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Exploration of the Evolving Federal and State Promise of Delivery System Reform Incentive Payment (DSRIP) and Similar Programs

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Executive Summary

Since 2010, 12 states have implemented Delivery System Reform Incentive Payment (DSRIP) or similar delivery system reform programs (referred to as DSRIP-like programs for the purposes of this report), which direct Medicaid payments toward provider-led efforts designed to lower costs and improve quality of care and health outcomes. These programs are negotiated under Section 1115 waiver authority, which provide states with the flexibility and expenditure authority to make additional/incentive payments that would not otherwise be permitted under federal managed care rules. As of June 2017, up to $48.4 billion in state and federal funds have been approved to support eligible providers participating in DSRIP and DSRIP-like programs in 12 states.

As new DSRIP and DSRIP-like programs have been approved, the design of these programs has evolved. In 2016 and 2017, the National Academy for State Health Policy (NASHP), under contract with the Medicaid and CHIP Payment and Access Commission (MACPAC), conducted a 12-month project that built on NASHP's prior research into DSRIP[1] and MACPAC, which was captured in Chapter 1, "Using Medicaid Supplemental Payments to Drive Delivery System Reform," of MACPAC's June 2015 *Report to Congress on Medicaid and CHIP*.[2] The purpose of the project was to explore the evolution of DSRIP and address outstanding questions about:

- Medicaid's role in delivery system transformation;
- The alignment of DSRIP with other initiatives, evaluation and program outcomes; and
- The financing and sustainability of DSRIP and DSRIP-like programs.

This report highlights the findings of that project and explores the similarities and differences between early programs (approved before 2014) and recent programs (approved in or after 2014). It provides a cross-state analysis of current DSRIP and DSRIP-like programs and describes development and implementation experiences from a variety of perspectives, including those of federal and state officials, providers, health plans, and evaluators.

This report focuses on four states with recently approved programs (New Hampshire, Rhode Island, Washington, and Arizona), two states with renewed programs (California and Massachusetts), and four continuing programs that were included in NASHP's prior study (New Jersey, New York, Oregon, Texas). It includes Alabama's Integrated Provider System program, which was approved by the Centers for Medicare & Medicaid Services (CMS) in 2016 but will not be implemented.[3]

For the purposes of this report, programs in New Mexico, Oregon, Rhode Island, Arizona,[4] and Alabama are referred to as DSRIP-like programs. In these states, CMS approved provider-based quality incentive programs that use Section 1115 waiver authority. These programs share other characteristics with DSRIPs. For instance, incentive payment disbursement is tied to achieving certain milestones (e.g., improved health outcomes or other quality metrics) and the nonfederal share of these quality incentive programs is financed through Designated State Health Programs (DSHPs), which are discussed later in this report. CMS does not consider these programs to be DSRIP programs.

DSRIP programs are continuing to evolve, and some are not fully operational. Nevertheless, the following key findings emerged from document review, interviews, and site visits.

Findings

Goals

- While early DSRIP programs were implemented through Section 1115 demonstration waivers that sought to preserve or enhance prior supplemental payments for safety net providers (e.g., Upper Payment Limit [UPL] payments), new DSRIP programs have no relation to prior supplemental payments and now place a greater emphasis on Medicaid payment and delivery system reforms.
- Most state and federal officials view DSRIP as a complement to other payment and delivery system transformation initiatives.
- States reported challenges in trying to align DSRIP implementation plans and metrics with those used in other delivery system reform initiatives.

Design

- New DSRIP and DSRIP-like programs share an increased emphasis on addressing behavioral health and improving population health.
- While most early DSRIP programs focused on hospitals, newer DSRIP programs are increasingly supporting various types of provider partnerships and risk-bearing networks.
- New and renewal DSRIP programs place an increased emphasis on payment for meeting outcome milestones; however, providers report that process milestones are still important.
- New and renewal DSRIP programs include mandatory statewide accountability targets, which must be met to avoid reductions in aggregate state DSRIP funding.
- Newer DSRIP programs often include a smaller set of standardized measures developed by the state with CMS collaboration and approval.
- States have adopted various alternative payment model (APM) targets and frameworks tailored to their unique state environments.
- The flow of funds to DSRIP provider partnerships is a complex process that varies widely based on the types of participating entities.
- Some newer DSRIP programs channel DSRIP funds to or through MCOs.

Financing

- Aggregate DSRIP funding levels vary widely across states.
- Compared to earlier DSRIP programs, new DSRIP and DSRIP-like programs use DSHPs to finance the non-federal share of incentive payments.
- Funding for new and renewed DSRIP programs is time-limited and is scheduled to expire after five years.
- CMS requires states to develop sustainability plans that typically include new Medicaid managed care and/or APM strategies in an effort to decrease reliance on continued federal funding.

Monitoring and Evaluation

- Midpoint assessments can be used to make programmatic changes.
- Published evaluations show that most providers are meeting most metrics and milestones, but it is too early to present significant findings related to outcomes.
- Evaluators across states have encountered challenges in isolating the impact of DSRIP.
- Final evaluation results are not available until after a state's initial DSRIP demonstration expires.

Introduction

Operating as a component of Section 1115 demonstration waivers, Delivery System Reform Incentive Payment (DSRIP) programs started in 2010 as a mechanism to restructure Medicaid supplemental payments to safety net hospitals into a pay-for-performance program. DSRIP programs aim to improve quality of care and health outcomes while bending the cost curve by incentivizing providers to transition care to a focus on prevention and management of health and wellness in patient populations. DSRIP programs tend to focus on providing better care in outpatient, ambulatory care, and community-based settings in order to avoid the need for and use of inpatient hospital services.[5]

In 2014 and 2015, the National Academy of State Health Policy (NASHP), under contract with the Medicaid and CHIP Payment and Access Commission (MACPAC), examined state DSRIP programs, which were then in their infancy. The research included a cross-state analysis of eight DSRIP programs that had been approved (California, Kansas, Massachusetts, New Mexico, New Jersey, New York, Oregon, and Texas) and posed key policy questions related to DSRIPs. Program design, financing, measurement, and monitoring were among the key topics investigated, and findings from the project were compiled in a report that offers insight into the role of DSRIPs in states' Medicaid delivery systems.[6]

Since publication of that 2015 report, the Centers for Medicare & Medicaid Services (CMS) has approved five more states to implement DSRIP and DSRIP-like programs and approved DSRIP renewals in two states with significant programmatic changes. Program funding has increased from approximately $33.5 billion in all combined state and federal funds for the first eight approved DSRIP and DSRIP-like programs, to a combined $48.4 billion in state and federal funds across 12 states.[7] MACPAC again contracted with NASHP to build on its earlier research; explore the evolution of DSRIP programs; and address outstanding questions about Medicaid's role in delivery system transformation, alignment of DSRIPs with other initiatives, evaluation and outcomes of DSRIP programs, and financing and sustainability of DSRIPs.

This report highlights the findings of the second project and examines the similarities and differences between early DSRIP programs (approved before 2014) and recent programs (approved in or after 2014). It provides a cross-state analysis of current DSRIP programs and describes development and implementation experiences from a variety of perspectives, including those of federal and state officials, providers, health plans, and evaluators. It focuses on nine states: three states approved in 2016 or 2017 (New Hampshire, Rhode Island, and Washington), two states with renewed programs (California and Massachusetts), and four continuing DSRIP programs (New Jersey, New York, Oregon, Texas). This report also includes the Arizona Targeted Investments Program, which shares several key characteristics with DSRIP programs, and Alabama's Integrated Provider System, which was approved but will not be implemented. Given that the new Massachusetts DSRIP program had just launched during the writing of this report, some program details were not available and thus are not reflected in some sections of this report.

Methodology

As the first step, NASHP conducted an environmental scan of states with DSRIP and DSRIP-like programs between August and December 2016 and compared programs on a variety of topics, including state goals, program structure and design, financing mechanism, program reporting and monitoring, integration and alignment with other existing delivery system and payment reform initiatives, evaluation outcomes, and plans to sustain DSRIP investments after the programs end. The primary documents used for the scan were the special terms and conditions included in demonstration approval docu-

ments. Additionally, NASHP reviewed DSRIP program protocols, publicly available evaluation reports, and other supporting state and federal documents and data. Using information gathered from the environmental scan, NASHP compiled state fact sheets and sent them to states for review (see *Appendix A*).

Following the environmental scan, NASHP conducted key informant interviews between December 2016 and August 2017 with federal officials, state officials, providers and provider associations, managed care organizations (MCOs) or their associations, and DSRIP evaluators to verify information collected in the scan and to gather additional insights into experiences with program implementation and lessons learned. NASHP interviewed key stakeholders in Alabama, Arizona, California, New Hampshire, New Jersey, Oregon, Rhode Island, Texas, and Washington. NASHP also interviewed CMS staff.[8]

NASHP also conducted site visits in New York in February 2017 and in Massachusetts in March 2017. New York was mid-way through implementing an innovative model that marks a turning point in DSRIP design. The New York demonstration project has no relation to prior supplemental payments and includes a greater emphasis than earlier DSRIP programs on payment and delivery system reforms. Massachusetts completed the final year of its original DSRIP program (Delivery System Transformation Initiative, DSTI) and began implementing a vastly different DSRIP program on July 1, 2017, that introduces a new Medicaid delivery system structure. During these site visits, the project team met with state Medicaid agencies, Medicaid MCOs, evaluators and independent assessors,[9] executives from participating DSRIP entities, provider associations (e.g., hospital associations, Federally Qualified Health Centers consortia, etc.), and other key DSRIP stakeholders.

Table 1 provides basic information about each state's DSRIP program, including stage of implementation, length, and funding. For more detailed information about each state's DSRIP program, *Appendix A* includes a fact sheet on each state with information about participating providers, financing, monitoring, and outcomes. All tables and fact sheets list DSRIP programs in chronological order of demonstration approval to illustrate how programs have evolved.

Table 1: DSRIP Program Length, Stage of Implementation, and Funding

State	Program Name	Implementation Time Frame	Stage of Implementation	Total Computable Funding
California	DSRIP	5 years (2010-2015)	Concluded	$6,671,000,000
	Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	5 years (2016-2020)	PRIME Year 2	$7,464,000,000
Texas	DSRIP	5 years plus 15-month extension (2011-2017)	Extension period – DSRIP Year 6	$11,418,000,000 for first 5 years plus $3,875,000,000 for 15 months
Massachusetts	Delivery System Transformation Initiative (DSTI)	6 years (2011-2017)	Concluded	$1,318,800,000
	DSRIP	5 years (2017-2022)	DSRIP Year 1	$1,800,000,000
New Mexico	Hospital Quality Improvement Incentive (HQII) Program	4 years (2015-2018)	HQII Year 3	$29,426,586
New Jersey	DSRIP	4 years (2014-2017)	Temporary extension, DSRIP concluded in June 2017	$583,000,000
Kansas	DSRIP	3 years (2014-2017)	DSRIP Year 3	$60,000,000
New York	DSRIP	6 years (2014-2019)	DSRIP Year 3	$12,837,000,000
Oregon	Hospital Transformation Performance Program (HTPP)	2 years plus 2-year extension (2014-2018)	Extension period – HTPP Year 4	$600,000,000
New Hampshire	DSRIP	5 years (2016-2020)	DSRIP Year 2	$150,000,000
Alabama	Integrated Provider System (IPS)	Approved for 3 years (2017-2020)	Will not be implemented	$278,125,000
Rhode Island	Health System Transformation Project	3 years plus 2-year extension (2016-2020)	Hospital and Nursing Home Incentive Program	$195,000,000
Washington	DSRIP	5 years (2017-2021)	DSRIP Year 1	$1,125,000,000
Arizona	Targeted Investments Program	5 years (2016-2021)	Year 1	$300,000,000

Notes: Stages of implementation are effective as of July 2017. Massachusetts DSTI funding represents two iterations of DSTI funding, and New York included a DSRIP planning year plus five years of DSRIP implementation and the state is currently in its third implementation year. Total computable refers to the sum of federal share (Federal Financial Participation - FFP) and state share, or “non-federal share,” of DSRIP incentive payments. New York’s total computable DSRIP funding figure does not include Interim Access Assurance Funds.

Findings

DSRIP Goals

The first DSRIP program was authorized in California in 2010 as part of the state's "Bridge to Reform" Section 1115 demonstration waiver. California's designated public hospital systems[10] partnered with the state Medicaid agency to develop a way to preserve upper payment limit (UPL) supplemental payments to public hospitals during the state's transition to a Medicaid managed care delivery system. Medicaid UPL supplemental payments are a large source of financing for safety net providers (accounting for 21 percent of Medicaid fee-for-service payments to hospitals in 2015), but are not permitted in managed care. CMS approved California's request for a Section 1115 demonstration waiver to preserve supplemental funding while expanding managed care, but required California to link the payments to CMS's strategic goals of better care, improved health, and lower costs.

Similar to California, many early DSRIP programs arose from states' interest in continuing to provide or make new supplemental payments to safety net hospitals while expanding managed care. However, many newer DSRIP programs are not directly related to prior supplemental payment programs and are being implemented in states that had previously transitioned to Medicaid managed care, as a mechanism to help catalyze delivery system reform among safety net providers.

While each DSRIP program has been developed in response to unique circumstances and negotiations between states and CMS, common themes and distinctions have emerged and evolved between early and more recent DSRIP programs. States have designed DSRIP programs to achieve some or all of the following high-level goals:

- **Preserve funding for safety net providers;**
- **Drive Medicaid payment and delivery system reforms; and**
- **Align or integrate with Medicaid and other multi-payer payment and delivery system reform initiatives.**

Relation to Prior Supplemental Payments and Emphasis on Medicaid Payment and Delivery System Reforms

While early DSRIP programs were implemented through Section 1115 demonstration waivers that sought to preserve or enhance prior supplemental payments for safety net providers, new DSRIP programs have no relation to prior supplemental payments and now place a greater emphasis on Medicaid payment and delivery system reforms. As described in NASHP's previous report, DSRIP programs approved between 2010 and 2012 were generally included in Section 1115 demonstration waivers that expanded states' use of managed care in Medicaid (Table 2). States designed most of their DSRIP programs to maintain supplemental payments (e.g.,UPL) to safety providers, while complying with federal regulations that prohibited UPL payments (which are calculated based on the volume of fee-for-service care provided) in capitated Medicaid managed care arrangements.[11] While early DSRIP programs required providers to make improvements in care delivery to receive DSRIP funds, states primarily used DSRIP as a supplemental payment preservation tool.

Table 2: Relationship of DSRIP and DSRIP-like Programs to Prior Supplemental Payment Programs

State	Date Initially Approved	Preserves Prior Supplemental Payments?	Implemented with Managed Care Expansion?
California	11/1/2010	Yes	Yes
Texas*	12/12/2011	Yes	Yes
Massachusetts	12/22/2011	Yes	No
New Mexico	9/04/2012	Yes	Yes
New Jersey	10/2/2012	Yes	Yes
Kansas	12/27/2012	Yes	Yes
New York	4/14/2014	No	No
Oregon	6/27/2014	No	No
New Hampshire	1/5/2016	No	No
Rhode Island	10/20/2016	No	No
Washington	1/9/2017	No	No
Arizona	1/18/2017	No	No

*Texas does not consider its DSRIP program to replace prior supplemental payments. However, the Section 1115 demonstration waiver that authorizes DSRIP implementation includes a related Uncompensated Care pool which replaces prior upper payment limit (UPL) payments to providers.

Beginning with the approval of the New York DSRIP program in 2014, the goal of DSRIP shifted from preserving supplemental payments to promoting greater payment and delivery system transformation. While all new DSRIP programs are still authorized under Section 1115 demonstration waivers, they are not typically implemented as part of managed care expansion as they were in early DSRIP states. As a result, new DSRIP programs (starting with New York) are not needed to preserve prior supplemental payments New DSRIP programs are not related to prior supplemental payments (*Table 2*).[12]

Most new DSRIP programs also aim to restructure or build new delivery systems and include more specific payment and delivery reform goals with higher bars for achievement. A CMS official explained the evolution from early to more recent DSRIP programs: “The evolution was from a less well-defined pool of funding that was broadly focused on care improvement and delivery to something more focused on delivery system reform with much more defined metrics, including delivery system milestones and standardized metrics. There is (now) more accountability on measuring and improving metrics on the state’s part.”

DSRIP Renewal Programs

Similar to new DSRIP programs, DSRIP renewal programs in California and Massachusetts have ambitious payment and delivery reform goals. Instead of simply renewing their existing programs, both states redesigned their programs to significantly restructure the delivery system. This is a departure from their original programs, which were primarily focused on preservation of the safety net while simultaneously incentivizing providers to make improvements in care delivery. While they continue to recognize the importance of the safety net, they are focusing increasingly on:

- Financing it in a sustainable way through linkage to Medicaid APMs, which are intended to reduce Medicaid spending and thus enable them to redirect funding; and
- Increasing the level of accountability for performance by setting higher benchmarks for achievement.

In California, Public Hospital Redesign and Incentives in Medi-Cal (PRIME) aims to have 60 percent of Medicaid managed care beneficiaries who are assigned to Designated Public Hospitals in an APM arrangement by 2020. The state has four established APM tiers:

- Partial capitation (primary care only);
- Partial plus (primary and some specialty care);
- Global (primary, specialty, ancillary and/or hospital care); and
- Additional payment methodologies approved by the state and CMS.

Massachusetts' renewal differs from the original DSTI program in even more fundamental ways; it is a time-limited investment to facilitate the transition away from fee-for-service payments to alternative payments. It primarily funds the development of Medicaid Accountable Care Organization (ACOs); community-based long-term services and supports (LTSS) and behavioral health Community Partners; and statewide infrastructure investments in technical assistance, primary care workforce development, and alternative payment preparation, among other initiatives. Safety net hospitals that previously received funding under the DSTI program must participate in a Medicaid ACO to access DSRIP funding. A portion of DSRIP funding, referred to as DSTI Glide Path Funding, is specifically reserved to provide operational support to safety net hospitals to help them transition to lower levels of supplemental payments.

Integration and Alignment with Other Transformation Initiatives

CMS and state officials have noted that neither DSRIP nor Medicaid alone can fully transform the delivery system from a volume- to a value-based system. Many states are striving to align DSRIP with other transformation initiatives to maximize delivery system reform levers and streamline reporting requirements. States are aligning initiatives through specific strategies, such as establishing similar overarching goals among programs, using the infrastructure created by one initiative as the foundation for future, more ambitious initiatives, and using the same metrics across multiple transformation initiatives.

Of the various federal payment and delivery system reform opportunities available to states, NASHP focused on how DSRIP intersects with other federal Medicaid initiatives, specifically the Section 2703 Health Home State Plan Amendment,[13] the Innovation Accelerator Program (IAP),[14] and multi-payer State Innovation Model (SIM) awards.[15] *Table 3* identifies DSRIP states participating in these initiatives. In addition to state participation in federal initiatives, NASHP also examined the relationship of DSRIP programs to state-specific payment and delivery system reform initiatives, such as Medicaid ACO demonstrations or broader, state-driven value-based payment initiatives.

Table 3: State Participation in Federal Delivery System and Payment Reform Initiatives

	State Innovation Model (SIM) Award (Design or Testing)	Innovation Accelerator Program (IAP)	Health Home SPA
California*	X	X	
Texas	X	X	
Massachusetts*	X	X	
New Mexico	X		
New Jersey*	X	X	X
Kansas			X
New York*	X		X
Oregon*	X	X	
New Hampshire*	X	X	
Washington*	X	X	X
Rhode Island*	X	X	X
Arizona*	X	X	

*Indicates states that expanded Medicaid eligibility to the new adult group.

Most states and federal officials view DSRIP as a complement to other payment and delivery system transformation initiatives. States reported that the high-level goals of DSRIP programs and other statewide transformation initiatives are usually aligned, and states envision all transformation initiatives to operate in tandem to achieve overarching Medicaid payment and delivery system reform objectives.

A few states provided specific examples illustrating how they have leveraged federal transformation opportunities to develop or support their DSRIP work. For example, Washington State's SIM award funded the design and launch of Accountable Communities of Health (ACHs), which will now be responsible for implementing DSRIP projects. According to officials, SIM enabled the state to "determine a pathway to a community delivery system," and DSRIP was the "vehicle to support, and bring more infrastructure money, to ACHs." Washington also plans to build on the success of its Health Home program to strengthen the substance use disorder and physical and mental health integration components of its DSRIP program.

A state official in New Hampshire described how the state leveraged some of the lessons learned from the Physical and Mental Health Integration track of IAP to develop APM goals for behavioral health initiatives under DSRIP.

Arizona officials explained that the concept for the Targeted Investments Program arose from the state's SIM planning process. The state incorporated many of the concepts from its SIM Testing proposal, which was not approved, into a DSRIP proposal, using the SIM Design grant as a "springboard to the DSRIP design." Arizona later amended its proposal to include a Targeted Investment Program that

shares many key characteristics with the DSRIP proposal and uses new authority from the revised 2016 Medicaid Managed care rules to provide directed delivery system improvement incentives to providers through MCOs. (For more information on Arizona's model, see the "funds flow" discussion in the DSRIP Design section.)

Beyond the various federal payment and delivery system initiatives, some states are striving to align DSRIP implementation with state-specific transformation initiatives. For example, New York's DSRIP program is an integral component of a broader value-based payment strategy that includes other initiatives such as the Value-Based Payment Quality Improvement Initiative,[16] designed to help hospitals in severe financial distress establish sustainable financing mechanisms through the same types of value-based payment models that the state is encouraging in DSRIP, such as bundles of care.

In Massachusetts, DSRIP is a key piece of a large Medicaid delivery system overhaul that aligns with the emergence of other prevalent payment reform models, such as Medicare shared savings programs and other payers' models in the state that emphasize total cost of care accountability. DSRIP will support the launch of three Medicaid ACO models, two of which are tightly integrated with Medicaid MCOs, as well as a complementary Community Partner program that builds infrastructure for care coordination supports for members with high behavioral health and LTSS needs. ACOs and Community Partners will largely rely on DSRIP funds for start-up costs and infrastructure development activities such as building primary care provider and care coordination capacity, performance management, contracting, enhancing information technology, and developing population health analytics. State officials in Massachusetts described everything from MCO contracting to its prior SIM award to DSRIP ACO procurement as programmatically and financially linked.

States reported challenges in trying to align DSRIP implementation plans and metrics with those used in other delivery system reform initiatives. While states strive to align DSRIP with other transformation initiatives as much as possible, unique program requirements have presented challenges in aligning programs beyond high-level policy goals. For example, a state official in California noted that while the state's separate initiatives are all "in the same vein of trying to accomplish change in the delivery of care and payment for care, there may not be specific connections." Another representative from a California MCO discussed how multiple delivery system reform programs motivate providers to make positive changes, but often are not fully aligned in their financing or measurement.

For example, MCOs have been overseeing behavioral health integration initiatives and Health Home implementation for some providers, which overlaps with some of the complex care projects in California's PRIME program. While the programs both strive to improve care for patients with multiple physical and behavioral health conditions through similar strategies such as implementing complex care teams and enhancing data analytic capacity, a managed care representative noted, "the measures end up being slightly different… and the members don't overlap 100 percent." Stakeholders noted this misalignment leads to complexity for providers who must report two different measure sets and comply with two separate financing mechanisms for very similar complex care interventions that ultimately aim to achieve the same goals. For example, providers must report PRIME measures to the state Medicaid agency to receive their incentive payments, and they must report slightly different measures to receive payments through their contracting arrangements with MCOs for the other behavioral health integration and Health Home initiatives.

Some states have made deliberate efforts to better align programs, yet stakeholders noted the challenge lies in finding quality measures that are applicable to multiple providers and programs. For example, in Oregon, one of the goals of the Hospital Transformation Performance Program (HTPP) has been to better align hospital payment and delivery reforms with Coordinated Care Organizations (CCOs), and the state has attempted to develop complementary measures for the programs. Of 17 incentive measures for CCOs[17] and 11 measures for hospitals participating in HTPP,[18] several metrics addressing screening, brief intervention, and referral for treatment (SBIRT) and follow-up after behavioral health hospitalization are shared by both programs. However, stakeholders noted difficulty in meaningfully aligning other measures, such as hospital readmissions, given differences in the methodology used to calculate the measure for CCOs and hospitals. Providers noted that alignment between the CCO and HTPP program could be improved by developing a subset of the same metrics to measure different Medicaid initiatives.

Design of DSRIP Programs

All DSRIP programs are authorized under Section 1115 demonstration waivers, which are negotiated by states and CMS, typically for five years. While the specifics of each program vary, this section describes the common features of DSRIP programs:

- **Program focus**: DSRIP programs emphasize redesigning common care delivery models to improve patient care and reduce costs.
- **Eligible providers**: Some DSRIP programs are limited to hospital providers, while others require hospital and non-hospital providers to form provider partnerships or networks in order to participate.
- **Incentive structure**: DSRIP programs tie the disbursement of payments to the achievement of specific milestones, including planning, project implementation, reporting, and outcome improvement milestones.
- **Standardization of metrics**: New DSRIP programs tend to include more standardized metric sets established by the state, with CMS collaboration and approval.
- **Alternative payment methodologies**: Most new DSRIP programs establish statewide alternative payment methodology targets that must be met to avoid a reduction in DSRIP funding.
- **Payment/funds flow**: Payments are made to eligible providers after achieving milestones and submitting reports to document their achievement.

Program Focus

As described in NASHP's prior DSRIP report, early DSRIP programs redesigned care delivery models through specific activities, such as implementing the primary care medical home model, expanding access to primary care, implementing chronic care models to improve chronic disease management, integrating physical and behavioral health, improving care transitions from inpatient to ambulatory care settings, and using health navigation to reduce hospital/emergency department use.

New DSRIP and DSRIP-like programs share an increased emphasis on addressing behavioral health and improving population health. While early DSRIPs included some focus on population health management through activities such as requiring providers to report on population health measures, new DSRIP programs aim to improve population health outcomes by implementing disease prevention initiatives and addressing the underlying social determinants of health. Similarly, while most early DSRIP programs included some behavioral health integration projects, new DSRIP programs elevate the focus on behavioral health issues as reflected by states' substantial allocation of DSRIP funds

towards behavioral health infrastructure and capacity building. For example, the New Hampshire DSRIP program focuses entirely on revamping the state's behavioral health delivery system and was the first DSRIP program to target only one specific health issue.

Population Health

New DSRIP programs' explicit focus on population heath improvement is exemplified by Washington's inclusion of a category of projects entitled Prevention and Health Promotion that focuses on achieving health equity and eliminating disparities. Within this category, the state has proposed projects that focus on addressing opioid use as a public health crisis, promoting maternal and child health, increasing access to oral health services to prevent oral disease, and preventing chronic disease.[19]

In Massachusetts, certified community-based organizations called Community Partners may use DSRIP funding to help members with behavioral health and long-term care needs navigate community resources and engage with social service providers.[20] State officials view DSRIP as a unique opportunity to expand provider collaboration to include community-based organizations and other providers who do not typically participate in Medicaid. This collaboration is intended to develop a more complete understanding of the issues affecting an individual's health, such as housing and nutrition. According to one DSRIP provider, "DSRIP has been able to innovate the Medicaid dollar to pay for social determinants of health. I think that's the biggest thing to be proud of for DSRIP."

DSRIP's Emphasis on Social Determinants of Health

Examples of how DSRIP programs address population health:

- Some of **California**'s PRIME participants perform breast, cervical, and colorectal cancer screening and follow-up; body mass index screening and follow-up; nutrition and physical activity counseling; high blood pressure screening and follow-up; and tobacco assessment and counseling.
- **Arizona**'s Targeted Investments Program, a DSRIP-like program, provides incentive payments to primary care providers, behavioral health providers, and providers serving individuals transitioning from the justice system who screen all members for the status of common social determinants of health, develop procedures for intervention or referral based on the results, and incorporate screening results into their integrated care plans. By the end of the third program year, 85 percent of a random sample of members who scored positively on the screening tool must have received appropriate intervention or referral for providers to receive payment.
- **Texas** and **New Jersey** providers who participate in DSRIP have used Medicaid dollars to reduce hospital admissions, emergency department (ED) visits, and missed school days associated with pediatric asthma. To achieve these goals, a DSRIP provider in New Jersey sends carpet cleaners to asthma patients' homes while a DSRIP provider in Texas sends mobile pediatric services to schools to reach children who have been identified as high ED utilizers.
- **Massachusetts**' new DSRIP program allows Accountable Care Organizations to use DSRIP funds to pay for so-called "flexible services" that address health-related social needs that Medicaid typically does not cover, such as services for individuals transitioning from an institution to the community, services to maintain a safe and healthy living environment, and support for individuals who have experienced violence.

Behavioral Health

Newer DSRIP programs often place a greater emphasis on behavioral health and some even provide funds for states to develop a new behavioral health infrastructure.[21] For example, New Hampshire's DSRIP program addresses behavioral health and substance use disorders (SUDs) through a new Integrated Delivery Network infrastructure, which the state is using as a vehicle to establish data exchanges and financial and governance relationships between behavioral health providers and other health care and community service providers. Massachusetts also focuses on enhancing its behavioral health infrastructure and capacity by funding the creation of behavioral health Community Partners, which support and provide services across the continuum of care for members with high behavioral health needs, including serious mental illness and/or substance use disorders. State officials want behavioral health Community Partners to complement other currently available behavioral health services -- such as targeted case management -- by offering a broader set of comprehensive care management services that include coordinating care across a number of health care entities such as ACOs, MCOs, community organizations addressing the social determinants of health, and behavioral health providers. Arizona's Targeted Investments Program incentivizes primary care practices to screen for depression, drug and alcohol misuse, anxiety, developmental delays in infancy and early childhood, and suicide risk. The program also incentivizes providers to identify members at high-risk for behavioral health service utilization, develop an electronic registry, and utilize care managers for those members.

Eligible Providers

While most early DSRIP programs focused on hospitals, newer DSRIP programs are increasingly supporting various types of provider partnerships and risk-bearing networks. Initially, DSRIP programs focused on preserving supplemental payments to safety net hospitals, as occurred in California and New Jersey.[22] Texas was the first state to require providers to work together and form a collaborative entity in order to receive DSRIP funding. In Texas, these entities, known as Regional Healthcare Partnerships (RHP), are comprised of an array of providers including hospitals, community mental health centers, local health departments, and others. Each RHP includes an anchor, which serves as an essential coordinating entity and is typically a public hospital that received UPL payments prior to DSRIP implementation.

DSRIP Provider Partnerships

Provider partnerships are now a common feature of most new DSRIP states. New Hampshire, New York, Rhode Island, and Washington all require providers to form partnerships in order to receive DSRIP funds. While the roles and responsibilities of provider partnerships vary among state DSRIP programs, they are generally entities comprised of an array of providers that collaborate to identify and address the health and health-related social needs of Medicaid beneficiaries in their region. All DSRIP provider partnership entities develop DSRIP plans and are responsible for implementing and reporting on DSRIP projects. Some states require each participating provider to implement its own DSRIP project and other states require projects to be implemented at the provider partnership level. For example, each provider participating in an RHP in Texas implements its own DSRIP projects while each PPS in New York implements a set of projects.

With the exception of ACHs in Washington, these provider entities did not exist prior to DSRIP. Although provider partnerships look different in each state and vary according to degree of provider integration/alignment, many recently approved DSRIPs encourage the participation of community-based organizations as well as behavioral health and other safety net providers. Some states are more prescriptive than others and require specific entities to participate. New Hampshire, for example, requires community

mental health centers, federally qualified health centers (FQHCs), and SUD providers to be included in its regional Integrated Delivery Networks.[23] A CMS official observed that the trend to require provider partnerships and networks in DSRIP programs has largely been state driven as states recognize the need to include various types of providers to ensure sustainable payment and delivery reform. *Table 4* illustrates some of the similarities and differences in participating DSRIP provider entities.

Table 4: DSRIP Programs That Fund Provider Partnerships

State	Provider Entities	Risk Bearing?	Participating Providers
Texas	Regional Healthcare Partnerships	No	Provider partners include hospitals, Community Mental Health Centers (CMHCs), local health departments, physician practice plans affiliated with an academic health science center, and other types of providers approved by the state and CMS.
New York	Performing Provider Systems	No	Eligible providers include hospitals and non-hospital-based providers. Eligible non-hospital-based providers must have a patient volume where at least 35 percent are covered by Medicaid, uninsured, and duals (with certain exceptions).
New Hampshire	Integrated Delivery Networks	No	IDN partner networks must include primary care practices; substance use disorder providers; regional public health networks; CMHCs; peer-based support and/or community health workers; hospitals; federally qualified health centers, community health centers, or rural health clinics, if available; community-based organizations that provide social and support services; county nursing facilities and correctional systems.
Rhode Island	Accountable Entities (AEs)	No	An AE needs to have a critical mass of multi-disciplinary providers with core expertise/direct service capacity in primary care, behavioral health, and social supports/determinants for the populations the AE proposes to serve. A specialized LTSS AE must demonstrate partnerships between participating nursing homes and home- and community-based service providers. All certified AEs must contract with MCOs to participate in the AE Incentive Program.
Massachusetts DSRIP	Accountable Care Organizations (ACOs)	Yes	Medicaid ACOs and procured LTSS and behavioral health Community Partners (CPs) are eligible to receive DSRIP funds. ACOs must partner with CPs and have exclusive primary care provider participation.
Washington	Accountable Communities of Health (ACHs)	No	ACHs are regional coalitions that include primary care providers, behavioral health providers, MCOs, hospitals/health systems, local public health, tribal organizations, and community-based organizations that provide social and support services (e.g., housing, education, employment, transportation). ACHs must include partners that serve Medicaid beneficiaries.

While DSRIP provider partnerships include a diverse array of partners and governance structures, partnerships typically include a lead entity, anchor, or backbone to lead administrative functions. In many DSRIP states, it is common for public hospital systems to lead provider partnerships given they may provide funding via intergovernmental transfers for the state share of DSRIP funding, or may have greater capacity to handle the administrative functions of DSRIP, such as coordinating partners in planning and implementing projects, receiving and distributing funds, and leading reporting and monitoring responsibilities.

As DSRIP provider partnerships evolve to include more types of providers, some partnerships in new DSRIP states are led by non-hospital entities that are well-positioned to achieve the goals of DSRIP. For example, while the vast majority of DSRIP provider partnerships in New York (referred to as Performing Providers Systems or PPS), are led by hospitals, there are several FQHC-led PPS. One member of a FQHC-led PPS explained that DSRIP has been a logical extension of the population health model that FQHCs were building and that having an FQHC-led PPS allowed FQHCs to maintain their mission and vision for delivery transformation. From the perspective of this FQHC-led PPS, DSRIP has been an unprecedented opportunity to invest in initiatives that address the most pressing needs of its population, especially behavioral health and primary care integration. In Rhode Island, FQHCs lead more than half of the pilot Accountable Entities (AEs). In Washington and New Hampshire, provider partnerships have substantial flexibility to develop their own governance structures and include several different types of organizations as the lead for each partnership entity. For example, several Integrated Delivery Networks in New Hampshire have non-hospital administrative leads.

Risk-Bearing DSRIP Provider Networks

Massachusetts is the only state that is leveraging DSRIP to launch Medicaid ACOs (see *Table 4*). As opposed to required provider partnerships in other DSRIP programs, Medicaid ACOs in Massachusetts are risk-bearing networks with a financial stake in their patients' care. Given that the three Medicaid ACO models in Massachusetts have various arrangements with MCOs, ACOs assume varying levels of risk and responsibilities.

While the Medicaid ACOs in Massachusetts had not yet been fully launched when this report was written, stakeholders shared their vision for the delineation between MCO and ACO risk-sharing and general roles of the three types of ACO models that relate to the Massachusetts DSRIP program. Most providers have applied to participate in an ACO/MCO partnership model that assumes the greatest level of risk. In this model, stakeholders expected the ACO would take primary responsibility for care management in order to move clinical functions closer to the patient care level. MCOs would assume a greater administrative role by handling call centers, claims processing, member enrollment, accounting, HEDIS (quality measure) reporting, and some data analytic functions.

In states that do not currently include risk-bearing provider networks, it remains to be seen if some provider partnerships may eventually evolve into this role. Some DSRIP states, such as Washington, have made it clear that the provider partnerships participating in DSRIP (i.e. ACHs) are not designed to become risk-bearing entities, and that risk will remain with MCOs. Other states envision that some DSRIP provider partnerships may evolve to become ACOs or other risk-bearing entities.

Stakeholders in several states have raised concerns regarding the future role of MCOs should DSRIP provider partnerships evolve into risk-bearing entities. For example, state officials in New Hampshire envision that Integrated Delivery Networks will develop a mechanism for delivering behavioral health

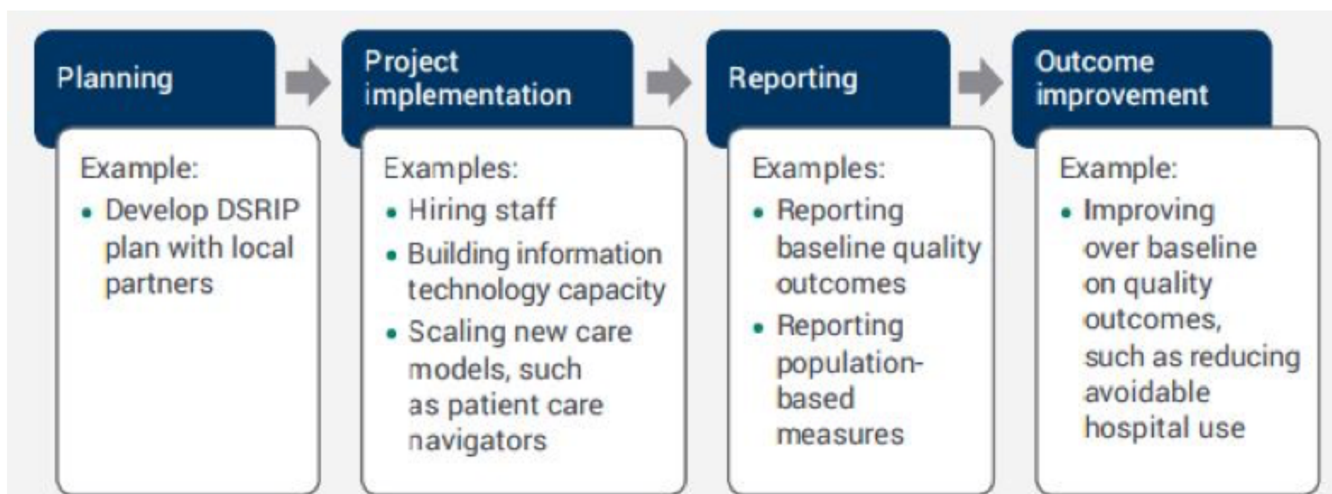
services that MCOs could purchase in the future. However, managed care plans have been apprehensive of this model and fear Integrated Delivery Networks will become behavioral health ACOs that could contract directly with the state and eliminate the need for MCOs. As the state continues to develop its APM framework, it is considering ways to mitigate these concerns and design a system where Integrated Delivery Networks and MCOs share risk and collaborate to improve care for Medicaid beneficiaries.

New York originally envisioned its Performing Provider Systems (PPS) evolving into Medicaid ACOs or other entities that could contract with MCOs. While initially this raised concerns among MCOs, it is now doubtful that PPS will be in direct competition with MCOs, due to anti-trust rules and other legal barriers that prohibit them from becoming contracting entities. Even if PPS are able to become legally-recognized contracting entities, such as Independent Practice Associations, some MCOs may be unwilling to contract with them. A representative from an MCO observed, “Some PPS are just amalgamations of providers stitched together,” that do not appear to be integrated or advanced enough to become risk-bearing entities. If DSRIP funding disappeared in the future, the MCO representative thought it was unlikely that PPS would be able to fully sustain themselves and take on enough risk to enter into value-based contracting arrangements. In light of these challenges, some PPS may still pursue the ACO path, but New York officials expect most PPS to evolve into regional planning entities, similar to Regional Health Information Organizations (RHIOs).

Incentive Structures

DSRIP programs tie the disbursement of payments to the achievement of specific milestones, including planning, project implementation, reporting, and outcome improvement milestones. The metrics may be process based (e.g., rewarding providers for project planning and implementation) or outcomes based (e.g., rewarding providers for improving health outcomes associated with the projects). Providers generally must meet more process metrics in the initial years of the program before they transition toward more outcomes-based metrics in later years.

Figure 1: Types of DSRIP Program Milestones



Source: MACPAC’s June 2015 *Report to Congress on Medicaid and CHIP*, Chapter 1: Using Medicaid Supplemental Payments to Drive Delivery System Reform

New and renewal DSRIP programs place an increased emphasis on payment for meeting outcome milestones; however, providers report that process milestones are still important. Newer DSRIP programs tend to include a greater proportion of outcomes-based metrics in the total number of metrics, which carries significant implications for providers. In order for providers to participate in DSRIP, they often need to train staff and devote resources to achieve certain metrics. However, there is a risk that providers will not be able to recoup this investment if they do not meet some metrics and therefore fail to receive incentive payments.

While there is an increased emphasis on outcomes, providers reported that process milestones are still important. Providers in Massachusetts expressed their appreciation for the process-based metrics in DSTI, which they described as often being necessary to drive related clinical improvement or outcomes measures. Providers shared that process metrics had prepared them to perform well in the state's upcoming DSRIP program, which places a greater emphasis on outcomes, by allowing them to build the staffing and information technology capacities necessary to undertake DSRIP projects. Without early process milestones and the incentive payments associated with them, providers would lack the money to make investments necessary to change how care is delivered.

New and renewal DSRIP programs include mandatory statewide accountability targets, which must be met to avoid reductions in aggregate state DSRIP funding. While there is a risk that participating providers will not be able to recoup their initial DSRIP investments if they fail to meet their milestones and metrics, many new DSRIP programs have also introduced risk at the state level. New York was one of the first to implement statewide performance metrics that must be met in order to avoid a reduction in total available DSRIP funds. In New York, this approach is called a statewide accountability test and features four statewide milestones related to delivery system improvement, project-specific and population-wide quality metrics, a reduction in the growth of statewide Medicaid spending, and managed care contracting. While achieving the milestones hinge on many factors—some of which are outside the realm of DSRIP—the state faces a 5 to 20 percent reduction in total available DSRIP funding if these milestones are not met. Additionally, 5 to 20 percent of total available Designated State Health Programs (DSHP) funding is at risk unless statewide emergency room spending reduction goals are met (see section on non-federal share for discussion of DSHP). Other recently approved or renewed demonstrations have adopted similar approaches. For example, Washington State risks losing 5 to 20 percent of statewide DSRIP and DSHP funding if it does not meet statewide value-based payment and quality improvement goals. DSRIP renewal programs in California and Massachusetts have introduced similar metrics that focus on statewide targets related to ACO and APM adoption and achieving a reduction in statewide Medicaid spending growth.

Standardization of Metrics

Newer DSRIP programs often include a smaller set of standardized measures developed by the state with CMS collaboration and approval. States continue to grapple with striking the right balance between statewide standardization of metrics and local flexibility. In general, early DSRIP programs tended to give providers greater flexibility in developing tailored projects and metrics for their specific populations, making it difficult to evaluate the effectiveness of DSRIP at the state level. Newer DSRIP programs, in contrast, tend to be more prescriptive with a limited scope of delivery system reform initiatives and a smaller set of standardized measures developed by the state. For example, in California's original DSRIP program, providers defined certain performance metrics differently, which made it challenging to compare performance across different providers and assess statewide progress.[24] In its newer PRIME program, California has incorporated a more standardized set of metrics. Approximately

80 percent of PRIME measures are comprised of nationally recognized measures, such as National Committee for Quality Assurance (NCQA) measures. In an attempt to preserve some flexibility for providers, about 20 percent of PRIME's metrics are "innovative metrics" that have not yet been vetted or tested by a measure steward such as NCQA, the American Medical Association, or CMS.

Alternative Payment Methodologies

While early DSRIP programs helped providers make investments to prepare them to implement APMs, six new and renewal DSRIP programs (California and Massachusetts renewal programs, and New Hampshire, New York, Rhode Island, and Washington State) require providers to adopt APMs. Using the Health Care Payment Learning and Action Network (HCP LAN) framework (with implementation categories described below), APMs aim to move providers beyond standard fee-for-service reimbursement to payment methods that use financial incentives to promote or leverage greater value.

Health Care Payment Learning and Action Network's APM Framework

Category 1: Fee-for-service with no link of payment to quality
Category 2: Fee-for-service with a link of payment to quality
- a) Foundational payments for infrastructure and operations
- b) Pay for reporting
- c) Rewards for performance
- d) Rewards and penalties for performance

Category 3: APMs built on fee-for-service architecture
- a) APMs with upside gainsharing
- b) APMs with upside gainsharing and downside risk

Category 4: Population-based payment
- a) Condition-specific population-based payment
- b) Comprehensive population-based payment

States have adopted various APM targets and frameworks tailored to their unique state environments. Though statewide APM benchmarks ultimately aim to increase the number of APM arrangements between providers and MCOs, states have established and defined different targets. While some states aim to transition a specific percentage of provider payments to an APM, other states aim to attribute a specific percentage of Medicaid beneficiaries to an APM by the end of their programs. For example, Rhode Island aims to attribute at least 33 percent of eligible Medicaid beneficiaries to an AE participating in an APM, whereas Washington aims to move 90 percent of Medicaid provider payments to an APM by the end of the initiative. While some states have developed their own frameworks and timelines for APM targets (California), others (Washington and New York) have adopted or incorporated elements of the HCP LAN APM framework.[25]

Table 5: State APM Targets in DSRIP Programs

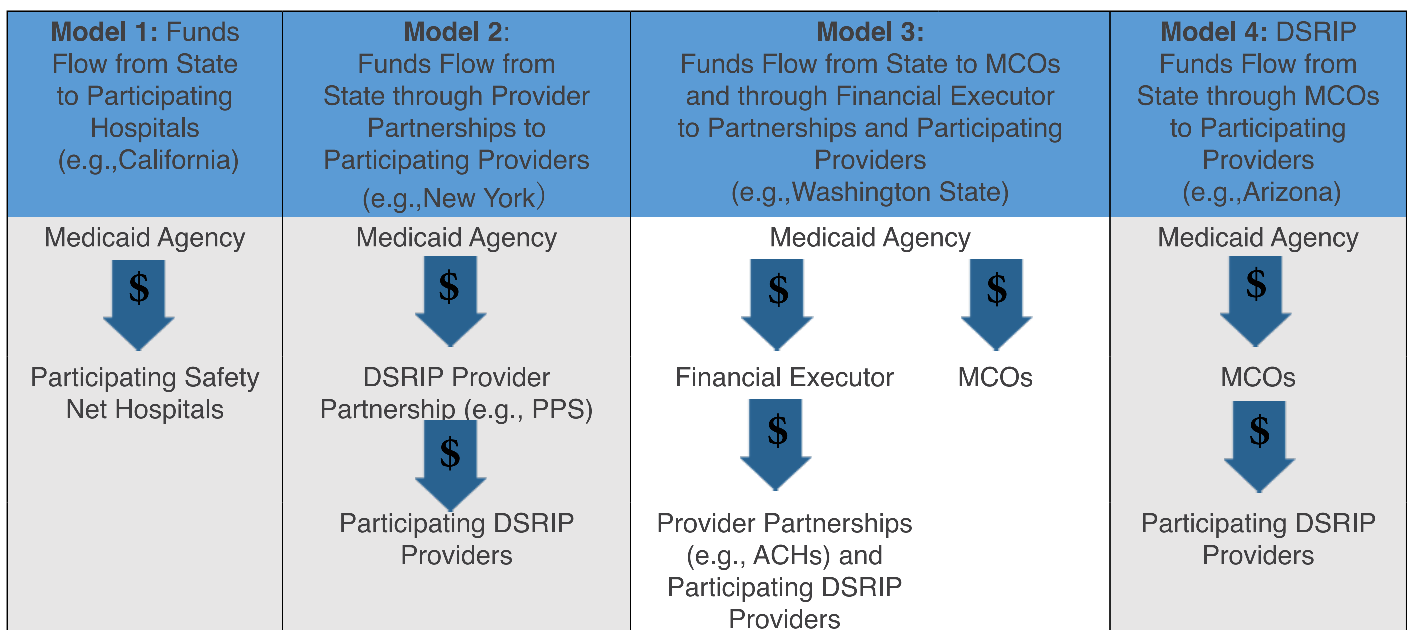
State	DSRIP Requirements for APM Adoption	APM Definition and Framework
California	Move 60 percent of Medi-Cal managed care beneficiaries assigned to Designated Public Hospitals to APM arrangements by the end of the demonstration.	Includes capitated payments and other APMs to be determined. California has established four tiers of capitated or alternative payments: 1. Partial: Primary care only 2. Partial-plus: Primary care and some specialty care 3. Global: Primary, specialty, ancillary and/or hospital care 4. Additional payment methodologies TBD
Massachusetts	Move 45 percent of MassHealth ACO-eligible lives to APM arrangements by the end of the demonstration.	Counted towards the state's APM adoption rate are all members who: • Are enrolled in or attributed to a MassHealth ACO; • Are enrolled in a MassHealth MCO and receive primary care from a primary care provider who is paid by that MCO under a shared savings and/or shared risk arrangement, or is similarly held financially accountable by that MCO for the cost and quality of care under a state-approved APM contract; and • Receive more than 20 percent of their non-primary care services (either gross patient service revenue or net patient service revenue) from providers who are paid under episode-based payments, shared savings and/or shared risk arrangements, or who are similarly held financially accountable for the cost and quality of care under a state-approved APM contract
New York	Move 80-90 percent of managed care payments to value-based payment (VBP) models by the end of the demonstration.	• Level 0 VBP: HCP LAN Category 2 • Level 1 VBP: HCP LAN Category 3a • Level 2 VBP: HCP LAN Category 3b • Level 3 VBP: HCP LAN Category 4
New Hampshire	Move 50 percent of Medicaid managed care payments in the MCO and Medicaid delivery contracts to APMs by the end of the demonstration.	TBD. State will draw on HCP LAN and MACRA APM frameworks.
Rhode Island	At least 33 percent of those eligible will be attributed to an Accountable Entity (AE), participating in an Executive Office of Health and Human Services-approved APM by the end of the demonstration.	The state will focus on total cost of care (TCOC) and other APMs as defined in the APM Methodology Document (expected 10/1/17). There will be three types of AEs: 1. Comprehensive AE: TCOC model 2. Specialized LTSS pilot AE: LTSS bundle 3. Specialized Medicaid pre-eligible pilot AEs
Washington	Move 90 percent of Medicaid provider payments to an APM by the end of the demonstration.	HCP LAN framework

Some states have also established specific benchmarks that specify the type of APM that must be achieved by a given year. In general, most states have established gradual APM adoption benchmarks that move provider contracts with MCOs along a continuum from a fee-for-service system with performance incentives (Category 2) in early demonstration years, to comprehensive population-based payments (Category 4) by the end of the demonstration. While states hope some providers will be participating in Category 4 APM models by the end of the initiative, states are focusing on moving the majority of providers into a minimum of a Category 3 model that includes some kind of upside or downside risk sharing. For example, by the end of its demonstration, New York aims to move 80 to 90 percent of MCO expenditures to Category 3A with at least 35 percent of payments in Category 3B. Washington aims to move 90 percent of payments to at least Category 2C, with 50 percent of payments in at least Category 3A. A CMS official noted that while the HCP LAN framework may be a useful guide for states, CMS is not prescribing specific APM requirements. Instead, CMS encourages states to take the lead on establishing APM definitions and targets, and CMS officials have encouraged states to come to them with proposals tailored to their own particular environments.

Flow of Funds to DSRIP Participants

The process for distributing funds to participating providers varies widely across states, largely based on the types of participating providers. All DSRIP programs pay providers based on their achievement of DSRIP metrics and milestones. In Massachusetts, where DSRIP is supporting the launch of ACOs and Community Partners, a portion of DSRIP funds are allocated to support start-up costs.[26]

Figure 2: Models of the Flow of Delivery System Transformation Funds



The flow of funds to DSRIP provider partnerships is a complex process that varies widely based on the types of participating entities. *Figure 2* illustrates several funds flow process models in delivery system transformation programs. In DSRIP programs that focus on hospitals (California, Kansas, Massachusetts (DSTI), New Jersey, New Mexico, and Oregon), DSRIP funds flow directly from the state to participating hospitals once the individual hospital achieves its DSRIP milestones and metrics. In DSRIP programs that require provider collaboration or the formation of provider partnerships (Texas, Massachusetts DSRIP, New York, Washington, New Hampshire, and Rhode Island), the flow of funds to participating providers is more complex. These programs allocate maximum potential DSRIP funding at the partnership level based on CMS-approved methodology that typically factors in providers' share of Medicaid and low-income, uninsured patients. Importantly, the formation of a new partnership structure typically requires additional funds to support the administrative capacity of partnership leads. Some states, such as Texas, manage the entire funds flow process, and the state Medicaid agency takes responsibility for calculating and disbursing DSRIP payments directly to Regional Healthcare Partnership leads and participating providers.

Other states give provider partnerships greater authority over the funds flow process. In New York, the state Medicaid agency makes DSRIP payments to PPS, and each PPS has discretion over allocating funds to participating providers based on a PPS-specific methodology. Though this approach promotes local flexibility and greater autonomy for PPS, providers participating in New York's DSRIP report a significant lag of several months to over a year between completing milestones and receiving payment from the state. Providers report the lag is partially due to a lengthy reporting process that results in delayed payments from the state to each PPS, and is in part due to the complexity of having each PPS use a different funds flow methodology.

Similar to New York, ACHs in Washington are responsible for determining how much DSRIP funding participating providers receive, but not for making the payments. Washington is the first state to use a financial executor to disburse DSRIP funds to participating providers in an effort to alleviate some of the administrative burden on ACHs.

States take different approaches to funding community-based organizations, and officials reported that this has been a particularly challenging process. To receive DSRIP funding, community-based organizations in New York that provide services related to the social determinants of health must contract with PPS. Many of these organizations have not previously received Medicaid funding and require assistance to enter into DSRIP contracts. To date, community-based organizations in New York have received little DSRIP funding from PPS compared to other participating providers, and PPS have received substantial pressure from stakeholders to address this issue. Stakeholders noted that complicated and lengthy contracting processes have been the primary cause of this problem. Despite these challenges, the state believes funds flowing through the PPS to community-based organizations will help break down silos and create an integrated system. A state official commented, "It's not easy, but you won't overcome silos through separate funding sources. It would be more expeditious, but you have to look at the goal. Integration comes with partnership and shared decision making."

Massachusetts has set up a separate funding stream to provide funds directly to Community Partners, community-based organizations that provide LTSS and behavioral health services and may have experience with Medicaid funding. The state believes its approach for funding these organizations will foster sustainability while continuing to promote important community-clinical partnerships. State officials commented that the funds flow decision relates directly to their goals: "We are building a structure so that

when DSRIP ends, we have a sustainable structure for these behavioral health and LTSS Community Partners. We also wanted to address some of the fear of ACOs over-medicalizing things. Many of the contractual responsibilities go back to the ACOs. If the ACOs are not working with Community Partners in the way we define, they won't get DSRIP money."

Some newer DSRIP programs channel DSRIP funds to or through MCOs. As *Figure 2* illustrates, Washington provides some DSRIP funding directly to MCOs separately from funding for ACHs, and Arizona makes all of its DSRIP payments through MCOs. In Washington, MCOs receive up to 5 percent of overall DSRIP funding, which is available based on MCO performance on quality measures and value-based purchasing targets. The state reports this funding is intended to support increased MCO reporting and performance on value-based payment targets.

Arizona's funding approach may be a model for states planning future delivery system transformation investments. Arizona plans to include a direct lump-sum payment in its capitation rates to Medicaid MCOs, which the MCOs can use to make incentive payments to providers using a standardized methodology developed by the state.[27] This approach was added as a state option in the Medicaid managed care rules 2016 update. The new regulations permit states to require MCOs to participate in particular value-based purchasing initiatives that are tied to common performance measures that align with the state's managed care quality strategy (42 CFR 438.6). CMS has developed guidance[28] for states interested in pursuing this option, and reports that it has approved proposals in three states and is currently reviewing four additional state proposals.

Arizona's approach may also be a model for how current DSRIP states can sustain their investments after their DSRIP demonstration waiver expires. It appears that several other states plan to move to such a model given the language in their Section 1115 demonstration waivers. For example, Oregon's most recently approved Section 1115 demonstration waiver notes the HTPP program, "will transition under managed care through the CCO contracts after Jan. 1, 2018."[29]

Financing of State DSRIP Programs

Aggregate DSRIP funding amounts and high-level financing mechanisms are established in the negotiated special terms and conditions of the authorizing Section 1115 demonstration waiver. While states may participate in a variety of programs to shift Medicaid to value-based payments and alternative payment methods, DSRIP is unique in its ability to direct incentive payments to eligible providers for infrastructure and capacity building needed to prepare for new care delivery and payment models. DSRIP funding provides performance-based incentives for successfully meeting metrics and outcomes associated with improvements in care delivery, and it is not intended to be a reimbursement for medical care services. CMS has made it clear that DSRIP payments cannot be considered patient care revenue for purposes of offsetting uncompensated care costs.[30]

This section looks at the following key components that pertain to state DSRIP financing:

- **Aggregate state DSRIP funding**
- **Non-federal share of DSRIP funding**
- **Sustainability**

Aggregate State DSRIP Funding

Aggregate DSRIP funding levels vary widely across states. Total computable DSRIP funding ranges from $29 million[31] in New Mexico's Hospital Quality Improvement Incentive (HQII) program to $12.8 billion in New York's DSRIP (see *Table 1*). In addition to the size of states, state officials report that aggregate state DSRIP funding amounts differ based on factors such as how budget neutrality is calculated, relation to prior supplemental funding programs, the availability of resources for the state share of funding, and the amount of funding approved in other states as described in the following sections.

States reported that budget neutrality was a key factor in their negotiations with CMS over total DSRIP funding. All Section 1115 demonstration waivers must be budget neutral, meaning the demonstration cannot cost the federal government more than would have otherwise been spent absent the demonstration waiver. Some states, such as California, have applied savings generated by expanding managed care under their prior Section 1115 demonstration waivers to the budget neutrality cap of their current demonstration, thus allowing for greater aggregate DSRIP funding.[32] States that have not generated such savings reported greater difficulty in reaching a sufficient level of DSRIP funding. For example, because Washington has operated its managed care program under state plan authority rather than a Section 1115 demonstration waiver, it could not apply any savings to its budget neutrality limit, resulting in less total available DSRIP funding.

In instances where DSRIP replaces prior supplemental payments, such as UPL funding, states reported that aggregate DSRIP funding was largely determined based on the prior amount of supplemental funding the state received. For example, in New Mexico and New Jersey, DSRIP funding is equivalent to the amount of federal supplemental funds these states previously spent on supplemental payments. In California and Massachusetts, DSRIP funding is comprised of repurposed funds from prior supplemental payment programs in combination with managed care savings.

In states where DSRIP has no relation to supplemental payment programs, several states reported proposing ballpark DSRIP funding figures to CMS based on the level of funding CMS approved in other states and the relative size of their Medicaid programs. From there, states negotiated with CMS to identify the appropriate amount of funding to meet program goals given budget neutrality requirements and available funding to cover the state share of DSRIP funding. Most reported that settling on the exact amount of total available DSRIP funding primarily depended on their ability to identify satisfactory sources of funding for the state share.

Non-Federal Share of DSRIP Funding

Given that states and the federal government jointly fund state Medicaid programs, DSRIP programs include federal and state (or non-federal) shares. The sum of these two components makes up total computable DSRIP funding. The source of non-federal share has been a focal point of DSRIP negotiations, and funding sources have evolved over time.

Compared to earlier DSRIP programs, new DSRIP and DSRIP-like programs use Designated State Health Programs (DSHPs) to finance the non-federal share of incentive payments. Early DSRIP states typically fund the state share of DSRIP through a combination of sources, such as intergovernmental transfers (IGT) from public entities (e.g., public hospitals, local governments), state general revenue, provider taxes, and, to a limited degree, DSHPs. However, recently approved DSRIP states increasingly leverage DSHP to fund most, if not all, of the state share of their programs (e.g., Rhode Island, New York, New Hampshire, and Washington).

Table 6: DSRIP Financing

State	Program Name	Source of the Non-Federal Share
California	DSRIP	Intergovernmental transfer (IGT) from Designated Public Hospitals
	Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	IGT from Designated Public Hospitals
Texas	DSRIP	IGT from public hospitals and local governmental entities
Massachusetts	Delivery System Transformation Initiative (DSTI)	State general revenue for private hospitals, IGT from the non-state, non-federal acute public hospital
	DSRIP	State general revenue and provider taxes
New Mexico	Hospital Quality Improvement Incentive (HQII) Program	State general revenue and IGT
New Jersey	DSRIP	State general revenue
Kansas	DSRIP	IGT
New York	DSRIP	IGT and Designated State Health Programs (DSHPs)
Oregon	Hospital Transformation Performance Program (HTPP)	Provider taxes
New Hampshire	DSRIP	DSHP and Certified Public Expenditure (CPE)
Rhode Island*	Health System Transformation Project	DSHP
Washington	DSRIP	DSHP and IGT
Arizona	Targeted Investments Program	DSHP and IGT

The special terms and conditions of Section 1115 demonstration waivers explain that DSHP funding provides federal funds to support critical state programs that currently do not qualify for federal matching funds. This allows states to reallocate a portion of those state funds once used to fund DSHP to instead provide the state share of their Section 1115 demonstration waivers. For example, the special terms and conditions from Washington's demonstration waiver explain: "Funding of DSHPs is to ensure the continuation of vital health care and provider support programs while the state devotes increased state resources during the period of this demonstration for DSRIP initiatives that will positively impact the Medicaid program, and result in savings to the federal government that will exceed the DSHP funding."

How States Use Designated State Health Program (DSHP) Funding

While there is no official guidance from CMS defining allowable sources of DSHP to provide the non-federal share of funds for Section 1115 demonstration waivers, language in the special terms and conditions (STCs) of state demonstrations provide valuable insights into the allowable and non-allowable uses of this funding source

State Programs That Qualify for DSHP Funding

Allowable DSHP programs vary widely across states. DSHPs are not limited to programs within state Medicaid agencies, and many states have used DSHP funds for programs in departments of mental health, corrections, public health, rehabilitation services, offices of children and family services, and more. The following are several examples of allowable state DSHP programs in two states:

New Hampshire (8 DSHP programs)

- Community Mental Health Center Emergency Services
- Governor's Commission on Drug and Alcohol Abuse, Prevention and Treatment, and Recovery
- Family Planning Program
- County Nursing Home Funding

New York (35 DSHP programs)

- Early Intervention Program Services
- Care Management
- Emergency Programs
- Community Services for the Elderly
- Outpatient and Methadone Programs
- Homeless Health Services

State Programs That Do Not Qualify for DSHP Funding

Examples of common programs that do not qualify for DSHP funding, as specified in STCs, include:

- Grant funding to test new models of care
- School-based programs for children
- Debt relief and restructuring
- Rent and utility subsidies normally funded by the U.S. Department of Housing and Urban Development
- Services provided to undocumented individuals
- Health information technology expenditures
- Administrative costs
- Prisons, correctional facilities, services for incarcerated individuals, and services provided to individuals who are civilly committed and unable to leave

States reported that DSHP funding also gives them flexibility to diversify the providers in their programs. Early DSRIP states, which relied heavily on IGT, had to limit providers' participation in part based on their ability to provide IGT.[33] While these states (e.g., Texas) included some providers that did not contribute IGT, their DSRIP programs depended on a subset of the eligible participating providers to generate enough IGT for all participants. In several instances, providers that could not generate enough IGT to draw down federal matching funds were not able to participate in DSRIP.

CMS is currently reviewing its DSHP policies. Although DSHP funding can provide the additional federal investment needed to support the start-up of a new initiative, one CMS official noted, "DSHP for the state share is not a sustainable source of funding. DSHP is meant to support a temporary investment in delivery system reform and not be an ongoing source of state share."

Sustainability

Funding for new and renewal DSRIP programs is time-limited and is scheduled to expire after five years. CMS is increasingly emphasizing the time-limited nature of DSRIP federal investments. The language in the terms and conditions of several states' Section 1115 demonstration waivers refers to DSRIP as a time-limited investment opportunity that states will need to sustain through future statewide payment reform initiatives. This is true of both new and renewal DSRIP states. As a result, many new and renewal DSRIP programs are reducing DSRIP and DSHP funding over the five-year demonstration period to gradually achieve sustainability. For example, the Massachusetts demonstration renewal waiver states, "This funding will be available only for this period as a one-time federal investment in delivery system reform within Massachusetts and will end after the five-year DSRIP program. Over time, DSRIP funding will phase down as programs should be sustainable without ongoing federal incentive payments."[34]

States emphasize the need for a continued source of funding to make delivery system improvements, citing the common five-year DSRIP demonstration timeframe as too short to achieve sustainable delivery system transformation. Most DSRIP providers report they will not be able to continue implementing their current DSRIP initiatives without continued DSRIP funding. For instance, providers who are redesigning care delivery processes to reduce hospital admissions or integrate physical and behavioral health care note that these ambitious goals require continuous quality improvement processes.

CMS requires states to develop sustainability plans that typically include new Medicaid managed care and/or APM strategies in an effort to decrease reliance on continued federal funding. APM adoption and MCO contracting strategies to encourage use of APMs in managed care may create the opportunity for providers to retain a portion of the savings that are generated from their delivery system investment. In other words, in the absence of additional federal DSRIP funding, providers could still invest in delivery system reform and recoup their investments through APM contracts that yield savings. Integrating value-based incentives into managed care contracts could also eliminate the need for a separate pool of federal supplemental funding and establish one unified payment system administered by MCOs. CMS is generally encouraging states to tailor these types of strategies to their specific payment environments. For example, states with limited or no Medicaid managed care penetration can consider other value-based purchasing strategies that do not include MCO contracting arrangements.

CMS's 2016 revision to the Medicaid managed care rule provides more explicit authority for states to require MCOs to adopt APMs. In particular, states can now include in managed care contracts requirements for managed care plans to make quality-based pass-through payments to providers without a Section 1115 demonstration waiver. This model of directing incentive payments through managed care plans is similar to how Arizona's DSRIP program is structured.

Officials across DSRIP states generally agreed on the advantages of requiring MCOs to participate in DSRIP and the value of DSRIP's APM targets. Several state officials noted that they view managed care APM requirements in DSRIP as the vehicle for achieving sustainability. A California official commented, "We needed to get to a place where we could build these kinds of delivery system incentives into our managed care program and not have a separate pool. The starting point is having these relationships between the plans and the systems that are focused on these types of value-based arrangements."

While most state officials agreed with CMS that DSRIP should integrate with managed care and implement APMs, they and other stakeholders raised questions about how to make the transition and whether such a model could sustain all DSRIP investments. Several states have established high-level APM targets, but are still developing state-specific APM definitions and working through implementation mechanics. Numerous providers raised concerns about their ability to sustain DSRIP improvements past the demonstration period due to their high volume of Medicaid and uninsured patients and relatively low payment rates. A provider in New York commented, “I don’t think we’ll be at full sustainability by the end of the demonstration. Some PPS are far ahead of the curve, and some are really not there yet.”

In states that have historically relied on Section 1115 demonstration waivers to make supplemental payments, providers pointed out that each state would have to develop some new form of funding to sustain the safety net after DSRIP. For example, a health system executive in Massachusetts observed, “We expect the state has a plan for the ongoing sustainability for the safety net. I don’t think just payment reform will resolve what it takes to deliver the full scope of care.”

Similarly, providers in California noted that sustaining delivery system reforms without continued supplemental funding was a great source of concern to them. “Any truly high-performing integrated system is always investing in ongoing transformation. There’s always improvement to be made. Whether it’s through PRIME or some other structure remains to be seen. It’s hard to say whether PRIME is a permanent or transitional program with all the uncertainties, but delivery system transformation as a priority for our member systems is ongoing, provided there are available resources to do it.”

In states that have yet to begin integrating DSRIP with managed care, stakeholders raised additional concerns about the ability of MCOs to sustain or participate in DSRIP initiatives. For example, providers in Texas described several challenges. First, a provider questioned how Medicaid MCOs would support DSRIP initiatives that benefit uninsured populations. The Texas DSRIP program serves a large number of uninsured individuals in addition to Medicaid beneficiaries because Texas has not expanded Medicaid and has a large uninsured population. Additionally, approaches to financing the non-federal share may affect the integration of DSRIP with managed care given that Texas finances the state share of its DSRIP program through IGT from participating public providers. Under the current system, public providers supply IGT *after* incentives have been earned. If DSRIP funding were included in a managed care construct, IGT funds would have to be incorporated *prospectively* into managed care rates and stakeholders fear MCOs would retain any unearned incentive funds.[35] Several stakeholders shared that they viewed the goals of DSRIP and of managed care as fundamentally different. Providers in Texas felt many of DSRIP’s delivery system innovations and long-term population health improvement strategies would be lost if DSRIP were incorporated into a managed care system. A state official in New Jersey echoed these concerns, noting that MCOs do not seem to be as focused on quality improvement and delivery system reform in comparison with the DSRIP program goals.

On the other hand, one Texas stakeholder shared that DSRIP could be a valuable opportunity for MCOs to learn how to structure more innovative performance-based incentives that encourage providers to improve the quality of care for their populations. MCOs in Texas currently have the flexibility to adopt some of the specific DSRIP projects that focus on Medicaid beneficiaries (as opposed to projects that focus on uninsured populations). An MCO representative reported that some MCOs in Texas are beginning to participate in some DSRIP projects and some MCOs intend to contract with providers who participate in DSRIP to expand promising DSRIP interventions in the future.

Monitoring and Evaluation

Monitoring and evaluation are required components of all Section 1115 demonstration waivers. In addition to routine progress reports to CMS on the status of providers' DSRIP metrics achievement, states generally use the following tools to monitor and assess the success of DSRIP programs:

- **Midpoint assessment**: Not all DSRIP programs are required to have midpoint assessments, but midpoint assessments are typically used to review DSRIP projects or project plans for compliance with approved DSRIP protocols and to provide recommendations to improve the programs.
- **Interim and final evaluations**: Interim evaluation reports generally present preliminary evaluation findings of DSRIP performance for the first half of a program. Final evaluation reports build on the interim reports and cover findings drawn from the entire duration of a program.

Public reports are available for early DSRIP programs (California DSRIP, Texas, Massachusetts DSTI, New Jersey, New York, and Oregon). California's and Texas's DSRIPs and Oregon's HTPP are the only programs that have completed all of their required evaluation components.

CMS is also evaluating DSRIP programs as part of its broader evaluation of all Section 1115 demonstration waivers, which will conclude in 2019. The federal DSRIP evaluation will specifically examine the impact of DSRIPs on improving individual care and health status for low-income populations, reducing the cost of care and avoidable hospital use, and creating sustainable system reform.[36]

This section focuses on currently available state-level monitoring and evaluation information, including use of metrics to monitor provider performance, the midpoint assessment process and results to date, evaluation challenges, and evaluation findings.

Midpoint Assessments

California, Texas, Massachusetts, New York, New Hampshire, and Washington DSRIP programs are required to conduct midpoint assessments. Such assessments typically review DSRIP projects or project plans for compliance with approved DSRIP protocols and provide recommendations to improve the program. The midpoint assessment is unrelated to the evaluation requirement of Section 1115 demonstration waivers and is not included in the state evaluation plan. Among DSRIP programs that have been approved since New York's, midpoint assessments are conducted by independent assessors who also approve project plans submitted by providers and monitor project implementation.

Midpoint assessments can be used to make programmatic changes. Among the six programs that have required midpoint assessments, California, New York, and Texas have their midpoint assessments completed and published. In each case, the midpoint assessment has resulted in programmatic changes.

- **California**'s midpoint assessment revealed the need to improve the specificity of data definitions and data accuracy to allow better comparison of participating providers' performance. The state re-evaluated and modified certain metrics accordingly to ensure standardization, and many of the changes went into effect in the fourth program year.[37]
- **Texas**'s midpoint assessment recommended changes to certain metrics and withdrawal of some projects. Both recommendations were implemented.

- **New York**'s midpoint assessment was conducted by an independent assessor. A Project Approval and Oversight Panel (PAOP) comprised of health care professionals, consumers, commissioners from state agencies, and others reviewed the independent assessor's recommendations and advised the state's Commissioner of Health whether to accept, reject, or modify those recommendations.[38] The PAOP is a unique feature of New York's DSRIP program and serves as a secondary, independent review body that primarily advises on any subjective issues. The PAOP accepted all of the independent assessor's recommendations on the midpoint assessment, some with modifications.[39]

Although midpoint assessments appear to be useful, states and providers may have different perspectives about their value. In California, the midpoint assessment allowed the state to identify an unforeseen measurement issue and make improvements to its target-setting methodologies for pay-for-performance metrics. A New York provider, on the other hand, pointed out the limitations of a midpoint assessment, "The independent assessor just presented data from July 2016 to the PAOP in February 2017. The reports were accurate at a point in time, but did not reflect the PPS world today. I don't know of any PPS that is relying on independent assessor feedback to do rapid-cycle improvement. Providers work with their own [information technology] systems due to state data lag."

Interim and Final Evaluations

States are generally required to submit both interim and final evaluations. DSRIP interim evaluation reports typically present preliminary evaluation findings in statewide performance for the first half of DSRIP programs, and all states are required to submit interim evaluations before the end of their demonstrations.

As of August 2017, final evaluations have been completed for California, Texas, and Massachusetts DSTI 1.0; however, only evaluations from California and Texas are publicly available. Massachusetts DSTI 2.0, New Jersey, and Oregon have published interim evaluations. See *Appendix B* for a summary of notable findings in publicly available DSRIP evaluation reports.

Published evaluations show that most providers are meeting most metrics and milestones, but it is too early to present significant findings related to outcomes. Providers participating in California's DSRIP and Massachusetts' DSTI on average achieved 90 percent or more of their planned milestones and metrics, but the percentage of achieved milestones and metrics may vary by program year. For instance, in California, as the proportion of outcome milestones in the total number of milestones increased with each year of the project, the percent of total milestones met decreased. This finding might be expected given the greater difficulty in achieving outcome milestones. According to Massachusetts DSTI and California DSRIP evaluators, participating providers achieved what they proposed. While there are no published clinical outcomes data for DSTI yet, DSTI evaluators provided the following insight during an interview, "DSTI investments have helped move these hospitals to be in a place to participate in APM. I don't know if we can say if they've moved the needle enough, but there's been transformation at these seven hospitals." According to CMS officials, states have reported on "very low hanging fruit" and given the challenges states have faced with collecting and reporting data (see following section), CMS suggests caution in interpreting results.

Evaluators across states have encountered challenges in isolating the impact of DSRIP. Many states that participate in DSRIP have other ongoing delivery system and payment reform initiatives, and DSRIP providers may participate in multiple initiatives simultaneously, making it challenging to isolate

the impact of DSRIP. A DSRIP evaluator observed, “Trying to figure out exactly what DSRIP accomplished is not necessarily possible. What you need to look at is what value DSRIP added. What they told us DSRIP provided was additional resources to scale up.”

Evaluators may try to identify impacts attributable to DSRIP activities using a comparison group, but depending on the health care landscape in the state, evaluators may not be able to find a good comparison group for a robust analysis because there are not enough non-DSRIP providers with similar characteristics as participating providers. In some states with multi-faceted evaluation approaches, it may be possible to use a comparison group to evaluate the impact of certain specific DSRIP interventions as opposed to the program overall. For example, the Texas DSRIP evaluators were able to collect data from comparison sites to evaluate the DSRIP-funded care navigation intervention.[40]

During interviews, some evaluators also raised data lag as a challenge for quantitative analysis, which prevents interim evaluations from being used for rapid-cycle improvement during the duration of DSRIP programs. For instance, a Texas evaluator shared that there can be a six-month lag for final adjudication of managed care encounter data. While evaluators also use qualitative data sources such as provider surveys, provider progress reports, and key informant interviews, data lag limits the usefulness of interim evaluations in understanding program achievement and often delays the completion of evaluations. Adding into account the lengthy review process of evaluation reports at the state and federal level (most reports are not published until a year after states submit drafts to CMS), the data presented in an interim evaluation may be two years old by the time the report is published.

Final evaluation results are not available until after a state’s initial DSRIP demonstration expires. This is partly due to the lag in the availability of quantitative data. As a result, final evaluation results are not available to inform demonstration renewal applications, which are generally submitted over a year in advance of the expiration date of their current demonstration. For example, California submitted its demonstration renewal request, which included a proposal to renew DSRIP for five additional years, to CMS in March 2015. It was approved in December 2015. However, California’s DSRIP final evaluation report was not completed until February 2016. Similarly, Massachusetts’ new DSRIP program was approved in November 2016 even though the DSTI 2.0 final evaluation is not due until December 2017. Texas’s Section 1115 demonstration waiver was originally set to expire in September 2016, with the draft final evaluation report due to CMS in January 2017. Texas has received a 15-month extension while the state is negotiating renewal with CMS, but the timeline for the final evaluation did not change, and the final evaluation report was published in May 2017 even though the program is ongoing.

Although final evaluations are not available at the time of renewal for DSRIP demonstration waivers (and other Section 1115 demonstration waivers), CMS noted that it does use interim evaluations when reviewing demonstration renewal requests. Evaluations from other states and CMS’s current federal evaluation of DSRIP are also helping to inform CMS’s views about DSRIP programs more generally.

Key Takeaways

- **DSRIP programs remain unique, with no "one-size-fits-all" model**. DSRIP programs, developed in response to unique state circumstances and shaped by negotiations between states and CMS, are designed to meet state goals and needs. As a result, they vary in their types of eligible providers, design features, funding, and financing. In addition, it is difficult to distinguish between DSRIP programs and other types of targeted investments that CMS now permits states to make without Section 1115 demonstration waivers.
- **Despite variation in DSRIP programs, there is a noticeable shift in DSRIP programs' design since New York's DSRIP was approved in 2014**. Compared to pre-2014 DSRIP programs, more recent ones:
  - **Place greater emphasis on payment and delivery system transformation and have no relation to prior supplemental payments**. Recent DSRIP programs complement other payment and delivery system transformation opportunities, and they place increased emphasis on addressing behavioral and population health.
  - **Support provider partnerships and networks that are increasingly comprised of an array of providers, rather than only hospitals**. Many recent and renewal DSRIP states encourage or even require greater integration and collaboration between hospitals and providers that did not typically participate in earlier DSRIP programs in order to meet the goals of state payment and delivery system transformation. The provider partnerships and networks vary in their degrees of formality and roles, with some planning to become risk-bearing entities, such as ACOs.
  - **Emphasize accountability for achieving outcomes at both the state and provider levels, with less emphasis on process**. More recent DSRIP programs have higher proportions of outcomes-based metrics in their total number of metrics, placing greater accountability on providers for results. Some also include mandatory statewide accountability targets that states must meet to avoid reductions in aggregate state DSRIP funding, introducing risk at the state level.
  - **Rely more heavily on DSHPs to finance the non-federal share of their programs, and less on other sources**. Use of DSHP funding provides greater federal investment in DSRIP and enables states to be less reliant on providers and local governments to provide the non-federal share of DSRIP funding. However, financing the non-federal share of DSRIP investments continues to be a challenge.
- **While recent DSRIPs are designed to sustain DSRIP investments through value-based purchasing strategies in managed care, it is not clear how this model will work in practice**. States are still developing plans to integrate DSRIP with managed care and sustain DSRIP delivery system reforms through increased use of alternative payment methodologies. CMS's 2016 revisions to the Medicaid managed care regulation provides new opportunities for states to make quality-based pass-through payments in managed care, but many questions remain whether this strategy will be enough to sustain all DSRIP improvements in care delivery and how this strategy would support DSRIP initiatives that target low-income, uninsured populations.
- **Given that few states have final DSRIP evaluation results available, it is too early to tell what impact DSRIP programs are having on the goals of improving care and health, and lowering costs**. Results that are available from interim evaluations and other sources show that most providers are meeting their DSRIP metrics and milestones and that states have achieved many delivery system transformation and improvement goals. However, it is too early to assess the overall impact of DSRIP programs on outcomes across states. Final evaluations and CMS's federal evaluation of DSRIP, which are still pending, promise to provide more information about DSRIP's effect on costs and quality.

Conclusion

There are now 12 states with DSRIP and DSRIP-like programs, and there continues to be wide variability across the states in their design, financing, and measurement. Nonetheless, there is increasing alignment around the goals of delivery system transformation. DSRIP is the central driver of payment and delivery system reform in some states, and is aligning with earlier transformation initiatives in other states to achieve overarching Medicaid payment and delivery system reform objectives.

As DSRIPs in all stages of development continue to evolve and more evaluation results become available, key considerations remain. Critical decisions about the future of the Medicaid program will also be relevant to the discussion.

Appendix A: State Fact Sheets

The information presented in the following fact sheets summarizes NASHP's understanding of the DSRIP and similar delivery system reform incentive programs (referred to as DSRIP-like programs) in California, Texas, Massachusetts, New Jersey, New York, Oregon, New Hampshire, Rhode Island, Washington, and Arizona as of July 2017. The fact sheets also include Alabama's Integrated Provider System, which was approved but will not be implemented. The fact sheets appear in chronological order of Section 1115 demonstration waiver approvals. NASHP compiled this information from a variety of sources, including the special terms and conditions (STCs) and attachments in each state's Section 1115 demonstration waiver and other readily available public information. For the purposes of cross-state comparison, each DSRIP program year begins with Year 1, though states may refer to DSRIP years in terms of Section 1115 demonstration waiver years. Furthermore, the funding amounts provided in the following fact sheets are estimates based on an analysis of figures provided in each state's Section 1115 demonstration waiver. Figures for maximum potential pool funding represent total computable funds that include the federal and non-federal share. Figures for the federal share and non-federal share are estimates as they are calculated based on Federal Medical Assistance Percentages (FMAP), which may fluctuate from year to year. DSRIP program funding may be contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

California

General Program Information and Context

- Through the "Medi-Cal 2020" demonstration, California aims to continue to improve the quality and value of care provided to Medi-Cal beneficiaries. Medi-Cal 2020 initiatives include a Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a Global Payment Program for Public Health Care Systems, a Whole Person Care Pilot program, and a Dental Transformation Initiative.
- The purpose of the PRIME program is to support participating entities in their efforts to change care delivery and strengthen those systems' ability to participate in alternative payment models (APMs) that align with HHS' delivery system reform goals. The PRIME program will also provide direct incentives to participating PRIME entities to support better integration of physical and behavioral health services in inpatient and outpatient settings, improved health outcomes, and increased access to health care services, particularly for those with complex health care needs. The PRIME pool will build on the delivery system transformation work achieved through the prior California Section 1115 demonstration waiver, Bridge to Reform. This prior demonstration waiver included a DSRIP program to drive system transformation by providing support for infrastructure and quality improvements while bolstering the safety net for the designated public hospitals (DPH) that serve large numbers of Medi-Cal enrollees and uninsured Californians.

General Information		
	Program Length	10 years (including DSRIP and PRIME)
	Stage of Implementation	Year 2 of PRIME (Demonstration Year (DY) 12)
	Date Submitted to the Centers for Medicare & Medicaid (CMS)	6/30/2010
	Date Approved by CMS	11/1/2010
	Date Implemented *(Date projects approved)*	Protocols were approved 3/17/2011. Project plans were submitted between February 18-April 15, 2011 (projects for certain categories had different timelines), and completely approved by the state and CMS by June 15, 2011.
	Date Demonstration Renewal/ PRIME Submitted	3/27/2015
	Date Demonstration Renewal/ PRIME Approved	12/30/2015
	Date PRIME Implemented *(Date projects approved)*	Protocols were approved by CMS on 3/2/2016. STCs noted protocols were required to be finalized by state and by CMS within 60 days of acceptance of final STCs (STC 102). A PRIME stakeholder webinar from April indicated projects were likely approved 6/3/2016.
	Date Expires	12/31/2020

Funding[1]		
	Maximum Potential Pool Funding (federal and state)	Funding for PRIME will not exceed $7.464 billion total computable ($3.732 billion in federal share and $3.732 billion in state share). The demonstration will provide up to $1.4 billion total computable annually for the Designated Public Hospital (DPH) systems and up to $200 million annually for the District/Municipal Public Hospitals (DMPHs) for the first three years of the demonstration. The pool will then phase down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the final year of the demonstration.
	Source of Matching Funds (non-federal)	Intergovernmental transfer (IGT) from participating PRIME entities or applicable government entities.
	Does DSRIP Replace Prior Supplemental Funding?	The DSRIP program exceeded prior supplemental funding, but DMPHs were not eligible to participate. The PRIME program includes DMPHs and continues to exceed prior supplemental funding.
	Process of Reallocating Unused Funds	<u>Unused Pool Fund</u> 1. If, through the PRIME Project Plan submission and approval process, there is Pool funding that remains unallocated, then the affected participating PRIME entity, in addition to all other participating PRIME entities, may implement additional projects or demonstrate greater performance that will be applicable to the remaining DYs to earn the unused funds. 2. The opportunity to earn additional funding will be offered and allocated first to the affected participating PRIME entity, then to participating PRIME entities within the same Sub Pool, then among participating PRIME entities in the same Pool. 3. Requests for additional projects must be approved by the state. <u>Unclaimed Pool Payment</u> Pay-for-performance (P4P) metrics can earn partial incentives proportional to the achievement value on a percentage basis, whereas pay-for-reporting (P4R) metrics can only earn full incentive payment for submitting the metric report. <u>Process for earning unclaimed funds</u>: A) Within a DY, PRIME entity can re-claim up to 90 percent of unearned funds on a P4P project by over performing on other P4P project metrics by 50 percent or greater. The total amount of unearned funds that can be claimed by a participating PRIME entity will be proportional to the amount of over performance on all other pay for performance metric targets in the aggregate (e.g. 50-74 percent over performance = 25 percent of metric value available to be reclaimed). The remaining 10 percent of unclaimed funds goes into a high performance pool (one for DPHs and one for DMPHs). B) Subsequent DY: If unable to reclaim 90 percent funding within DY, PRIME entity can reclaim up to 90 percent unearned funds in the subsequent DY through the same mechanism in A. There are no further opportunities to reclaim unclaimed funding for a metric after the relevant DY and subsequent year if 90 percent unearned funding still not claimed. In this case, remaining funds go into high performance pool.

Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	The amount associated with the Safety Net Care Uncompensated Care (UC) Pool under the Bridge to Reform demonstration, combined with a portion of the state's DSH allotment that would otherwise be allocated to the Public Health Care Systems (PHCS), is now in the Global Payment Program (GPP). GPP funding includes up to $472 million (total computable) in funds for the UC component for PRIME DYs 2-5.
	Corresponding Designated State Health Program (DSHP) Expenditures	DSHP funds are authorized for specific state-only medical programs and workforce development programs. The federal financial participation (FFP) the state may claim for DSHP shall not exceed $375,000,000 total for the five years or $75,000,000 FFP per year for DYs 11-15. If the state does not claim all DSHP money one year, the state may claim the rest in a following year. DSHP limit is $150,000,000 total computable per year and $750,000,000 total computable for five years. DSHP funding is not tied to PRIME.
Providers	**Participating Providers**	Participating PRIME entities will consist of two types of entities: Designated Public Hospital (DPH) systems and the District/ Municipal Public Hospitals (DMPHs). There are 21 DPHs that operate 17 health and hospital systems with one system comprised of four hospitals in Los Angeles County. There are 39 DMPHs spanning 19 countries across California.
	Provider Partnerships	N/A
Projects	**Project Domains**	• Domain 1: Outpatient Delivery System Transformation and Prevention (e.g. physical and behavioral health integration, ambulatory care redesign) • Domain 2: Targeted High-Risk or High-Cost Populations (e.g. improved perinatal care, complex care management for high risk medical populations) • Domain 3: Resource Utilization Efficiency (e.g. resource stewardship, high-cost imaging) DPHs are required to do at least nine projects: four projects in Domain 1 (three are pre-selected), four projects in Domain 2 (three are pre-selected), and one project in Domain 3. DMPHs are required to implement at least one project from any domain.

Outcomes	**Standardized Metrics**	The core set of standardized metrics for each project is outlined in PRIME Projects and Metrics protocol.
	Attribution Methodology	For DPHs: Determine the PRIME Defined Population composed of (a) all Medi-Cal managed care primary care lives assigned to the participating PRIME entity as listed by DHCS at the end of each measurement period; and (b) all individuals with at least two encounters by the participating PRIME entity for an eligible primary care service during the measurement period. For DMPHs: Determine the PRIME Defined Population composed of all individuals with at least two encounters by the participating PRIME entity among Medi-Cal beneficiaries. These Defined Populations serve as the starting point for all metric denominators, and then for each project is refined based on the project population and metric measurement specifications.
	Statewide Accountability Test	The state faces penalties if certain percentages of Medi-Cal managed care beneficiaries assigned to DPHs by their managed care plan (MCP) are not in an APM arrangement as follows: • By DY 13: 50 percent • DY 14: 55 percent • DY 15: 60 percent The DPH portion of the PRIME pool will have 5 percent of the yearly allocated pool amount at risk in DY 14 and 5 percent at risk in DY 15. Each year's potential reduction will consist of two portions: • 2.5 percent: contingent on aggregate APM adoption of 55 percent (DY 14) and 60 percent (DY 15) • 2.5 percent: this penalty would occur if providers fail to meet the aggregate 55 percent or 60 percent AND fail to meet a lesser aggregate APM adoption rate of 45 percent (DY 14) and 50 percent (DY 15)

Reporting & Monitoring		
	Date Interim Evaluation Report Submitted	DSRIP interim evaluation report was finalized in September 2014.
	Date Final Evaluation Report Submitted	DSRIP final evaluation report was completed in February 2016.
	Mid-Point Assessment Process	A midpoint assessment of DSRIP occurred in Year 3 that reviewed progress made in each category. This process resulted in changes to the DSRIP protocols that apply to Years 4-5 of Category 4. The midpoint assessment process for PRIME is not articulated in the Medi-Cal 2020 STCs.
	Program Evaluation	The UCLA Center for Health Policy Research is evaluating California's DSRIP and PRIME programs. The DSRIP evaluation was designed to examine the progress of DPHs in implementing DSRIP projects, the process of implementation and challenges faced by DPHs, and whether DSRIP projects impacted the Triple Aim of improving quality of care and patient outcomes, and increased cost containment or efficiency. UCLA examined the implementation of each Category as well as impact of categories on each other. Data sources for the interim DSRIP evaluation included: DSRIP plans and annual DPH reports (DYs 6-8), DPH questionnaire, DPH key informant interviews, data from the Office of Statewide Health Planning and Development (OSHPD). According to the draft PRIME evaluation design, the PRIME evaluation will assess the program's effectiveness in five areas: • Transforming outpatient delivery systems with a focus on prevention • Transforming how care for targeted high-risk or high-cost populations is aligned and coordinated • Utilizing resources efficiently • Improving health and health system outcomes that cross PRIME project domains through better care, better quality, and enhanced value • Moving the safety net toward sustainable change in a managed care environment. The PRIME evaluation will be a multi-method outcomes-focused study with quantitative and qualitative components. Quantitative methods will include pre- and post-PRIME comparisons. The largest data source will be performance metrics. Qualitative analysis may include methods such as key informant interviews, case study approaches, and a technical expert panel.

Other Delivery System Activities		
	Medicaid Managed Care Penetration (as of August 2016)	80 percent
	Other Payment and Delivery System Reform Initiatives	• SIM Design Award • IAP: Targeted Learning Opportunity (SUD), Housing Tenancy (LTSS) • Integrated Healthcare Association (IHA): value-based P4P program • Some federally qualified health centers (FQHCs) receive capitation for primary care services.
	Requirement to Support Alternative Payment Models (APMs)	California aims to move 60 percent of managed care beneficiaries assigned to DPHs into an APM by the end of the demonstration. DPHs must contract with at least one Medi-Cal managed care plan in its service area using APM by 1/1/2018.

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

Texas

General Program Information and Context

- The Texas DSRIP program is part of the state's Healthcare Transformation and Quality Improvement Program Section 1115 demonstration waiver. The major components of the demonstration include the statewide expansion of Medicaid Managed Care and the development of two funding pools supported by federal matching funds to support providers for uncompensated funds and to support delivery system reforms: the Uncompensated Care (UC) Pool and the DSRIP Pool. Savings generated from the managed care expansion and the elimination of prior supplemental payments to hospitals (Upper Payment Limit funding) allow the state to preserve supplemental payment funding to hospitals through the new UC and DSRIP pools.
- DSRIP incentivizes hospital and non-hospital providers to implement multi-year projects that enhance access to health care, the quality of care, experience of care, and the healthcare system for Medicaid and low-income uninsured individuals across the state. Texas has adopted a localized approach to DSRIP implementation by organizing providers into 20 geographically defined Regional Healthcare Partnerships (RHPs), which conduct local community needs assessments and are coordinated by a public hospital or some other local governmental entity.

General Information	**Program Length**	5 years plus a 15 month temporary extension
	Stage of Implementation	Currently in 15 month extension period as of 10/1/16
	Date Submitted to CMS	7/12/2011
	Date Approved by CMS	12/12/2011
	Date Implemented *(Date Projects Approved)*	Most RHP plans were approved by May 2013
	Date Expires	Original 5-year demonstration expired 9/30/2016, extension expires 12/31/2017
	Date Renewal Submitted	9/30/2015
Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$11,400,000,000 for first five years plus $3,875,000,000 for 15 months. State was authorized to use DY 5 DSRIP funding level ($3.1 billion annually) during extension period. Total available funding over six years and three months is $15,275,000,000 (state and federal).
	Source of Matching Funds (non-federal)	Intergovernmental transfers (IGTs) from major public hospitals, or other units of local government such as counties, cities, community mental health centers, state-funded academic medical schools, and hospital districts.
	Does DSRIP Replace Prior Supplemental Funding?	The Section 1115 demonstration waiver that authorizes DSRIP implementation includes a related Uncompensated Care Pool that replaces prior supplemental UPL payments.
	Process of Reallocating Unused Funds	• There is a carry-forward policy for categories 1-3. If the performing providers do not fully achieve a milestone, they can carry forward available incentive funding for that milestone for up to one additional DY. After that, if the metric is still not achieved, the associated incentive payment is forfeited. • Unallocated funding from Years 3-5 in the amount of $1,169,205,548 was redistributed among the RHPs for additional three-year projects for those years. • Further unclaimed funding cannot be redistributed. • Unclaimed DY 2 funding was forfeited.

Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	Yes, maximum UC pool funding is $17,582,000,000 over five years plus $3,875,000,000 for 15 months. State was authorized to use DY 5 UC funding level during extension period. Total available funding over six years and three months is $21,457,000,000 (state and federal).
	Corresponding Designated State Health Program (DSHP) Expenditures	No
Providers	**Provider Partnerships**	Medicaid providers are organized into 20 RHPs. RHPs are typically anchored by a public hospital and can also include community mental health centers, local health departments, physician practice plans affiliated with an academic health science center, and other types of providers approved by the State and CMS.
	Participating Providers	A total of 297 providers are currently participating in DSRIP (as of September 2016).
Projects	**DSRIP Project Categories**	Project categories include: 1. Infrastructure development 2. Program innovation and redesign 3. Quality improvement 4. Population focused improvements Each RHP must implement a minimum of 4-20 projects (depending on the RHP's share of the statewide population under 200 percent of the poverty level) from Categories 1 and 2. Category 3 represents outcomes reporting related to Category 1 and 2 projects and Category 4 represents reporting on population-level measures.
Outcomes	**Standardized Metrics**	Yes, state provided standardized menu of metrics (available in metric specification guide) corresponding to menu of projects for providers to choose from.
	Attribution Methodology	Attribution is determined by providers. Providers can modify denominator for quality measurement based on criteria such as payer source, target condition, and demographic factors. Most outcomes are reported at a facility level for all-payer types.
	Statewide Accountability Test	N/A

Reporting & Monitoring	**Date Interim Report Due/ Submitted**	Interim evaluation report was completed 9/30/2015
	Date Final Report Submitted	Final evaluation report was submitted 5/29/17
	Mid-Point Assessment Process	The mid-point assessment was completed by Myers and Stauffer on 5/27/2015. The midpoint assessment found that overall, 79 percent of DSRIP projects are on track for meeting their project outcome objectives. The assessment also made recommendations for improvements to the DSRIP program and the state has accordingly made changes to specific metrics and projects.
	Program Evaluation	The Center for Data Analytics and Decision Support unit of HHSC oversaw the entire Section 1115 demonstration waiver evaluation, and Texas A&M led the evaluation of DSRIP. Given the large scope of DSRIP projects, the evaluation focused on evaluating a single DSRIP project type, care navigation services to reduce inappropriate ED use, and evaluated specific projects in this area that are as similar to each other as possible. The evaluation assessed the impact of these projects on health outcomes, quality and costs and evaluated specific strategies used in different projects.
Other Delivery System Activities	**Medicaid Managed Care Penetration (2016)**	89 percent
	Other Payment and Delivery System Reform Initiatives	Texas received a CMS/SAMHSA planning grant for a VBP pilot for integrated mental health, substance abuse and limited primary care services. Texas applied for, but did not receive, an implementation grant. Texas also received a SIM design grant. Texas requires its managed care organizations (MCOs) to implement VBP models with providers, focused on improving enrollee outcomes, and to report their usage of alternative payment models so that the state may track MCO efforts. Texas is developing a VBP roadmap, which may include new contractual targets for MCOs by September 2017.
	Requirement to Support Alternative Payment Models (APMs)	Not in the current program. However, Texas has submitted a demonstration renewal proposal which includes plans to establish value-based purchasing arrangements between DSRIP providers and MCOs.

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

Massachusetts

General Program Information and Context

- In 2006, Massachusetts created the Safety Net Care Pool (SNCP) under the authority of its Section 1115 demonstration waiver to support Uncompensated Care (UC) payments to providers and funding for low-income individuals to purchase insurance. In its 2011-2014 Section 1115 demonstration waiver, Massachusetts created the Delivery System Transformation Initiative (DSTI 1.0) under the SNCP, which provided incentive payments to seven safety net hospitals to further develop an integrated system, improve health outcomes and quality, prepare for value-based payments, and report on population health improvement initiatives. In its 2014-2019 Section 1115 demonstration waiver, Massachusetts received approval to implement a DSTI 2.0 program for three years that included increased requirements for participating hospitals to demonstrate improvement on health outcome and quality measures.
- In November 2016, CMS approved a redesigned, five-year Section 1115 demonstration waiver to replace the prior demonstration (2014-2019) with an effective date of July 1, 2017. Under the new demonstration, DSTI is replaced by a larger DSRIP program with up to $1.8 billion (total computable) available to entities that choose to participate in Massachusetts' care delivery and payment restructuring.
- The new DSRIP program makes funding available to Medicaid accountable care organizations (ACOs) and community partners (CPs), which are community-based entities that will provide care coordination supports for members with high behavioral health (BH) and long-term care (LTSS) needs. In order to qualify for DSRIP funding, ACOs and CPs must contract with the Medicaid program and take accountability for total cost of care (for ACOs only) and quality (for ACOs and CPs) for an attributed population of members. The objective of the DSRIP program is to further key goals of the Section 1115 demonstration waiver, including: (1) enacting payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improving integration among physical health, BH, LTSS, and health-related social services; and (3) sustainably supporting safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals.
- DSRIP is part of the $7.9 billion SNCP, which also includes Disproportionate Share Hospital, UC, Designated State Health Program (DSHP), and Public Hospital Transformation and Incentive Initiative (PHTII) funding.
- Given the shift from DSTI which focused on seven safety net hospitals, the Section 1115 demonstration waiver also authorizes ~$811 million over five years to be allocated in pre-determined amounts for an expanded group of 14 safety net hospitals. These hospitals must participate in an ACO to access funding, a portion of which will be at-risk to increase accountability for these funds. Additionally, the demonstration waiver's PHTII program provides performance-based funds to the state's only acute public hospital ($852 million total computable over five years).

General Information	**Program Length**	• DSRIP is a 5-year program (7/1/17 – 6/30/22) • DSTI 1.0 was a 3-year program (7/1/11-6/30/2014) • DSTI 2.0 was a 3-year program (7/1/14-6/30/2017)
	Stage of Implementation	Year 1 of DSRIP began on 7/1/2017
	Date Initial DSTI Protocol Submitted to CMS	• DSTI 1.0 submitted on 6/30/2010 • DSTI 2.0 submitted on 9/30/2013 (re-submitted 1/27/2014)
	Date DSTI Authority Approved by CMS	• DSTI 1.0 approved 12/20/2011 • DSTI 2.0 approved 10/30/2014
	Date DSTI Protocol Implemented *(Date projects approved)*	• DSTI 1.0 hospital projects approved in June 2012 • DSTI 2.0 hospital projects approved October 30, 2015
	Date Demonstration Renewal/DSRIP Authority Submitted	7/22/2016
	DSRIP Demonstration Approved	DSRIP demonstration authority approved 11/4/2016. DSRIP protocol approved 5/15/2017.
	Date Expires	DSRIP expires June 30, 2022
Funding[1]	**Maximum Potential DSRIP Funding (federal and state)**	$1.8 billion total computable over five years.
	Source of Matching Funds (non-federal)	General fund, including annual $250 million hospital provider assessment (based on private sector charges) in the DSRIP Trust Fund. Intergovernmental Transfers from the public hospital fund the non-federal share of PHTII.
	Does DSRIP Replace Prior Supplemental Funding?	DSRIP exceeds prior supplemental payments under DSTI.
	Process of Reallocating Unused Funds	May be reallocated to certain funding streams within the DSRIP program
Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	Yes. The SNCP includes Uncompensated Care Costs (UCC), which are defined as payments made to providers for providing uncompensated care to uninsured individuals. This UCC pool includes two components: 1) Health Safety Net payments to hospitals and community health centers for low-income, uninsured patients and 2) Certified Public Expenditures for hospitals operated by Dept. of Public Health and Dept. of Mental Health for care provided to uninsured. In 2017-2018 the UCC pool will be set at a transitional level of $212 million. The pool will be set at $100 million each year beginning in July 2018 through the remainder of the extension period.
	Corresponding Designated State Health Program (DSHP) Expenditures	The Section 1115 demonstration waiver authorizes $1.25 billion total computable in DSHP expenditures for Health Connector premium assistance and cost sharing subsidies. DSHP funding is separate from DSRIP funding.

Providers	**Providers Eligible to Receive DSRIP Funds**	1. **Accountable Care Organization (ACO) entities:** "entities that enter into population-based payment models with payers, wherein the entities are held financially accountable for the cost and quality of care for an attributed Member population." There are three ACO models: Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs. 2. **LTSS and Behavioral Health (BH) Community Partners (CPs)**: community-based entities that have been procured by MassHealth to provide: comprehensive care management including coordination of physical, BH, LTSS and social service needs; and LTSS care planning and care coordination including LTSS and social service needs. Behavioral health CPs must show experience in: serving members with complex behavioral health needs, delivering culturally competent outpatient mental health and substance use disorder services, and performing care coordination and referral services. LTSS CPs must show experience in: serving members with complex LTSS needs, including members with disabilities, coordinating between the physical health and LTSS systems, and assessing needs and counseling members to access appropriate LTSS providers. MassHealth released a procurement for CPs in March 2017, with 22 BH CP and 12 LTSS CP bids received in May 2017.
	Provider Partnerships	Yes, model requires all DSRIP eligible providers to participate in an ACO. ACOs are required to have exclusive participation from a number of PCPs and affiliations with hospitals to coordinate care. PCPs may only be affiliated with one ACO; hospitals may contract with multiple ACOs. In the areas that they serve, ACOs must contract with all behavioral health CPs and at least two LTSS CPs so as to ensure appropriate access for their members. There are 3 ACO models: 1. **Accountable Care Partnership Plans** are a partnership between an MCO and an exclusively-partnered ACO. The Partnership Plan contracts directly with MassHealth and receives a prospective capitated payment for attributed members and is at risk for losses beyond that rate. Partnership Plans must develop a provider network and pay claims. MassHealth received 15 applications from prospective ACO Partnership Plans, and selected all of them to enter into contract negotiations. 2. **Primary Care ACOs** are provider-led ACOs that contract directly with MassHealth as Primary Care Case Management entities to take financial accountability for a defined population of enrolled members. Primary Care ACOs are subject to shared savings and loss payments based on total cost of care and quality performance for attributed members. MassHealth received three applications for prospective Primary Care ACOs, and selected all of them to enter into contract negotiations. 3. **MCO-Administered ACOs** are essentially a value-based payment arrangement between a provider-based ACO and an MCO; they include shared savings and losses. The provider ACO may contract with multiple MCOs to create a value based payment or "MCO-administered ACO." MassHealth received three applications for prospective MCO-administered ACOs, and selected one of them to enter into contract negotiations.

Projects	Project Domains	There are four DSRIP Funding Streams/Investment Domains: 1. **Supporting ACO development** (60 percent total DSRIP funds): ACOs may use DSRIP funds for: (a) ACO startup/ongoing support: provides funding to new and existing ACOs to develop capacity to serve MassHealth population. ACOs may use the funds to build up primary care provider capacity and sophistication, and enhance information technology, care coordination capacity, and population health analytics. ACOs will be required to use a portion of their startup/ongoing funds to support primary care investment; the remaining funds may be used for other discretionary purposes. (b) "Glide path" funding for DSTI safety net providers: provides funding to ACOs that include a DSTI safety net hospitals to help them transition to lower levels of supplemental funding for the care they provide to Medicaid/uninsured members. (c) Support for flexible services: provides funding for ACOs to pay for currently non-reimbursed services that address health-related social needs (e.g. services for individuals transitioning from an institution to the community, physical activity and nutrition, and support for individuals who have experienced violence). Funds for the first two purposes (1a and 1b) will be partially at risk, based on ACO DSRIP accountability score. 2. **Supporting Community Partners** (30 percent total DSRIP funds): CPs will use DSRIP funds for: (a) care coordination and navigation: supports ACOs and MCOs in care coordination and management and mitigation activities for members with complex behavioral health and LTSS needs. DSRIP funds will support behavioral health CPs in delivering the six core activities that will be required of them: comprehensive care management, care coordination, health promotion, transitional care, member and family support, and referral to community and social supports. For LTSS CPs, the funding will be used for LTSS care planning, care team participation, LTSS care coordination, support for transitions of care, health and wellness coaching, and referral to community and social supports to provide independent assessments, counseling, and referrals to LTSS providers. (b) infrastructure and capacity building: funds may be used for specific types of investments, including workforce capacity, health information technology, performance management, contracting and networking, and project management. Similar to ACOs, a portion of the payments will be at-risk, based on a CP accountability score. 3. **Statewide investments** (6 percent total DSRIP funds)**:** DSRIP funds also will support statewide investment initiatives, including student loan repayment, primary care residency training, workforce development grants, an alternative payment model preparation fund, and projects to improve accessibility for people with disabilities. 4. **Implementation and operations** (4 percent total DSRIP funds): The remaining DSRIP funds will support the Commonwealth's implementation and oversight of DSRIP (e.g. administering grant programs, hiring staff and vendors).

Outcomes	**Measurement**	ACOs and CPs receive DSRIP funding contingent upon their respective DSRIP accountability and scores. Preliminarily, these scores are determined based on standardized metrics established by the state. MassHealth is finalizing these specifics, including the Quality Measure Slate, with CMS. **ACO Quality Score**: The state anticipates that it will use an ACO's quality score as a component in the ACO's "DSRIP Accountability Score" (see below), and to determine shared savings and losses. The score is based on ACO performance on a set of measures in seven domains: (1) prevention and wellness, (2) chronic disease management, (3) behavioral health/substance use disorder, (4) LTSS, (5) avoidable utilization, (6) progress towards integration across physical health, behavioral health, LTSS, and health-related social services, and (7) member care experience. ACOs will be scored based on their progress towards meeting quality measures benchmarks and utilization targets. **ACO DSRIP Accountability Score**: Funds for ACO startup/ongoing support and the glide path payments will be partially at risk, based on an "ACO DSRIP Accountability Score" that measures performance on ACO total cost of care and on quality and utilization. Fifty percent of the discretionary portion of ACO startup/ongoing support (i.e. the portion not required to be used for primary care investment) will be at-risk by Year 5, whereas the DSTI glide path funding will be at-risk up to 20 percent by Year 5. The measures used to evaluate the ACO's quality and utilization performance are the same measures by which the state will be held accountable for statewide quality and utilization performance. During Year 1 of the program, all measures will be reporting only. In subsequent years, MassHealth will transition those measures to P4P. **CP DSRIP Accountability Score**: CPs will be paid on a per-member per-month (PMPM) basis. Similar to the DSRIP ACO funding, CP funding will be partially at risk on the basis of a CP Accountability Score. CP DSRIP Accountability Scores will be based on performance in quality domains that include prevention and wellness; member experience; progress toward integration across physical health, LTSS, and behavioral health; avoidable utilization; and engagement.
	Attribution Methodology	The attribution methodology is determined by state and based on the ACO model. ACOs are paid based on attributed Medicaid beneficiaries, who are able to actively enroll in one ACO model. MCO members are attributed to MCO-administered ACOs based on primary care provider. Members who do not actively enroll in an ACO model will be enrolled by the state based on members' existing primary care providers.
	Statewide Accountability Test	In Years 2-5, a percentage of total DSRIP expenditures (between 5-20 percent) are at risk based on the "State DSRIP Accountability Score." The state DSRIP accountability score is calculated based on performance in three domains: 1. MassHealth ACO/APM adoption rate 2. Reduction in state spending growth 3. ACO quality and utilization performance

<table>
<tr><td rowspan="4">Reporting & Monitoring</td><td>Date Interim Evaluation Report Due/Submitted</td><td>• DSTI 1.0 interim report published September 2013
• DSTI 2.0 interim report published February 2016
• DSRIP interim report due June 2020</td></tr>
<tr><td>Date Final Evaluation Report Due</td><td>• DSTI 1.0 final report completed October 2014
• DSTI 2.0 final report due December 2017
• DSRIP final report due June 2024</td></tr>
<tr><td>Mid-Point Assessment Process</td><td>A midpoint assessment of the DSRIP program will be completed by an independent evaluator that will be procured by MassHealth using DSRIP expenditure authority. The midpoint assessment will provide an independent analysis of the DSRIP program through December 2020, using both quantitative and qualitative methodologies, to evaluate whether the investments made through the DSRIP program have contributed to achieving the demonstration goals. The results from the midpoint assessment will be used to develop an interim evaluation of the DSRIP program, due to CMS by June 2020.</td></tr>
<tr><td>Program Evaluation</td><td>A final evaluation of the DSRIP program will be conducted by an independent evaluator. The final evaluation will provide a summative overview of the DSRIP program over the five year demonstration period, and evaluate whether the investments made through the DSRIP program contributed to achieving the demonstration goals.</td></tr>
<tr><td rowspan="2">Other Delivery System Activities</td><td>Medicaid Managed Care Program Information</td><td>19 percent of MassHealth members are in the fee-for-service program with no managed care. These members represent 23 percent of expenditures. Remaining MassHealth members participate in managed care, including:

1. MCOs: MassHealth currently contracts with six MCOs. These entities manage 70 percent of managed care expenditures.
2. State-Run Primary Care Clinician Plan
3. Senior Care Options
4. One Care Dual Eligible Program
5. Program for All Intensive Care for the Elderly

As part of its overall restructuring, MassHealth has issued an MCO procurement (program #1 above). MassHealth has announced it will decrease the number of MCOs it contracts with per region given that ACOs will also be a managed care options for enrollees.</td></tr>
<tr><td>Other Payment and Delivery System Reform Initiatives</td><td>• In 2013, MassHealth received a $44 million SIM Testing grant from CMS. The SIM grant supported a myriad of delivery system reforms. The Primary Care Payment Reform Initiative was a major part of SIM and under this program Patient-Centered Medical Home, including some federally qualified health centers (FQHCs), receive a fixed dollar amount for a comprehensive set of primary care services, including integrated behavioral health services. This initiative concluded in December 2016. SIM also supported the development and implementation of the ACO, CP, and DSRIP programs.
• Pilot Accountable Care Organizations: Six ACOs were selected to participate in the MassHealth Pilot ACO Program which began December 2016 and will run for approximately one year.</td></tr>
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[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

New Jersey

General Program Information and Context

- Through DSRIP, New Jersey aims to achieve the goals of transitioning hospital payments from the previous supplemental payment system (Hospital Relief Subsidy Fund) to an incentive-based model where payment is contingent on achieving quality improvement goals.
- Each participating hospital implements a Hospital DSRIP Plan, which describes how it will carry out one project that is designed to improve quality of care, efficiency, or population health in one of the following focus areas: asthma, behavioral health, cardiac care, substance abuse, diabetes, HIV/AIDS, obesity, and pneumonia. Hospitals may qualify to receive DSRIP payments for fully meeting performance metrics, which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care. DSRIP projects target Medicaid and CHIP beneficiaries as well as low-income uninsured individuals.

General Information	**Program Length**	Five Years
	Stage of Implementation	The demonstration expired in June 2017 and as of July 2017, New Jersey is in a one-month extension period while the State negotiates a longer extension with CMS.
	Date Submitted to CMS	9/14/2011
	Date Approved by CMS	10/1/2012
	Date Implemented *(Date projects approved)*	Most hospital plans were approved by CMS on 4/8/2014
	Date Expires	6/30/2017
	Date Renewal Submitted	6/10/2016
Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$583,100,000 ($291,550,000 state and $291,550,000 federal)
	Source of Matching Funds (non-federal)	State general revenue funds.
	Does DSRIP Replace Prior Supplemental Funding?	Yes; DSRIP funding amount is same as prior supplemental payments under Hospital Relief Subsidy Fund
	Process of Reallocating Unused Funds	New Jersey has a Universal Performance Pool (UPP) which is made up of the following funds: • For DY 2, hospital DSRIP Target Funds from hospitals that elected not to participate or where CMS did not approve the hospital's submitted plan. There will be no Carve Out Allocation amount for DY 2. • For DYs 3-5, Hospital DSRIP Target Funds from hospitals that elected to not participate, the percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount, and Target Funds that are forfeited from hospitals that do not achieve project milestones/metrics, less any prior year appealed forfeited funds where the appeal was settled in the current DY in favor of the hospital.

	Corresponding Uncompensated Care (UC) Pool	No. The demonstration does, however, authorize Transition Payments in DYs 1-2 which were included in total DSRIP funding such that each DY of the entire five year demonstration allowed for payments equal to $166.6 million annually.
	Corresponding Designated State Health Program (DSHP)	No.
	Provider Partnerships	N/A
	Participating Providers	All acute care hospitals are eligible to participate in DSRIP. Total of 71 eligible hospitals; 49 are currently participating.
Projects	**Project Domains**	Each hospital must select one project from a menu of 17 projects that address one of the following focus areas: behavioral health, HIV/AIDS, chemical addiction/substance abuse, cardiac care, asthma, diabetes, obesity, pneumonia, or another medical condition that is unique to a specific hospital, if approved by CMS. There are then four stages of activities: Stage 1: Infrastructure Development Stage 2: Chronic Medical Condition Redesign and Management Stage 3: Quality Improvements Stage 4: Population-Focused Improvements
Outcomes	**Standardized Metrics**	The state created a standardized list of all DSRIP metrics. DSRIP providers must report Stage 3 measures (project-specific) and Stage 4 measures (universal). The state will calculate measures that use claims data and hospitals are responsible for calculating all other measures.
	Attribution Methodology	The state uses a retrospective attribution methodology and assigns patients to hospitals based on two years of a patient's utilization pattern identified through claims.
	Statewide Accountability Test	N/A

Reporting & Monitoring	**Date Interim Evaluation Report Due/Submitted**	DSRIP evaluation is separate from the Section 1115 demonstration waiver evaluation. Rutgers Center for State Health Policy submitted the draft DSRIP mid-point evaluation in September 2015, and the report became publicly available in December 2016.
	Date Final Evaluation Report Due	March 2018
	Mid-Point Assessment Process	N/A
	Program Evaluation	Rutgers will complete the final DSRIP evaluation as a separate process from the overall Section 1115 demonstration evaluation. The purpose of the summative evaluation is to assess how well the DSRIP program achieves better care, better health and lower hospital costs for populations in the hospital catchment areas. The evaluation will use a combination of quantitative and qualitative methods including analysis of Medicaid claims and encounter data, key informant interviews, and a hospital web survey.
Other Delivery System Activities	**Medicaid Managed Care Penetration (2014)**	92 percent
	Other Payment and Delivery System Reform Initiatives	• Medicaid ACO demonstration launched 7/1/2015. There are currently three certified ACOs. • MCO performance-based contracting program.
	Requirement to Support Alternative Payment Models (APMs)	N/A

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

New York

General Program Information and Context

- New York's Delivery System Reform Incentive Payment (DSRIP) program is part of the state's Partnership Plan Section 1115 demonstration waiver. As described in Amendment 13, the state invested savings generated from reform under New York's Medicaid Redesign Team (MRT) into state health care reform efforts including the DSRIP pool. Under DSRIP, Medicaid providers and community-based organizations are organized into structures called Performing Provider Systems (PPS) that collectively implement 5 to 11 quality improvement projects designed to create regional integrated delivery systems able to accept value-based payments for attributed populations.
- A specific goal of DSRIP is to reduce avoidable hospital use by 25 percent over five years within the state's Medicaid program. In addition, DSRIP focuses on: "(1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform."
- New York's DSRIP program was created to incentivize provider collaboration at the community level to improve the care delivered to Medicaid beneficiaries. The majority of DSRIP funds flow directly from the New York State Department of Health to PPS for achieving specific project milestones, metrics and outcomes. DSRIP also includes $1.58 billion in supplemental Equity Infrastructure and Performance Programs (for specific Public and Safety Net PPS that are not eligible to participate in all DSRIP projects) as well as an Additional High Performance Program (AHPP) open to all PPS which is aimed at further incentivizing specific DSRIP measures crucial to meeting the program's objectives. In these programs, DSRIP funds flow through MCOs to PPS. Supplemental programs are funded outside of the Partnership Plan Section 1115 demonstration waiver.

General Information		
	Program Length	Six years (including one planning year, DY 0)
	Stage of Implementation	Year 4 of the demonstration including planning year (referred to by state as DY 3)
	Date Submitted to CMS	8/6/2012
	Date Approved by CMS	4/14/2014
	Date Implemented *(Date projects approved)*	Project plans were approved March 2015, and Year 1 began 4/1/2015.
	Date Expires	3/31/2020

Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$13,837,000,000 all funds ($6,919,000,000 federal funds). Total DSRIP valuation is $7,385,825,815 including supplemental DSRIP programs.
	Source of Matching Funds (non-federal)	Intergovernmental transfers (IGTs) from major public hospitals, supplemented by some state general revenue funded by Designated State Health Programs (DSHPs)
	Does DSRIP Replace Prior Supplemental Funding?	No. DSRIP funding has no relation to prior supplemental funding. NY DSRIP funding is comprised of MRT savings.
	Process of Reallocating Unused Funds	Beginning in DY 2, payments will only be made for full achievement of the milestone/metric. Unclaimed payment in each year will be rolled into the High Performance Fund for a period of one year. Following the one-year carry forward period, the performance payments that remain unearned will be returned to CMS. The High Performance Fund is available beginning in DY 2 for PPSs that exceed their performance benchmarks on specified P4P measures. Funding is divided equally across two tiers. Tier 1 rewards PPS that close the gap between their performance and statewide performance goal by at least 20 percent in one year. Tier 2 rewards PPSs who meet or exceed the statewide performance goal. The funding for the High Performance Pool is initially seeded by withholding 3 percent of the DSRIP Performance Funds and any unearned performance payments from the previous DY are added.
Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	No
	Corresponding Designated State Health Program (DSHP) Expenditures	Yes, $4 billion in DSHP expenditures are related to DSRIP (total, all funds); additional DSHP had previously been approved as part of other initiatives.
Providers	**Provider Partnerships**	Yes. Providers and organizations participate in 25 regional coalitions known as Performing Provider Systems (PPS). Major public hospitals or other eligible safety net providers lead PPS. PPS can include health care providers, health services, community-based organizations, and others.
	Participating Providers	Eligible providers include hospitals and non-hospital based providers. Eligible hospitals are public hospitals, Critical Access Hospitals or Sole Community Hospitals, or hospitals that pass two tests: at least 35 percent of outpatient volume and at least 30 percent of inpatient volume is Medicaid, uninsured and dual eligibles, or they serve at least 30 percent of all Medicaid, uninsured, and duals in the PPS service area. Eligible nonhospital based providers must have a total volume where at least 35 percent is Medicaid, uninsured, and duals (with certain exceptions). The state and CMS may also approve non-qualifying organizations for participation in a PPS as long as DSRIP payments to these organizations are less than 5 percent of the total project valuation.

Projects	**Project Domains**	1. Overall Project Progress 2. System Transformation and Financial Stability 3. Clinical Improvement 4. Population Health
Outcomes	**Standardized Metrics**	Yes, state provides standardized menu of metrics that fall into four domains corresponding with the DSRIP project domains. All DSRIP plans must include all core metrics in Domain 1 (P4R), all metrics in Domain 2 (P4R and P4P), and all core metrics in Domain 4 (P4P). From Domain 3 (P4R and P4P), DSRIP plans must include the behavioral health metrics in Domain 3.a. and project-specific metrics based on the Domain 3 and 4 projects selected. The state or CMS will add project-specific Domain 1 metrics to DSRIP project plans as necessary to address concerns with "at risk" projects, based on input from the independent assessor. A subset of Domain 2 and Domain 3 metrics related to avoidable hospitalizations, behavioral health and cardiovascular disease will also be part of the High Performance Fund.
	Attribution Methodology	Each patient will be assigned to only one PPS for measurement purposes. The patient population attributed for valuation will form the basis for quality measurement for all population-based measures with the appropriate criteria applied for each measure. For episodic-based measures, the initial population attributed to each PPS will be limited to only those members seen for that episode of care within the PPS network during the measurement period. Episode of care refers to all care provided over a period of time for a specific condition (e.g. Diabetes - all diabetes care received in a defined time period for those members). The eligible population is everyone attributed to the PPS who qualifies for the measure. The eligible population is NOT limited to people who have gone to providers or sites that are involved in project-specific activities, or people residing in a specific county or area. Members who are dually eligible (Medicare and Medicaid) will NOT be included in PPS measure results for measurement Years 1 to 3.
	Statewide Accountability Test	If the state fails to meet specified performance metrics, DSRIP funds will be reduced in Years 4-6 (DYs 3-5) by 5 percent, 10 percent, and 20 percent respectively. If penalties are applied, CMS requires the state to reduce funds in an equal distribution, across all DSRIP projects. If the state fails to meet 50 percent of the inpatient/emergency room spending reduction goals, DSHP funding will be reduced in Years 4-6 (DYs 3-5) by 5 percent, 10 percent, and 20 percent respectively.

Reporting & Monitoring	**Date Interim Evaluation Report Due/Submitted**	The state is required to submit a draft interim evaluation report 90 days following the completion of DY 4 of the demonstration. (DY 4 ends 3/31/2019 draft interim evaluation due 7/1/ 2019).
	Date Final Evaluation Report Due	Preliminary summative evaluation report is due 180 days following the expiration of the demonstration. (Demonstration ends 3/31/2020. Preliminary summative evaluation due 10/1/2020). Within 360 days of the end for DY5, the state shall submit a draft of the final summative evaluation report to CMS (3/26/2021).
	Mid-Point Assessment Process	The Independent Assessor, Public Consulting Group, completed the Mid-Point Assessment in November 2016. After PPS and the public submitted comments, Midpoint Assessment recommendations were reviewed by the New York DSRIP Project Approval and Oversight Panel in February 2017. The New York Commissioner of Health and CMS also reviewed recommendations. PPS submitted Midpoint Assessment Action Plans for review by the independent assessor in March 2017. Action Plans were finalized for implementation in DY 3, which began 4/1/2017.
	Program Evaluation	The DSRIP evaluator is the University of Albany School of Public Health. The New York DSRIP evaluation will make pre- and post-DSRIP comparisons to assess change in health care system transformation, implementation of clinical improvements, population health, avoidable hospital use, and health care costs. The evaluation will primarily employ the measures described in the DSRIP Strategies Menu and Metrics, Attachment J, in testing the hypotheses under each objective. Existing data available within the New York State Department of Health will be used to calculate the measures.
Other Delivery System Activities	**Medicaid Managed Care Penetration (2014)**	75.5 percent
	Other Payment and Delivery System Reform Initiatives	New York's Value-Based Payment Roadmap outlines the strategies the state is pursuing to support value-based payment methodologies in managed care payments to providers. The state has outlined several value-based payment models for providers and MCOs to consider, including: • Total Care for General Population • Integrated Primary Care • Bundles of Care • Total Care for Special Needs Subpopulations The Value Based Payment Quality Improvement Program (VBP QIP) will pilot some of these models. The goal of VBP QIP is to help distressed facilities improve the quality of care and achieve financial sustainability by implementing VBP models. Through VBP QIP, funds are flowed from MCOs through PPS to participating facilities. New York also received a SIM Round Two Testing Award and has a Health Home SPA for chronic conditions.
	Requirement to Support Alternative Payment Models (APMs)	New York aims to move 80-90 percent of managed care payments to value-based payment models. This is one of four performance metrics the state must meet to avoid an overall reduction in DSRIP funding.

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

Oregon

General Program Information and Context

- Diagnosis-related group (DRG) hospitals, defined as "urban hospitals with a bed capacity of greater than 50," will earn incentive payments under the Hospital Transformation Performance Program (HTPP) by meeting specific performance objectives designed to advance health system transformation, reduce hospital costs, and improve patient safety.
- The major goals of the program are to accelerate health system transformation among a targeted group of providers, reduce costs, and improve quality of care. The state specifically hopes to use HTPP, in part, as a vehicle to accelerate transformation and quality improvements in CCOs.

General Information	**Program Length**	Four years (two years plus two one-year extensions)
	Stage of Implementation	Year 4
	Date Submitted to CMS	6/26/2013
	Date Approved by CMS	6/27/2014
	Date HTPP Implemented (*Date Projects Approved*)	N/A; HTPP does not include projects
	Date Expires	6/30/2018
Funding[1]	**Maximum Potential Pool Funding (federal and state)**	Up to $150,000,000 total computable each year ($289,365,000 in federal share and $160,635,000 in state share for the first three years)
	Source of Matching Funds (non-federal)	The non-federal share of payments to providers may be funded by a hospital reimbursement assessment (provider tax).
	Does DSRIP Replace Prior Supplemental Funding?	No
	Process of Reallocating Unused Funds	Unused funds cannot be rolled over into the following year.
Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	No; Oregon has a Tribal Health Program for Uncompensated Care that is not directly tied to the HTPP.
	Corresponding Designated State Health Program (DSHP)	Yes. State may claim federal matching funds for certain DSHP expenditures to support health system transformation goals in DY 11-15 of demonstration. Maximum potential pool funding is $704,000,000 (federal funds) over 5 years and the total amount available per year gradually decreases from $230 million in DY 11 to $68 million in DY 15. CMS may reduce available DSHP funding if the state fails to meet goals for reductions in per capita growth rates.
Providers	**Provider Partnerships**	None for HTPP
	Participating Providers	28 urban DRG hospitals with bed capacity of greater than 50.

Projects	**Project Domains**	HTPP is not project-based, but there is a standardized list of 11 performance measures that hospitals have to report. The hospital quality measures are captured in two overarching focus areas, hospital-focused and hospital-CCO-coordination-focused. • Domains for the hospital focus area include readmissions, medication safety, patient experience, and healthcare-associated infections. • Domains for the hospital-CCO collaboration focus area include behavioral health and sharing ED visit information.
Outcomes	**Standardized Metrics**	Yes, the Hospital Performance Metrics Advisory Committee worked with Oregon Health Authority (OHA) and CMS to develop a set of hospital-appropriate benchmarks and improvement targets for which the state can measure progress toward the state's health system transformation goals.
	Attribution Methodology	Specified attribution methodology for performance measures is determined by state. For mental health follow-up after hospitalization, OHA is taking a tiered approach to attribution: (1) Use individual hospital rate; (2) Use system rate if individual hospital rate is unavailable and hospital is part of a system; and, (3) Use statewide CCO rate if neither individual nor system rates are available.
	Statewide Accountability Test	HTPP payments are included in Oregon's calculations of total expenditures under the demonstration. If Oregon fails to meet trend reduction targets, the state faces reduced federal funding for DSHP.
Reporting & Monitoring	**Date Interim Evaluation Report Due/Submitted**	The interim evaluation was completed 6/29/2016.
	Date Final Evaluation Report Due	OHA is not planning to conduct any additional evaluation.
	Mid-Point Assessment Process	No midpoint assessment process specific for HTPP, but there was a midpoint assessment for the entire Section 1115 demonstration waiver due to CMS in August 2015.
	Program Evaluation	Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University (OHSU), in collaboration with Providence CORE, evaluated the program's effect on the 11 key metrics for the first two years of the program. The evaluation included the following questions and comparisons: • How have the DRG hospitals performed on all the HTPP metrics, as compared to baseline; • How have the DRG hospitals performed on the metrics that are also CCO metrics, as compared to hospitals not receiving HTPP payments; • What contributed to the success of those hospitals successfully meeting the HTPP measurement goals; • What barriers prevented the successes of any hospitals not meeting HTPP measurement goals; • What changes in hospital practice have been made as a result of HTPP; vi. What kinds of quality improvements or investments have hospitals made as a result of receiving HTPP incentive payments; vii. What, if any, changes to the incentive structure for the CCOs by the state and by the CCOs for the providers is the state considering, as a result of lessons learned from HTTP.

Other Delivery System Activities		
	Medicaid Managed Care Penetration (2014)	92.30 percent
	Other Payment and Delivery System Reform Initiatives	• CPC+ (statewide) • Round One SIM Testing Award • IAP: Beneficiaries with High Utilization and Complex Needs (BCN), Targeted Learning Opportunity (SUD), Housing Tenancy (LTSS) • Primary care capitation (FQHC providers) • "Global budget" (CCOs receive capitated payment to cover all the services a beneficiary needs) • "Payment within the payment" (the front-line providers within CCOs receive a capitated performance-based payment to deliver high-value care)
	Requirement to Support Alternative Payment Models	None

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent upon: (1) the achievement of milestones, metrics, and outcomes; and (2) the provision of the non-federal share.

New Hampshire

General Program Information and Context

- Through its Section 1115 demonstration waiver, Building Capacity for Transformation, New Hampshire aims to greatly improve access to and the quality of behavioral health services by establishing regionally-based Integrated Delivery Networks (IDN). IDN performance will be evaluated and incentivized through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program targets individuals at risk for or already diagnosed with mental health and substance use disorders (SUDs). Along with the implementation of this demonstration, the state will be expanding its SUD benefit to cover those Medicaid enrollees not already protected by it and implementing value-based purchasing in its managed care and other Medicaid service contracting. New Hampshire's DSRIP program will serve as one component of the state's broader health reform efforts that includes, for example, the expansion of health coverage under the New Hampshire Health Protection Premium Assistance Section 1115 demonstration waiver.
- Under DSRIP, each of New Hampshire's IDNs is required to integrate behavioral health and primary care, strengthen mental health and SUD workforce, and develop health information technology (health IT) infrastructure to support integration.

General Information	**Program Length**	5 years
	Stage of Implementation	Year 2
	Date Submitted to CMS	05/30/2014
	Date Approved by CMS	01/05/2016
	Date Implemented (*Date Projects Approved*)	12/21/2016
	Date Expires	12/31/2020
Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$150 million total computable ($75 million federal share and $75 million state share)
	Source of Matching Funds (non-federal)	Designated State Health Program (DSHP), state general funds, Certified Public Expenditures (CPEs)
	Does DSRIP Replace Prior Supplemental Funding?	No
	Process of Reallocating Unused Funds	IDNs will be permitted to "reclaim" incentive funding that is unearned because the IDN failed to achieve certain performance metrics for a given reporting period. Funding amounts that are unearned will be available to the IDN for two immediate, subsequent reporting periods, with the exception of DY 5. To "reclaim" the unearned incentive funds, an IDN must not only demonstrate that it has achieved the original process or outcome metric target, but that it has also achieved its most recent target for the same metric. If an IDN is not able to reclaim the unearned incentive funding in the two immediate, subsequent reporting periods, the funds will be forfeited by the IDN and placed into a general DSRIP Performance Pool. The DSRIP Performance Pool will be used to the support the scope of the statewide DSRIP program or to reward IDNs whose performance substantively and consistently exceeds their targets. The State does not plan to withhold any amounts to subsidize this Performance Pool.

Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	No
	Corresponding Designated State Health Program (DSHP)	Yes, the state may claim federal matching funds for certain DSHP expenditures for a total of $71,391,981 over five years.
Providers	**Provider Partnerships**	Participating providers must form regional coalitions called IDNs and apply collectively for pool funds as a single IDN. There are seven IDN Service Regions.
	Participating Providers	IDN partner networks must include primary care practices; SUD providers; Regional Public Health Networks; Community Mental Health Centers; peer-based support and/or community health workers from across the full spectrum of care; hospitals; FQHCs, Community Health Centers, or Rural Health Clinics, if available; community-based organizations that provide social and support services; county organizations representing nursing facilities and correctional systems.
Projects	**Project Domains**	**1. Community-driven projects:** • Care Transitions (three options) • Capacity Building (four options) • Integration (five options) **2. IDN core competency project: a mandatory project focused on integrating behavioral health and primary care.** **3. Statewide projects (mandatory):** • Strengthen mental health and SUD workforce • Develop health IT infrastructure to support integration
Outcomes	**Standardized Metrics**	Yes
	Attribution Methodology	The state determines attribution methodology for performance measures. Beneficiaries are attributed to IDNs based on where they currently receive care.
	Statewide Accountability Test	The state must meet statewide metrics in order to secure full funding beginning in 2018. Funding for IDNs may be reduced in DYs 3, 4, and 5 if the state fails to demonstrate progress on four statewide metrics.

Reporting & Monitoring	**Mid-Point Assessment Process**	A midpoint assessment will be conducted in DY 3. Based on qualitative and quantitative research and stakeholder and community input, the midpoint assessment will be used to systematically identify recommendations for improving individual IDNs and implementation of their Project Plans; state policies and procedures for oversight; and any other elements of the demonstration that may be hampering the effective and efficient use of funds and progress toward the demonstration's goals. IDNs will be required to participate in the midpoint assessment, and to adopt IDN-specific recommendations that emerge from the review. The state may withhold future IDN Transformation Fund incentive payments to an IDN if it fails to adopt recommended changes even if all other requirements for DSRIP payment are met. If the review identifies recommendations for change to the STCs (including attached protocols), the state will submit an amendment request, in accordance with STC 7, to CMS for changes on or before 10/1/2018.
	Program Evaluation	The program evaluator is yet to be determined. The evaluation will attempt to answer the following questions: a. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP? b. To what extent has the DSRIP enhanced the state's health IT ecosystem to support delivery system and payment reform? Has it specifically enhanced these four key areas through the IDNs: governance, financing, policy/legal issues and business operations? c. To what extent has the DSRIP improved integration and coordination between providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care, and alignment of care coordination and to serve the whole person?
Other Delivery System Activities	**Medicaid Managed Care Penetration (2014)**	85.1 percent
	Other Payment and Delivery System Reform Initiatives	New Hampshire is a SIM Design state and participates in the Physical and Mental Health Integration, Targeted Learning Opportunity (SUD) and Housing Tenancy (LTSS) tracks of IAP. New Hampshire also plans to pursue a Health Home SPA.
	Requirement to Support Alternative Payment Models (APMs)	New Hampshire is required to develop in collaboration with stakeholders a roadmap for moving 50 percent of Medicaid managed care payments to APMs. The APMs will move Medicaid from primarily a volume-based reimbursement approach to primarily a value-based payment approach. It is expected that this will create the opportunity to establish sustainable financing mechanisms for the work being undertaken by IDNs.

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

Alabama

General Program Information and Context

- Under its Section 1115 demonstration waiver, Alabama Medicaid Transformation, Alabama aims to improve the health of, and care for, its beneficiaries by moving from a fee-for-service delivery system to enrollment in managed care under locally administered provider-based Regional Care Organizations (RCOs). The demonstration provides Transition Pool funding, which contains two components: transition payments to RCOs (RCO start-up pool) and transition payments to qualified providers through the Integrated Provider Systems (IPS) pool.
- The Integrated Provider System (IPS) pool is part of a statewide Medicaid transformation effort intended to improve care coordination, efficiency of service delivery, and beneficiary outcomes. Providers must contract with RCOs to participate in the IPS pool, and RCOs coordinate IPS work plans and distribution of payments to providers. RCOs and/or providers must contribute 10 percent of the budgeted cost of the total cost of the work plans/projects. Forty percent of the total maximum payment award will be paid to the providers upon approval of the work plan while the remaining 60 percent will be distributed on a quarterly basis per the number of quarters that occur over the course of the work plan (the duration of each work plan within the first three years of the demonstration may vary).
- On July 27, 2017, Alabama Medicaid Commissioner announced that the Alabama Medicaid Agency will pursue an alternative to the RCOs to transform the Medicaid delivery system.

General Information	**Program Length**	Three years
	Stage of Implementation	IPS will not be implemented.
	Date Submitted to CMS	05/30/2014
	Date Approved by CMS	02/09/2016
	Date IPS Implemented *(Date Projects Approved)*	N/A
	Date Expires	03/31/2020
Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$278,125,000 total computable ($195,132,500 estimated federal share and $82,992,500 estimated state share)
	Source of Matching Funds (non-federal)	Designated State Health Programs (DSHPs)
	Does DSRIP Replace Prior Supplemental Funding?	No
	Process of Reallocating Unused Funds	Each RCO Region's combined maximum award will be based on a proportionate share of beneficiaries in the region. If the approved applications do not reach a RCO Region's maximum award amount, Alabama Medicaid Agency may allocate that region's remaining funds to other Regions. The maximum award for a single Integrated Provider System plan cannot exceed $20 million or the work plan's budgeted cost, whichever is lower.

Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	No
	Corresponding Designated State Health Program (DSHP)	Yes, the state may claim federal matching funds for certain DSHP expenditures as the state share, but the DSHP will be reduced in the prospective DY if the RCOs did not meet the target for the previous year. The total computable amount for DSHP is $312,834,000 over five years.
Providers	**Provider Partnerships**	Only providers that have pending contracts with at least one RCO are eligible to submit a work plan to apply for the IPS funding.
	Participating Providers	Hospitals, federally qualified health centers (FQHCs), community mental health centers, primary medical providers, specialists, and other providers approved by the Alabama Medicaid Agency.

Projects	**Project Domains**	The state does not have a menu of projects. Providers propose their own projects when they submit IPS work plans, but the provider work plan must have the following components, among other requirements:
		• A description of which of the following RCO program objectives the IPS project will impact: a) Improved prevention and management of chronic disease; b) Improved access to and care coordination of health services; c) Improved birth outcomes; or d) Healthcare delivery system financial efficiency.
		• The specific program interventions and approach.
		• The key activities and milestones to be accomplished over the duration of the IPS project and the dates by which each activity and milestone will occur; quarterly IPS payments may be based on the achievement of these milestones.
		• If applicable to the IPS project, a description of:
		  • Health information technology (HIT) protocols, including how the IPS work plan/project will increase electronic information sharing for care coordination and treatment planning
		  • Care coordination protocols that demonstrate coordination between Primary Medical Providers, relevant specialists and hospital clinical staff
		  • Transition of care protocols to ensure the coordination and continuity of health care

Outcomes	**Standardized Metrics**	Providers can choose from among the RCO Quality Measures listed in the RCO contract for tracking as a part of their work plan, but they may propose to use other measures to monitor and evaluate the IPS work plan/project.
	Attribution Methodology	Patient attribution to RCOs: • Beneficiaries eligible for RCO enrollment will receive notice that informs them that they are required to enroll in an RCO serving their geographic region. If more than one RCO exists in their geographic region, beneficiaries must be able to choose a plan. • Beneficiaries who receive at least 30 days' notice, but do not choose a plan by deadline, will be auto-assigned to an RCO. Individuals listed in STC 23 may opt out of mandatory enrollment into RCOs at any time and receive Medicaid services as otherwise authorized under the approved state plan. Individuals listed in STC 24 must not be auto-assigned, but must be able to choose to opt into RCO enrollment. Patient attribution to specific providers under an RCO is not yet specified.
	Statewide Accountability Test	There are quality/operational improvement targets (listed below under Program Evaluation) that must be met to ensure full DSHP funding.
Reporting & Monitoring	**Mid-Point Assessment Process**	There will be no mid-point assessment specific to the IPS program.
	Program Evaluation	The Institute for Rural Health Research at the University of Alabama will evaluate the entire Section 1115 demonstration waiver. Alabama Medicaid Agency (AMA) will evaluate the IPS work plan/project's ability to support the following quality and operational targets: • Increase well-child visits by 7.22 percentage points from the current baseline of 59.65 percent for children ages 3-6 • Increase well-care visits for adolescents age 12-21 by 4.8 percentage points from current baseline of 40.5 percent • Reduce rate of ambulatory care-sensitive condition admissions by 9 percentage points from current baseline of 1,226 per 100,000 • Increase percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment by 16.0 percentage points from the current baseline of 64.4 percent
Other Delivery System Activities	**Medicaid Managed Care Penetration (2014)**	60.80 percent
	Other Payment and Delivery System Reform Initiatives	Health Home SPA and Targeted Learning Opportunity (SUD) track of IAP
	Requirement to Support Alternative Payment Models	None

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. Quarterly IPS payments may be contingent on the achievement of milestones, metrics, and outcomes; and (2) the provision of the non-federal share.

Rhode Island

General Program Information and Context

Through the Health System Transformation Project (HSTP), Rhode Island will progressively move towards the development of alternative payment methodologies and value-based models such as the Medicaid Accountable Entity (AE) program. The Medicaid AE program consists of shared savings agreements between MCOs and certified AEs. AEs are integrated provider organizations that will be responsible for improving the quality of care, member experience, and total cost of care for Medicaid beneficiaries who are enrolled in MCOs. HSTP also includes the Hospital and Nursing Home Incentive Program, which is a one-time transitional funding opportunity intended to prepare hospitals and nursing homes for participation in AEs and to achieve additional progress in managing long-term services and supports through a rebalancing strategy that includes the introduction of alternative AE payment methods. HSTP also includes investments in partnerships with Institutions of Higher Education for statewide health workforce development (Health Workforce Partnerships).

General Information[1]	**Program Length**	Five years (Calendar Year (CY) 2016 is considered Year 1)
	Stage of Implementation	Year 2 (Hospital and Nursing Home Incentive Program and AE Incentive Program)
	Date Submitted to CMS	May 17, 2016
	Date Approved by CMS	October 20, 2016
	Date Implemented *(Date projects approved)*	The Hospital and Nursing Home Incentive Program will make one-time incentive payments to providers, which are not to exceed $20.5 million, on or before 12/31/2017.
	Date Expires	12/31/2020
Funding[2]	**Maximum Potential Pool Funding (federal and state)**	$195,000,000 total computable ($99,489,000 estimated federal share and $95,511,000 estimated state share)
	Source of Matching Funds (non-federal)	Reallocated state funds under Designated State Health Programs (DSHPs)
	Does DSRIP Replace Prior Supplemental Funding?	No
	Process of Reallocating Unused Funds	Not specified
Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	No
	Corresponding Designated State Health Program (DSHP) Expenditures	The state may claim a total of $129.8 million of federal financial participation (FFP) for certain DSHP expenditures to support the goals of the HSTP over five years. Specifically, the state may claim up to $79,980,610 through December 31, 2018. FFP for CYs 2019 and 2020 is contingent on approval of demonstration extension. The annual limit for DY 8 (10/14/2016-12/31/2016) is $20.5 million.

Providers	**Provider Partnerships**	The Hospital and Nursing Home Incentive Program is intended to prepare hospitals and nursing homes for participation in AEs. There will be two types of qualified AEs depending on the capacity and focus of the participating entities: Type 1 AEs (comprehensive AEs) will be accountable for the care furnished to the general Medicaid eligible population, and will focus on the integration of primary care and behavioral health services; Type 2 AEs (Specialized AEs) will be accountable for the care furnished to specified specialized populations, i.e., substance use, behavioral health, and severe behavioral health disorders. Specialized AEs are required by CMS to be an interim arrangement to enable providers to form networks that will build the capacity and infrastructure needed to manage special populations across providers. Full partnership with a Comprehensive AE is to be achieved within three to five years. The initial type of Specialized AE under consideration is an LTSS AE, for a defined population of persons admitted to nursing homes.
	Participating Providers	Hospitals and nursing facilities for the Hospital and Nursing Home Incentive Program. For the AE Incentive Program, an AE needs to have a critical mass of either Partner Providers or Affiliated Providers that are multi-disciplinary with core expertise/direct service capacity in primary care, behavioral health, social supports/determinants for the populations the AE proposes to serve. A Specialized LTSS AE would need to demonstrate defined partnerships between participating nursing homes and Home- and Community-Based Services (HCBS) providers. All certified AEs must contract with MCOs in accordance with state specified APM guidance in order to participate in the AE Incentive Program.
Projects	**Project Domains**	The Hospital and Nursing Facility Incentive Program is measure-based, not project-based. The measures are detailed in Attachment J. The AE Incentive Program requires AEs to construct project plans that include detailed and robust "gap analysis" of the AEs and their provider networks. Specifically, the gap analysis must clearly identify the infrastructure development support needed to build capacities and capabilities within and across the following core readiness domains: 1. Breadth and Characteristics of Participating Providers 2. Corporate Structure and Governance 3. Leadership and Management 4. Commitment to Population Health and System Transformation 5. IT Infrastructure: Data Analytic Capacity & Deployment 6. Integrated Care Management 7. Member Engagement & Access 8. Quality Management

Outcomes	**Standardized Metrics**	Yes.
	Attribution Methodology	Specified attribution methodology is determined by the state.
	Statewide Accountability Test	The state must meet certain quality/operational improvement targets by the due dates listed in Attachment T. The DSHP will be reduced in the prospective DY if the state did not meet the specified target. The percent of DSHP funding reduction for not meeting the targets varies (5-15 percent) by improvement targets.
Reporting & Monitoring	**Mid-Point Assessment Process**	None articulated in the STCs.
	Program Evaluation	An interim evaluation report of the Accountable Entities program is due to CMS on 12/31/2018.
Other Delivery System Activities	**Medicaid Managed Care Penetration (2014)**	84.90 percent
	Other Payment and Delivery System Reform Initiatives	• SIM Round One Model Design Award and Round Two Model Test Award • Health Home SPA: CEDARR Family Center, Community Mental Health Organization, and Opioid Treatment Program • Statewide CPC+ • IAP: Housing Tenancy (LTSS) track
	Requirement to Support Alternative Payment Models (APMs)	MCOs must follow the APM guidelines in contracting with certified AEs.

[1] Rhode Island's Section 1115 demonstration waiver is approved through December 31, 2018, but HSTP is approved for five years. Funding for the last two years of HSTP is contingent on CMS approval of demonstration extension.

[2] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

Washington

General Program Information and Context

- Through Washington's Section 1115 demonstration waiver, Medicaid Transformation Project, Washington aims to transform its health care delivery system and test new models of payment, health care delivery models, and targeted services for Medicaid beneficiaries. The objectives of the demonstration are to 1) integrate physical and behavioral health purchasing and service delivery to better meet whole person needs; 2) convert 90 percent of Medicaid provider payments to reward outcomes instead of volume; 3) support provider capacity to adopt new payment and care models; 4) implement population health strategies that improve health equity; and 5) provide new targeted services that address the needs of the state's aging populations and address key determinants of health.
- Under Initiative 1 of the demonstration, Accountable Communities of Health (ACHs), comprised of providers, managed care organizations, and community partners, will implement regional transformation projects. Projects will strive to improve care for Medicaid beneficiaries with a focus on building health systems capacity, care delivery redesign, prevention and health promotion, and preparing for value-based payments.

General Information		
	Program Length	Five years
	Stage of Implementation	DY 1 (1/9/17-12/31/17)
	Date Submitted to CMS	08/24/2015
	Date Approved by CMS	1/9/2017
	Date Implemented (*Date Projects Approved*)	No later than 12/31/17
	Date Expires	12/31/2021

Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$1,125,000,000 total computable ($562,500,000 federal share and $562,500,000 state share)
	Source of Matching Funds (non-federal)	Designated State Health Program (DSHP) funding is a major source, but state is also expected to provide additional matching funds through other sources. Intergovernmental transfers (IGTs) are a potential source.
	Does DSRIP Replace Prior Supplemental Funding?	No
	Process of Reallocating Unused Funds	Unearned funds will go into the challenge pool and reinvestment pool. **Challenge pool**: An annual budget, not to exceed 5 percent of total available DSRIP funding, is established as incentive payments for MCO attainment and progression toward VBP targets. In addition, if unearned incentives from the MCO premium withholds and DSRIP funding for MCO VBP attainment remain after the annual performance period, any remaining funds will be used for incentive payments for MCOs meeting exceptional standards of quality and patient experience, based on a subset of measures defined in DSRIP planning protocol. **Reinvestment pool**: An annual budget, not to exceed 10 percent of total available DSRIP funding, is established to reward ACH partnering providers' (regional) attainment and progression toward VBP targets. To the extent unearned incentives remain after the annual performance period from ACH Projects or VBP unearned incentives, any remaining funds will be used for incentive payments to the ACH for performance against a core subset of measures.
Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	No
	Corresponding Designated State Health Program (DSHP) Expenditures	Yes, $928.5 million total computable in DSHP funding.
Providers	**Provider Partnerships**	Yes, demonstration includes regionally-based ACHs.
	Participating Providers	ACHs are regional coalitions that include primary care providers, behavioral health providers, MCOs, hospitals/health systems, local public health, tribal organizations, and community-based organizations that provide social and support services (e.g. housing, education, employment, transportation, etc.). ACHs must include providers and organizations that serve Medicaid beneficiaries. A subset of DSRIP funding is set aside for MCOs in particular.

Projects	**Project Domains**	• Health systems capacity building (e.g. HIT, data analytics, and workforce) • Care delivery redesign (e.g. behavioral and physical health care integration, care coordination, transitions of care, person-centered care models with clinical-community linkages) • Prevention and health promotion (e.g. clinical and community prevention, engaging individuals in personal behavior change, health equity) The state will also include tribal specific projects.
Outcomes	**Standardized Metrics**	**Project milestones**: At a high level, project metrics will be organized into the following categories: a) Project planning progress milestones: includes plans for investments in technology, tools, stakeholder engagement, and human resources. Performance will be measured by a common set of process milestones including project development plans, consistency with statewide goals and metrics, and provider engagement. b) Project implementation progress milestones: includes milestones that demonstrate progress towards process-based improvements, as established by the state, in the implementation of projects. c) Scale and sustain progress milestones: includes milestones that demonstrate project implementation progress, as established by the state, related to efforts to scale and sustain project activities in pursuit of the demonstration objectives. **ACH Performance Indicators and Outcome Measures**: The state will choose performance indicators and outcome measures that are connected to the achievement of the goals of the demonstration. The DSRIP performance indicators and outcome measures will comprise the list of reporting measures that the state will be required to report under each of the DSRIP projects. The state will provide a full menu of metrics and projects in the DSRIP planning protocol.
	Attribution Methodology	The state will determine attribution based on residence. The state will use defined regional service areas, which do not have overlapping boundaries, to determine populations for each ACH. Determination will be made based on beneficiary residence. There is only one ACH per regional service area.
	Statewide Accountability Test	A percentage of statewide DSRIP and DSHP funding will be at risk for value-based payment and quality improvement goals under DSRIP. The at-risk outcome measures will be developed by the state and included in the DSRIP Planning Protocol for approval by CMS. They must be statewide and measure progress toward the state's Medicaid transformation goals. The percentage of both DSRIP and DSHP funds at risk will gradually increase from 0 percent in DYs 1-2 to 5 percent in DY 3, 10 percent in DY 4, and 20 percent in DY 5.

Reporting & Monitoring	**Mid-Point Assessment Process**	During DY 3, the state's independent assessor will assess project performance to determine whether ACH Project Plans merit continued funding and provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5.
	Program Evaluation	Washington's DSRIP program evaluator is to be determined and the draft evaluation plan is due within 120 days of the demonstration approval. Washington's demonstration will test the following hypotheses (relevant to DSRIP): • Whether community-based collaborations that define community health needs can (1) support redesigned care delivery, (2) expand health system capacity, and (3) improve individual and population health outcomes—resulting in a reduction in the use of avoidable intensive services, a reduction in use of intensive service settings, bringing spending growth below national trends, and accelerating value-based payment reform. • Whether federal funding of DSHPs enables the state to leverage Medicaid spending to support delivery system reforms that result in higher quality care and in long term federal savings that exceed the federal DSHP funding. The draft evaluation must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state (i.e. SIM grant). Possible evaluation approaches for evaluating the impact of ACH transformation projects include: measuring intervention impacts on trends in HEDIS and using Washington Integrated Client Database (ICDB) to track state defined quality and outcomes measures, intervention impact on health and social service cost measures, and intervention impact on utilization of inpatient and institutional services.

Other Delivery System Activities		
	Medicaid Managed Care Penetration (2017)	90.00 percent
	Other Payment and Delivery System Reform Initiatives	• SIM Round Two Model Test Award • Health Home SPA for chronic conditions • IAP: Physical and Mental Health Integration track, High Intensity Learning Collaborative (SUD) track, and Housing Tenancy (LTSS) track. The State is reforming its purchasing for physical and behavioral health care services through a new regional approach to Medicaid managed care contracting.
	Requirement to Support Alternative Payment Models (APMs)	Washington aims move to 90 percent of Medicaid provider payments to APMs by end of demonstration. APMs are defined based on the HCP-LAN framework and the targets for APM adoption by providers and MCOs are as follows: • DY 1: 30 percent payments in HCP LAN categories 2C-4B • DY 2: 50 percent payments in HCP LAN categories 2C-4B, of which 10 percent are in categories 3A-4B • DY 3: 75 percent payments in HCP LAN categories 2C-4B, of which 20 percent are in categories 3A-4B • DY 4: 85 percent payments in HCP LAN categories 2C-4B, of which 30 percent are in categories 3A-4B • DY 5: 90 percent payments in HCP LAN categories 2C-4B, of which 50 percent are in categories 3A-4B

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. DSRIP funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share.

Arizona

General Program Information and Context

- The Targeted Investments (TI) Program is intended to support physical and behavioral health care integration and coordination for beneficiaries with behavioral health needs enrolled in Arizona's Medicaid managed care (AHCCCS), including beneficiaries who have transitioned to the community from criminal justice facilities. In its capitation rates paid to managed care entities, Arizona will include directed lump sum payments that the managed care entities will use to make incentive payments to certain providers to meet the following goals:
  1. Reduce fragmentation that occurs between acute care and behavioral health care.
  2. Create efficiencies in service delivery for members with behavioral health needs.
  3. Improve health outcomes for the affected populations.
- Financial incentives will be paid on an annual basis to participating eligible primary care, mental health, and hospital providers based on requirements that vary over the five years of the TI Program. For Year 1 of the program, participating TI providers will receive payment following acceptance into the program. For Years 2 and 3, payment of directed incentive payments will be tied to completing Core Components and related milestones. For Years 4 and 5, payment will be based on meeting or exceeding performance improvement targets for specified quality measures [in development].

General Information	**Program Length**	Five years
	Stage of Implementation	Pre-implementation
	Date Submitted to CMS	9/30/2015
	Date Approved by CMS	1/18/2017
	Date TI Program Implemented *(Date projects approved)*	Not yet implemented
	Date Expires	9/30/2021
Funding[1]	**Maximum Potential Pool Funding (federal and state)**	$300 million total computable • $285 million Targeted Investments (approximately $197,334,000 federal share and $87,666,000 state share) • 15 million administrative funding ($7.5 million federal share and $7.5 million state share)
	Source of Matching Funds (non-federal)	Designated State Health Programs (DSHPs) and Intergovernmental Transfers (IGTs)
	Does Program Replace Prior Supplemental Funding?	No
	Process of Reallocating Unused Funds	Not specified in STCs

Corresponding Funding Pools	**Corresponding Uncompensated Care (UC) Pool**	Arizona has a Safety Net Care Pool under the Section 1115 demonstration waiver, but it's not related to the TI Program.
	Corresponding Designated State Health Program (DSHP) Expenditures	The state may claim federal matching funds for certain DSHP expenditures for a total of up to $90,824,900 over five years. DSHP funding will be phased down over the course of the demonstration, and starting from Year 3, the DSHP funding will be reduced in the prospective DY if the state does not meet the targets for the previous year.
Providers	**Provider Partnerships**	None
	Participating Providers	Primary care providers, behavioral health providers, integrated clinics (behavioral health and primary care clinicians working in the same physical space), and hospitals that meet eligibility requirements can participate in the TI program. Medicaid managed care entities (Acute Health Plans, Regional Behavioral Health Administration) distribute payments.
Projects	**Project Domains**	Projects are categorized based on the type of provider and area of concentration: 1. Hospital Project Hospital applicants will automatically participate in the hospital project. The hospital project incentive dollars will be based on demonstrated performance for adults with a primary behavioral health diagnosis and/or designated by AHCCCS as individuals with Serious Mental Illness (SMI). 2. Ambulatory Care Project The ambulatory care project incentive dollars will be based on demonstrated performance for three focused populations: (i) adults with behavioral health needs; (ii) children and youth with behavioral health needs, including children and youth engaged in the child welfare system with Autism Spectrum Disorder; and (iii) adults who have transitioned from a criminal justice facility. Within the ambulatory care project, there are five areas of concentration, each of which contain Core Components that describe an action that help to further integrate primary care and behavioral health. The five areas of concentration are: a. Ambulatory Project for Primary Care Providers Treating Adults with Behavioral Health Needs b. Ambulatory Project for Behavioral Health Providers Treating Adults with Behavioral Health Needs c. Ambulatory Project for Pediatric Primary Care Providers Treating Children/Youth with Behavioral Health Needs d. Ambulatory Project for Behavioral Health Providers Treating Children/Youth with Behavioral Health Needs e. Ambulatory Project for Providers Serving Individuals Transitioning from the Justice System

Outcomes	**Standardized Metrics**	Yes, there are statewide focus population measures that the state has to meet starting from Year 3 to receive full DSHP funding.
	Attribution Methodology	Mostly primary care provider attribution for the statewide focus population measures: 1. Child Physical and Behavioral Health Integration measure (well-child visits) Denominator: AHCCCS members with a BH diagnosis who are age 3–6 years as of the last calendar day of the measurement year and are attributed to a participating primary care provider. 2. Adult Physical and Behavioral Health Integration measure (follow-up after hospitalization for mental illness) Denominator: Acute hospital discharges of AHCCCS members 18 years of age and older at any time during the measurement period for treatment of selected mental illness diagnoses 3. Care Coordination for Medicaid Enrolled Released from Criminal Justice Facilities (adults access to preventive/ ambulatory health services) Denominator: AHCCCS members age 20-44 years during the measurement period recently released from a criminal justice facility and assigned to a probation or parole office at which a new integrated clinic has been situated
	Statewide Accountability Test	None that impacts the TI Program funding specifically, but there are statewide focus population measures that the state is required to meet in the previous year in order for the state to qualify for DSHP funding in Years 3-5. Statewide performance on those measures could impact a portion of the DSHP funds.
Reporting & Monitoring	**Mid-Point Assessment Process**	Not articulated in STCs.
	Program Evaluation	The TI Program will be evaluated in the Section 1115 demonstration waiver evaluation. The state shall submit an update to its Section 1115 demonstration waiver evaluation design no later than 120 days after the approval of the amendment to implement the TI Program.

Other Delivery System Activities	**Medicaid Managed Care Penetration (2014)**	85.1 percent
	Other Payment and Delivery System Reform Initiatives	• SIM Round Two Design Award • IAP SUD Targeted Learning Opportunity track • Arizona requires plans to have 50 percent of provider payments paid through an APM by 2017. If MCOs in Arizona meet the threshold for use of alternative payments, they are then eligible to recoup a one percent withhold based on the quality performance of the plan. • Arizona has implemented a model where Regional Behavioral Health Authorities are responsible for both behavioral health and physical health care services for members with serious mental illness. Under its contract, Arizona requires these vendors to enter into value-based contracts with integrated providers. • Arizona requires its health plans to increase alternative LTSS payments through its MCOs.
	Requirement to Support Alternative Payment Models	None

[1] All amounts provided in this fact sheet represent the total computable (federal and non-federal) figure. Targeted Investments funding is contingent on the achievement of milestones, metrics, and outcomes, and the provision of the non-federal share

Appendix B: Delivery System Reform Incentive Payment (DSRIP) Evaluation Findings

State	Achievement of Milestones/ Metrics	Non-Clinical Findings	Clinical Outcomes Results
California DSRIP's Final Evaluation[41]	By comparing the semi-annual and annual reports that participating DSRIP providers submitted to the state, evaluators found that providers achieved 97 percent of planned DSRIP milestones.	• According to providers' annual reports and semi-annual reports, most providers exceeded their annual improvement targets for Infrastructure Development and Innovation and Redesign categories. • A survey of providers found that providers perceived DSRIP projects to have had the greatest impact on quality improvement and the least impact on cost containment among the goals of better care, improved health, and lower costs. • Lack of health information technology infrastructure, including lack of an electronic health record system, is frequently cited in provider annual reports, surveys, and interviews as a challenge in implementing DSRIP. • Surveyed providers reported they planned to continue all or some aspects of most DSRIP projects and metrics.	• Analysis, comparing DSRIP providers who implemented care transition projects and/or chronic care management projects against those who did not, showed statistically significant improvements in smoking cessation rates, influenza immunization, and cholesterol and diabetes control among providers who implemented either or both projects. • Comparing data submitted in provider annual reports by year indicated increased rates of mammography, child weight screening, and tobacco cessation during DSRIP initiatives. • Provider annual reports indicated a consistent increase in sepsis bundle compliance and a decline in sepsis mortality. • A comparison of DSRIP providers to non-DSRIP providers in the state found a consistent decrease in stroke mortality among DSRIP providers' patients. Stroke mortality rates among non-DSRIP providers increased during the same time period. • In their annual reports, providers reported an increase in the percentage of patients on antiretroviral therapy, and a large increase in the percentage of people living with HIV/AIDS who received vaccinations for pneumonia, hepatitis B, and influenza.
Texas's Final Evaluation[42, 43]		• A survey of providers found that, on average, collaboration among organizations increased slightly from the year prior to regional healthcare partnership (RHP) formation to demonstration year (DY) 2, and decreased between DY 2 and DY 4. • A survey found that stakeholders were generally positive about RHP anchor leadership and the productivity of communication between the RHP anchor and RHP members. Among respondents, 95 percent indicated they were satisfied with their RHP's progress in addressing community needs.	A longitudinal case study comparing 10 DSRIP care navigation projects related to emergency department (ED) use to 10 providers without these projects found care navigation services decreased hospitalization encounters by 19 percent.

State	Achievement of Milestones/ Metrics	Non-Clinical Findings	Clinical Outcomes Results
Massachusetts's Delivery System Transformation Initiative (DSTI) 1.0[44] and DSTI 2.0[45] Interim Evaluations	Based on hospital reports from the first year of DSTI 1.0, this interim evaluation found 95 percent of metrics were achieved across all participating hospitals. Based on combined semi-annual/ year-end reports that providers submitted for the July 1, 2014- June 30, 2015, reporting period, DSTI 2.0 interim evaluation found that all participating providers met 100 percent of metrics for that demonstration year.	In a National Academy for State Health Policy (NASHP) stakeholder interview, DSTI evaluators indicated that most of the hospitals achieved the organizational transformation proposed in DSTI 1.0.	
New Jersey's Interim Evaluation (called "Midpoint Evaluation")[46]		Providers reported in a survey that: • DSRIP reporting requirements were too onerous and resource intensive. Many providers were "unsure of the value of measures to be reported." • There was no adverse impact of DSRIP activities on hospitals' finances. • They found learning collaboratives to be valuable.	• Evaluator's analysis of participating providers' Medicaid claims data indicated reductions in avoidable hospitalization rates among Medicaid beneficiaries. • Analysis of Medicaid claims data showed that statistically-significant improvements in the rates of avoidable asthma and diabetes hospitalizations were attributable to DSRIP. • Analysis of Medicaid claims data showed increased emergency department visits for adults with asthma. • Analysis of Medicaid claims data indicated significant improvements in access to primary care providers for children ages 7-11 and adolescents 12-19, in hospital admission rates for chronic obstructive pulmonary disease (COPD) and heart failure, and in the percentage of HIV patients with 2+ CD4 (healthy) T-cell count taken during the year. • Analysis of Medicaid claims data showed that, other than hepatitis B vaccination rates, which improved significantly, and rotavirus vaccination, which improved slightly, the rates of all remaining vaccinations significantly decreased from 2013 to 2014.

State	Achievement of Milestones/ Metrics	Non-Clinical Findings	Clinical Outcomes Results
Oregon's Hospital Transformation Performance Program (HTPP) Interim Evaluation [47]		• In stakeholder interviews conducted by evaluators, hospital officials reported they were engaged in a wide variety of activities to improve their performance on targeted measures. The most common activities involved changing processes or redirecting existing staff. In a survey of HTPP providers: • 93 percent of providers said HTPP helped their quality improvement efforts and programs. • 39 percent said HTPP was "very important" for improving quality. • 39 percent said they would "probably not" or "definitely not" be performing as well on HTPP measures if HTPP had never existed.	• There were statistically significant improvements in 2 of 11 HTPP quality measures: the rate of ED Information Exchange (EDIE) and the rate of screening for alcohol misuse in the ED. • Analysis of data reported by HTPP hospitals to the state showed a 0.5 percent increase in hospital-wide, all-cause readmissions and a 19.1 percent reduction in the rate of brief intervention for alcohol misuse in the ED. • Analysis of data extracted from EDIE did not indicate statistically significant reductions in all-cause readmissions for HTPP providers compared to non-HTPP providers.

Endnotes

1. Melanie Schoenberg et al., *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools* (Washington, DC: Medicaid and CHIP Payment and Access Commission, 2015), https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf.
2. MACPAC, *Report to Congress on Medicaid and CHIP*, "Chapter 1: Using Medicaid Supplemental Payments to Drive Delivery System Reform," June 2015, https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf.
3. On July 27, 2017, the Alabama Medicaid Commissioner announced that the Alabama Medicaid Agency will not implement its Section 1115 demonstration waiver and will pursue an alternative initiative to transform its Medicaid delivery system. For more information, please see https://medicaid.alabama.gov/news_detail.aspx?ID=12363.
4. Arizona previously applied for a Section 1115 demonstration waiver to implement a DSRIP program and later amended this application to implement a Targeted Investments Program using new regulatory authority available under the updated 2016 Medicaid managed care rules. Arizona's original DSRIP proposal is available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-pa4-dsrip-proposal-07262016.pdf.
5. Schoenberg et al., *State Experiences*.
6. Ibid.
7. As of June 2017, $48.6 billion in state and federal DSRIP funds has been approved across all active DSRIP programs for all demonstration years.
8. NASHP completed research for this report in July of 2017, at which point the new federal administration was still reviewing its policies pertaining to DSRIP.
9. Evaluators and independent assessors serve separate roles in DSRIP programs. Evaluators are responsible for conducting the federally required Section 1115 demonstration waiver evaluation. Independent assessors are a feature of some recent DSRIPs (New York, New Hampshire, and Washington) and are generally responsible for approving projects and monitoring milestone accomplishments.
10. In California, designated public hospitals are 21 government-owned hospital systems, including University of California hospitals and county owned and operated hospitals. Only the designated public hospitals participated in California's DSRIP.
11. 42 CFR 438.60
12. The terms and conditions of New York's Section 1115 demonstration waiver include an optional provision for the state to move certain supplemental payments to providers authorized under its State Plan to its Section 1115 demonstration waiver; however, New York did not pursue this option and its Section 1115 demonstration waiver has no relation to other supplemental payment programs. For more information see STC 14.e of the demonstration approved in 2014, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Partnership-Plan/ny-partnership-plan-cms-dsrip-amend-appvl-04142014.pdf.
13. For more information about health homes, please visit https://www.medicaid.gov/medicaid/ltss/health-homes/index.html.
14. For more information about the Medicaid Innovation Accelerator Program (IAP), please visit https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html.
15. For more information about the State Innovation Models (SIM) initiative, please visit https://innovation.cms.gov/initiatives/state-innovations/.
16. For more information, see https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_initiatives/.
17. A list of CCO incentive measures is available at http://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/2018%20Measures.pdf.
18. For a list of HTPP incentive measures, see http://www.oregon.gov/oha/HPA/ANALYTICS/HospitalData/Year%204%20Measures%20and%20Benchmarks%20(updated%20July%202017).pdf.
19. Washington's current DSRIP project toolkit is available at https://www.hca.wa.gov/sites/default/files/program/medicaid-transformation-toolkit.pdf.
20. *MassHealth Medicaid Section 1115 Demonstration*, Centers for Medicare and Medicaid Services, November 4, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf.
21. Although Arizona and New Hampshire focus explicitly on the integration of behavioral health and primary care, other states' DSRIP programs also include projects or goals that emphasize integrating behavioral health care with physical health care.
22. While New Jersey's DSRIP program does focus on hospitals, there is no formal designation of safety net hospitals in New Jersey.
23. For more information, see http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrip-overview-052016.pdf.
24. *Aggregate Public Hospital System Annual Report on California's 1115 Medicaid Waiver's Delivery System Reform Incentive Program Demonstration Year 8*, California Health Care Safety Net Institute, December 31, 2013, http://www.dhcs.ca.gov/Documents/DSRIP_DY8_Aggregate_Pub_Hosp_System_Annual_Report.pdf.
25. For more information, see http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.
26. ACOs and Community Partners in Massachusetts are allocated some DSRIP funding prospectively. Based on those funding allocations, ACOs and Community Partners will submit plans, budgets, and budget narratives for how they will spend that allocation. The State approves and disburses those funds. A portion of those funds are at-risk and are withheld until the State calculates an ACO or Community Partner Accountability Scores. Once the score is calculated, then the State will disburse the at-risk funding that was earned.
27. As of July 2017, Arizona is still finalizing some details of the funds flow mechanism. For more information on program structure, see https://www.azahcccs.gov/PlansProviders/Downloads/TI/Stakeholder%20Meeting%202017%206-9.pdf. For updates as they become available, see www.azahcccs.gov/PlansProviders/TargetedInvestments/.
28. https://www.medicaid.gov/federal-policy-guidance/downloads/cib072916.pdf
29. See STC 54 of Oregon's Section 1115 demonstration waiver: http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Documents/Waiver%202017.pdf.

30. For example, see STC 57 of *MassHealth Medicaid Section 1115 Demonstration*.
31. Total computable refers to the sum of federal share (Federal Financial Participation (FFP)) and state share, or "non-federal share," of DSRIP incentive payments.
32. Federal regulations allow states that generate savings from Section 1115 demonstration waivers, by expanding managed care or implementing other reforms, to "roll-over" a limited amount of savings into future Section 1115 demonstration waivers, thus increasing their budget neutrality limit. For more information, see https://www.nga.org/files/live/sites/NGA/files/pdf/2016/1606MedicaidBudgetNeturalitySavings.pdf.
33. For more information on IGT funding, see the first NASHP report: *State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools*.
34. *MassHealth Medicaid Section 1115 Demonstration, CMS.*
35. *Health and Human Services Commission (HHSC) Value-Based Purchasing Roadmap*, Texas HHSC, June 2017, https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115-waiver-draft-vbp-roadmap.pdf.
36. Carol V. Irvin et al., *Medicaid 1115 Demonstration Evaluation Design Plan*, Mathematica Policy Research, May 15, 2015, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/evaluation-design.pdf
37. *Annual Report on California's 1115*, SNI.
38. "DSRIP Project Approval and Oversight Panel (PAOP)," New York State Department of Health, accessed July 16, 2017, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/project_approval_oversight_panel.htm.
39. "PPS Presentations," New York State Department of Health, last updated February 2017, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/summary_paop_meeting.htm
40. *Evaluation of the 1115(a) Texas Demonstration Waiver – Healthcare Transformation and Quality Improvement*," Texas Health and Human Services, May 30, 2017, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf.
41. Nadereh Pourat et al., *Final Evaluation Report of California's Delivery System Reform Incentive Payments (DSRIP) Program* (Los Angeles, CA: UCLA Center for Health Policy Research, 2016), http://www.dhcs.ca.gov/provgovpart/Documents/DSRIPFinalEval.pdf.
42. *Evaluation of the 1115(a) Texas Demonstration Waiver*, Texas HHS.
43. Additional clinical outcomes for the Texas DSRIP program are available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/HHSC-to-CMS.pdf.
44. Teresa E. Anderson et al., *MassHealth Section 1115(a) Demonstration Waiver 2011-2014 Interim Evaluation Report*, UMass Medical School Center for Health Policy and Research, September 26, 2013, http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/appendix-b-interim-evaluation-of-the-demonstration-09-2013.doc.
45. Deborah Gurewich and Linda Cabral, *MassHealth Section 1115(a) Demonstration Waiver 2014-2017 Interim Evaluation Report*, UMass Medical School Center for Health Policy and Research, February 2016, http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/07-022-16-appendix-e-interim-evaluation.pdf.
46. Sujoy Chakravarty et al., *A Midpoint Evaluation of the New Jersey DSRIP Program: Findings from Stakeholder Interviews, Hospital Survey, Medicaid Claims Data, and Reported Quality Metrics, Rutgers Center for State Health Policy*, September 2015, http://www.nj.gov/humanservices/dmahs/home/NJCW_Renewal_App_C2_DSRIP_Mid_Point_Evaluation_Report.pdf.
47. Jonah Kushner et al., *Hospital Transformation Performance Program (HTPP) Evaluation Report*, OHSU Center for Health Systems Effectiveness, June 29, 2016, http://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Hospital%20Transformation%20Performance%20Program%20(HTPP)%20Evaluation%20Report.PDF.