Implications of the Latest Round of Delivery System Reform Incentive Payment (DSRIP) Waivers for MACPAC's Work on Value-Based Payment

Medicaid and CHIP Payment and Access Commission

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Medicaid Payment Policy

- MACPAC is required to examine state payment policies and their relationship to access and quality of care
- Key questions:
  - What payment methods promote efficiency and value?
  - How can disproportionate share hospital (DSH) payments be better targeted to states and hospitals that need them most?
  - What is the future of value-based payment in Medicaid?

Overview

- Background on current value-based payment efforts in Medicaid
- Findings from our recent study of Delivery System Reform Incentive Payment (DSRIP) programs
- Implications for MACPAC's work on value-based payment
- Policy questions

Value-Based Payment in Medicaid

- State Medicaid programs have implemented a variety of value-based payment models, including:
  - Enhanced payments to patient centered medical homes (PCMH) and health homes
  - Shared savings payments to Medicaid accountable care organizations (ACOs)
  - Episode-based payments
  - Global budgets
  - DSRIP

Delivery System Reform Incentive Payment Programs

- DSRIP programs provide incentive payments to providers that undertake delivery system reform projects and meet milestones
  - Payment is tied to meeting implementation, reporting, and performance milestones
- Authorized under Section 1115 waiver authority
- MACPAC reported on DSRIP programs in its June 2015 report, and conducted a follow-up study between August 2016 and August 2017

Evolution of DSRIP Program Design

- During our follow-up study, we noted several differences between early DSRIPs (approved before 2014) and more recent DSRIPs
- Compared to earlier DSRIPs, newer DSRIPs:
  - Do not have a relationship to prior supplemental payment programs
  - Use designated state health program (DSHP) funds to finance the non-federal share of DSRIP
  - Support the formation of provider networks made up of hospital and non-hospital providers
  - Are more explicitly focused on statewide delivery system reform goals

Currently Approved DSRIP Programs, 2017

State	Date initially approved/ renewed	Program name	Total funding (millions)	Source of non-federal share	Preserves prior supplemental payments?
California	Nov. 2010/ Dec. 2015	DSRIP/ Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	$14,130	IGT	Yes
Texas	Dec. 2011	DSRIP	$15,300	IGT	Yes
Massachusetts	Dec. 2011/ Nov. 2016	Delivery System Transformation Initiative (DSTI)/DSRIP	$3,120	State revenue and provider taxes	Yes
New Mexico	Nov. 2012	Hospital Quality Improvement Incentive Program	$29	State revenue and IGT	Yes
New Jersey	Oct. 2012	DSRIP	$583	State revenue	Yes
Kansas	Dec. 2012	DSRIP	$60	IGT	Yes
New York	Apr. 2014	DSRIP	$12,840	IGT and DSHP	No
Oregon	Jun. 2014	Hospital Transformation Performance Program	$600	Provider taxes	No
New Hampshire	Jan. 2016	DSRIP	$150	DSHP and CPE	No
Alabama[1]	Feb. 2016	Integrated Provider System	$278	DSHP	No
Rhode Island	Oct. 2016	Health System Transformation Project	$195	DSHP	No
Washington	Jan. 2017	DSRIP	$1,130	DSHP and IGT	No
Arizona	Jan. 2017	Targeted Investments Program	$300	DSHP and IGT	No

Notes: DSRIP is delivery system reform incentive payment. IGT is intergovernmental transfer. DSHP is designated state health program. CPE is certified public expenditure. Total funding includes state and federal funds for DSRIP activities. Demonstrations that preserved prior supplemental payments include prior upper payment limit (UPL) or disproportionate share hospital (DSH) payments in the budget neutrality assumptions for the demonstration; in other words, savings from the elimination of UPL or DSH payments in these states is used to help justify the approval of DSRIP expenditure authority.

[1] Alabama is not planning to implement their approved DSRIP-like program.

Source: NASHP, 2017, analysis for MACPAC of Section 1115 demonstration special terms and conditions.

Implications for MACPAC's Work on Value-Based Payment

- States have used DSRIP to address many common challenges identified across Medicaid value-based payment models
  - Accessing capital for upfront investments
  - Incentivizing providers to change their behavior
  - Preparing providers to participate in alternative payment models (APMs)
  - Addressing social determinants of health
  - Evaluating effects on health outcomes and spending

Upfront Investments in Delivery System Transformation

- DSRIP provides additional federal funds for providers to invest in infrastructure and care improvements
  - Over the course of the demonstration, incentive funding shifts from project implementation milestones to pay-for-performance milestones
- States report challenges financing the non-federal share of DSRIP investments
  - DSHP funding allows states to finance the non-federal share without relying on intergovernmental transfers (IGTs) from public providers

Incentivizing Providers to Change Behavior

- DSRIP provides a mechanism for states that use managed care delivery systems to invest directly in provider-led projects
  - Under capitated managed care, states generally cannot make payments directly to providers for services included in the capitation rate
- Newer DSRIP programs are encouraging the formation of provider partnerships that are beginning to take on some roles traditionally done by managed care plans

Alternative Payment Models

- Some newer DSRIP programs include statewide goals for adoption of APMs, such as shared savings arrangements
- Providers reported that DSRIP investments were helping them prepare to participate in APMs by:
  - Investing in infrastructure needed to monitor performance
  - Gradually transitioning from pay-for-reporting to pay-for-performance

Social Determinants of Health

- Providers can use DSRIP funds to support investments in population health activities and other services not covered by Medicaid
- Some states direct a portion of DSRIP funding to community-based organizations
  - In Massachusetts, funding is provided to community-based organizations directly
  - In New York, funding for community-based organizations flows through DSRIP provider networks

Evaluation

- States are required to conduct interim and final evaluations of their DSRIP programs
- Evaluations so far show that DSRIP providers are meeting their milestones and are demonstrating some improvement in health outcomes
- It is difficult to evaluate whether these changes would have occurred without the demonstration

Future of DSRIP

- In recent DSRIP approvals, CMS has indicated that it views DSRIP as a one-time investment
- CMS has encouraged states to develop plans to sustain DSRIP activities through managed care
  - CMS's 2016 revised managed care regulations added a new option for states to direct payments to providers for delivery system reform activities
  - Arizona's Targeted Investment Program appears to be permissible under this new authority
- States and providers we interviewed expressed uncertainty about how this model would work in practice

Policy Questions

- How should upfront investments in delivery system reform be financed?
- How do current managed care regulations affect states' ability to pursue DSRIP-like approaches without a Section 1115 waiver?
- To what extent should the performance measures and program design of Medicaid value-based payment models align with other payers?
- How can Medicaid payment approaches facilitate state efforts to address the social determinants of health?
- How can the evaluation design of DSRIP and other value-based programs be improved to make evaluation findings more useful for policymakers?

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