative funds to support management functions

Source: CHCS Interview with Texas officials

Texas DSRIP: Lessons Learned

- Keep it simple – make projects specific and measurable
- Use a data-driven approach to identify community needs
  - Reliable, comprehensive and consistent data source
- Acknowledge competitive dynamics but focus on mutual interest in transformation
- Be inclusive
- Focus on transparency and clear communication
  - Project selection
  - Implementation status
- Implement a statewide or regional learning collaborative

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ACO Overview

- **Key ACO features include:**
  - On the ground care coordination and management
  - Payment incentives that promote value, not volume
  - Provider/community collaboration
  - Financial accountability and risk
  - Robust quality measurement
  - Data sharing and integration
  - Multi-payer opportunities

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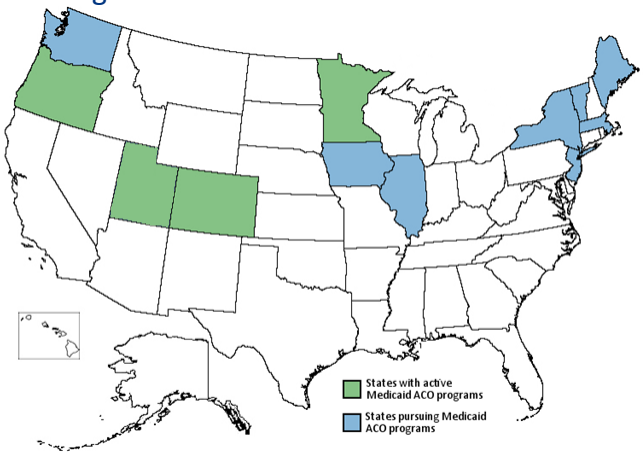
Medicaid ACOs: A National Perspective

- Twelve states have active Medicaid ACO programs in place or are pursuing ACO initiatives



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Medicaid ACO Organization Structures Vary

Provider-Driven ACOs	MCO-Driven ACOs	Regional/Community Partnership ACOs
• Providers establish collaborative networks • Provider network assumes some level of financial risk • Providers oversee patient stratification and care management • State or MCO pays claims • States: Maine, Massachusetts Minnesota, Vermont	• MCOs assume greater role supporting patient care management • MCOs retain financial risk but implement new payment models • Providers partner with the MCO to improve patient outcomes • States: Oregon	• Community orgs partner to develop care teams and manage patients • Regional/community org receives payment, shares in savings • Providers partner with regional/community orgs and form part of the care team • MCOs/states retain financial risk • States: Colorado, New Jersey

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A Closer Look: Federally Qualified Health Center Urban Health Network (FUHN)

- Coalition of 10 FQHCs in Minneapolis-St. Paul area
- Governed under a "repurposed" 501c3 network
  - Board of Directors is composed of the 10 FQHC CEOs – operates under consensus model
  - CQI and CFO subcommittees
- Partners with Optum for analytic support
  - Patient ID and Stratification
  - Financial benchmarking/management
  - Process and Quality Improvement
  - Care Planning and Transitions

FUHN

A Closer Look: Federally Qualified Health Center Urban Health Network (FUHN)

- Payment Model
  - Lump Sum + Panel Size Payment + Performance Payment
    - Funds distributed from shared savings pool
  - High variation in distributions across FQHCs
    - Large performance variation in savings and quality

FUHN

A Closer Look: Hennepin Health

- County-based pilot program that offers medical, behavioral health, and social services for residents of Hennepin County.
  - Individuals 21-64 years old without children and Medicaid eligible
- Composed of a medical center, a CHC, a health plan, and the county public health department
- Coordinates care between typically siloed care entities to achieve person-centered care

Hennepin Health: Governance

- Contract with state under HMO license
- MOUs between partner organizations
- BAAs facilitate data sharing
- Leadership and decision making:
  - Small administrative team
  - Committee structure
  - Consensus-based decision-making
  - Report to Policy & Steering Committee, as well as to County Commissioners and executive leadership of partner organizations

Hennepin Health: Payment Model

- PMPM payments from Metropolitan Health Plan
- Risk-sharing quality withholds are distributed in two ways:
  - Direct distributions to partner organizations based on relative size and performance metrics
  - Reinvestment projects determined by Hennepin Health's Operations and Finance committees

Contact Information

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