Payment Reform Efforts in Medicaid: A National Perspective

Western New York DSRIP meeting
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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.
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

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 projects at once
    - Average of 217 milestones per hospital system

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

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
Medicaid ACOs: A National Perspective

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

### Medicaid ACO Organization Structures Vary

#### Provider-Driven 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

#### MCO-Driven ACOs
- 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

#### Regional/Community Partnership ACOs
- 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
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

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
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 withhold distributions 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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