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Leveraging Government Funding to Build Long-Term Success in Value-Based Payments: Insights from New York

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States have a number of mechanisms to collaborate with CMS, health plans, and providers to redesign care and financial funds flow in order to improve outcomes and lower costs for their Medicaid members. One of these is the 1115 Medicaid waiver and programs such as Delivery System Reform Incentive Payments (DSRIPs), now known as Public Hospital Redesign and Incentives in Medi-Cal (PRIME) in California. For many providers, these funds, a form of investment by CMS and the state Medicaid program into care and payment transformation, have helped them begin to make the transition to value-based payments and drive down the total cost of care. This is particularly important as the responsibility for managing risk shifts across the country from health plans to providers, who are now charged with thriving in an environment of pluralistic payment models, political uncertainties around the future of Medicaid, disproportionate share hospital cuts, and major transformations in care and payment for care.

States such as California, Texas, New York, and Washington have implemented 1115 Medicaid waivers in an effort to transform their Medicaid programs, reducing the total medical spend and simultaneously improving patient outcomes. New York has been a trailblazer in Medicaid reform and its waiver includes the implementation of a focused improvement program known as the DSRIP program. The New York DSRIP program is allocated up to $6.42 billion over five years based on performance with a primary goal to reduce avoidable hospital use by 25 percent.

New York relies on public and private healthcare systems and provider collaboratives called Performing Provider Systems (PPSs) to lead the implementation of DSRIP for attributed Medicaid member populations across defined regions through the state. The PPS networks are eligible

A Look at New York

New York's DSRIP networks have uniformly invested millions of dollars in core functions that prepare them for success with value-based payments:

- Care coordination: Clinical leaders in primary care and behavioral health lead the development and diffusion of evidence-based practice models to support clinical integration efforts.
- Value-based contracting: Finance executives and network development teams focus on the transition to value-based payments by leveraging funds flow for performance to both traditional Medicaid providers as well as community-based organizations.
- Data analytics: Information technology experts have been developing data analytics capabilities to support the implementation of targeted initiatives that result in reduction in cost and improvement on quality measures.
- Care management: Integration of care management into core business allows for a more robust approach to care delivery and helps ensure chronically ill patients and those with behavioral health needs are effectively managed.
- Project management: Formal project management offices have been implemented to support clinical redesign initiatives and projects aimed at supporting the provider network.

to earn DSRIP funds based on their ability to perform as a PPS independently, as well as the aggregate performance for all PPSs in the state. Earned dollars are available to invest in innovative strategies, network development, and community-based care programs that will drive long-term financial sustainability. The current New York DSRIP program will end in March 2020, so health plans, providers, and community-based organizations are preparing for what their future will look like in a post-DSRIP world. Lessons learned in the New York market can lend important insights for health plans, providers, and community-based organizations across the country that are interested in utilizing successful strategies to achieve large-scale transformation efforts.

Many DSRIP PPS networks in New York are led by major health systems. This has created new opportunities for health system executives and boards to drive down costs while building new revenue-generating platforms that align with their organizational goals. New York's DSRIP networks have invested millions of dollars in core functions around care coordination, value-based contracting, data analytics, care management, and project management in an effort to prepare for success in value-based payment contracts with health plans (see sidebar "A Look at New York"). These investments in new core functions have prepared many DSRIP organizations to evolve into future state managed care contracting and/or population health management entities that will last long after waiver funds are gone.

Five Options for Future New York DSRIP Networks

Five commonly explored options for the future state of New York DSRIP networks include: establishing risk-bearing entities (e.g., IPAs and ACOs), management services organizations (MSOs), performance improvement/care delivery redesign organizations, think-tank/trade associations, or some combination of these options. Each comes with its own set of pros and cons that should be actively fleshed out in strategic planning sessions and board meetings. To prepare for the future options, key competencies and core functions must be developed within the networks as the foundation for the transformation.

Key Board Takeaways

Hospitals and health systems invest significant dollars in order to operationalize various grants and waiver programs. Upon sunset of such programs and their funding, hospital leadership needs to ensure that the investments are optimally leveraged toward the organization's financial sustainability. The following are key takeaways for board members to consider:

- Public hospitals must establish a process by which investments made through temporary government funded programs to support the organization's long-term vision and future sustainability are evaluated proactively on a frequent and regular basis.
- Hospital and health system leadership should conduct thorough analysis and assessments to ensure revenue or cost savings opportunities are aligned with transitioning the investments made through such programs. Questions for board members to ask the CEO or CFO are:
  - What is the long-term operational and financial strategy that is being supported by these investments?
  - What is the additional incremental cost required to enhance the value of these investments?
  - What are redesign opportunities within the organization to ensure the investments made through grants are effectively integrated within the organization's operations?

Here we take a closer look at some of the options under development as well as high-level pros and cons associated with each:

1. **Risk-bearing entities**—independent physician association (IPA), All-Payer Accountable Care Organization (APACO), and the Medicaid Innovator:
   - Upon securing a certification for an APACO or IPA, organizations can enter into "risk transfer" contracts with health plans on behalf of a defined provider network and take control of the premium dollar in a fully delegated capitated model.
     - With the addition of a New York Medicaid Innovator (Innovator) designation, an APACO or IPA is eligible for 90–95 percent of premium sub-capitation contracts with health plans; the percent of premium is based on the population health and management functions the APACO or IPA is able to take on.
   - *Pros:* Achievement of economies of scale and overall control of the premium dollar on behalf of the health system and its community providers.
     - With Innovator in particular, sustainability plans for population health management services are developed using DSRIP dollars.
   - *Cons:* Requires risk-based capital and a robust network to start and must be supported by a strong population health infrastructure to ensure success.
     - Network, medical management, budgeting, or contracting missteps can lead to significant losses.

2. **Population health services management or managed services organizations (PHSO or MSO**):
   - DSRIP PPS organizations can leverage services developed under the waiver to grow capabilities needed to successfully support a network of providers under risk through an IPA or APACO, as well as New York State Health Homes and the new Behavioral Health Care Collaboratives (BHCCs).
   - *Pros:* Builds the muscles and infrastructure required to support risk-based contracts for networks of providers and community-based organizations.
   - *Cons:* Can require significant upfront investment and requires adequate scale in order to sustainably fund operating costs.

3. **Performance improvement/care delivery redesign organizations**:
   - Build expertise needed to implement clinical interventions that support providers, IPAs, and ACOs to: 1) increase quality scores, 2) maximize their at-risk revenue, 3) increase patient satisfaction, and 4) reduce total cost of care.
   - *Pros:* Provides economies of scale by leveraging the performance improvement capabilities built through the DSRIP program, and can serve as a centralized performance improvement/care delivery redesign organization arm for health systems, IPAs, or ACOs.
   - *Cons:* May not provide a long-term value proposition if it does not serve enough health systems, IPAs, ACOs, or providers.

4. **Think-tank or grant management entity**:
   - Supports the facilitation of clinical integration and collaborative projects across a set of partners or a region, development of thought leadership, creation of tools for organizations to use to drive standardized solutions. Leverages the skills gained managing the DSRIP program to help other organizations by providing proficiency in writing private and governmental grants and proposals for safety-net organizations and support in running grant programs.
   - *Pros:* Provides economies of scale for medium and small providers.
   - *Cons:* Many of these services are available by other organizations at competitive prices. Without a unique customer base, this option may not be sustainable long term.

5. **Multi-faceted approach**: Some New York DSRIP PPS networks are exploring a combination of options, such as creating a risk-bearing entity as the contracting vehicle and development of an MSO as the supporting arm to manage and better control medical spend.

As with any strategic decision or new direction, data-driven analysis and planning should be used to help select the most suitable option for the post-DSRIP role of a PPS. This includes detailed cost modeling to estimate implementation and operating costs, as well as a self-assessment of potential roadblocks and cultural readiness to restructure, scale, and redeploy resources as needed. To be successful, organizations should develop a phased transformation roadmap supported by strong project management resources and informed ongoing data analysis.

Conclusion

Government cuts, impacting the majority of the patient care revenue for public hospitals, are likely to continue for the healthcare industry, particularly when measured as a global annual cost per covered person. Using all available funds strategically to invest in core competencies and services needed to thrive in value-based payments is critical for public hospitals. Leveraging governmental funding through programs such as an 1115 Medicaid waiver can help public hospitals find success as they take on new non-traditional roles such as managing contracts that involve risk transfer from managed care organizations. New York's experience can provide value and insights for healthcare organizations across the nation with a set of practicable options for how to transform into non-traditional sectors of the market and prosper in a risk-based world.

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