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Future of Medicaid hospital improvement program in doubt

By [Virgil Dickson](#) | March 28, 2015



The UC Davis Medical Center uses the DSRIP program as part of its medication-management system for patients. Charles Casey, UC Davis

For years, Santa Clara Valley Medical Center in

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San Jose, Calif., faced a problem with sepsis in patients.

There was a concentrated effort to screen for sepsis when patients arrived in the emergency department. But once patients were admitted, there was no consistent screening or treatment approach. And there was no facility-wide training effort, said Kathy Madlem, a nurse who serves as sepsis **quality** improvement coordinator at the safety net hospital.

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Hospital leaders wanted to improve their care for these patients, but the safety net hospital was hamstrung by lack of financial resources. Then in 2011, the hospital launched a campaign to improve the early detection and treatment of sepsis. That year, 14.6% of patients with

sepsis died. By June of last year, the mortality rate had dropped to 6.5%.

The improvement program was made possible by California's Delivery System Reform Incentive Payment (DSRIP) program, a federally approved waiver program that allows federal **Medicaid** funding to be used to create financial incentives for providers to pursue delivery-system reforms. Those reforms involve infrastructure development, system redesign and clinical-outcome and population-focused improvements. Under these programs, the initial focus is on meeting process-type metrics in setting up the reforms; in the later years, the focus shifts to outcomes-based metrics such as **population health** improvements.

In 2010, California became the first state to win federal approval for and launch a DSRIP initiative as part of a broader Medicaid Section 1115 waiver. The waiver programs provide states with significant funding to support hospitals and other providers in reforming how they deliver care to Medicaid beneficiaries. "We needed support and incentives to get to the place we wanted to be," said Dr. Susan Ehrlich, CEO at San Mateo (Calif.) Medical Center.

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MH Takeaways

The DSRIP initiative is important for safety net hospitals because they often have lagged their richer cousins in launching strong population-health-management programs.

Additional CMS waivers including DSRIP programs were approved for Texas in 2012, Kansas in 2013, and New Jersey and New York in 2014. Similar provider incentive programs were approved in Massachusetts in 2011 and New Mexico in 2014. Alabama and Illinois have pending Medicaid waiver requests that include DSRIP programs.

The DSRIP initiatives typically are part of a broader Medicaid transformation waiver, where the other initiatives aim to produce savings. For instance, California and Texas

used their broader waivers to shift beneficiaries to Medicaid managed care. From 2010 up to this year, California public hospitals could earn up to \$3.3 billion in federal incentive payments for achieving care and quality milestones. The state's waiver is set to expire in October, followed by Texas' in September 2016.

The broader Medicaid waivers must be budget-neutral—the CMS can't spend more in Medicaid funds than it would have spent without the waiver. So in exchange for agreeing to allocate a certain amount of federal Medicaid funds to be spent in a more flexible way, states must promise that the changes will create offsetting savings.

The program is important for safety net hospitals because they have lagged their richer cousins in improving care coordination and patient service to improve their management of the health of the populations they serve. In the seven states with DSRIP or similar programs, the CMS has dedicated nearly \$30 billion for the programs.

But it's unclear whether the Obama administration will renew the DSRIP programs in California and other states. That's at least partly because evidence is mixed on whether these programs have truly improved care for large numbers of Medicaid beneficiaries and uninsured patients. Critics say the states have set lax performance targets and have not used uniform metrics to track progress.

“We're still doing a lot of analysis,” said Robin Rudowitz, an associate director at the Kaiser Commission on Medicaid and the Uninsured.

Medicaid delivery reform programs

STATE	YEARS	PROGRAM FUNDING	ELIGIBLE PROVIDERS
California	2010-15	\$6.67 billion	Public hospital systems
Kansas	2013-17	\$60 million	Large public teaching hospitals or border city children's hospitals
Massachusetts	2011-14	\$628 million	Hospitals with high Medicaid volume
New Jersey	2014-17	\$583.1 million	All acute-care hospitals
New Mexico	2014-18	\$29 million	Sole community providers; state teaching hospitals
New York	2014-19	\$6.92 billion	Safety net providers
Texas	2012-16	\$11.4 billion	Providers participating in a regional partnership

Source: National Association of Medicaid Directors

Also, the future of the DSRIP initiative could be threatened by congressional Republicans' recent proposal to convert Medicaid into a capped, state block-grant program that would reduce Medicaid funding by nearly \$1 trillion over 10 years. “Generally, block grants mean a reduction in funding, so it would be really hard to continue these programs should this

occur,” said Barbara Eyman, principal and founder of Eyman Associates, a law firm that focuses on health law and policy.

Nevertheless, hospital leaders and patient advocacy groups hope the DSRIP programs will be renewed. California officials say they intend to submit a five-year renewal application for the DSRIP initiative by April. Texas officials also have signaled their intention to reapply next year.

Under California's DSRIP initiative, public hospitals each are carrying out 15 care-delivery reform projects, with an average of 217 milestones per system over five years. All the hospitals have reported progress in bringing down wait times, reducing healthcare-associated infections and improving their interactions with patients.

But the DSRIP program is struggling to demonstrate effective results statewide because of a flawed evaluation design, said Erica Murray, CEO of the California Association of Public Hospitals and Health Systems. "Even though many of the projects were the same, different performance measures were used, making it hard five years later to compare apples to apples," she said.

Still, she hopes the CMS will look at success stories at the individual hospitals as a sign that the program is producing positive results for Medicaid beneficiaries. She noted that California's waiver-renewal proposal includes more standardized measures to better track progress across the state. The data issues "shouldn't undervalue the success of individual systems that improved quality of care," she said.



Dr. Michelle Bholat, right, gives a lesson on electronic health records to international medical graduate students at UCLA, who are being trained as part of its DSRIP project.

For instance, Kern Medical Center in Bakersfield, Calif., launched an emergency department navigator program in 2011 to help patients, particularly those seen for non-urgent conditions, better navigate the healthcare system. By the following year, there was a 61% reduction in ED visits and a 66% reduction in avoidable inpatient admissions.

The waiver renewal application, posted on the California Department of Health Care Services website on March 16, asks for federal permission to allow providers to be reimbursed for needed nonmedical services, such as housing support for patients. The state agency said case-management services that help homeless patients obtain housing can improve patient outcomes and reduce costs.

But patient advocates have doubts that the CMS will renew California's waiver. The CMS wants to see evidence of long-term sustainability for initiatives launched under DSRIP when the waiver ends, said Sarah de Guia, executive director of the California Pan-Ethnic Health Network, a patient advocacy group that supports renewal of the program. "There's really a 50/50 shot at this moment," she said.

The CMS did not respond to a request for comment.



Dr. Alpesh Amin, a leader of the venous thromboembolism program at UC Irvine Medical Center, Orange, Calif., talks with a patient. The venous thromboembolism effort is one of the hospital's DSRIP projects.

Losing the waiver would dismantle much of the progress made in reforming safety net hospitals' delivery systems, said Anthony Wright, executive

director of Health Access California, a patient advocacy organization. "It would mean a loss of a lot of momentum and it would be a shame to have to go backward," he said.

In New Jersey, hospitals are concerned about the CMS' effort to get more quality data as part of that state's DSRIP program. Hospitals originally expected to report on less than a dozen quality indicators. But now they are required to report on 45 measures.

"We don't dispute that you need data, but we want to make sure that the dollars we're receiving are going more to patient care than for data-reporting expenses," said Sean Hopkins, senior vice president of health economics at the New Jersey Hospital Association.

With approval being granted just last year, New Jersey hospitals have been focusing on putting in place the infrastructure necessary to run their programs, he said.

New York, the most recent state to get approval for a waiver with a DSRIP program in April 2014, also has received requests from the CMS for more quality data. New York received approval for its DSRIP program after achieving major savings under its previous Section 1115 Medicaid waiver and redesign, and the CMS agreed to re-invest a portion of that savings in the DSRIP initiative.

"CMS noticed that some programs in other states had performance benchmarks that were too low and they wanted to try to address that in this waiver," said Kathleen Shure, senior vice president at the Greater New York Hospital Association. "They are investing \$8 billion in New York and they want to make sure that deliverables are being met."

New York's waiver is unique in that the CMS is holding the state itself, not just eligible providers, responsible for meeting targets tied to reducing avoidable hospitalizations, according to a Kaiser Family Foundation analysis of the waiver. New York as a whole must ensure that total Medicaid spending as well as expenditures for inpatient and emergency department services fall at or below target trend rates, or else DSRIP payments to providers will be reduced.

Tags: **Government**, **Hospitals**, **Managed Care**, **Medicaid**, **Patient Care**, **Population Health**, **Providers**, **Safety Net Hospitals**

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