

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.

Twelve 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, 11 additional states—Arizona, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Texas, and Washington—have implemented DSRIP or DSRIP-like programs.¹ All of these efforts have been approved as part of broader demonstrations under Section 1115 of the Social Security Act (the Act), which allows states to test, for up to five years at a time, program changes that advance the objectives of the Medicaid program.

Recently, the Centers for Medicare & Medicaid Services (CMS) has indicated that it does not plan to approve new DSRIP programs or renew existing DSRIP programs when they expire. As a result, many states with existing DSRIP programs are exploring ways to continue to support delivery system reform efforts using other Medicaid authorities, such as the new option to make directed payments in managed care.

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 (Rosenthal et al. 2017, MACPAC 2015, and Schoenberg et. al 2015).²

Overview

DSRIP or DSRIP-like programs have been implemented in 12 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 April 2020, \$55.4 billion in state and federal funds had been approved for such efforts.



TABLE 1. Delivery System Reform Incentive Payment and Similar Program Features, by Date of Initial Approval

State	Date initially approved	Program name	Implementation timeframe	Total maximum state and federal DSRIP funding (millions)	Source of non-federal share
Early programs (approved before 2014)					
California	November 2010	DSRIP	5 years (2010–2015)	\$6,671	IGT
		PRIME	5 years (2016–2020)	\$7,464	IGT
Texas ¹	December 2011	DSRIP	5 years (2011–2016)	\$11,418	IGT
		DSRIP	15 months (2016–2017)	\$3,100	IGT
		DSRIP	4 years (2017–2021)	\$11,600	IGT
Massachusetts ²	December 2011	Delivery System Transformation Initiative	6 years (2011–2017)	\$1,319	state revenue and IGT
		DSRIP	5 years (2017–2022)	\$1,800	state revenue and provider taxes
New Jersey	October 2012	DSRIP	4 years (2014–2017)	\$583	state revenue
		DSRIP	3 years (2017–2020)	\$500	state revenue
Kansas	December 2012	DSRIP	3 years (2014–2017)	\$60	IGT
		DSRIP	2 years (2019–2020)	\$60	IGT
New Mexico	July 2013	HQII	4 years (2015–2018)	\$29	state revenue and IGT
		HQII	3 years (2019–2021)	\$36	state revenue and IGT
Recent programs (approved after 2014)					
New York	April 2014	DSRIP	6 years (2014–2020)	\$12,837	IGT and DSHP
Oregon	June 2014	HTPP	2 years + 2-year extension (2014–2018)	\$600	provider taxes
New Hampshire	January 2016	DSRIP	5 years (2016–2020)	\$150	DSHP and CPE
Rhode Island	October 2016	Health System Transformation Project	3 years + 2-year extension (2016–2020)	\$195	DSHP
Washington	January 2017	DSRIP	5 years (2017–2021)	\$1,125	DSHP and IGT
Arizona	January 2017	Targeted Investments Program	5 years (2017–2021)	\$300	DSHP and IGT



TABLE 1. (continued)

Notes: DSRIP is Delivery System Reform Incentive Payment. IGT is intergovernmental transfer. PRIME is Public Hospital Redesign and Incentives in Medi-Cal. DSTI is Delivery System Transformation Initiative. HQII is Hospital Quality Improvement Incentive program. IGT is intergovernmental transfer. DSHP is designated state health program. HTPP is Hospital Transformation Performance 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. Alabama received approval for a DSRIP program in February 2016 but never implemented it.

¹ Texas's DSRIP was extended for 15 months in May, 2016, and extended for four years in December, 2017. As part of the four-year extension, total DSRIP funding for 2016–2017 was adjusted from \$3,875 million to \$3,100 million.

² Massachusetts DSTI funding represents two iterations of DSTI funding. DSTI 1.0 was approved for 2011–2014 and DSTI 2.0 was approved for 2014–2017.

Source: MACPAC analysis of Rosenthal et al. 2017 and Section 1115 demonstration special terms and conditions available on Medicaid.gov.

Increasing use of managed care in Medicaid is one factor that contributed to state decisions to pursue DSRIP or other waivers. While many states make substantial supplemental payments—referred to as upper payment limit (UPL) payments—under fee for service, they cannot make such payments for services covered by capitated managed care programs.³ Flexibility available under Section 1115 waiver authority has allowed states 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.

In 2016, CMS revised the Medicaid managed care rules to add a new option for states to direct managed care payments to providers without a Section 1115 waiver (42 CFR 438.6).⁴ As a result, states with existing DSRIP programs have been exploring ways to continue DSRIP-like incentives using directed payments when their DSRIP programs expire.

DSRIP Program Design

Although 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 (those 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



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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.⁵

In addition to promoting delivery system reform goals, the early DSRIP programs allowed states 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 Massachusetts, New Hampshire, New York, Rhode Island, and Washington.

The structure of provider partnerships varies across states, but partnerships 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. 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.



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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 include all providers in a geographic region and are therefore too large to become ACOs.

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 would experience a 5 to 20 percent reduction in available DSRIP funds if it failed 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.⁶ 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.⁷ By providing federal financing for previously state-funded programs, these DSHP demonstrations make more state funding available to finance additional



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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 the 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 April 2020, five states (California, Kansas, New Jersey, Massachusetts, and Texas) have completed final evaluations and an additional two states (New Mexico and New York) have completed interim evaluations of their first round of DSRIP funding (Cabral et al. 2019, Valdivia et al, 2019, Weller et al. 2019, Chakravarty et al. 2018, Deloitte 2017, HHSC 2017, Kushner et al. 2016, Pourat et al. 2016). In addition, California has completed an interim evaluation of the second iteration of its DSRIP program, renamed Public Hospital Redesign and Incentives in Medi-Cal (PRIME) (Pourat et al. 2019).

The results from these state 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.



CMS has released an interim federal evaluation of DSRIP and seven rapid-cycle reports highlighting findings on specific topics (CMS 2020a). The interim evaluation examined early outcomes in California, New Jersey, and Texas relative to hospitals that did not participate in DSRIP and found mixed results on measures of emergency department (ED) visits, follow-up after ED visits, and diabetes testing. For example, although DSRIP hospitals in California reported declines in ED visits, ED visits declined more in the comparison group of hospitals that did not participate in DSRIP. Moreover, in all states studied, there was not a significant increase in follow up after ED visits or diabetes testing. Mathematica's final evaluation report will include a longer post-intervention period and analyses of more states and delivery system measures (Baller et al. 2018).

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. For DSRIP programs initially approved in 2014 or later, CMS has indicated that it views DSRIP funding as a one-time investment and does not plan to renew DSRIP demonstrations.⁸ Instead, CMS has encouraged states to develop plans to sustain their DSRIP by incorporating value-based purchasing strategies into their managed care contracting.

As noted above, federal managed care rules now provide states with the option to require managed care plans to participate in alternative payment models, referred to as directed payments.⁹ Arizona's DSRIP program uses this authority to make DSRIP-like investments. 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. Many DSRIP states have added requirements that MCOs increase their use of APMs, but in interviews MACPAC conducted in 2019 and 2020 regarding use of APMs in managed care, stakeholders in New York viewed the state's APM efforts as complementing but not replacing its DSRIP program (Bailit Health 2020). 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 because they include most Medicaid providers in the region.

The special terms and conditions of some DSRIP programs require states to develop formal transition plans to sustain delivery system reform improvements after DSRIP funding expires. New Jersey submitted its transition plan in September 2018 and proposed to make the same amount of payments to hospitals under a directed payment arrangement as it had through DSRIP (DMAHS 2018). Texas's transition plan, submitted in September 2019, included a variety of strategies, including increasing the use of APMs, establishing new quality-based directed payment programs, and adding new Medicaid state plan benefits based on successful DSRIP activities (e.g., coverage of community health worker services, enhanced chronic care management benefits, and new billing codes for integrated behavioral and physical health services) (HHSC 2019). California did not submit a formal transition plan to CMS, but in October 2019, the state released a proposal to transition its PRIME program to a managed care directed payment that would make a similar amount of payments to safety net hospitals based on performance on a common set of quality measures (DHCS 2019).

Endnotes



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¹ Alabama received approval for a DSRIP-like program but never implemented it.

² 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).

³ CMS's 2016 revisions to Medicaid managed care rules added a new option for states to require plans to direct a portion of their capitation payment to providers participating in delivery system reform activities (42 CFR 438.6). These directed 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.

⁴ Unlike UPL payments, managed care directed payments must be tied to quality objectives and cannot be conditioned on provider participation in IGT funding arrangements.

⁵ Medicaid health homes provide additional case management and support services to coordinate care for individuals with chronic conditions. IAP is a CMS innovation center-funded initiative that provides technical assistance for state delivery system reform efforts in a variety of program areas. SIM was a CMS innovation center-funded grant program to help states design and implement multi-payer delivery system reform efforts.

⁶ 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.

⁷ 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.

⁸ CMS has renewed DSRIP demonstrations that were initially approved before 2014 but has indicated that it does not plan to renew these demonstrations further. In 2020, New York requested to renew its DSRIP program, but CMS denied this request (CMS 2020b).

⁹ 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).

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