CHAPTER 1

Using Medicaid Supplemental Payments to Drive Delivery System Reform

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Key Points

- Delivery system reform incentive payments (DSRIPs) are a new type of Medicaid supplemental payment authorized under Section 1115 waiver authority that supports provider-led efforts to change the delivery of care, improve the quality of care, and promote population health.
- In fiscal year 2015, up to $3.6 billion in federal DSRIP funds are available to eligible providers in six states (California, Texas, Massachusetts, New Jersey, Kansas, and New York).
- The Centers for Medicare & Medicaid Services (CMS) approved the first DSRIP program in California in 2010, and subsequent states have adapted this model to their circumstances:
  - Payment is tied to the achievement of specific milestones, including planning, implementation, reporting, and health outcomes.
  - Most state DSRIP programs are limited to hospitals, but some programs also include other providers.
  - In many DSRIP programs, public hospitals contribute most of the non-federal share of funding.
- The DSRIP approach, if taken to scale, has the potential to fundamentally change Medicaid's role from financing medical care to driving system change toward value and improved health outcomes.
- MACPAC interviews with CMS and state Medicaid officials as well as site visits to selected states revealed that implementing DSRIPs can be challenging:
  - While many states view DSRIP programs as a way to preserve or make new supplemental payments, CMS describes their primary purpose as catalyzing delivery system transformation.
  - States reported that finding a source of non-federal share is a challenge.
  - Implementation is resource intensive for states, providers, and the federal government.
  - It is challenging to evaluate these programs, and results are not yet available.
  - States and providers expressed concerns about sustainability.
- Clear and consistent federal guidance for DSRIP programs is needed. The Commission looks forward to learning more about the programs as they mature; a cross-state synthesis of DSRIP outcomes would be particularly useful in considering whether to expand the approach.

CHAPTER 1: Using Medicaid Supplemental Payments to Drive Delivery System Reform

Delivery System Reform Incentive Payment (DSRIP) programs, which direct Medicaid funds toward provider-led efforts to improve health care quality and access, were first authorized in California in 2010 as part of its Section 1115 demonstration waiver. Since then, five additional states—Texas, Massachusetts, New Jersey, Kansas, and New York—have also implemented DSRIP programs as part of their Section 1115 demonstration waivers.[1] DSRIP programs serve as both financing mechanisms for states to make supplemental payments that would otherwise not be permitted under federal managed care rules and as tools for states to invest in provider-led projects designed to advance statewide delivery system reform goals. In fiscal year 2015, up to $3.6 billion in federal DSRIP funds (and a total of $6.7 billion when state funds are included) are available to eligible providers in six states (MACPAC analysis of CMS 2015a, 2015b, 2015c, and 2015d).

As more states seek approval of DSRIP programs, and states with current DSRIP programs request renewals, MACPAC has been working to better understand this policy development and its relationship to broader policy issues, particularly the role of supplemental payments and Medicaid's role in delivery system transformation. We contracted with the National Academy for State Health Policy (NASHP) to conduct an environmental scan of the design of DSRIP programs and met with states, providers, and other stakeholders to discuss their experiences so far and their expectations for success. Specifically, NASHP and MACPAC conducted key informant interviews with state and federal policymakers as well as site visits in Texas, New Jersey, and California (Schoenberg et al. 2015).

This chapter summarizes the findings of our review of DSRIP programs and builds on the Commission's previous analyses of supplemental payment policies. In the March 2014 *Report to the Congress on Medicaid and CHIP,* the Commission raised concerns about the lack of transparency of Medicaid supplemental payments and the extent to which such payments further policy goals of promoting efficiency, economy, quality, and access. The design of DSRIP programs addresses some of these concerns due to the specific terms and conditions of each waiver, milestones for providers, and detailed process and documentation requirements. However, the Commission is still interested in better understanding the effectiveness of the DSRIP approach overall, how it is being implemented in different states, and its effects on the process and outcome of care.

We begin this chapter with a review of the Commission's previous work as context for understanding the historical factors that led to the development of DSRIP programs. We go on to describe the design and operation of DSRIP programs, including the approval process, program structure, eligible providers, and financing. We then present five themes that emerged during key informant interviews and site visits, and outline some of the policy implications for our continuing work related to Medicaid supplemental payment policy and delivery system transformation.

The DSRIP approach could fundamentally change Medicaid's role from financing health care services to driving system change toward value and improved health outcomes. Even so, questions remain, and more clear and consistent federal guidance is necessary to promote more effective oversight. The Commission looks forward to learning more about the impact of these programs as they mature; a cross-state synthesis of DSRIP outcomes would be particularly useful in considering whether to expand the approach.

Medicaid Supplemental Payments

In order to understand the design of DSRIP programs, it is important to understand state practices of making supplemental payments to providers without the use of Section 1115 waivers.[2] Of particular relevance to DSRIP programs are upper payment limit (UPL) supplemental payments, which are permitted under fee-for-service arrangements. When fee-for-service Medicaid rates to certain providers (primarily hospitals and nursing facilities) result in aggregate provider payments that are lower than what Medicare would have paid for those services, states may make lump-sum UPL payments to such providers.

States reported about $24 billion (including federal matching funds) in UPL payments in fiscal year 2013, which accounted for about 5 percent of total Medicaid benefit spending nationwide and 23 percent of Medicaid fee-for-service payments to hospitals (MACPAC 2014). The use of UPL payments varies widely by state. Some states do not make UPL supplemental payments. In other states, UPL payments account for more than half of Medicaid fee-for-service payments to hospitals (MACPAC 2014).

UPL payments need not be tied to specific federal policy objectives in the same manner as, for example, disproportionate share hospital (DSH) payments are tied to uncompensated care.[3] Instead, states establish their own criteria for UPL payments within broad federal guidelines. Data on UPL payments are only readily available in the aggregate, which further limits the ability of federal policymakers to understand what UPL payments are for.

The Commission has previously expressed concern that lack of provider-level information about UPL supplemental payments makes it difficult for federal policymakers to determine whether Medicaid payment policies are promoting policy goals of ensuring access and promoting efficiency, economy, and quality. In its March 2014 *Report to the Congress on Medicaid and CHIP,* the Commission recommended, as a first step toward improving transparency and facilitating the understanding of Medicaid payments, that the Secretary of the U.S. Department of Health and Human Services (the Secretary) collect and make publicly available UPL supplemental payment data at the provider level in a standard format that enables analysis (MACPAC 2014).

DSRIP is a different type of Medicaid supplemental payment that is authorized through Section 1115 waivers.[4] Unlike lump-sum UPL payments, DSRIP funding is based on achievement of particular milestones that are agreed upon up front through the waiver process. Because DSRIP funding is associated with predefined milestones, we have a greater understanding of what DSRIP payments are for and how they are distributed. This additional information helps address some of the Commission's prior concerns about the transparency of supplemental payments and allows the Commission to examine DSRIP programs in more depth.

History of DSRIP Programs

The Centers for Medicare & Medicaid Services (CMS) approved the first DSRIP program in California in 2010, and subsequent states have adapted this model to their circumstances. In many states, DSRIP programs emerged out of regulatory limits on UPL supplemental payments under managed care and a desire to align prior supplemental payments with larger delivery system reform goals. However, in the most recently approved DSRIP program in New York, DSRIP payments are not linked to prior supplemental payments and are primarily designed to advance the state's vision for delivery system transformation.

The DSRIP model is still in its infancy, and in the absence of federal guidance, CMS's expectations for DSRIP continue to evolve based on the early experience of these programs. Like other Section

1115 waivers, each state's DSRIP program is the product of state-specific waiver negotiations.

Interaction between supplemental payments and Medicaid managed care

The increasing use of managed care delivery models in Medicaid is one factor that has contributed to some states' decisions to pursue Section 1115 waivers that allow them to continue or make new supplemental payments. While many states have made extensive use of supplemental payments under fee for service, federal rules limit their ability to make these payments in capitated managed care programs. Specifically, federal regulations require capitation payments made to Medicaid managed care organizations to account for the full cost of services under a managed care contract (42 CFR 438.60). This means that under capitated managed care, the state does not have the ability to make supplemental payments directly to providers for services included in the capitation rate.[5]

The amount of money providers stand to lose when states can no longer make UPL supplemental payments is often substantial. For example, Texas hospitals faced the prospect of losing approximately $3 billion per year in supplemental payments when the state expanded managed care statewide in 2011 (Millwee 2011). Some public hospital officials reported to MACPAC that such a loss would have threatened their financial stability (Schoenberg et al. 2015). In some states, the prospect of losing supplemental payments motivated providers, provider associations, and state policymakers to agree on including a DSRIP in their Section 1115 waiver proposals. Although states could increase Medicaid payment rates statewide without a waiver, targeted supplemental payments allow states to direct payments to particular providers, including public providers that can help finance these payments.

States can use Section 1115 waiver authority to continue or make new targeted supplemental payments to providers while implementing managed care programs. CMS has broad authority under Section 1115 of the Social Security Act (the Act) to allow the use of federal Medicaid funds for "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid. Since 1994, CMS began allowing some states (including four of the current DSRIP states) to make supplemental payments under Section 1115 authority through uncompensated care pools, which are lump-sum payments similar to DSH payments.[6] Since 2010, however, all new Section 1115 waivers authorizing supplemental payments have included a DSRIP program or similar quality improvement component.

Growing focus on value-based payment methods

DSRIP programs also dovetail with state and federal interest in linking Medicaid payments to value instead of volume. Under traditional fee-for-service payment methods, payments to providers increase as the volume of services provided increases, regardless of the quality of care. In light of this, federal policymakers have increased efforts to encourage payment methods that take the quality of services and other measures of value into account. DSRIP programs specifically link payments to achievement of a variety of system-level improvements, such as improved care management and integration across settings, which are intended to improve health outcomes for the Medicaid and low-income uninsured population.

Consistent with the growing focus on value-based payment methods nationwide, states implementing DSRIP programs are also implementing other initiatives focused on value and system transformation. For example, five of the six state DSRIP programs are currently working to implement Medicaid accountable care

organizations, which reward providers that achieve quality and savings targets. In addition, five states with DSRIP programs have also been awarded State Innovation Model (SIM) grants to develop and test multipayer payment-and-delivery system models (Schoenberg et al. 2015). Many of these initiatives are permissible under current managed care regulations and do not require Section 1115 waiver authority.

DSRIP has the potential to complement and support these broader delivery system reform strategies, particularly for Medicaid providers that may not otherwise have access to capital to make the changes needed to thrive in a value-based payment environment. For example, in New York, the most recently approved DSRIP program, the state's demonstration is explicit about the goal of linking Medicaid payments to value instead of volume and requires the state to develop a strategic plan to move 90 percent of its Medicaid managed care payments to value-based methodologies by the time its DSRIP program ends (NYDOH 2015).[7]

DSRIP Program Design

Although CMS has not issued formal guidance defining DSRIPs, approved DSRIP programs share several design features. Generally, DSRIP is a mechanism for providing Medicaid payments to qualifying organizations that are implementing infrastructure and care transformation initiatives that align with state and CMS delivery system reform goals. However, each state uniquely adapts this framework to its specific Medicaid program goals, as negotiated between the state and CMS.

Demonstration and protocol approval process

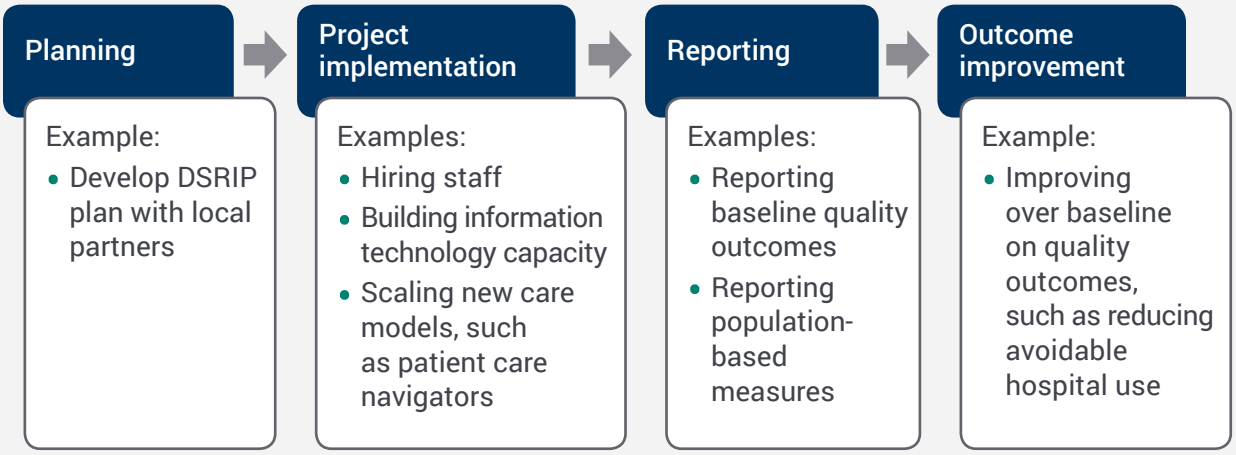
As noted above, DSRIP programs are authorized under Section 1115 demonstration authority. The state-specific parameters (e.g., total DSRIP funding and the providers eligible to receive DSRIP payments) are negotiated by CMS and the state and outlined in the special terms and conditions of the demonstration. The features for each DSRIP program are then further developed by states and CMS in protocols or master plans that describe operational requirements, for example, performance measures that providers must meet in order to receive DSRIP payments, a methodology for distributing funds, reporting requirements, and an implementation timeline. States, in turn, require participating providers to develop plans for the projects they intend to implement, for instance, a schedule of milestones a provider must achieve in order to be eligible for the associated incentive payments.

CMS encourages the involvement of community stakeholders in DSRIP project design by requiring project plans to demonstrate how the project meets community needs. In addition, since 2012, all Section 1115 demonstrations have been subject to enhanced transparency requirements, which were added under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (CMS 2012).

Program structure

DSRIP programs tie disbursement of supplemental payments to the achievement of specific milestones, including planning, project implementation, reporting, and outcome improvement (Figure 1-1). The specific goals vary depending on the state's master plan, the maturity of the DSRIP program, and the individual project plan negotiated with the provider. DSRIP programs tend to allocate more funding for planning activities and project implementation milestones in earlier program years and more funding for reporting and outcome improvement milestones in later program years. More recently negotiated DSRIP programs tend to have larger proportions of their total DSRIP funding dedicated to reporting and outcome improvement and less toward project implementation milestones.

FIGURE 1-1. Types of Delivery System Reform Incentive Payment (DSRIP) Program Milestones



Source: MACPAC analysis of Schoenberg et al. 2015.

In most states, providers can receive initial funding to conduct community needs assessments and complete their DSRIP project plan. Community stakeholders, including consumer representatives, may be involved in the community needs assessment process, but they are not directly supported through planning funds, and decisions of which projects to implement rests with the provider receiving DSRIP funds (subject to state and CMS approval). After the initial DSRIP project plan is approved, providers have opportunities to revise their project plans, and states and CMS have a limited opportunity to re-evaluate approved DSRIP projects during a mid-point assessment.

The number of and nature of projects varies by state. The number of projects ranges from 4 approved projects in Kansas to over 1,400 projects in Texas (Table 1-1).[8] The proposed delivery system reforms also vary. DSRIP projects generally fall into two categories:

- Infrastructure development—these projects tie DSRIP payments to activities that add or improve provider capacity for supporting delivery system reform, such as expanding primary care clinics, creating mobile health teams, and hiring additional care management staff. Infrastructure activities can also include investments in health information technology, for example, to develop telehealth infrastructure and disease registries.
- Care innovation and redesign—these projects seek to change the way care is delivered, improve the quality of care provided, or promote population health. Some projects in this category have implemented medical homes, improved discharge and transition planning programs, co-located behavioral and primary health care providers, and created patient navigator programs for high-utilizing enrollees; for example, enrollees who have frequent visits to emergency rooms for non-emergent health care needs.

DSRIP projects are oriented toward improvements in health outcomes, such as reducing readmissions and improving access to care, for both Medicaid enrollees and low-income uninsured individuals. Because many DSRIP providers do not have the data and analytic capacity to report on the quality

measures required by DSRIP, a portion of DSRIP funding is directed toward improving providers' ability to report and calculate baseline performance levels. In later years of DSRIP implementation, a portion of DSRIP funding is tied to achieving improvements on the quality measures related to providers' DSRIP projects. In New York, the most recently approved DSRIP program, a portion of DSRIP funding is also tied to meeting a statewide set of transformation goals, such as reducing the number of avoidable emergency department visits and hospital readmissions.

Unlike most Medicaid payments, DSRIP supplemental payments are based on reporting and performance milestones rather than services provided. In most states' DSRIP programs, if a provider fails to achieve a milestone, then the provider is not eligible for the full DSRIP payment tied to that milestone. Because DSRIP projects include several phases and are implemented over several years, a provider may incur costs (for example, hiring staff to implement a project) or provide a service for which they ultimately do not receive payment if they fail to achieve their milestones.

However, some design features mitigate the potential risk to providers. For example, partial payments can be made for partial milestone achievement in California and Texas DSRIP programs.[9] Providers in California, Massachusetts, and Texas have an opportunity to carry forward some DSRIP milestones (and the associated funding) to subsequent years if they miss their targets. New York and New Jersey DSRIP programs both have a high performance pool that reallocates funding from missed milestones to make additional payments to providers who exceed their targets. As a result, a provider who misses a milestone has the opportunity to earn some payment for outperforming expectations in another area.

Setting appropriate milestone targets is challenging for states and CMS, particularly for health outcome measures. Performance milestones that are set too low and are easy to achieve raise questions about whether incentive payments were necessary in the first place. On the other hand, if performance milestones are difficult to achieve and DSRIP payments are withheld, this can have adverse consequences for both providers and Medicaid enrollees. These consequences could include, for example, reducing services (particularly DSRIP-financed services), reducing staffing levels, and in some extreme cases, closing facilities. In more recently approved DSRIP programs, CMS has addressed some of these concerns by introducing more standardized methods for setting outcome improvement targets.[10]

To date, most DSRIP providers have achieved most of their milestones. Massachusetts reported 95 percent DSRIP milestone achievement in its first year and California reported 99 percent milestone achievement in its first three years of DSRIP implementation (Anderson et al. 2013, Pourat et al. 2014). However, DSRIP milestones may be harder to achieve in later years of DSRIP implementation when a greater proportion of payments are tied to outcome improvement. For example, Texas estimates that only 83 percent of allocated DSRIP funding will be claimed in the fourth year of its demonstration (HHSC 2015).

Eligible providers

Most state DSRIP programs are limited to hospitals that were previously receiving supplemental payments and that serve a high proportion of Medicaid enrollees and uninsured individuals. These typically include both public and private hospitals (except for New Jersey, which does not have public hospitals, and California, whose DSRIP program only includes public hospitals). A few states allow other providers to participate in their DSRIP programs as well, including community mental health centers, physician groups, and local health departments.

Due to variations in program scope and provider eligibility requirements in each state, the number

of participating provider organizations also varies across states, from 2 in Kansas to 309 in Texas (Schoenberg et al. 2015).[11] Four states—California, Kansas, Massachusetts, and New Jersey—specify which providers are eligible to participate in the program and receive incentive payments. In these states, DSRIP programs limit participation to hospitals, and most often hospitals that serve high volumes of Medicaid and uninsured patients.[12] New York and Texas DSRIP programs have many more participating providers than other DSRIP programs because they are required to form regional coalitions that include a variety of non-hospital providers. Hospital-based DSRIP programs in other states also encourage providers to collaborate with each other and with other stakeholders in their communities in the development and implementation of their DSRIP projects, but they do not make DSRIP funding directly available to non-hospital providers.

In general, providers that serve a higher proportion of Medicaid enrollees and the uninsured are eligible for larger DSRIP payments. Because of their payer mix, these providers generally have lower operating margins and less access to capital than providers that serve a higher proportion of commercially insured patients (Bachrach et al. 2012). In 2013, hospitals reported that Medicaid paid 89.8 percent of costs in the aggregate (including Medicaid DSH payments), which was substantially lower than private payers, which paid 143.6 percent of costs in the aggregate (AHA 2015).

Financing

Total DSRIP funding is established in each demonstration's special terms and conditions, and includes both federal and non-federal contributions. The total federal funding available to the states over the course of each demonstration varies from less than $34 million in Kansas to more than $6 billion in Texas and New York. As a percent of total state Medicaid benefit spending in each state, DSRIP ranges from 1 percent in Massachusetts, New Jersey, and Kansas, to 7 percent in Texas (Table 1-1).

CMS applies a budget neutrality test for Section 1115 waivers before approval to ensure that federal spending under the waiver will be no more than projected spending without the waiver. In some DSRIP demonstrations (e.g., New Jersey), DSRIP expenditures are at least partially offset by savings from eliminating prior supplemental payments that could have hypothetically continued in the absence of the demonstration. In addition, some states (e.g., New York) also apply prior and projected savings from implementing or expanding managed care to the budget neutrality assumptions. Although all Section 1115 waivers must be budget neutral, DSRIP programs that are not offset by reductions to prior supplemental payments often represent new funding to providers, which makes it easier for providers to invest in new initiatives.

The special terms and conditions also describe the funding sources that states intend to use as the non-federal share necessary to draw down federal matching funds. Like other Medicaid payments, the non-federal share of DSRIP payments can be supplied from one or more sources, including state general revenue funds, health care-related taxes, and intergovernmental transfers (IGTs) from governmental entities, such as public hospitals and local governmental entities.[13] In addition, some Section 1115 waivers include federal funding for designated state health programs (DSHP), an indirect method for financing the non-federal share.[14]

In all DSRIP programs except those in New Jersey and Massachusetts, public hospitals contribute all or most of the non-federal share of DSRIP funding through intergovernmental transfers.[15] In these states, hospitals that have implemented DSRIP projects are contributing the funds to draw down federal matching funds for their projects, reducing their net DSRIP payments. In some cases, public providers are also contributing IGT funds to finance the non-federal share of other providers' DSRIP projects.

Private providers are often dependent on public hospitals or local governmental entities for the non-federal share of DSRIP funding because private providers cannot make IGTs. This arrangement poses risks for private providers because of the voluntary nature of IGTs.[16] For example, four regional health care partnerships in South Texas were initially unable to receive most of the DSRIP funds allocated to them because they lacked enough IGT funds (HHSC 2015).

Monitoring and evaluation

States and CMS both have roles in oversight of DSRIP projects after the demonstration is approved. In general, CMS is responsible for monitoring state compliance with the special terms and conditions associated with the demonstration, including the upper limit on available DSRIP funding and the demonstration's overall budget neutrality test. States and CMS together establish and oversee the process for distributing DSRIP funding to eligible providers, including rules for the share of funding that must be allocated for achievement of particular types of milestones, and they develop a list of eligible projects and corresponding outcome measures that providers can select. States are primarily responsible for review of the specific proposed projects and provider progress reports used to approve payments for documented achievements.

DSRIP projects and protocols are typically posted on state websites, providing more transparency and opportunities for public comment than many other types of Medicaid supplemental payments. In New York, the most recently approved DSRIP program, CMS required the state to use independent assessors to evaluate DSRIP projects based on predefined criteria. In addition, the New York DSRIP protocols add more structure to DSRIP payment levels by establishing a formula for determining DSRIP project value based on the quality of the project and the number of attributed Medicaid and uninsured individuals for the provider organization.

CMS also requires each state to design DSRIP-specific evaluation plans for CMS approval. In addition to reviewing the outcome improvements reported by each DSRIP project, most DSRIP evaluations must include qualitative assessments of the program's impact, and some DSRIP evaluations will also include comparative information about the relative performance of DSRIP and non-DSRIP providers. States must submit an interim evaluation prior to the expiration of the demonstration and a final evaluation after the completion of the demonstration. So far, Massachusetts and California have completed interim evaluations, but no state has finished its final DSRIP evaluation yet.

DSRIP Program Summaries

Since 2010, CMS has approved six Section 1115 demonstrations with incentive arrangements that are classified as DSRIP programs for this analysis (Table 1-1). We include Massachusetts's Delivery System Transformation Initiative (DSTI) because it is similar to DSRIP programs. Other Section 1115 demonstrations with quality-related provider incentive programs, such as New Mexico and Oregon, differ in some important respects and are thus described in the subsequent section as DSRIP-like programs.

California

California's DSRIP program is open to 21 designated public hospitals that serve a large portion of the state's Medicaid population. Each hospital has selected 12 to 19 projects across five categories: infrastructure development, innovation/redesign, population-focused improvement, urgent improvements in care (patient safety), and HIV/AIDS transition projects (NAMD 2014). Payment for improvement in quality outcomes is only included for patient safety projects, such as reducing central line-associated bloodstream infections.

TABLE 1-1. Summary of Current Delivery System Reform Incentive Payment (DSRIP) Programs, 2015

State	Implementation time frame	Participating providers	Number of DSRIP projects	Total maximum federal DSRIP funding (millions)	Total maximum state and federal DSRIP funding (millions)	DSRIP funding as share of total state Medicaid benefit spending
California	5 years (2010–2015)	Public hospitals (n = 21)	388	$3,336	$6,671	2%
Texas	5 years (2011–2016)	Hospital and non-hospital providers participating in one of 20 Regional Healthcare Partnerships (n = 309)	1,491	6,646	11,418	7
Massachusetts	6 years[1] (2011–2017)	Public and private hospitals (n = 7)	49	659	1,318	1
New Jersey	4 years (2013–2017)	Private hospitals (n = 50)	50	292	583	1
Kansas	3 years (2014–2017)	Public teaching hospital and children's hospital (n = 2)	4	34	60	1
New York	6 years (2014–2019)	Hospital and non-hospital safety net providers, organized into 25 Performing Provider Systems (n = 64,099)[2]	258	6,419	12,837	3

Notes: The funding amounts provided in this table are estimates based on an analysis of the figures provided in each state's Section 1115 demonstration special terms and conditions. All amounts represent maximum potential funding; earning the funding is contingent upon achieving milestones and providing non-federal share of funding. Federal funding was calculated based on a year-by-year analysis of total computable DSRIP funding and the federal medical assistance percentage (FMAP) for that year, which may vary slightly from actual federal funds paid. DSRIP funding as a percent of total Medicaid spending in the state was estimated based on historic spending and Congressional Budget Office Medicaid spending projections applied to fiscal year 2014 spending. Definitions of DSRIP projects vary by state and may change due to subsequent DSRIP plan modifications.

[1] Massachusetts's Delivery System Transformation Initiative (DSTI) was initially approved for three years and was extended for three years in October 2014 to include additional funding and create a new Public Hospital Transformation and Incentive Initiative (PHTII) pool, to allow one DSTI hospital to implement additional delivery system reform projects. The table above describes the total funding for DSTI for all 6 years of approval and described the number of projects included in the state's initial DSTI. The $330 million in federal funds for PHTII is not included.

[2] New York estimates that 64,099 unique providers are participating in the state's 25 Performing Provider Systems, but did not provide an estimate of the number of provider organizations (e.g., hospitals and physician groups), which is how other states report their DSRIP participating providers.

Source: Schoenberg et al. 2015; MACPAC analysis of CBO 2015 and CMS-64 Financial Management Report (FMR) net expenditure data as of April 2015 (used to calculate DSRIP funding as a percent of total Medicaid benefit spending).

For example, the Hope Center Clinic in Oakland, which is part of the Alameda County Health System, is implementing a project to provide complex case management for patients struggling to manage their chronic conditions. The program identifies the most costly patients based on prior avoidable emergency department use and provides them with ongoing care in an outpatient setting. For the first milestone and subsequent payment, the Hope Clinic was required to develop a plan for two disease-specific care management clinics (including staffing model, budget, space, and scheduling logistics). Other milestones were based on reporting objectives, for example, reporting the number of patients enrolled into the Complex Care Clinic. In the last year of the demonstration, the final milestone requires the Hope Clinic to complete a cost-effectiveness study of utilization and patient satisfaction of the Complex Care Clinic. Initial program results of the Complex Care Clinic show a 20 percent reduction in admissions per patient per year and a 23 percent reduction in bed days per patient per year (CAPH 2014).

Overall, the Alameda County Health System may earn up to $14 million (state and federal) for this complex case management project and a total of $300 million (state and federal) over five years for completing all 19 of its DSRIP projects, which include a total of over 100 distinct milestones.[17] On average, this level of DSRIP funding per year is equal to approximately one quarter of the hospital's 2010 total Medicaid revenue (MACPAC 2015a).[18] Alameda County Health System finances the state share of this project and its other DSRIP projects through its own IGT funding.

Texas

The Texas DSRIP program is open to virtually all Medicaid providers in the state, including community mental health centers, physicians, and local health departments. DSRIP providers are organized into 20 Regional Healthcare Partnerships (RHPs), which are anchored by a public hospital or other governmental entity. Each RHP anchor is responsible for coordinating activities such as conducting community needs assessments, managing reports, and convening learning collaboratives for otherwise independent DSRIP providers.

More than 300 providers are implementing over 1,400 DSRIP projects in Texas. In addition to the projects proposed by 224 hospital providers, DSRIP projects were also submitted by 38 community mental health centers, 20 local health departments, and 18 physician groups.[19] A wide variety of projects are being implemented, but the most common are: (1) projects that expand access to primary and specialty care, (2) behavioral health interventions to prevent unnecessary use of services in more acute settings, and (3) programs to help targeted patients navigate the health care system (Khalsa 2014). Each project is linked to one or more corresponding quality outcome improvement milestones, which are a basis for payment in the final two years of implementation.

One example of regional collaboration in the Texas DSRIP program can be found in Austin, Texas. The county's health district (Central Health) and the largest hospital system in Austin (Seton Healthcare Family) joined together to form the Community Care Collaborative (CCC), the initial phase of an integrated delivery system for the safety net population. This jointly owned non-profit is implementing 15 DSRIP projects that are performed by contracted service providers within the community. For example, the CCC is partnering with Travis County's three federally qualified health centers (FQHCs) to structure and standardize the treatment of individuals with certain high-prevalence chronic conditions, like diabetes and congestive heart failure, and to provide integrated treatment for approximately 1,000 patients with co-occurring depression and diabetes. Through its contracted providers, the CCC is also partnering with churches and food pantries using mobile health teams to bring primary care and chronic care management services to patients with limited access, including individuals who are homeless or living in geographically underserved communities (CCC 2013).

The CCC is eligible to receive a total of approximately $240 million (state and federal) over four years for the implementation of its DSRIP projects. Most of this funding ($157 million) is for project implementation and about one quarter of the funding ($62 million) is based on reporting and improvement in corresponding outcome measures. The CCC also is eligible to receive up to $21 million over four years for reporting on a standard set of population health measures that most DSRIP hospitals are required to report.

Central Health, the public health care district that is part owner of the CCC, provides the state share for the CCC's projects and 18 other projects in its RHP (Central Health 2014). Travis County voters approved a tax increase in 2012, at the start of the DSRIP implementation process, in order to make funding for this IGT and other health care projects available.

Massachusetts

The Massachusetts Delivery System Transformation Initiative (DSTI) program is open to seven hospitals serving a high volume of Medicaid patients. Each hospital implements projects focused on the goals of developing integrated delivery systems, moving toward value-based purchasing, and instituting population-focused improvements. Outcome measures were initially included for most projects on a reporting basis, but as part of the state's three-year DSTI extension, the state is required to transition more DSTI funding toward improvement on quality outcomes.

The October 2014 extension of the state's demonstration also includes a new Public Hospital Transformation and Incentive Initiative (PHTII) pool, which will allow one DSTI hospital (Cambridge Health Alliance) to implement additional delivery system reform projects to improve its capacity to operate as an accountable care organization for Medicaid. As part of the PHTII authorized under the Massachusetts demonstration renewal, Cambridge Health Alliance is eligible to receive $660 million over three years to expand these efforts.

New Jersey

New Jersey's DSRIP program is open to all 63 acute hospitals in New Jersey that previously received supplemental payments, and 50 hospitals are participating. Each hospital is implementing a project focusing on one of eight conditions: HIV/AIDS, cardiac care, asthma, diabetes, obesity, pneumonia, behavioral health, or substance abuse conditions.

New Jersey's DSRIP program was the first to include a high performance fund to reward providers for exceeding benchmark performance on a core set of quality measures. The high performance fund is composed of some funds set aside from the initial DSRIP allocation and any unclaimed DSRIP funding from providers that do not meet earlier DSRIP milestones.

One example of a DSRIP project in New Jersey is Robert Wood Johnson University Hospital's Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions. Eligible patients are selected to participate based on criteria including income, having a cardiac disease or risk factors for developing a cardiac disease, and being at high risk for readmission due to a cardiac condition. Once patients are enrolled in the project, a patient navigator, typically a registered nurse, reviews all cases and discusses any medication issues with physicians. Once patients have been discharged, a nurse makes home visits within 48 hours to high-risk patients to perform a symptom and medication check; for instance, it might be possible for a physician to prescribe a more affordable medication. Within seven days of hospital discharge, patients have a follow-up appointment at a discharge clinic set up in the hospital. Finally, a social worker follows up with three phone calls to identify any outstanding issues that may lead to readmission. The hospital is eligible to receive approximately $4 million (state

and federal) a year, which represents less than 5 percent of the hospital's 2010 total Medicaid revenue (MACPAC 2015b).[20]

Kansas

Kansas's DSRIP program only includes one teaching hospital and one children's hospital. These hospitals were receiving UPL supplemental payments prior to the implementation of the demonstration.

Each hospital is implementing at least two projects related to either access to integrated delivery systems, the prevention and management of chronic diseases, or both. For example, the University of Kansas hospital is using DSRIP funding to provide additional monitoring for heart failure patients and their caregivers following a hospital discharge. The program also provides training and education, so that these patients can monitor their condition at home. The goal of the program is to improve health outcomes and reduce hospital readmissions (University of Kansas 2014). Both participating hospitals receive larger DSRIP funding if they partner with other providers across the state, particularly in rural and underserved areas. Each project is linked to pay-for-performance outcome measures, which are collected and calculated by the state's external quality review organization.

New York

New York's DSRIP is open to providers who collaborate to form a Performing Provider System (PPS), a coalition of providers that assume responsibility for improving health outcomes for a defined patient population. The New York DSRIP program is the only DSRIP program that includes a statewide outcome improvement goal to reduce avoidable hospital use by 25 percent over five years.

While hospitals generally serve as the anchor entities for these systems, a wide variety of providers can participate, including hospitals, health homes, nursing facilities, and any other Medicaid provider that meets the state's definition of a safety net provider.[21] In addition to playing a coordinating role similar to RHP anchors in Texas, the anchor entity for a New York PPS is also fiscally responsible for distributing DSRIP payments among participating providers.

Each PPS will implement 5 to 11 projects focusing on system transformation and clinical and population-wide improvements. The DSRIP funding for each project will be based on each project's application score and the number of individuals attributed to each PPS. By the final year of the demonstration, all of the funding will be allocated toward outcome milestones. In addition, the demonstration includes a high performance fund for providers (similar to New Jersey) and a penalty for all providers if statewide performance standards are not met.

A total of 25 New York PPS coalitions have submitted applications to implement a total of 258 DSRIP projects. The three most commonly selected projects are integration of primary and behavioral health, creation of integrated delivery systems, and implementation of care transitions intervention models to reduce 30-day readmissions for chronic disease (Shearer et al. 2015). The state estimates that more than 64,000 unique providers are participating in this program (Schoenberg et. al 2015).

DSRIP-like programs

In addition to the DSRIP programs described above, CMS has approved provider-based quality incentive programs in New Mexico and Oregon, also using Section 1115 expenditure authority. In this chapter, we refer to these programs as DSRIP-like because they do not include funding for the implementation of particular projects. The structure of these DSRIP-like programs and their relationship to full DSRIP programs are briefly described below.

New Mexico. New Mexico's Hospital Quality Improvement Incentive (HQII) program was

approved in 2012 as part of the state's Centennial Care Section 1115 waiver. This program provides a total of $20 million (in federal funds) to 29 hospitals over five years. The program is different from DSRIP programs in other states because there are no specific hospital projects that providers implement. Instead, the funding is tied solely to each hospital's performance on a common set of quality measures, primarily measures of hospital safety and preventative care.

Oregon. Oregon added a Hospital Transformation Performance Program (HTPP) to its Oregon Health Plan Section 1115 waiver in June 2014. This program provides approximately $95 million a year in federal funds to urban hospitals with more than 50 beds. Participating hospitals are required to report and improve on a set of quality measures that are similar to the measures used for the state's Coordinated Care Organizations (CCOs), which are also authorized under the state's Section 1115 waiver.[22] Similar to New Mexico's HQII, Oregon's program does not have any specific projects for providers to implement.

MACPAC Interviews and Site Visits

To better understand the role of DSRIP programs in the Medicaid delivery system, MACPAC contracted with NASHP to document and analyze the variety and common features of DSRIP programs. The project sought to provide a comprehensive review of all existing DSRIP programs, as well as an in-depth examination of the DSRIP's genesis, goals, and functioning in three states.

The project had three phases. In the first phase, NASHP conducted an environmental scan of six state DSRIP programs and two DSRIP-like programs to gather information on state goals and DSRIP categories, participating providers, financing mechanisms, provider projects, clinical outcomes, program reporting and monitoring, and outputs to date. Following the environmental scan, NASHP conducted key informant interviews with Medicaid officials in four states (New York, New Mexico, Oregon, and Massachusetts) and with CMS officials to verify material collected in the environmental scan and gather additional information such as state and federal experiences with DSRIP implementation and lessons learned. Finally, site visits were conducted in Texas, New Jersey, and California. These states were selected to represent various stages of DSRIP program development, implementation, and experience. California is in the final year of its program, Texas is mid-way through implementation, and New Jersey began project implementation at the end of 2014. Interviews and site visits were conducted between September and December, 2014.

Themes from interviews and site visits

Below, we describe five themes that emerged from these interviews and site visits. These reflect the perspectives of hospital administrators and other providers, state and CMS officials, and state evaluators on the purpose of the program, the challenges of operating and financing the program, their efforts to understand whether DSRIP programs are succeeding, and the future of delivery system transformation.

While many states view DSRIP programs as a way to preserve or make new supplemental payments, CMS describes the primary purpose of DSRIP programs as catalyzing delivery system transformation. Although CMS describes DSRIP programs as a tool primarily intended to assist states in transforming their delivery systems in order to fundamentally improve care for beneficiaries, states have been candid that DSRIP programs have been pursued as a means to make supplemental payments. With the introduction of DSRIP programs, states shift from a system where supplemental funding was designed to make up for Medicaid payment shortfalls toward a system where funding is earned when quality and improvement goals are met. This has been a

significant culture shift for state Medicaid officials and health care providers, and stakeholders reported that the culture continues to evolve.

Differing perspectives on the purpose of DSRIP programs lead to differing expectations for the scope and breadth of delivery system transformation. If DSRIP programs are considered to be a replacement for prior supplemental payments, then states and providers may expect to limit funding to hospitals that previously received supplemental payments. On the other hand, if DSRIP programs are seen primarily as tools for transformation, then DSRIP programs may be expected to expand to other providers that are also critical to systemwide change. At issue is whether state DSRIPs are meant to stimulate improvement for all providers or to stabilize particular providers that have historically received supplemental payments and serve a high proportion of Medicaid enrollees and uninsured individuals.

The relationship between DSRIP and supplemental payments is complicated and evolving. Although early DSRIP demonstrations often replaced or expanded prior supplemental payments, New York's DSRIP is not related to prior supplemental payments and is primarily focused on supporting the state's delivery system goals. More recently, as part of the extension of Massachusetts's DSTI program, CMS required the state to conduct an analysis of the interplay between the DSRIP and other types of provider financing in order to provide insight into how the state's supplemental payment programs will look in the future.

States reported that finding a source of non-federal share was a challenge. States and providers noted that finding a source of non-federal share is difficult, and presents a host of complications (political, technical, and financial). States report federal inconsistency on policies such as IGTs and other sources of non-federal share for DSRIP programs. In many states, the provision of the non-federal share is directly linked to which participants qualify for DSRIP, which can inhibit non-public provider's participation. Furthermore, the entity providing the non-federal share may net less DSRIP funding than a privately owned health care provider for comparable work after accounting for IGT contributions.

DSRIP implementation is resource intensive for states, providers, and the federal government States, providers, and federal officials suggest that DSRIP mechanisms for accountability have produced results, but have also required substantial upfront investment. Most states have increased staff or consulting capacity and expertise in clinical quality and performance improvement. For example, the Texas Health and Human Services Commission dedicated an additional 13 full-time equivalent employees to support the administration of DSRIP. Providers, too, report adding staff and contractor time to implement projects, comply with DSRIP reporting, and address data and technology limitations.

The significant administrative burden of DSRIP was highlighted by all stakeholders. State officials and providers expressed concerns that the DSRIP program negotiation and approval process took longer than anticipated, and truncated the time for implementation of delivery system reforms. They also expressed concern that operational delays shortened the implementation time frame, which might limit providers' ability to realize the full potential of reforms. CMS officials have noted that they too find the administration challenging but that the size and complexity of the programs require greater oversight. While participants understand the value of DSRIP monitoring and federal oversight, they question whether there may be an equally valuable, but less administratively burdensome approach.

DSRIP program evaluation is challenging and results are not yet available. Most DSRIP programs are currently in their initial approval period, with the exception of Massachusetts, which was extended for an additional three years in October 2014. States continue to develop evaluation plans and

collect data, but no state has yet completed a final evaluation of its DSRIP.

At the time of our interviews, most states did not yet have aggregate data demonstrating improved health outcomes or cost savings. Absent these data, states reported that they could not yet determine if the DSRIP program reforms could be sustained. State officials were enthusiastic that early provider reports suggested that the projects were bringing about real change in the delivery of care and improving the health of Medicaid beneficiaries. However, they were concerned that more time is needed to fully realize their vision for transformation and that continued funding would be needed to sustain improvements in the short term.

Officials in California and Texas, who had completed or were in the process of conducting mid-point assessment of their DSRIP programs at the time of our interviews, reported that they encountered challenges in collecting data from providers. And once collected, it took considerable effort to format data from different providers so that it would be useful for making comparisons.

States and providers expressed concerns about sustainability. While most states were interested in continuing DSRIP after their initial approval period, they were uncertain how long CMS would make DSRIP funding available. In the fall of 2014, CMS extended the DSTI program in Massachusetts for an additional three years, instead of the five years that the state initially requested. CMS is currently reviewing a request from California to renew its DSRIP program for an additional five years.

Providers also expressed concern about the sustainability of the programs without DSRIP funding. The infusion of capital from DSRIP payments allowed providers to enhance their services for Medicaid enrollees by allowing them to develop infrastructure, increase their capacity, or provide new services. Providers were optimistic that these enhancements improved the quality of care provided to their patients. At the same time, they expressed concern that the time frame to implement projects was not sufficient to realize their performance goals. Some providers noted that without continued funding, DSRIP projects would be discontinued and providers would not realize their goals for the transformation of care delivery and improved health outcomes. This raises questions about whether capital is needed as a one-time investment or on an ongoing basis, and the length of time necessary to realize transformation goals.

Policy Implications

While DSRIP policy continues to evolve with each new demonstration, our analysis raises a number of larger policy issues that the Commission will explore as states continue to implement and evaluate their DSRIP programs. We highlight four policy implications below.

Medicaid's role in delivery system transformation. The DSRIP approach, if taken to scale, has the potential to fundamentally change Medicaid's role from financing medical care to driving system change toward value and improved health outcomes. DSRIP is part of a broader shift from volume-based payment to new approaches that incentivize both prudent use of resources and improvements in health outcomes. This shift is particularly important for providers that serve a high proportion of Medicaid enrollees and otherwise have limited access to capital to invest in new models of care delivery on their own.

On the other hand, DSRIP supplemental payments do not affect the underlying mechanisms by which providers are paid for Medicaid services. Although DSRIP payments are large compared to other funding available for delivery system reform, they represent only a portion of overall Medicaid spending and may not be enough by themselves to support and sustain delivery system reform efforts. Moreover, the process is disruptive for providers that have historically relied on supplemental payments. While risk-based payments are an

important motivator for practice transformation, providers that are particularly reliant on Medicaid supplemental payments will have to reexamine their business model under DSRIP.

The extent to which Medicaid can drive such change will likely depend on the success of specific initiatives such as DSRIP, as well as how such programs align with other approaches to value-based purchasing, both within Medicaid and beyond. For example, as noted earlier, many of the states with DSRIP programs are also implementing accountable care organizations and developing and testing multipayer payment-and-delivery system models under a SIM grant (Schoenberg et al. 2015). The integration of DSRIP with other value-based purchasing efforts has become an increasing focus in more recent DSRIP programs, such as New York, which explicitly requires a plan to transition DSRIP to other value-based payment mechanisms.

Need for federal guidance. As state Medicaid programs embark on a new role through DSRIP, it is the Commission's view that clear and consistent federal guidance is needed. Greater clarity of DSRIP policies and expectations would help states and providers implement their programs (for instance, addressing some of the delays that occurred in the states we studied) and also allow for more effective involvement of external stakeholders, such as consumer groups. In addition, while Section 1115 demonstration negotiations are state-specific by design, greater consistency around DSRIP program design, policies, and goals would help reduce barriers for new states interested in implementing DSRIP programs.

In the most recently approved DSRIP programs, CMS has begun to further standardize DSRIP program design. For example, performance measurements are increasingly prescriptive, with predefined, population-based outcome targets replacing provider-defined improvement goals based on their own facilities and patients. However, these efforts at standardization have been limited to state-by-state waiver negotiations and their applicability to other states are unclear.

Medicaid supplemental payments. DSRIP programs provide more transparency about payment than UPL supplemental payment programs, the lack of transparency of which was noted by the Commission in its March 2014 report. DSRIP programs and processes are well documented in the special terms and conditions of each demonstration and in state protocols. As a result, there is more information available about DSRIP than about UPL supplemental payments regarding which providers are eligible to receive payments, how much they can receive, and the milestones and achievements that are tied to payments.

Even so, most state Medicaid programs continue to make UPL supplemental payments. The concerns the Commission raised about the ability to analyze these payments at the provider level and about the lack of transparency around their use remain significant. Moreover, while there is growing interest among states in implementing the DSRIP approach, the budget neutrality test and other federal requirements of Section 1115 waivers may limit the ability of all states to adopt this model.

Value of cross-state evaluation. Finally, given the potential of DSRIP to transform care delivery and the amount of funding at stake, it is important to independently assess the success of these programs. Evaluating the success of DSRIP programs should go beyond whether or not providers achieved their particular milestones and whether budget neutrality is maintained. In particular, it is critical to learn whether the quality and access improvements achieved through DSRIP are sustainable in the long-term without DSRIP payments.

Although each state is required to evaluate its own program, measures should also be aligned across states wherever possible to promote cross-state comparison. A cross-state synthesis of DSRIP outcomes would be a valuable addition to state-specific findings.

Endnotes

[1] We include the Massachusetts Delivery System Transformation Initiative (DSTI) in our analysis of DSRIP programs because it uses a similar structure. Other Section 1115 demonstrations with quality-related provider incentive programs, such as New Mexico and Oregon, do not include direct funding for project implementation and are thus described as "DSRIP-like" programs in this report.

[2] A supplemental payment is a Medicaid payment to a provider, typically in a lump sum, that is made in addition to the standard payment rates for services. More background information on Medicaid supplemental payments can be found in Chapter 6 of MACPAC's March 2014 report.

[3] DSH payments are supplemental payments to hospitals that serve a disproportionate share of low-income patients. Payments to each hospital are limited to the actual cost of uncompensated care to Medicaid enrollees and uninsured individuals for hospital services.

[4] We consider DSRIPs to be supplemental payments because they are Medicaid payments to a provider made in addition to the standard payment rates for services. However, DSRIPs are not directly linked to Medicaid services provided.

[5] There are two exceptions: states can make DSH and graduate medical education (GME) supplemental payments under capitated managed care. In addition, states can make payments directly to providers for Medicaid services not included in the capitation rate.

[6] Four of the six approved DSRIP programs (California, Texas, Massachusetts, and Kansas) operate in parallel to uncompensated care pools, which pay providers for the costs of providing uncompensated care. The relationship between the DSRIP program and such pools varies by state. For example, the size of the Texas uncompensated care pool is linked to the amount of DSRIP funding available. Over the duration of the waiver, funding for uncompensated care decreases while funding for DSRIPs increases. In other states, the relationship is less direct (Schoenberg et al. 2015). While uncompensated care pools are tied directly to underpayment for Medicaid services and care for the uninsured (similar to DSH), DSRIP payments are not considered payments for services.

[7] New York's draft value-based payment roadmap does not have a single definition of value, but rather it outlines a menu of potential payment methodologies. The draft framework discourages incentive payments based on quality scores alone and instead promotes shared savings methodologies that are linked to the total cost of care for a particular population or service (such as integrated primary care or episodic care bundles). Global capitation and bundled payments are highlighted as the highest level of value-based purchasing. This model will continue to evolve as it is reviewed by CMS (NYDOH 2015).

[8] In all states except for New Jersey, providers may implement multiple concurrent projects. Hospitals in New Jersey can only implement one project.

[9] In the Texas DSRIP program, partial payment is only permitted for outcome improvement milestones (referred to as Category 3 milestones).

[10] For example, the New York DSRIP program requires providers to set outcome improvement targets based on a gap-to-goal methodology modeled after the Quality Improvement System for Managed Care (QISMC) method. The state establishes a high performance goal for each outcome measure and providers must close 10 percent of the gap between the baseline performance and the high performance goal each year.

[11] New York estimates that 64,099 unique providers are participating in the state's 25 Performing Provider Systems, but did not provide an estimate of the number of provider organizations (e.g., hospitals and physician groups), which is how other states report their DSRIP participating providers (Schoenberg et al. 2015).

[12] In New Jersey, the state's DSRIP program is open to all hospitals in the state.

[13] Intergovernmental transfer (IGT) is a transfer of funds from another government entity (e.g., counties, other state agencies, providers operated by state or local government) to the Medicaid agency.

[14] DSHPs are authorized under Section 1115 demonstrations and provide states with additional funding for state programs that are related to the health of Medicaid, the State Children's Health Insurance Program (CHIP), and other low-income populations, but

are not Medicaid benefits. By providing federal financing for previously state-funded programs, these DSHP demonstrations make more state funding available to finance additional Medicaid spending on programs such as DSRIP.

[15] New Jersey does not have public hospitals and finances DSRIP through state general revenue. Massachusetts has one public hospital that contributes IGTs toward the state's DSTI program. Other payments to other DSTI providers are financed through state general revenue.

[16] Section 1905(cc) of the Social Security Act limits the ability of states to require political subdivisions to contribute additional IGT funding for Medicaid.

[17] We do not include population health reporting requirements (classified as Category 3 projects in California's DSRIP program) as projects for this comparison because they only include reporting milestones.

[18] Illustrative estimate based on MACPAC analysis of 2010 DSH audit data and provider DSRIP documentation. Total Medicaid payments include disproportionate share hospital payments and are not adjusted for inflation.

[19] As of October 2014, 309 providers were participating in the Texas DSRIP program, slightly more than the 300 DSRIP providers that initially proposed projects.

[20] Illustrative estimate based on MACPAC analysis of 2010 DSH audit data and provider DSRIP documentation. Total Medicaid payments include disproportionate share hospital payments and are not adjusted for inflation.

[21] In New York, up to 5 percent of a performing provider system's DSRIP funding can go to providers that do not meet the state's safety net provider definition.

[22] Oregon currently operates a statewide accountable care model that consists of a network of Coordinated Care Organizations (CCOs). These community-level entities provide coordinated and integrated care to Oregon Medicaid beneficiaries and are held accountable for the populations they serve by operating under a global budget. The state specifically hopes to use its DSRIP-like program, in part, as a vehicle to accelerate transformation and quality improvements in CCOs.

References

American Hospital Association (AHA). 2015. Chapter 4: Trends in hospital financing. In *Trends affecting hospitals and health systems*. Washington, DC: AHA. http://www.aha.org/research/reports/tw/chartbook/ch4.shtml.

Anderson, T., G. Willis, D. Lang, et al. 2013. *MassHealth Section 1115(a) demonstration waiver 2011–2014 interim evaluation report.* September 26, 2013. Worcester, MA: University of Massachusetts Medical School Center for Health Policy and Research. http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/appendix-b-interim-evaluation-of-the-demonstration-09-2013.pdf.

Bachrach, D., L. Braslow, and A. Karl. 2012. *Toward a high performance health care system for vulnerable populations: Funding for safety-net hospitals.* March 2012. New York, NY: The Commonwealth Fund. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2012/mar/1584_bachrach_funding_safety_net_hosps_final.pdf.

California Association of Public Hospitals and Health Systems (CAPH). 2014. *Leading the way: California's Delivery System Reform Incentive Program.* September 2014. Oakland, CA: CAPH. http://caph.org/wp-content/uploads/2014/09/Leading-the-Way-CA-DSRIP-Brief-September-2014-FINAL.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015a. Section 1115 of the Social Security Act Medicaid demonstration: Temporary extension of New York Partnership Plan. March 31, 2015. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/ny-partnership-plan-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015b. Section 1115 of the Social Security Act Medicaid demonstration: Technical corrections to California Bridge to Reform Demonstration. February 27, 2015. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-bridge-to-health-reform-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015c. Section 1115 of the Social Security Act Medicaid demonstration:

Amendment to Texas Healthcare Transformation and Quality Improvement Program. February 26, 2015. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthcare-transformation-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015d. Section 1115 of the Social Security Act Medicaid demonstration: Technical corrections to MassHealth. January 20, 2015. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014a. Section 1115 of the Social Security Act Medicaid demonstration: Technical corrections to New Jersey comprehensive waiver demonstration. August 14, 2014. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014b. Section 1115 of the Social Security Act Medicaid demonstration: Amendment to KanCare. January 29, 2014. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Revised review and approval process for Section 1115 demonstrations. April 27, 2012. Baltimore, MD: CMS. http://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf.

Central Health. 2013. *Transforming health care in Central Texas.* Austin, TX: Central Health. http://communitycarecollaborative.net/wp-content/uploads/2013/12/CH-Brochure-Reprint-v3-Spreads.pdf.

Community Care Collaborative (CCC). 2013. Integrated behavioral health intervention for chronic disease management project. Austin, TX: Texas Regional Health Partnership 7. http://texasregion7rhp.net/wp-content/uploads/2012/09/CCC-IBH-for-Chronic-Disease-Management-Cat-2-N-T.pdf.

Congressional Budget Office (CBO). 2015. Medicaid baseline projections. March 9, 2015. Washington, DC: CBO. https://www.cbo.gov/publication/44204.

Khalsa, A. 2014. Presentation before the House County Affairs Committee, March 10, 2014, Austin, TX. http://www.hhsc.state.tx.us/news/presentations/2014/House-County-Affairs-Committee.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. Analysis of DSH audit data for federal fiscal year 2010 as of April 2015 and California Department of Health Care Services (2015), Delivery System Reform Incentive Payments (DSRIP). http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. Analysis of DSH audit data for federal fiscal year 2010 as of April 2015 and New Jersey Department of Health (2015), DSRIP Payment Schedules. https://dsrip.nj.gov/Home/Payment.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2014. Examining the policy implications of Medicaid non-disproportionate share hospital supplemental payments. In *Report to the Congress on Medicaid and CHIP.* March 2014. Washington, DC: MACPAC. https://www.macpac.gov/publication/ch-6-examining-the-policy-implications-of-medicaid-non-disproportionate-share-hospital-supplemental-payments/.

Millwee, B. 2011. Payment and financing issues in Medicaid managed care expansion. Presentation before the Medicaid and CHIP Payment and Access Commission, November 18, 2011, Washington, DC. http://www.macpac.gov/wp-content/uploads/2014/12/MACPAC_2011-11_Transcript.pdf.

National Association of Medicaid Directors (NAMD). 2014. *Medicaid innovation : Delivery system reform incentive pools.* June 2014. Washington, DC: NAMD. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/medicaid_delivery_system_reform_incentive_pool_1.pdf.

New York State Department of Health (NYDOH). 2015. *VBP roadmap – third draft.* March 2015. Albany, NY: NYDOH.

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/roadmap_third_draft.pdf.

Pourat, N., G. Kominski, D. Roby, et al. 2014. *Interim evaluation report on California's Delivery System Reform Incentive Payments (DSRIP) program.* September 2014. Los Angeles, CA: UCLA Center for Health Policy Research. http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCDSRIP.PDF.

Schoenberg, M., F. Heider, J. Rosenthal, et al. 2015. *State experiences designing and implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) pools.* June 15, 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/State-experiences-designing-and-implementing-Medicaid-Delivery-System-Reform-Incentive-Payment-pools/.

Shearer, C., L. Kennedy-Shaffer, and N. Myers. 2015. *Performing Provider System projects: Tackling the health needs of communities.* January 16, 2015. New York, NY: United Hospital Fund. https://www.uhfnyc.org/publications/881032.

Texas Health and Human Services Commission (HHSC). 2015. *Texas healthcare transformation and quality improvement program. Section 1115 quarterly, biannual, and annual Report.* January 2015. Austin, TX: HHSC. http://www.hhsc.state.tx.us/1115-docs/2014-1115-4th-quarterly-and-annual-report.pdf.

University of Kansas. 2014. *Supporting personal accountability and resiliency for chronic conditions (SPARCC).* December 16, 2014. Lawrence, KS: University of Kansas. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-SPARCC-12162014.pdf.