Forum on Delivery System Reform Incentive Payment:
Planning for Medi-Cal's Future

Discussion Summary

Peter Harbage, Ingrid Aguirre Happoldt, Jennifer Ryan, Lisa Chan-Sawin
Harbage Consulting, LLC

Overview

On December 17, 2014, the California HealthCare Foundation, Blue Shield of California Foundation and the California Department of Health Care Services sponsored a public forum on California's Delivery System Reform Incentive Payment (DSRIP) program. The event was organized by Harbage Consulting. The goal of the forum was to learn from the DSRIP experiences of California and other states and to foster discussion that would inform the next version of California's 1115 waiver. The day-long event featured: an overview of California's DSRIP program and lessons learned; an overview of DSRIP programs in other states followed by a panel discussion of the DSRIP experiences of New York, Massachusetts and Texas; and a panel discussion of the implications of lessons learned from California and other states for the future of California's DSRIP. Each panel was followed by a period of Q&A.[1]

This document summarizes key takeaways from the event.

Lessons from other States

Key lessons from other states included the following:

- **Collaboration with the Center for Medicare and Medicaid Services (CMS)** was essential in every state. The nature of DSRIP is evolving and CMS's priorities and expectations are as well. CMS will push states to be somewhat uncomfortable and challenged. Also, bandwidth is challenging at CMS, especially since standardization across states is difficult given the diversity of systems and circumstances. That said, CMS worked as a partner with states, helping them solve problems rather than just saying no. There was an appreciation of CMS objectives, including the evolutionary nature and the long-term uncertainty of DSRIP.

- There was acknowledgment that **the private/public hospital participation mix** caused some tension in every state. **Texas** felt it was important that Medicaid patients have choices across hospitals, so they created a process with stakeholders to create trust and increase the availability of funds for all hospitals. In **New York**, there was concern about public hospitals closing, so they created a collaborative process where all stakeholders were heard. There were difficult discussions between the public and private hospitals that were crucial to building trust.

[1] Meeting materials and video of the event are available at www.chcf.org/events/dsrip-forum

- Every state exercised caution and strategy when **choosing DSRIP projects,** aligning project choices with state policy goals. **Massachusetts** identified work that the hospitals already wanted and needed to do so the goals would have champions and leaders. They prioritized measurable and quantifiable quality goals. They identified "stretch" goals but not ones that were impossible to meet, finding a balance of aspirational but achievable. **Texas** focused on what was driving cost and negatively impacting quality and viewed projects through that lens. Texas created a menu of project options, but felt it was important for each region to choose from that menu (based on findings from community needs assessments). In hindsight, Texas might have made the menu too broad and could have narrowed the focus of the projects even more. **New York** also had needs assessment data to better understand community needs. They tried to be prescriptive about the types of projects but allow flexibility within them. There were conversations about how failure would result in funds to stop flowing to all the projects, not just those failing to meet targets. This focused everyone on helping each other out.

- The importance of **partnerships with non-hospital systems** to improve quality was a recurring theme. Hospitals cannot improve population health by working alone. In **Texas**, outreach to the Mental Health Authority resulted in community mental health centers collaborating with hospitals on reducing readmission for substance abuse and mental health services. **New York**, which set out to improve the health of their members, understood the importance of partnering with social services providers in order to address social determinants of health and other factors upstream of the health care system. Their goal was to move beyond collaboration by promoting interdependent relationships. An integrated state data system and health information exchange enabled easier coordination between health entities and non-hospital partners, including social services agencies.

- There was agreement across states that **an inclusive process** with room for public input strengthens outcomes. Both **Texas** and **New York** relied heavily on a community needs assessment process that involved data analysis as well as qualitative interviews. Stakeholder input on what changes were needed out of DSRIP and how the health system could be made better were valued. Community input was sought on defining the problems and identifying solutions.

California's Challenges

California stakeholders view DSRIP as an opportunity to address important program, population health and infrastructure goals. The discussion also surfaced several challenges as the state seeks to design "DSRIP 2.0."

- **Choosing the right goals and measurable targets** was identified as key challenge. One aspect of this challenge is balancing the desire to establish bold, challenging and "transformational" goals – one the one hand - with the desire "not to leave money on the table" or jeopardize the health of California's safety net providers – on the other. As one participant asked, "Is there an appropriate success rate?" Another aspect of this challenge is balancing desires for uniformity and prescriptiveness with the desire to create

opportunities for local innovation. Having a strong and clear vision for the outcomes California wants to achieve is important.

- There was concern that there are not **clearly defined roles for all the players** across the continuum of care. More work needs to be done, for example, to establish the vision and specific roles of health plans, counties, public and private hospitals and clinics, physicians and physician groups, and community based organizations.

- **Fostering collaboration, aligning incentives and creating interdependencies** are difficult but essential if California is going to get measurable and meaningful advances in efficiency, cost savings and health outcomes. Diversity among providers (large and small, inpatient and outpatient) must be taken into account to ensure continuity and collaboration. Not all stakeholders will be able to participate at the same levels of intensity based on resource constraints.

- It is important to be mindful that **infrastructure, clinical programs and payment programs** are connected. Together they determine the quality and value of the care you get. Long term sustainability must take into account all three. The conversation shouldn't be just about quality or cost, but rather value.

Moving Forward

The experiences of California and other states with existing DSRIP programs provide valuable lessons and ideas for those developing the next generation of DSRIP programs. While each state is unique, California has much to learn from the experiences of DSRIP programs in Massachusetts, Texas and New York. It is imperative that those who developed the first DSRIP program in California, including state officials and public hospital representatives, engage a broader group of interests to identify and advance more ambitious and transformational goals for DSRIP 2.0.