Delivery System Reform Incentive Payment Programs

State and federal policymakers have expressed interest in reforming the health care delivery system to use resources more efficiently and direct resources in ways that improve health outcomes and population health. States have implemented various strategies for changing health care delivery in their Medicaid programs, including delivery system reform incentive payment (DSRIP) programs.

Thirteen states have implemented DSRIP or DSRIP-like programs that invest in provider-led projects designed to advance statewide delivery system reform goals. California implemented the first DSRIP program in 2010. Since then, 12 additional states—Alabama, Arizona, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Texas, and Washington—have implemented DSRIP or DSRIP-like programs. All of these efforts have been approved as part of broader demonstrations under Section 1115 of the Social Security Act (the Act).

This brief describes the design and structure of these programs and how they have evolved over time. Our analysis draws on work published in MACPAC’s June 2015 report to Congress as well as newer information gleaned from key informant interviews conducted in 2016 and 2017 with officials from state Medicaid agencies, Medicaid managed care organizations (MCOs), and provider organizations, as well as site visits to New York and Massachusetts.

Overview

Currently DSRIP or DSRIP-like programs are operating in 13 states (Table 1). These programs allow states to make supplemental payments to providers that otherwise would not be permitted under federal managed care rules and to invest in provider-led projects to advance statewide delivery system reform goals. As of June 2017, $48.6 billion in state and federal funds had been approved for such efforts.

Increasing use of managed care in Medicaid is one factor contributing to state decisions to pursue DSRIP or other waivers that allow them to continue or make new supplemental payments. While many states have made extensive use of supplemental payments—referred to as upper payment limit (UPL) payments—under fee for service, states cannot make UPL payments in capitated managed care programs. However, Section 1115 waiver authority can be used to continue or make new targeted supplemental payments to providers while implementing managed care. Since 2010, all new Section 1115 waivers authorizing supplemental payments have included a DSRIP program or similar quality improvement component.
<table>
<thead>
<tr>
<th>State</th>
<th>Date initially approved</th>
<th>Program name</th>
<th>Implementation timeframe</th>
<th>Total maximum state and federal DSRIP funding (millions)</th>
<th>Source of non-federal share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early programs (approved before 2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>November 2010</td>
<td>DSRIP</td>
<td>5 years (2010–2015)</td>
<td>$6,671</td>
<td>IGT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Hospital Redesign and Incentives in Medi-Cal (PRIME)</td>
<td>5 years (2016–2020)</td>
<td>$7,464</td>
<td>IGT</td>
</tr>
<tr>
<td>Texas¹</td>
<td>December 2011</td>
<td>DSRIP</td>
<td>5 years (2011–2016)</td>
<td>$11,418</td>
<td>IGT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DSRIP</td>
<td>15 months (2016–2017)</td>
<td>$3,875</td>
<td>IGT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DSRIP</td>
<td>4 years (2017–2021)</td>
<td>$10,825</td>
<td>IGT</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>December 2011</td>
<td>Delivery System Transformation Initiative (DSTI)</td>
<td>6 years (2011–2017)</td>
<td>$13,192</td>
<td>state revenue and IGT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DSRIP</td>
<td>5 years (2017–2022)</td>
<td>$1,800</td>
<td>state revenue and provider taxes</td>
</tr>
<tr>
<td>New Mexico</td>
<td>November 2012</td>
<td>Hospital Quality Improvement Incentive (HQII) Program</td>
<td>4 years (2015–2018)</td>
<td>$29</td>
<td>state revenue and IGT</td>
</tr>
<tr>
<td>New Jersey</td>
<td>October 2012</td>
<td>DSRIP</td>
<td>4 years (2014–2017)</td>
<td>$583</td>
<td>state revenue</td>
</tr>
<tr>
<td>Kansas</td>
<td>December 2012</td>
<td>DSRIP</td>
<td>3 years (2014–2017)</td>
<td>$60</td>
<td>IGT</td>
</tr>
<tr>
<td>Recent programs (approved after 2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>April 2014</td>
<td>DSRIP</td>
<td>6 years (2014–2019)</td>
<td>$12,837</td>
<td>IGT and DSHP</td>
</tr>
<tr>
<td>Oregon</td>
<td>June 2014</td>
<td>Hospital Transformation Performance Program (HTPP)</td>
<td>2 years + 2 year extension (2014–2018)</td>
<td>$600</td>
<td>provider taxes</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>January 2016</td>
<td>DSRIP</td>
<td>5 years (2016–2020)</td>
<td>$150</td>
<td>DSHP and CPE</td>
</tr>
<tr>
<td>Alabama</td>
<td>February 2016</td>
<td>Integrated Provider System (IPS)</td>
<td>5 years (2017–2022)</td>
<td>$278</td>
<td>DSHP</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>October 2016</td>
<td>DSRIP</td>
<td>3 years + 2-year extension (2016–2020)</td>
<td>$195</td>
<td>DSHP</td>
</tr>
<tr>
<td>Washington</td>
<td>January 2017</td>
<td>DSRIP</td>
<td>5 years (2017–2021)</td>
<td>$1,125</td>
<td>DSHP and IGT</td>
</tr>
<tr>
<td>Arizona</td>
<td>January 2017</td>
<td>Targeted Investments Program</td>
<td>5 years (2016–2021)</td>
<td>$300</td>
<td>DSHP and IGT</td>
</tr>
</tbody>
</table>
Notes: IGT is intergovernmental transfer. DSHP is designated state health program. CPE is certified public expenditure. More information on financing the non-federal share of Medicaid spending can be found at https://www.macpac.gov/subtopic/non-federal-financing/. Total funding amounts represent maximum potential funding; earning the funding is contingent upon achieving milestones and providing non-federal share of funding.

1 Texas’s DSRIP was extended for 15 months in May, 2016, and extended for four years in December, 2017. The total DSRIP funding for the 15 month extension was adjusted from $3,875 million to $3,100 million, and the difference was allocated to the first demonstration year of the most recent extension.

2 Massachusetts DSTI funding represents two iterations of DSTI funding.


DSRIP Program Design

Although the Centers for Medicare & Medicaid Services (CMS) has not issued formal guidance defining DSRIP, approved DSRIP programs share several design features. Generally, DSRIP is a mechanism for providing Medicaid payments to qualifying organizations implementing infrastructure and care transformation initiatives that support state and federal delivery system reform goals. Each state adapts this framework to its specific Medicaid program goals, as negotiated between the state and CMS.

In general, there are several differences between early DSRIP programs (approved prior to 2014) and more recent programs. In the more recent waivers, key policy changes include:

- increased focus on delivery system reform goals rather than preserving prior supplemental payments;
- increased use of provider partnerships;
- the addition of statewide performance milestones;
- increased use of designated state health programs (DSHP) to finance DSRIP investments;
- more standardized monitoring and evaluation requirements; and
- requirements to develop plans for sustaining DSRIP activities through value-based purchasing strategies in managed care.

Below we describe common DSRIP features and how they have evolved over time. We begin by describing program goals, the types of providers eligible to participate, and how DSRIP funds are distributed. Then we describe how DSRIP programs are financed and evaluated. We conclude by discussing state plans to sustain DSRIP investments in the future without DSRIP funding.

Program goals

DSRIP programs aim to advance state and federal delivery system reform goals, such as reducing avoidable hospital use, improving care coordination, and improving the integration of physical and behavioral health services. Some states are implementing DSRIP programs alongside other Medicaid payment initiatives that have similar objectives, including Medicaid health homes and Innovation Accelerator Program (IAP) initiatives, and some states are implementing DSRIP alongside multi-payer reform efforts, such as the State Innovation Model (SIM) grants from the CMS innovation center.

Earlier DSRIP programs also used DSRIP as a mechanism to preserve or make new supplemental payments to providers. These states (California, Kansas, Massachusetts, New Jersey, New Mexico, and
Texas) were increasing the use of managed care, but were prohibited under the Medicaid managed care rules from making non-DSH supplemental payments to providers in addition to capitated managed care payments. Section 1115 waiver authority allowed them to continue or make new supplemental payments, and the federal government required that these payments be tied to improvements in quality or health outcomes.

However, more recent DSRIP programs do not have a relationship with prior supplemental payment programs. They are not associated with managed care expansions and are more explicitly focused on delivery system reform goals. New Hampshire’s DSRIP program, for example, focuses on strengthening the state’s mental health and substance use disorder delivery system. The focus on delivery system reform goals in newer DSRIP programs is also reflected in decisions to distribute DSRIP payments to both hospitals and non-hospital providers, and in more specific goals for milestone achievement.

Eligible providers

States specify which providers are eligible to receive DSRIP funding. Most early programs limited eligibility to hospitals that previously received supplemental payments and served a large share of Medicaid enrollees and uninsured individuals. More recently approved programs support the formation of provider partnerships made up of hospitals and providers such as clinics, behavioral health providers, community-based organizations, and others. Texas was the first state to use DSRIP funds to support provider partnerships; this approach has since been adopted by Alabama, Massachusetts, New Hampshire, New York, Rhode Island, and Washington.

The structure of provider partnerships varies across states, but they share some common features. A lead entity typically establishes a governance structure and handles administrative functions related to DSRIP. Public hospitals most commonly serve as lead entities, but others can fill this role. For example, Massachusetts, New York, and Rhode Island have some partnerships led by federally qualified health centers (FQHCs). In addition, Massachusetts and Rhode Island also allow community-based organizations to receive DSRIP funds even though they are not traditional Medicaid providers.

States and providers we interviewed were optimistic about the potential of partnerships to accomplish more than hospital-based projects alone, since multi-provider partnerships could address challenges of transitions in care across settings and address social determinants of health. However, providers participating in multi-provider partnerships noted several governance challenges, including how decisions would be made and how funds would flow between lead entities and participating providers.

In newer DSRIP states, provider partnerships are beginning to take on some roles traditionally performed by managed care plans, such as care management for patients assigned to them (referred to as their attributed population). However, most of these partnerships do not assume financial risk if the costs of care for their attributed population are higher than expected. In Massachusetts, the state intends that DSRIP provider partnerships will become Accountable Care Organizations (ACOs), sharing both upside and downside risk for the total cost of care for an attributed population. In other states, the provider partnerships are too large to become ACOs because they include all providers in a geographic region.
**Incentive structure**

DSRIP programs tie disbursement of DSRIP funding to implementation of projects and achievement of specific milestones. Milestones can be process based (such as those related to project planning, implementation, and reporting), or outcomes based (such as improving health outcomes associated with the projects). Providers generally must meet more process milestones in the initial years of the program before transitioning to outcomes-based milestones in later years.

Compared to earlier DSRIP programs, more recent DSRIP programs have higher proportions of outcomes-based milestones than process milestones. However, all DSRIP programs include at least one year of pay-for-reporting milestones before transitioning to pay-for-performance milestones.

Some newer DSRIP programs include both statewide and provider-specific performance goals. For example, New York will experience a 5 to 20 percent reduction in available DSRIP funds if it fails to meet four statewide milestones related to delivery system improvement, project-specific and population-wide quality metrics, reduced growth of statewide Medicaid spending, and managed care contracting. Six states (California, Massachusetts, New Hampshire, New York, Rhode Island, and Washington) have similar statewide milestones as well as requirements for providers to adopt alternative payment models (APMs).

State targets for the share of Medicaid payments made through APMs vary widely from 50 percent in New Hampshire to 90 percent in Washington. Typically states define APMs using the framework developed by the Health Care Payment Learning and Action Network (HCP-LAN), but CMS officials noted in interviews that they did not require states to use this CMS framework when setting state-specific goals.

**Financing**

Total DSRIP funding is negotiated by states and CMS and documented in each demonstration’s special terms and conditions. CMS applies a budget neutrality test for Section 1115 waivers to ensure that federal spending under the waiver will be no more than projected spending without the waiver. In some earlier DSRIP demonstrations (e.g. New Jersey), DSRIP expenditures are at least partially offset by savings from eliminating prior supplemental payments. Other states (e.g. New York), also apply prior and projected savings from implementing or expanding managed care to the budget neutrality assumptions. Newer programs that are not implementing DSRIP alongside managed care expansions must find other sources of savings to ensure that their Section 1115 demonstrations are budget neutral.

Like other Medicaid payments, the non-federal share of DSRIP payments can be supplied from state general revenue funds, health care-related taxes, and intergovernmental transfers (IGTs) from public hospitals and local governmental entities. In addition, some more recent waivers allowed states to access additional federal funding by allowing use of state spending on DSHPs to finance the non-federal share. DSHPs are specified in the demonstration’s special terms and conditions and must be related to the health of Medicaid enrollees and other low-income populations. By providing federal financing for previously state-funded programs, these DSHP demonstrations make more state funding available to finance additional Medicaid spending on system transformation initiatives. State officials we interviewed reported...
that DSHP financing has made it easier for the state to provide DSRIP funding to providers that are not public hospitals and do not have IGT funding to contribute to the non-federal share.

In December 2017, CMS indicated that it will no longer accept state proposals for new or renewing Section 1115 waivers that include DSHPs, noting that DSHPs have been used as a financing mechanism in Section 1115 waivers, rather than a tool to drive delivery system transformation or coverage reforms (CMS 2017). The Government Accountability Office has also raised concerns with the use of DSHP financing, finding that CMS lacked consistent and transparent criteria for determining whether state health programs were linked to eligible populations or promoted the goals of Medicaid (GAO 2015).

**Monitoring and evaluation**

States and CMS each have roles in the oversight of DSRIP projects. In general, CMS is responsible for monitoring state compliance with the waiver’s special terms and conditions, including the upper limit on available DSRIP funding and budget neutrality. States and CMS together establish and oversee how funds are distributed to eligible providers, including rules for the share of funding allocated for the achievement of particular types of milestones; they also develop a list of eligible projects and corresponding outcome measures that providers can select. States are primarily responsible for review of proposed projects and provider progress reports used to approve payments for documented achievements.

Compared to older DSRIP programs, more recent programs have included a standardized but more discrete set of measures for monitoring provider performance. This makes monitoring and evaluation easier since more providers are reporting the same measures and working on similar projects. In recent programs, CMS has also required use of an independent assessor to monitor projects and conduct a mid-point assessment to ensure that DSRIP projects remain on track.

CMS requires each state to design DSRIP-specific evaluation plans for CMS approval. In addition to reviewing the reported outcome improvements, most DSRIP evaluations include qualitative assessments of the program’s impact; 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 completion of the demonstration and a final evaluation at its end. CMS is also funding a federal evaluation of DSRIP programs in nine states (Irvin et al. 2015).

As of December 2017, five states (California, Massachusetts, New Jersey, Oregon, and Texas) have completed interim evaluations, and three (California, Texas, and Massachusetts) have completed final evaluations (Anderson et al. 2013, Chakravarty et al. 2015, Gurewich and Cabral 2016, Kushner et al. 2016, Pourat et al. 2016, and THHS 2017). Results are not yet available from more recent DSRIP programs. The results from final evaluations are mixed: while most providers are meeting DSRIP targets, there is little evidence of sustained cost savings from these efforts. There is some evidence that DSRIP is improving health outcomes and reducing hospital utilization, but it is difficult to isolate the effect of DSRIP projects given other policy changes and initiatives that occurred concurrently. Moreover, because of a lack of a control group, it is not clear whether providers would have achieved similar gains without DSRIP funding.
Sustainability

Like other Section 1115 demonstrations, DSRIP programs are typically approved by CMS for a period of five years. After that time, states can submit a request to CMS to renew their demonstration for up to five additional years. To date, California, Massachusetts, and Texas have renewed their DSRIP programs. In recent DSRIP approvals, CMS has indicated that it views DSRIP funding as a one-time investment, and does not plan to renew DSRIP demonstrations. Instead, CMS has encouraged states to develop plans to sustain their DSRIP by incorporating value-based purchasing strategies into their managed care contracting.

Revisions to the Medicaid managed care rule in 2016 provide states with a new option to require managed care plans to participate in alternative payment models. Arizona’s DSRIP program uses this authority to make its DSRIP-like investments through the managed care plans in the state, which may be a model for other states seeking to implement a similar approach. However, without a Section 1115 demonstration, Arizona could not finance the non-federal share of its DSRIP program through DSHP funding and would have to find another source of state funding instead.

Based on our interviews with states, providers, and health plans, it is not clear how the managed care model for sustaining DSRIP activities will work in practice. Conversations between state officials and managed care contractors about how to achieve this goal are underway, and tend to focus on how and to what extent Medicaid MCOs should adopt APMs. In addition, some states, such as Massachusetts, are planning for the provider partnerships that they create through DSRIP to become ACOs. However, some regional DSRIP provider partnerships may be too large to become ACOs, and managed care plans are still developing the new types of APMs that they would use to sustain DSRIP.

Endnotes

1 MACPAC contracted with the National Academy for State Health Policy (NASHP) to update its 2015 review of state DSRIP programs (Schoenberg et. al 2015). The work was conducted in three phases: (1) an environmental scan of approved programs; (2) key informant interviews with state and CMS officials to verify material collected in the environmental scan and gather additional information and their experiences with DSRIP implementation; and (3) site visits in New York and Massachusetts. Interviews and site visits were conducted between December 2016 and June 2017. For more detail, see Exploring of the Evolving Federal and State Promise of DSRIP Programs and Similar Programs (Rosenthal et al. 2017).

2 CMS’s 2016 revisions to Medicaid managed care rules added a new option for states to require plans to pass through a portion of their capitation payment to providers participating in delivery system reform activities (42 CFR 438.6). These pass-through payments differ from UPL payments permitted under fee-for-service Medicaid because they must be tied to quality objectives and cannot be conditioned on provider participation in intergovernmental transfer (IGT) funding arrangements.

3 Washington state and DSRIP renewal states California and Massachusetts have introduced similar milestones related to statewide quality improvement, adoption of value-based payment, and reductions in Medicaid spending growth, which, if not achieved, could lead to reduced federal DSRIP and DSHP funds.
Examples of DSHPs include community services for the elderly and mental health and substance use disorder programs. Some programs that explicitly do not qualify for DSHP funding include rent subsidies and services provided to undocumented immigrants.

Specifically, 42 CFR 438.6(c) allows states to require managed care plans to make quality-based pass-through payments to providers without a Section 1115 demonstration. These quality-based pass-through payments must be approved by CMS and must be re-evaluated by CMS each time the managed care contract is renewed (CMS 2016).

References


Medicaid and CHIP Payment and Access Commission
www.macpac.gov


