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State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools

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EXECUTIVE SUMMARY

Since 2010, eight states (California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas), have negotiated with the federal government to implement Delivery System Reform Incentive Payment (DSRIP) or "DSRIP-like" programs. These programs are a component of Section 1115 demonstrations that incentivizes system transformation and quality improvements in hospitals and other providers serving high volumes of low-income patients. DSRIPs aim to meet strategic goals, based on the Triple Aim[1] principles of better care, improved health, and lower costs by incentivizing reforms that transition away from episodic treatment of disease toward prevention and management of health and wellness among patient populations. DSRIP programs restructure historic Medicaid supplemental payment funding that provides hospitals[2] with critical financial support to care for underserved patients into a pay-for-performance structure in which hospitals and other providers are rewarded for achieving specified delivery system reform metrics. DSRIP and DSRIP-like programs—worth up to a combined $3.6 billion in federal funds ($6.7 billion state and federal) in fiscal year 2015—provide states with a unique opportunity to redesign Medicaid delivery systems within the context of state-specific needs and goals.

This report provides an in-depth cross-state analysis of current DSRIP and DSRIP-like programs. It describes implementation experiences from the federal, state, and provider perspectives.

While DSRIPs are still in their infancy, this examination of DSRIP and DSRIP-like state programs has revealed several takeaways:

- DSRIP signals a shift in Medicaid financing toward greater accountability as supplemental payments originally intended to make up for Medicaid payment shortfalls shift to incentive-based payments. Although the Centers for Medicare & Medicaid Services (CMS) describes DSRIP as a tool intended to assist states in transforming their delivery systems to fundamentally improve care for beneficiaries, states have been candid that DSRIP programs have been pursued as a means to preserve supplemental funding. Key financing questions persist, including the use of DSRIP to make payments that exceed prior supplemental payments and states' ability to come up with the non-federal share of DSRIP incentive payments.
- Though each state program is intentionally unique, DSRIPs continue to evolve toward being more standardized, increasing accountability by incorporating more outcomes-based payments, and operating through community partnerships. While respecting local flexibility and innovation for projects to achieve improvements, DSRIPs must be able to demonstrate outcomes and ensure accountability for allocated funding.
- DSRIPs are being designed to support broader delivery system reforms, yet questions remain regarding DSRIP's lifespan and its linkage to other Medicaid financing strategies. According to CMS, while DSRIPs can provide critical support, they are not intended to be a long-term solution for Medicaid under-reimbursement, nor are they intended to be the sole funding source for system transformation over the long-term.
- While lacking comprehensive DSRIP evaluation data, there are multiple examples of quality improvement and care delivery redesign activities implemented as a result of DSRIP. States and providers note anecdotally that as they focus on driving innovation, not all improvements can be captured by DSRIP metrics (e.g. cultural transformation), yet CMS is increasingly focused on

standardizing metrics in areas where there is strong evidence.

- Providers, states, and the federal government must spend significant time to launch DSRIP programs; as a result, a five-year transformation project may in reality be only three to four years. Additionally, most DSRIPs require significant resources for administration and implementation.

INTRODUCTION

At a time of sweeping national health care reforms, states have a number of opportunities to strengthen the systems providing care to low-income patient populations. Of the numerous initiatives states are pursuing, Delivery System Reform Incentive Payment (DSRIP) programs are a more recent mechanism to incentivize system transformation and quality improvements in hospitals and other providers that serve high volumes of low-income patients. Operating under the authority of Section 1115 demonstration waivers, DSRIP programs provide states with a unique opportunity to redesign delivery systems and increase capacity for population health management within the context of state needs and goals.

This report aims to elucidate the potential role of DSRIP programs in the Medicaid delivery system by providing an in-depth cross-state analysis of current DSRIP (and DSRIP-like) programs, and describing implementation experiences from the federal, state, and provider perspectives.

This report focuses on six current DSRIP and two "DSRIP-like" programs; all provide funding contingent upon providers achieving specific metrics tied to areas such as program planning, delivery system reform strategies, reporting, and results.[3] Six DSRIPs (California, Kansas, Massachusetts, New Jersey, New York, and Texas) aim to accomplish system reform through the use of "projects." Though they vary depending on each state's DSRIP design, projects are initiatives that generally focus on infrastructure development and redesign of care processes. This report also examines "DSRIP-like" programs in New Mexico and Oregon. While these programs resemble those of the other states, they are less comprehensive and do not include funding for projects. All eight programs provide funding after providers meet reporting and benchmark requirements on clinical outcome measures.

This report is the product of a 10-month project conducted by the National Academy for State Health Policy (NASHP) under contract with the Medicaid and CHIP Payment and Access Commission (MACPAC). The goal of this project was to shed light on DSRIPs by documenting and analyzing their variety and common features, and understanding their role in the Medicaid delivery system. Specifically, this project aimed to provide a comprehensive review of all existing DSRIPs, and to provide an in-depth examination of their genesis, goals, and functioning in three states to explain various approaches and help inform the work of MACPAC. NASHP sought to gain a better understanding of fundamental issues and questions surrounding DSRIPs, such as: the key features of each state's DSRIP approach, the activities and milestones required to implement the programs, how programs operate, the status of DSRIP implementation and results to date, program evaluation methods, and the differences and commonalities among state DSRIP programs.

Methodology

As part of the project that informed this report, NASHP conducted an environmental scan of eight state DSRIP and DSRIP-like programs and compiled topics for comparison, including: state goals and DSRIP categories, participating providers, financing mechanisms, provider projects, clinical outcomes, program reporting and monitoring, and outputs to date. The primary documents used to inform the scan were waiver approval documents, specifically the special terms and conditions. Additionally, NASHP reviewed DSRIP program protocols, state DSRIP master plans, provider DSRIP plans/applications, state annual DSRIP aggregate reports, and other supporting state and federal documents and data that describe basic information about each state's DSRIP program. Upon completion of the environmental scan, NASHP

compiled seven state fact sheets that condensed information collected from the scan in a digestible format and sent these fact sheets to states for review.[4]

Following the environmental scan, NASHP conducted key informant interviews with state and federal DSRIP stakeholders to verify material collected in the scan and gather additional information that could not be obtained from the scan, such as state experiences with DSRIP implementation and lessons learned. NASHP interviewed key DSRIP program leaders in the Medicaid offices in New York, New Mexico, Oregon, and Massachusetts.

Finally, NASHP visited DSRIP sites in California, New Jersey, and Texas. NASHP worked with MACPAC to identify a conceptual framework for the site visits and decided to select states at various stages of development and implementation to identify new and emerging issues along with past experiences. These three states met the selection criteria; California is in the final year of its program, Texas is mid-way through implementation, and New Jersey's program is fairly recent with project implementation having begun at the end of 2014. In addition to these states being at different stages of implementation, the programs vary considerably on key features such as maximum pool funding, participating providers, projects, and financing. These distinguishing characteristics allowed for in-depth comparison and analysis of DSRIP programs and provided insight into the role of DSRIP programs in the Medicaid delivery system. As part of these site visits, the project team met with state health departments and Medicaid agencies, hospital associations and DSRIP-participating hospital executive, clinical, and financial representatives. In California, the team also toured a facility heavily impacted by DSRIP funding and initiatives.

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

Table 1: DSRIP Key Features

State	Program Name	Program Length	Stage of Implementation	Date Approved	Date Expires
California	Delivery System Reform Inventive Payment (DSRIP) Pool	5 years	DSRIP Year 5	11/1/2010	10/31/2015
Texas	Delivery System Reform Incentive Payment (DSRIP) Pool	5 years	DSRIP Year 4	12/12/2011	9/30/2016
Massachusetts	Delivery System Transformation Initiative (DSTI)	6 years[5]	DSTI Renewal Year 1	12/22/2011	6/30/2014
New Mexico	Hospital Quality Improvement Incentive (HQII) Program	5 years	HQII Year 1 (planning only)	9/04/2012	12/31/2018
New Jersey	Delivery System Reform Incentive Payment (DSRIP) Pool	5 years	DSRIP Year 3	10/2/2012	6/30/2017
Kansas	Delivery System Reform Incentive Payment (DSRIP) Pool	3 years	DSRIP Year 1	12/27/2012	12/31/2017
New York	Delivery System Reform Incentive Payment (DSRIP) Pool	6 years	DSRIP Year 1 (planning only)	4/14/2014	12/31/2019
Oregon	Hospital Transformation Performance Program (HTPP)	2 years	HTPP Year 1	6/27/2014	6/30/2016

Note: For the purposes of cross-state analysis, the first year of each DSRIP project is described as DSRIP Year 1, though states may describe planning years or general demonstration years differently. The information in this table is true as of March 2015.

FINDINGS

Genesis

Historically, states have used flexibility in the Medicaid program to provide supplemental payments to providers that ensure access to health care for vulnerable populations. As a major payer, Medicaid is a core source of financing for safety net hospitals serving low-income communities, including many of the uninsured. Federal payment policies allow states to claim supplemental federal matching payments to hospitals (Upper Payment Limit, or UPL), set at the amount that the Federal Medicare program pays for services.

In 2010, California's designated public hospital systems[6] partnered with the Medicaid agency to propose that their waiver renewal include increased supplemental payments as a mechanism to stabilize public hospitals given financing changes in 2005 that reduced much of their funding.[7] The Centers for Medicare & Medicaid Services (CMS) expressed interest in providing comparable funding levels as proposed to the public hospitals in California, but not through a typical supplemental payment program disconnected from quality of care. In the context of a national health reform debate, CMS and California agreed to a new funding source for public hospitals that was linked to better care, improved health, and lower costs. Based on the framework put forth by CMS, California's public hospitals proposed the first ever DSRIP program building on their decade-long experiences with quality improvement programs. The general construct of the program was shaped through eight months of negotiations between the public hospitals, CMS and the state. The California DSRIP was considered as part of a "bridge to reform" as the safety net was transitioning and transforming into a coordinated system.

Since the California experience, DSRIPs continue to evolve. According to CMS, DSRIPs are intended first and foremost to drive delivery system reform and hold the system accountable for fundamentally improving care for beneficiaries. DSRIP programs tend to focus on providing better care in the outpatient, ambulatory care, and community-based settings in order to avoid the need for and use of hospital inpatient services. They are geared toward increasing capacity in these settings, redesigning services around population health management, integrating services, and increasing communication among providers in various health care settings. However, except in the case of a couple of states, states interviewed spoke of DSRIP as a mechanism to preserve funding for the safety net while simultaneously providing performance-based payments.

State interest in a DSRIP often originates from a transition to Medicaid managed care. Many state Medicaid programs, recognizing unsustainable costs, have pursued managed care as an opportunity to improve care and control costs. More than half of the nation's 67.9 million Medicaid beneficiaries now receive their health care in comprehensive managed care organizations (MCOs) – and the number and share are growing.[8] However, UPL payments, which are calculated based on the volume of fee-for-service care provided, are prohibited by federal regulations under capitated Medicaid managed care arrangements because federal regulations require managed care rates to account for the full cost of services under a managed care contract.[9] As states shift Medicaid financing to capitated managed care contracting, they face challenges in maintaining their historic UPL support for safety net providers.[10] For instance, Texas faced the prospect of losing approximately $3 billion in UPL that was paid to hospitals in 2011. DSRIP allows states to repurpose that money into a pool of incentive-based payments while simultaneously expanding Medicaid managed care.

In discussions with states, it became clear that maintaining supplemental funding was a critical driver in most states' decisions to implement a DSRIP.[11] In some states, safety net hospitals, which often have

limited access to capital and risk losing out in payment methods that reward results due in part to a complex patient mix, are recognizing that DSRIPs are a tool to fund the clinical and financial investments necessary to reorient care toward achieving population health goals for low-income patients.

Design of DSRIP Programs

All state DSRIP programs are based on the strategic goals of better care, improved health, and lower costs. DSRIP program funding is earned by qualifying organizations that demonstrate improvements in health care through reforms that transition away from the episodic treatment of disease to prevention and management of health and wellness among the populations of patients for which the organizations are taking increased responsibility. DSRIP programs are designed to catalyze delivery system transformation by providing incentive payments if and after participating providers achieve milestones of improvement. Each state uniquely adapts this framework to its specific Medicaid program needs, as negotiated between the state and CMS.

DSRIP programs share common design characteristics, but vary in many ways. This section provides a cross-state analysis of DSRIP programs' participating providers and program structures. It describes the DSRIP development process, the types of strategies that DSRIP enables in states, the balance of risk and payment for states and providers, and alignment of DSRIP programs with other state quality improvement and delivery reform initiatives.

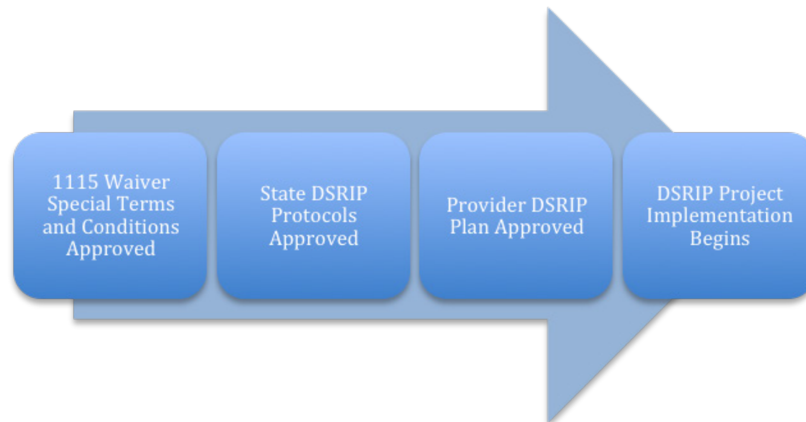
DSRIP Development and Approval Process

DSRIPs are an element of Section 1115 demonstrations. Section 1115 demonstration waivers give states flexibility to demonstrate and evaluate policy approaches within their Medicaid and CHIP programs to expand eligibility, provide services not typically covered by Medicaid, and develop innovative service delivery systems. These waivers are approved by CMS for no more than a five-year period, although they can be renewed. Demonstrations must be "budget neutral" to the Federal government, meaning that Federal Medicaid expenditures will not be more than Federal spending would have been without the waiver.[12] These demonstrations require states to work closely with CMS throughout the duration of the program given the complexity of designing broad system transformation and the need for accountability for investments of billions of dollars that are specific to each state.

The special terms and conditions in each state's waiver outline key design elements for DSRIP programs and provide a conceptual framework. For most states, once the special terms and conditions have been approved, states are required to develop state protocols or master plans that provide details on program implementation such as a methodology for distributing funds, specific project metrics, reporting requirements, and an implementation timeline. All state protocols must receive final approval from CMS; they serve as an important guide for providers to develop provider-specific DSRIP project plans. DSRIP project plans articulate a schedule of what a provider must achieve and report to be eligible for the associated incentive payments, and must demonstrate how selected projects meet the needs of the communities they serve. Importantly, the state protocol negotiation process typically occurs after the demonstration has begun; negotiations with CMS typically last for about nine months to over one year. As a result, the protocol approval process has been shown to truncate timelines for DSRIP project implementation and has presented multiple challenges to providers who must begin projects prior to final approval of state protocols. For example, as of March 2015, Massachusetts is in the eighth month of its three-year DSTI renewal, yet its DSTI project plan has yet to be approved by CMS. This lag contributes

to a feeling among DSRIP providers that they are "building the plane while flying it," although CMS notes attempts to mitigate this problem, with New York as an example of protocols signed at same time as STCs.

Figure 1: DSRIP Waiver and Protocol Approval Process



Participating Providers

Most state DSRIPs focus delivery system transformation and quality improvement efforts on hospitals, particularly public hospitals and their health systems and other safety net hospitals.[13] Due to program scope and provider eligibility requirements in each state, the number of participating providers varies greatly across states with approved DSRIPs, from two in Kansas to 309 in Texas.[14] Six states with approved DSRIPs or DSRIP-like programs (California, Kansas, Massachusetts, New Jersey, New Mexico, and Oregon) specify which providers in the state are eligible to participate in the program and receive incentive payments. In these states, DSRIP programs limit participation to hospital providers, and most often hospitals must serve high volumes of Medicaid and uninsured patients.

DSRIP programs in New York and Texas require providers to form regional coalitions. Major public hospitals or other eligible safety net providers generally lead these regional coalitions; additional participating providers can include community-based organizations, local health departments, community mental health centers, and physician practices associated with academic medical centers. New York's Performing Provider Systems (PPSs) must collectively implement DSRIP projects whereas Texas' Regional Healthcare Partnerships (RHPs) are comprised of performing providers who are individually responsible for projects.[15] In interviews in both New York and Texas, state officials emphasized the need for collaboration among multiple types of providers, including those based outside of hospital inpatient settings, in order to achieve the level of system change the states hope to accomplish. In New York specifically, the state would like to consider building on the regional PPS structure established under DSRIP to establish Medicaid accountable care organizations (ACOs) in the future.

> *"We wanted to create healthier communities and it wouldn't work if hospitals, primary care doctors, clinics, social services, etc. weren't all focused in the same direction on the same quality measures."*
> -New York State Medicaid Official

Beyond the explicit regional partnership structure in New York and Texas, collaboration is strongly encouraged in New Jersey's DSRIP. For many California and Massachusetts projects, successful project implementation is contingent upon some sort of collaboration. In interviews, hospital-based providers in New Jersey stressed the importance of participation by a broad range of providers, but acknowledged difficulties in engaging project partners in DSRIP activities due to a lack of appropriate resources or a

requirement for their participation. CMS notes that the emphasis on building system capacity is critical to broad delivery system reform but states need to find the best way to build the regional and organizational framework to make specific reforms work to improve care for beneficiaries.

Program Structure

The structure of DSRIP programs varies by state due to unique state health delivery system goals. DSRIP programs (California, Kansas, Massachusetts, New Jersey, New York, and Texas) provide incentive payments for meeting milestones on both system reform projects and outcome measures, while DSRIP-like programs in New Mexico and Oregon do not include projects and only pay providers for meeting milestones on outcome measures. In states that include projects, DSRIP programs are generally structured around four categories of funding which participating providers then use to propose provider-specific DSRIP plans.

For the purposes of cross-state analysis, this report characterizes the DSRIP program structure as the following:

1. *Program Planning:* Most states allow an initial period for participating providers to select their delivery system reform projects as part of planning efforts prior to the start of the projects. During this time, the providers design, submit and receive approval for their specific DSRIP project plans. A crucial element of this planning period includes conducting a community health needs assessment as the basis for the DSRIP plan.

2. *Delivery System Reform Strategies:* As described further below, participating providers select projects to transform how care is delivered; most of these projects are focused on increasing and improving care in outpatient settings, reducing hospital inpatient use, and building strong linkages between providers both within and among hospital systems. These projects are the focus of the early years of the DSRIP program and generally fall into one of two categories:

   A. *Infrastructure development*: General areas of activities include improving access to primary and specialty care and increasing health management technology functionalities. Examples of specific infrastructure development projects include building new clinics, hiring new staff, training workforce, implementing telehealth strategies, and developing disease registries.

   B. *Redesign of care processes*: These projects typically focus more on transforming the delivery of care and include activities such as implementing the primary care medical home model and chronic

State Spotlight

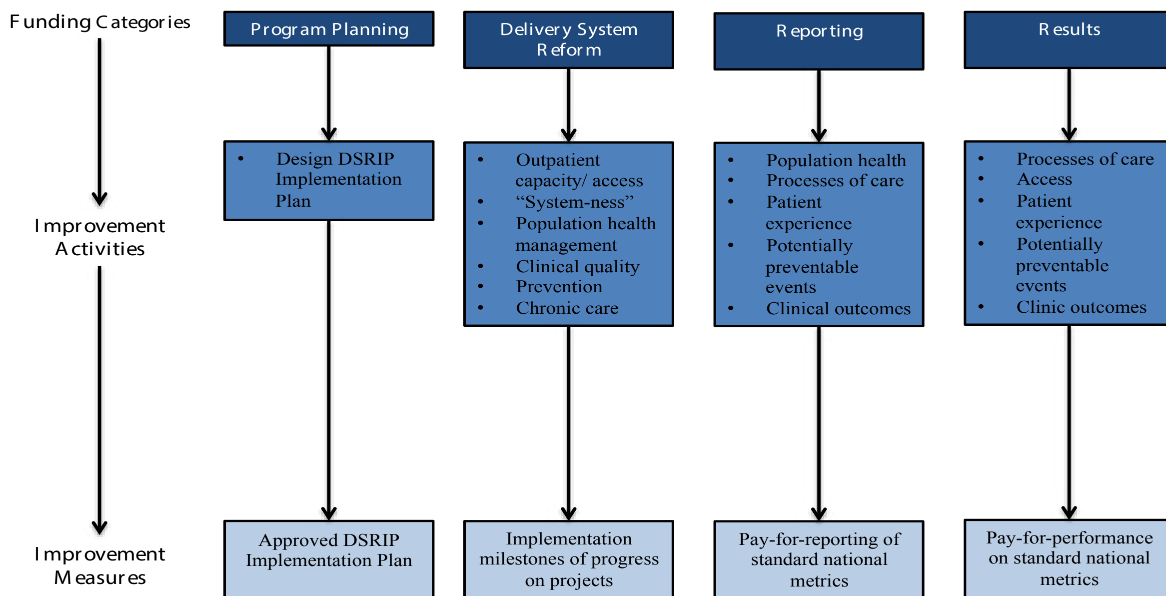
Texas: Increasing Access to Care through Strong Community Partnerships

Texas' Section 1115 demonstration accelerated the implementation of a new partnership between the Travis County Healthcare District and the Seton Healthcare Family. After working together for many years to provide access to care to the county's indigent, the organizations launched the Community Care Collaborative (CCC) to create an integrated delivery system, knitting together hospital care and the county's clinical systems to provide a seamless system of care for the patient. The CCC has implemented 15 DSRIP projects to transform the safety net care system and provide a better care experience at lower cost to improve the health of the uninsured patient population. One of these DSRIP system transformations is the provision of health screenings and primary care through Mobile Health Teams. The mobile unit provides care at church sites and food pantries, and recently launched a Street Medicine team to reach homeless patients.[16]

care model, integrating physical and behavioral health care, improving care transitions from inpatient to ambulatory care settings, and using health navigation to reduce hospital/emergency department use.

3. *Reporting:* DSRIPs push participating providers to be able to report on population-focused measures. Reporting tends to be phased in throughout the program.
4. *Results:* DSRIPs require participating providers to achieve quality improvements in clinical outcomes tied to their DSRIP projects. DSRIPs emphasize the need to achieve such results by the end of the program. More recent DSRIP programs emphasize the importance of sustainability after improvements are achieved.

Figure 2: DSRIP Program Structure



Using this general structure, states can tailor domains and the activities and measures within them to best meet their unique needs and goals. For example, California allows for HIV transition projects and Massachusetts includes projects designed to help providers prepare for the statewide transition to value-based purchasing.[17]

Delivery System Reform Strategies: DSRIP Projects

As discussed above, DSRIP programs allow for participating providers to obtain Medicaid funding for changing how care is delivered through specified delivery system reform strategies. These strategies are implemented through DSRIP projects that tend to improve infrastructure and redesign care delivery so that patients can stay healthy and out of the hospital. Some projects help to improve access to primary care and other ambulatory care services, and to better

Common DSRIP Projects:

- Expand access to primary care
- Integrate physical and behavioral health
- Improve care transitions from hospital to ambulatory care settings
- Enable chronic disease management
- Use telemedicine

enable delivery of those services from a population health management perspective. Other projects use models intended to deliver preventive care to cohorts of patients (such as patients with diabetes), using techniques such as self-management to empower patients to better manage their conditions. Examples of the delivery system reform strategies these projects employ include increasing access to primary care and behavioral health services, coordinating care across services, and transforming the system to enable more timely and proactive patient care in the most appropriate setting. In many states, DSRIP presents an opportunity for a state to increase its focus on certain issues. For example, in Texas over 25 percent of projects focus on behavioral health care.[18]

While the more traditional fee-for-service Medicaid reimbursement model may reward filling hospital beds, DSRIP helps reward the value of the care delivered. Because many of these projects seek to provide more care in the outpatient setting and therefore reduce hospital use, providers participating in DSRIP are able to receive incentive payments for reducing utilization of otherwise reimbursable inpatient and emergency services that are costly to the Medicaid program. Nearly all DSRIP states include reducing emergency room use as a program goal and most programs use various emergency room visit rates as a measure of project success. New York's DSRIP has the explicit statewide goal to "reduce avoidable hospital use by 25 percent over five years within the state's Medicaid program."[19] As a result, the implementation of these delivery system reform strategies demands change among more traditionally structured medical institutions, which tend to operate in siloes and be predominantly hospital based.

The general structure of delivery system reform strategies has evolved over time. Earlier DSRIP programs in California and Massachusetts provided high-level guidance for participating providers around allowable projects and metrics, but allowed providers greater flexibility to design projects to be most relevant to the populations and regions served. More recently approved DSRIP programs, such as New Jersey's, are more prescriptive about project goals and which measures are reported. In other words, a provider in California, Massachusetts and Texas may select the same high-level project area as another provider in its state, but implement different improvements and choose varying metrics to measure progress. For example, multiple providers in Texas may choose to implement the project on expanding primary care capacity, but may do so through creating more clinics, expanding clinic hours, expanding mobile clinics, or other options and therefore apply different metrics to measure success. Conversely, in states with a more narrowly defined project menu such as New Jersey and New York, any provider that selects a project will be assessed by the same set of measures as other providers selecting the same project in the state. For example, any provider in New Jersey that chooses to implement the project on hospital-wide screening for substance use disorder must report on the same

State Spotlight

New Jersey: Robert Wood Johnson University Hospital's Cardiac Transitions Project

Robert Wood Johnson University Hospital's DSRIP project seeks to reduce readmissions among patients with cardiac disease. Through this project, patient navigators, typically Registered Nurses, review cases, discuss medication issues with physicians, make home visits within 48 hours of discharge to perform a symptom and medication check, and ensure the patient has a follow-up appointment within seven days after discharge. The navigators may, for instance, find out if a physician can prescribe a more affordable medication. Finally, a social worker follows up with three phone calls to identify any outstanding issues that may lead to readmission.

pre-determined set of metrics. That said, providers across different states selecting the same projects will likely be assessed by distinct measures, since each state's program is unique.

During site visit interviews, DSRIP stakeholders expressed varying opinions on the trend towards more standardized projects. For example, while the Texas DSRIP program includes more than 1,400 projects that must undergo an arduous state and federal review process, providers expressed an appreciation for the flexibility to design projects that met the needs of the communities they serve. Conversely, stakeholders in New Jersey shared their frustration with the limited project menu and pointed out confusion among providers about the extent to which DSRIP activities can build on existing projects.[22]

State Spotlight

California: From Responsive to Proactive Care in a Clinic

The Hope Center Clinic[20] in Oakland earned DSRIP funding by providing complex case management for patients struggling to manage their chronic conditions. The program identifies the five percent most costly patients, who had historically received episodic treatment in ERs throughout the city, and provides them with ongoing care in the outpatient setting. Ronnie Crawford, a patient, shared that he was "going hospital to hospital, program to program [until this program]… with your guidance and your help, I've changed medications where I'm breathing better." Initial program results show reductions in hospitalizations: 20 percent in admissions per patient per year and 23 percent in bed days per patient per year.[21]

Balancing Risks and Incentives

As described above, DSRIP incentive payments are earned *if* and *after* participating providers demonstrate planning, improve care delivery by implementing delivery system reform strategies, report on measures, and improve the quality of care. As such, DSRIP funding is both performance-, as well as risk-based; providers run the risk of investing in care improvements on the front end but not achieving the required results and therefore not earning the full incentive payment. For providers accustomed to funding levels from prior supplemental payment programs, DSRIP may bring increased budget unpredictability or tensions. However, public hospitals in California related that from a budgeting perspective, DSRIP is a more predictable source of funding than some other sources, as long as the hospitals are able to achieve most or all of their milestones. Moreover, many states and providers who are key participants in their state's DSRIP program anticipate a long-term return-on-investment in DSRIP programs in the form of reduced costly services (such as costly Medicaid readmissions, meaning savings for states and capitated providers) and improvements in the care delivery system (such as increased volume in the outpatient/community settings). The flip side, of course, is that institutions that only offer acute care services lose revenue with reduced acute care utilization (which is representative of the DSRIP program incentives to shift away from episodic treatment to health and wellness).

> *"I think DSRIP is achieving its goals in terms of stabilizing the safety net hospital system. Hospitals aren't closing. We have definitely seen quality changes such as integrating primary care and behavioral health through co-location, expanding access to specialty care through E-consults and expanding primary care."*
>
> \- California Medicaid Official

DSRIP programs tend to set a high bar for earning funding. Initially, providers are able to earn incentive payments for planning and implementing delivery system reform strategies. Over time, payments shift

away from these implementation activities towards demonstrating improved health outcomes. States and providers reported this shift makes it increasingly difficult to earn incentive payments over time. The financing of improved care—as opposed to cost or volume-based funding—reflects the program's intent to test a method of shifting Medicaid supplemental payments away from the fee-for-service structure toward a value-based payment.

In addition to putting providers at risk to receive performance-based payments, New York's DSRIP program also holds the state accountable if it fails to meet certain statewide performance metrics. These specific metrics include statewide performance on avoidable hospital use, project metrics, meeting target trend rates for reducing the growth of total state Medicaid spending, and implementing value-based purchasing arrangements in managed care. Beginning in the third year of the project, if the state fails to meet any of these four metrics, the total amount of available DSRIP funding will be reduced and providers will not be eligible to receive as much in incentive payments. New York is the only state to include this level of statewide accountability in their program. In an interview, the state discussed this as a positive aspect to its program noting the power of collective accountability on public dollars to drive change.

DSRIP in the Context of Other System Transformation Initiatives

DSRIPs can complement other health system transformations within the state's Medicaid system including managed care expansion, payment reform, coverage expansion, and other aspects of delivery system reform. States with higher levels of DSRIP funding and greater numbers of participating providers especially reported the importance of DSRIP programs to accomplishing broader waiver and state Medicaid policy goals, and so the interplay among such programs is both intentional and mutually beneficial. For these states, DSRIP is a substantial component of their health system transformation efforts and its large scope positions it well to complement other health reform initiatives. For instance, many of California's public hospitals participated in both DSRIP and coverage expansion (Low Income Health Program (LIHP)) as part of the state's current waiver, and have found both efforts make each more successful. In one example, the LIHP requires enrollees to be assigned to medical homes, and 17 public hospitals expanded the medical home model as part of DSRIP. Both programs are aligned with broader state strategies related to the Affordable Care Act (ACA), managed care expansion and improving the quality, while lowering the cost, of Medicaid care. In New York, DSRIP complements the Medicaid Redesign Team (MRT) waiver and seeks to accomplish broader state payment reform and cost-lowering goals: by the end of the DSRIP, the goals are for Medicaid providers to accept risk for populations under alternative payment models (such as capitation and global payments) and to reduce hospital use by 25 percent. Table 2 (next page) shows other delivery system reform initiatives and hospital supplemental payments available in DSRIP states.

Table 2: Delivery Reform Programs in DSRIP States

Delivery System Reform	California	Texas	Massachusetts	New Mexico	New Jersey	Kansas	New York	Oregon
State Innovation Model (SIM) Round 1 Design Award[23]	√	√						
SIM Round 1 Testing Award			√					√
SIM Round 2 Design Award	√			√	√			
SIM Round 2 Testing Award							√	
Medicaid Expansion State	√		√	√	√		√	√
Medicaid Managed Care Expansion	√	√	√	√	√	√	√	√
State Accountable Care Organization Activity	√	√	√		√		√	√

Financing of State DSRIP Programs

DSRIP funding is available as supplemental incentive payments for improvements in care, health and cost within the safety net. This section provides a cross-state analysis of states' DSRIP program funding, the reporting and payment processes, and considerations related to drawing down federal funding. Perspectives from states, providers and the federal government, the evolution of the program, and key issues related to the financing of DSRIPs are discussed below.

Funding Amounts

As a Section 1115 demonstration waiver program, the limit on the total DSRIP pool funding is established in the negotiated waiver special terms and conditions based on budget neutrality analysis.[24] As shown in Table 3 and discussed in more detail below, these amounts vary considerably by state, have differing relationships to the states' prior and current supplemental payment programs, and are distributed among distinct numbers and types of providers using unique criteria.

Table 3: DSRIP Approximate Funding Amounts and Distribution

State	Current Federal Match	Approximate Maximum Federal Funding	Approximate Maximum State and Federal Funding	Number of Participating Providers
California	50%	$3,336,000,000	$6,671,000,000	21
Texas	58.05%	$6,646,000,000	$11,418,000,000	309 providers (organized into 20 RHPs)
Massachusetts*	50%	$659,000,000	$1,318,000,000	7
New Mexico	69.65%	$21,000,000	$29,000,000***	29
New Jersey	50%	$292,000,000	$583,000,000	50
Kansas	56.63%	$34,000,000	$60,000,000	2
New York	50%	$6,419,000,000**	$12,837,000,000	64,099 estimated providers (organized into 25 PPSs)
Oregon	64.06%	$191,000,000	$300,000,000	28
TOTAL		**$17,598,000,000**	**$32,216,000,000**	

Notes: The funding amounts provided in this table are estimates based on an analysis of the figures provided in each state's waiver. All amounts represent maximum potential funding; earning the funding is contingent upon achieving milestones. The approximate federal funding figures were calculated based on a year-by year analysis of total computable DSRIP funding and FMAP and may vary slightly from actual FFP paid.

* The Massachusetts DSTI was renewed for an additional three years in October 2014. These figures represent funding for all six years of the program. These figures do not include the $330 million in federal funds included in the renewal demonstration for the Public Hospital Transformation and Incentive Initiative pool, which will allow one DSTI hospital to implement additional delivery system reform projects.

**This figure does not include funds from the New York Interim Access Assurance Fund.

***Additional funding may be added from unclaimed funding in the Uncompensated Care (UC) Pool.

Relationships with Other Medicaid Supplemental Payments

States' DSRIP programs have varying relationships to prior Medicaid waiver supplemental payment programs for hospitals (e.g. UPL), which fall within the following:

- *Equals prior supplemental funding:* Maximum potential DSRIP pool funding may equal prior supplemental payment aggregate amounts at the state level. In these cases, DSRIP pools are comprised solely of repurposed supplemental funding sources for hospitals (e.g. UPL payments the state was no longer eligible to receive due to managed care expansion).
- *Exceeds prior supplemental funding:* Maximum potential DSRIP pool funding may exceed prior supplemental payment aggregate amounts at the state level. In these instances, DSRIP pools are comprised of repurposed supplemental funding sources (e.g., UPL payments the state was no longer eligible to receive due to managed care expansion) in addition to managed care savings.
- *No relation to prior supplemental funding:* DSRIP dollars may not be based on prior supplemental payments. Instead, DSRIP pool funding may be based solely on managed care savings.

Table 4: DSRIP Relationship to Supplemental Payments

State	Delivery Reform and Supplemental Payment Programs		
	Uncompensated Care (UC) Pool	Designated State Hospital Program (DSHP)	Relation to Prior Supplemental Payments
California	√	√	Exceeds
Texas	√		Exceeds
Massachusetts	√	√	Exceeds
New Mexico	√		Equals
New Jersey			Equals
Kansas	√		Equals
New York		√	No relation
Oregon		√	No relation

The nature of DSRIP funding in comparison to prior supplemental payments is more risk-based, meaning that the actual DSRIP incentive payments to some providers within states may be less than what they had received as prior supplemental payments (even if state-level DSRIP funding exceeds prior supplemental payments), due to factors such as: (a) missing a project goal or improvement target and therefore not being eligible to claim some funding; (b) a project that required additional spending offsets the incentive payment; and (c) for providers that serve as the source of the non-federal share, the amount of funds a provider supplies offsets the amount of funding earned.

Due to the fact that funding is tied to implementing delivery system reforms and improving health outcomes, DSRIP funding demands more accountability from providers to deliver high quality care compared to lump-sum supplemental payments. The increased risk and investment inherent in DSRIP funding was prominent in interviews with providers in New Jersey, where the sentiment was that the same level of funding received in the prior program would now need to be earned at a substantial cost, (in terms of effort and finances required to implement the projects), and at high risk (due to needing to achieve challenging metrics). Many providers across states reported that supplemental payment streams are making up for Medicaid payment shortfalls (e.g., California, New Jersey), so optimizing the funding is critical to their institutions. In many states, the public providers receiving the most DSRIP funding tend to serve a disproportionate share of Medicaid enrollees and low-income uninsured individuals, often with complex health issues. Such institutions tend to have payer mixes typified by a high percentage of Medicaid patients, high uncompensated care costs, and a low percentage of commercially insured patients relative to other hospitals; narrow profit margins; a heavy reliance on public funding; and minimal funds for ongoing quality improvement and transformation.

Thus, the shift to DSRIP raises policy considerations, such as how the original purpose of supplemental payments should be reconciled to DSRIPs, whether DSRIP funding is effective in achieving its quality of care goals, and the general relationship between Medicaid payment options and the value of health care (e.g., access, quality, efficiency and utilization).

In addition, DSRIPs can be complemented by:

- *Uncompensated Care (UC) Pools:* Five of the eight approved DSRIP and DSRIP-like programs (California, Texas, Massachusetts, Kansas, and New Mexico) operate in parallel to UC pools, which reimburse providers for the costs of providing uncompensated care. The relationship between the DSRIP and the UC pools varies by state. For example, Texas' UC pool is closely tied to

DSRIP funding; over the duration of the waiver, funding for UC decreases while funding for DSRIP increases. In other states, the relationship is less direct. In our interview, however, CMS related that it views DSRIPs and UCs as increasingly separate.

- *Designated State Health Programs (DSHP) Funds:* Four of the Section 1115 demonstrations that authorize DSRIP and DSRIP-like programs (California, Massachusetts, New York, and Oregon) also authorize DSHP funds. DSHP in Section 1115 demonstrations provides federal match for state Medicaid-like services that are not currently federally matched. As with UC pools, the relationship between DSRIP and DSHP funds varies by state.

How DSRIP Funding Is Distributed

Medicaid waivers' special terms and conditions determine how DSRIP funding is distributed by states and the federal government. This happens in the following ways:

- By the total limit on pool funding per year;
- Among categories of funding;
- Among participating providers;
- Within participating providers' DSRIP implementation plans; and
- For any unclaimed DSRIP funding.

Total Pool Funding

Maximum pool funding varies from state to state (see Table 3 above); variations in the number of participating providers, prior supplemental funds, and size of the state make like comparisons of total pool funding across the states challenging. Among states with approved DSRIPs, the average total state and federal funding available per year ranges from $7 million in New Mexico to $2.3 billion in New York.[25] Some states have consistent amounts of DSRIP funding per year (Massachusetts, New Jersey and Oregon). Others have ascending amounts to shift priority to a pay-for-performance financing model and emphasize the increasing importance of achieving program results in the later program years (Kansas, New Mexico and Texas), while New York's DSRIP funding peaks in the middle of the program. This design in New York is intended to promote sustainability of the reforms post-waiver. The maximum pool funding represents only the total cap on potential funding that may be distributed.

Categories of Funding

Waivers also dictate how DSRIP funding is distributed across funding categories (see Figure 2 above). As individual agreements, the specifics of funding amounts and how it is earned differ across states, making it difficult to achieve like comparisons. Below is a summary of the general types of categories in which DSRIP incentive payments can be earned, though not all states include all of these types of funding categories, and the distribution of DSRIP funding across these types of funding categories varies:

1. *Program Planning:* Most states have dedicated DSRIP funding for planning and detailing specific DSRIP project plans.[26]
2. *Delivery System Reform Strategies:* The bulk of most states' DSRIP funding is for pre-approved delivery system reform "projects," (or programs/initiatives) and associated metrics of improvement (called "implementation milestones" in this report).

3. *Reporting:* DSRIP funding can be earned by reporting on standard metrics ("pay-for-reporting").
4. *Results:* Additionally, DSRIP funding is for "pay-for-performance,"[27] or improvement on standard quality metrics of outcomes.

As noted above, DSRIPs tend to include more funding for planning and delivery system reform in earlier program years, and more for pay-for-reporting and pay-for-performance in later program years. At the same time, there is more funding toward planning in more recent DSRIPs. Consistent with the trend for more recently negotiated state DSRIP programs to be more standardized and outcomes-based, states with more recent DSRIPs tend to have larger proportions of their total DSRIP funding dedicated toward reporting and results to hold the system accountable to fundamentally improve care for Medicaid beneficiaries.

Allocating Pool Funds

In most DSRIP programs, funding is allocated to providers first, and participating providers then submit DSRIP project plans that must reflect their allocated amounts. Allowable funding per provider is calculated differently and amounts vary significantly among states. The allocations tend to be dependent on a formula that the state has created based on factors such as volume, cost, Medicaid share, historic levels of supplemental payments, provision of non-federal share and scoring of the projects/application.

Notably, New York (the most recent DSRIP program approved) instead scores each aspect of the providers' DSRIP implementation plan first, the sum of which then produces the amount that will go to a network of providers. Scoring in New York rests upon multiple criteria in the DSRIP application, with a major factor being the number of Medicaid members attributed to the network.

Valuation of DSRIP Implementation Plans

Project valuation – how funding is allocated across providers for completion of projects or achievement of performance goals – varies significantly by state. Early state DSRIP programs (e.g., California and Texas) tended to allow more flexibility for participating providers to propose valuation for certain proposed projects within the provider's DSRIP plan (for example, infrastructure development and process redesign projects), while valuations for clinical improvements and population health tended to be more formulaic. More recent state DSRIP programs (i.e. New York) base project valuation and total per-provider funding allocations on standardized formulas. Still others base valuation upon historic levels of previous Medicaid supplemental payment programs (e.g. New Jersey) or on factors including hospital size and patient population (e.g. Massachusetts).

DSRIP incentive payment amounts are not tied to the actual cost of achieving care improvements, nor are they considered patient care revenue. Because payments are value and performance based, most DSRIP programs do not require providers to report on the cost of achieving care improvements, though later DSRIPs (i.e. New Jersey and New York) do require participating providers to submit project budgets. Additionally, most DSRIPs do not require the incentive payments be spent in any particular way (though, depending on how program requirements are interpreted/implemented, more recently approved DSRIPs may require participating providers to report at a high level how incentive payments are spent).

In other words, both within and across states, there is no like-comparison of the "price" being paid for a particular improvement or performance level. In more recent DSRIP programs, the federal government has tried to focus on standardizing payment within and across states by linking the calculation to an attributed population and making improvement goals based on a consistent formula. CMS notes that standardization in valuation methodology can enable comparisons that are critical to ensure payments are not arbitrary.

States and providers contend that what is needed to drive transformation and support the safety net may vary within and across states.

Unclaimed Funding

Since it is a performance-based funding program, some portion of each state's DSRIP pool may go unclaimed. Each state's waiver agreement has distinct methods for dealing with these funds. California purposefully laid out financing policies to align with the public hospitals' experiences of quality improvement – it may not always happen on time, or in a linear fashion, but rather in bits and spurts with plateaus. As such, California's DSRIP allows for partial payment of partial achievement of implementation milestones and outcomes metrics, as well as for the ability of an organization to carry forward the milestone/metric and the associated incentive payment for up to one program year. For example, one public hospital reported that a clinical outcome goal was 12 percent, and by the end of the program year and a lot of hard work, the organization achieved 11.9 percent, falling short of full achievement. The hospital was eligible for partial payment to reflect its progress and reward continued improvement. Furthermore, in California, 90 percent of unclaimed funding after the additional program year is available to the same public hospital if the public hospital adds milestones/metrics to its DSRIP implementation plan. If the public hospital fails to do so, other public hospitals can access the funding with additional milestones/metrics. Any remaining DSRIP unclaimed funding may be rolled into the UC pool, with CMS approval, but California has not made that request.

Over time, CMS has moved away from partially conditional payment to all-or-nothing payment in order to simplify administration and clarify the goal of true system transformation. The ability to have an additional year to fully achieve a milestone or metric ("carry-forward") has been replaced with high performance funds. For example, in New York's DSRIP program, metrics not met in full and on time (characterized by CMS as demonstration of modest improvement over baseline, generally 10 percent), will result in forfeited funding. The missed metric will be carried forward into the following year (but not the missed funding), requiring all metrics in the following year to be recalibrated (so each metric in the following year will have reduced incentive payment amounts, but in aggregate represent the same total funding amount for that year). Unclaimed funding is rolled into a High Performance Fund, which is awarded to top performers who exceed their metrics for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health population. This model, which is also used in other more recent DSRIPs, ensures that all DSRIP funding is distributed, but encourages providers who meet their metrics to achieve additional improvements. How the evolved financing policies influences quality improvement remains to be seen.

Payment Mechanics

DSRIP incentive payments are triggered by: (1) reported achievement; and (2) provision of the non-federal share. DSRIP reports are typically required twice per year, while DSRIP achievement is measured annually; therefore, some achievement may be accomplished within the first six months of the program year, but many measures may not be able to be reported until the end of the program year (for example, measures requiring 12 months of data from the program year).

Report templates are developed by each state and approved by CMS; as public program reporting tied to significant sums of federal funding, interviewees relate the reports to be administratively complex and arduous, both for providers to complete and states to review. Both types of entities have reported the need to to hire or redeploy staff/contractors to specifically attend to DSRIP program reporting and administration.

DSRIP reports tend to be due to the state one month after the program period of reporting, then the state reviews the reports and may approve or deny payment, then the non-federal share is due and federal matching payment is made to the provider. As a simple example, a provider may spend $100 in January to meet a milestone. That provider may then report achievement of that milestone in July, with payment in August of $200.

The payment mechanics process is similar in all DSRIPs, but each waiver dictates a unique timeframe for payment following reporting. For example, California's Department of Health Care Services has one month to review reports; Texas' Health and Human Services Commission has one month to review reports with payments occurring within three months. Much of that reflects the significantly high number of reports with which the State of Texas must contend; however, the delayed payment timeframe can pose budget challenges to the providers.

Role of Non-Federal Share

Since Medicaid is a joint state-federal program, its funding is shared by the state and federal governments. As a Medicaid waiver program, DSRIP incentive payments have both a federal share (Federal Financial Participation (FFP)) and a state share, or "non-federal share," the sum of which is the total computable incentive payment. The percentage of the total computable incentive payment provided through FFP is based on the state's Federal Medical Assistance Percentage (FMAP).[28] In the Medicaid program generally, states pay providers for services rendered or costs incurred, and then the federal government reimburses the state for a portion of those costs, dependent upon the FMAP for the state and how the cost is classified. Likewise, the FFP portion of the DSRIP incentive payment is triggered by the state providing the non-federal share of the incentive payment.

Section 1115 demonstration agreements reflect how the state is sourcing the non-federal share. DSRIPs allow the non-federal/state share to be supplied from one or more sources, including state general revenue funds, provider taxes, intergovernmental transfers (IGTs) from public entities (public providers and local governmental entities), and federalized state programs (DSHP). Certain sources of the non-federal share, such as IGT, tend to dictate which providers are eligible to participate in DSRIP. Providers who have no source of matching funds to support their DSRIP projects may not be able to participate. For example, in the second year of its DSRIP program, Texas did not claim $352 million of the pool's total computable funding for that year due to areas in the state that did not have adequate IGT sources.

Many states struggle with how to finance their contribution to the DSRIP program. Since containing costs is a primary driver, states with DSRIPs are not taking on additional funding share responsibilities through state general revenue/appropriations beyond what the state had been providing through prior waivers/supplemental payment programs. The exception is New Mexico, which currently pays the non-federal share from state general revenue but is working with its counties and other stakeholders to identify another funding source.

Oregon has used provider taxes to generate public revenue that can be used as the source of the non-federal share. Provider taxes can prove challenging because, while the assessment on providers tends to be standardized (e.g. a 6% tax on providers), providers may be eligible to earn very different levels of DSRIP funding or, for some, no DSRIP funding at all. In addition, implementing new or expanded provider taxes may not be politically feasible in some states.

Many states are looking to public providers and local governments to fund the non-federal share through IGTs. IGTs are transfers of public funds from one level of government to another; entities supplying the IGT for DSRIPs include public hospitals, local governmental entities and state university hospitals and, in

Texas, local mental health authorities. Thus, most IGTs funding the state's share of the DSRIP incentive payments are derived from local tax revenues. IGTs have become the largest non-federal funding source for DSRIPs (see Table 5). Federal policies dictate that states cannot require increased financing of the non-federal share from governmental entities, so providing the IGT is voluntary.[29,30]

IGTs for DSRIP require a high level of funding that may pose challenges to public providers and local governmental entities supplying IGT. These public providers often serve a disproportionately high number of Medicaid patients and are likely to already face budget challenges. The large amount of IGT that needs to be transferred as the non-federal share prior to receiving the incentive payments can make the cash flow challenge of DSRIP more acute for those providers who are providing IGTs. For example, one provider in California described the need to work closely within its system and with the county to make sure there is enough IGT. In another example, a provider in New York is borrowing to be able to provide IGT for DSRIP. Moreover, public providers who also provide IGT for private providers (as in Texas and New York) must put up additional IGT, which reduces the amount of DSRIP funding that they can retain.

Table 5: Source of Non-Federal Share

State	State General Revenue	Provider Taxes	IGTs from Public Entities	DSHP	Entities Supplying Non-Federal Share Dollars
California			√		Designated public hospitals
Texas			√		Public hospitals, local government
Massachusetts	√		√		State for private hospitals, public hospital self-funded
New Mexico	√		√		State for private hospitals, public hospital self-funded
New Jersey	√				State
Kansas			√		Public hospitals
New York			√	√	Mostly public hospitals, supplemented by some state (DSHP)
Oregon		√			Hospitals

Private providers are excluded from providing non-federal share, or from exchanging comparable funds with a governmental entity providing the IGT on their behalf, because it would violate provider-related donations prohibitions.[31] In the context of IGTs, private providers are often dependent on public providers or governmental entities for the non-federal share of their DSRIP incentive payment. This arrangement poses risks for private providers. For example, a private hospital in Texas achieved DSRIP milestones, but the county serving as the IGT source had lower-than-expected tax revenues, and failed to supply the IGT, so the provider did not receive the full incentive payment for which it was eligible.

In Texas this arrangement can also be problematic for the public providers supplying the IGT, since IGT is the sole source of the non-federal share and a significant number of private providers are participating in DSRIP. Essentially, only public providers are putting up the state share for the entire set of participating hospitals. Providers have related that the matter of determining non-federal share in Texas has been highly

complex and challenging. Texas stakeholders also acknowledge that the state's county-by-county funding approach limits the ability of the RHP structure to foster meaningful regional transformation; although the RHPs have led to increased conversation and collaboration between providers, counties are prohibited from allocating funds towards patients in other counties, even if they belong to a single RHP.

Finally, New York State supplements IGTs by using the Designated State Health Program (DSHP)) to fund a small portion of its DSRIP program. DSHP in section 1115 demonstrations provides federal match for state Medicaid-like services that are not currently federally matched. CMS has generally limited DSHP as a source of non-federal share in DSRIPs to this point.

Due to these issues around the provision of the non-federal share, a state may be limited in how it designs its DSRIP program, especially regarding provider eligibility (if providers do not have a way to finance the non-federal share, they may not be able to participate) and provider allocation/project valuation (states grapple with creating formulaic and performance-based methods to allocate funding among providers and value projects that reflect comparable parity of net incentive payments between private and public providers). CMS related that IGTs especially tend to influence how local providers participate in DSRIP, which needs to be considered in ensuring that DSRIP funding supports a beneficiary-centered system.

DSRIP Measurement and Monitoring

In addition to the monitoring required for research and demonstration purposes of the overall Section 1115 demonstration, DSRIP participating providers must measure progress toward the goals of better care, improved health, and lower costs to the Medicaid program for payment purposes. At an aggregated level, CMS and states are examining DSRIPs' impacts on these aims. A key policy consideration for DSRIPs is how to meaningfully align clinical quality with payment in a way that optimizes real improvements; the experiences of states may help policymakers explore questions such as:

- How can measurement and payment best be designed to activate actual improvement on the ground for Medicaid and uninsured populations?
- What measures most appropriately reflect better care, improved health status, and lower costs?
- On which measures can a provider reasonably move the needle within the DSRIP lifespan?
- What is the appropriate number of measures to balance reporting data with the work of performance improvement?
- What are appropriate data sources, i.e., financial/administrative data (e.g. claims) versus clinical data (e.g. charts)?
- Is there a way to balance standardized measures with experimental ones?

This section summarizes states' experiences with and trends in DSRIPs relative to measuring improvement, reporting achievement, and program monitoring, assessment and evaluation.

Measuring Improvement

Each DSRIP program includes measurement of quality and performance improvement, but the specifics of measurement vary by state. Generally, the program has evolved from allowing more state/local flexibility to select and tailor metrics toward a more standardized and prescribed set of metrics.

Milestones and Metrics

This report categorizes DSRIP metrics into three types (though New Mexico and Oregon programs do not include the first type); each of which is discussed in further detail below.

- *Implementation Milestones and Metrics:* These metrics are intended to measure progress toward delivery system reform within DSRIP projects. Earlier DSRIP programs allowed extensive lists of permissible milestones and metrics for each project, and providers simply had to select a minimum, and sometimes maximum, number of milestones/metrics to report (i.e. California, Massachusetts, and Texas). Later DSRIP programs require any provider selecting a certain project to implement the same prescribed set of evidence-based activities (e.g. New Jersey). Such activities can be tailored to the needs of the organization and population; for example, all providers may need to train staff, but the number of staff trained may vary. Later DSRIPs also mandate that implementation milestones/metrics address community health needs, as demonstrated in an assessment.
- *Pay-For-Reporting Metrics:* Many DSRIP programs include: (1) a standard set of measures that all participating providers must report; and (2) project-specific pay-for-reporting metrics. Pay-for-reporting metrics are either standard national measures, or adapted from them.
- *Pay-For-Performance Metrics:* Every DSRIP program requires results in outcomes. Later DSRIPs more closely align pay-for-performance metrics with delivery system reform projects; California's pay-for-performance category focuses on reducing hospital-acquired conditions, while its projects tend to emphasize the ambulatory care setting. Other states must relate pay-for-performance metrics to their projects; for example, a provider with a care transitions project might have to reduce readmissions.

Table 7 provides examples of the three types of metrics. Most state DSRIP programs tend to generally categorize metrics similarly. However, there are thousands of measures across state DSRIP programs with limited overlap and variances where there is overlap, making state-to-state comparisons difficult. For example, blood pressure control can be categorized as a pay-for-reporting metric in New Jersey and a pay-for-performance metric in New York. Likewise, Texas and Massachusetts measure the congestive heart failure ambulatory sensitive condition admission rate slightly differently.

Table 7: Examples of Types of DSRIP Metrics

Implementation Milestones/ Metrics	Pay-For-Reporting Metrics	Pay-For Performance Metrics
• Redesign care processes • Deploy reformed workforce strategies, including hiring/ training • Use process improvement methodologies • Increased access to and capacity for prevention, primary care, chronic care and behavioral health services • Increased volume in outpatient settings	• Clinical outcomes • Potentially preventable events[32] • Ambulatory sensitive condition admission rates • Population health metrics[33] • Processes of care metrics (e.g. New Jersey) • Patient experience scores (i.e. California)	• Clinical outcomes • Potentially preventable events • Ambulatory sensitive condition admission rates (i.e. New Jersey and New York) • Processes of care metrics (i.e. New York[34]) • Patient experience scores (i.e. Texas) • Access measures (i.e. Texas, such as Third Next Available Appointment[35])

Stakeholders noted complications with tying pay-for-performance metrics directly to a DSRIP project. For example, in Texas, providers with the same projects can select different outcome measures from a menu of more than 250 pay-for-performance measures. Even so, some providers remain concerned that the menu did not include a measure that would present an accurate representation of the project result, and so in addition to the required reporting, some providers are also reporting other data in their DSRIP reports. Similarly, in New Jersey, one stakeholder expressed concern about the use of adult-focused asthma measures that were not appropriate for the hospital's pediatric asthma project.[36]

States and CMS struggle to balance flexibility to meet local needs with an ability to compare and aggregate data. In earlier DSRIP programs, delivery system reform projects are individualized and the results among providers are not comparable. In later programs, projects require common components and work steps among any providers selecting those projects, and all providers must report and improve on the same set of process and outcome measures. In stakeholder interviews, providers noted they strongly preferred having more flexibility, but they and states also recognized the drawback of not being able to demonstrate aggregate statewide improvements if there is too much variation. CMS notes that its ultimate goal is a parsimonious set of metrics that ensures accountability for funding, while at the same time providing flexibility to achieve improvements on those metrics by demonstrating system transformation that fundamentally improves care for beneficiaries.

In our interviews, we heard concerns that strong evidence may not yet be fully substantiated to support the effects of outpatient-based delivery system reforms on national standardized outcome measures. Yet CMS notes this is the precise reason why it has been narrowing the types of metric sets in order to focus on areas where there is a strong evidence base for true system transformation and improved care. Those interviewed also expressed a concern that the ability of DSRIP providers to see results in the ambulatory care setting for populations of patients within the three- to five-year timeframe remains to be seen in coming years. Moreover, the measurement of cost has been the most difficult of the key goals to incorporate into DSRIPs. DSRIP measure sets tend to focus on potentially preventable events to get at cost avoidance, but measuring cost, per capita spending, resource use, and efficiency has only been introduced selectively and carefully.

Improvement Population

Over time, state DSRIP programs have been required to increase the proportion of the population represented by the denominator in DSRIP measures across states, indicating that states must achieve improvements for an increasingly broader segment of the their safety net population. This evolution is consistent with CMS' goal of providing comprehensive care for beneficiaries, but does not necessarily mean the state is affecting more patients. More recent DSRIPs have used attribution models to assign a large portion of the state's low-income patients to specific participating providers.

- Implementation metrics across states tend to have denominators specific to the project, or intervention, population (e.g. patients enrolled in a care management program).
- Pay-for-reporting measures in California are limited to the patients for whom the hospital is actively managing care[37], but other states tend to include larger populations – all patients meeting measurement criteria (i.e. Texas) or all attributed patients (i.e. New Jersey and New York).
- Pay-for-performance measures, similarly, have evolved from patients receiving the intervention (i.e. California) to all patients within the provider system meeting the measurement criteria (i.e. Texas), to all attributed patients (i.e. New Jersey), to all attributed Medicaid members within the

geographic region (i.e. New York). Thus, the same measure of improvement in two states may encompass different segments of the population or community.

New Jersey providers noted challenges with attribution. DSRIP providers operate within an open health system where patients can choose where to receive their care (within or beyond the provider system to which they are "attributed"), and they tend to serve a transient population. For example, one provider asked how it should reach out to attributed individuals whose care the provider does not currently manage – should the provider track them down and try to get them into its system, even if the patient seeks care elsewhere? Many DSRIP providers have a mission of serving all low-income patients, and this raises questions about the patients who come to their doors that are not attributed to them. Realizing the importance of this issue, CMS has addressed attribution challenges in later DSRIPs—such as the New York program—where providers are made aware of their attributed population at the beginning and any differences are reconciled at the end of the year.

Since results have yet to be reported in most states for pay-for-performance metrics, anticipated issues such as small numbers of cases relative to larger populations and the ability to capture data for larger patient populations consistently and accurately remains to be seen. Furthermore, the ability of various types of providers to effectively collaborate to make a dent in the health of safety net populations, which can be particularly disenfranchised, transient and difficult to follow, in an open health care system within a five-year timeframe is yet to be fully explored.

Improvement Methodology

In order to draw down funding for milestone achievement, DSRIP providers must meet prescribed improvement targets for outcome measures in the latter years of the program. As the first DSRIP, California originally set improvement targets based on: (a) improvement over the individual provider's baseline by a set percentage (such as 10 percent); (b) set brackets of improvement toward benchmarks (such as a hospital moving from middle performance to top performance based on benchmarks); and (c) absolute improvement targets regardless of baseline (e.g. zero falls with injury per 1,000 patient days). However, CMS introduced a standardized improvement methodology from Medicare and Medicaid managed care that has been used in all DSRIPs since, and was incorporated into California's program during its mid-point assessment.

The Quality Improvement System for Managed Care (QISMC)[38] sets improvement targets based on closing the gap between baseline and benchmark. The QISMC methodology establishes benchmarks of high performance levels (HPLs; i.e. 85th or 90th percentile), toward which every program must move, and minimum performance levels (MPLs; i.e. 25th percentile), which every program must achieve.[39]

Each state's DSRIP program establishes unique benchmarks for its pay-for-performance measures based on state or national data. Programs also mandate different levels of improvement target setting; for example, Texas providers must close the gap between baseline and HPL by 20 percent by the end of the program, whereas New York providers must close the gap between the prior year's baseline and the HPL by 10 percent each of the last couple of years.

So far, California is the only state with results using this methodology, and uniquely has the experience of comparing the use of QISMC (program Year 4) with the prior methodologies used to determine improvement targets (Year 3).[40] In our interview, the clinical panel of California public hospitals described how the QISMC methodology can be problematic when dealing with measures dependent on a small number of cases, because one patient can dramatically swing results. However, other states using the

QISMC methodology for population-based measures may not experience the same challenges due to larger sample sizes. California also expressed reservations about the ability of reports to capture what it means to miss, meet, or exceed a target from a clinical standpoint.

Reporting Achievement

All DSRIPs require substantial, regular, and prescribed reporting from providers to the state, and from the state to CMS. State DSRIP reporting requirements are shaped by each state's broader Section 1115 demonstration reporting requirements as negotiated by the state and CMS and described in the waiver's special terms and conditions. The goals of reporting are two-fold: (1) to demonstrate improvement and trigger payment; and (2) to derive meaning from the data in order to drive continued performance improvement and determine what works and what does not.

DSRIP Reporting Requirements

The number of measures reported through DSRIP programs is high; some providers are reporting on hundreds of measures to participate in the program. Provider reports trigger incentive payments and allow each state to evaluate progress and initial outcomes. Providers are typically required to report on progress twice a year through a reporting process described in state DSRIP protocols. Provider reports must be approved by the state and sent to CMS. Some DSRIPs— particularly those with large numbers of participating providers—require ongoing monitoring of reporting compliance (further discussed below).

States are required to report on aggregate progress and early findings from DSRIPs and broader waiver activities to CMS quarterly, semi-annually, and/or annually, depending on the terms of each state's Section 1115 demonstration.

Data Infrastructure

While DSRIP investment in electronic data must not duplicate other federal funding,[41] the availability of electronic data was conveyed to be of high importance to success in DSRIPs, due to: (1) the volume and type of reporting involved; and (2) the need to have access to data rapidly and be able to use it to drive improvement. For example, California reported in Year 3 "…sites have demonstrated the capacity to use data to pinpoint areas of noncompliance [with the intervention] and to direct resources to the highest priority areas."[42] One of the largest public hospital systems in the country explained in an interview that it needed a complete overhaul of its data infrastructure in order to be successful in DSRIP. A major New Jersey safety net provider commented that while it has a comprehensive inpatient electronic medical records system, outpatient systems are still in early adoption within the hospital and its provider network, and the two must be connected for a truly successful DSRIP program. Moreover, the sharing of data among providers is imperative; even in DSRIPs that do not mandate it, collaboration among providers is often necessary to achieve the delivery system reforms effectively and/or report on measures.

> *"One big challenge has been reporting. We don't have the infrastructure or technology for some of it. We had to select some projects based on reporting capacity."*
>
> -Texas DSRIP Provider

At the same time, the expansion of electronic systems was communicated to be highly disruptive to DSRIP reporting and projects. While DSRIP requires providers to improve data collection, reporting, and the sophistication of information technology (IT) and quality management practices, the implementation of IT solutions mid-program can result in fluctuating rates as new workflows, data collection, and documentation standards are

deployed. Significant time and resources are needed to make electronic health records (EHRs) functional, which states reported can be an iterative, onerous, and multi-year process. There is also a tension between electronic systems designed to capture data for administrative and billing purposes and the need to demonstrate quality and drive clinical results.

A state's data infrastructure also impacts DSRIP reporting. California notes that the lag time in statewide data limits its use for filtering into DSRIP reports; public hospitals rely on their own data sources and definitions. However, lack of statewide data can result in inability to establish a benchmark required for the QSMIC methodology. Conversely, New Mexico expects to generate information for performance measurement through existing statewide databases rather than collect additional data from the participating hospitals. Evaluators reported wariness in using hospital-generated data, but also were concerned about accuracy in state data sources. States and evaluators related that an all-payer claims database could be beneficial.

Data Collection and Validation

Accuracy of data sources was cited as a common concern, especially when data is generally reported for one purpose, but under DSRIP is needed for clinical/analytical purposes. Comparability also remains problematic; even with standard measures, the details of collecting and validating the measures may vary among providers. Furthermore, standardized measures are under constant flux, as exemplified in California's Year 3 aggregate annual report:

> *"Not until mid-[program Year 3], in January 2013, did national consensus form around the National Quality Forum's standardized methodology for reporting sepsis bundle compliance. However, understanding the need for comparable data year to year and among [public hospital systems (PHSs)], in April 2012, PHSs, along with [the State] and CMS, agreed on using two ICD-9 codes (severe sepsis and septic shock) as a standardized measure. Thus, [Year 3] data is more comparable than [Year 2]. Yet, sepsis has more complexity than those codes, and the fact that PHSs are using various data definitions for reporting other components allows for the learning laboratory for performance measurement initially envisioned in the DSRIP program. Changes … as a result of the Mid Point Assessment, will be implemented in [Year 4] and will further improve comparability."*[43]

Even attempts to correct measurement mid-program may not necessarily reconcile an outdated design of project interventions and data collection and validation practices with new measures of success.

Using Data to Drive Improvement

DSRIPs necessitate the use of data to drive continuous quality improvement, and many DSRIP providers utilize process improvement methodologies. Additionally, DSRIP program participants share successes and setbacks through improvement collaboratives.[44] Some states require providers to participate and may tie funding to participating in collaboratives (i.e. Kansas, Massachusetts, New Jersey, New York, and Texas). In other states, it is not required (i.e. California and Oregon), but may be used as an effective tool for successful DSRIP implementation. In California, for example, DSRIP participating providers established and self-funded learning collaboratives directly as a result of the program.

During the project interview, California underscored the importance of balancing the quantity and quality of reporting; too much data collection can diffuse the ability to focus and potentially leads to a data-rich, information-poor scenario. The state related a need to focus on measures that are actionable and provide meaningful data, and that are accompanied by a narrative to describe what is behind the numbers.

Monitoring and Assessment

As a public program, DSRIP reporting is subject to monitoring for program compliance and potential audits. Later and larger DSRIPs mandate substantial monitoring and assessment activities (e.g. annual and quarterly reports in New York and Oregon). Key aspects include the following:

- *Mid-Point Assessment*: Many states with approved DSRIPs use mid-point assessments as an opportunity to review progress, evaluate provider and state performance so far, and renegotiate waiver terms. To date, only California has completed a mid-point assessment, with changes made to the improvement target setting methodology for pay-for-performance metrics.
- *Independent Assessor*: Many states contract with an independent assessor for a variety of purposes, including reviewing provider DSRIP plans, compiling and submitting regular reports to CMS, and serving as external compliance audit and review entities.

Evaluation of DSRIP Programs

All states are evaluating their DSRIP programs as part of evaluations required for Section 1115 demonstration waivers. States submit evaluation plans to CMS for approval and appoint independent—typically academic—entities to complete interim and final evaluations. Interim evaluations tend to coincide with state applications to renew the waiver/DSRIP program. Final evaluations are generally expected within a year after the DSRIP ends, which in some cases may be prior or close to when final DSRIP program results will be reported.

DSRIP evaluations will assess the efficacy of projects, proportion of milestones/metrics met, and whether improvements were made on measures quantitatively. Evaluations may also qualitatively aim to assess the program's impact on the goals of better care, improved health and lower costs, but generally find difficulty in devising an appropriate methodology, due to factors such as not being able to control for corresponding catalysts such as ACA implementation, compare DSRIP participating providers to a peer group,[45] access comparable data sets within the same timeline, or access pre- / post-DSRIP data for the participating providers. Evaluations are relying on data reported through the DSRIP program, state-level data, key stakeholder interviews and/or provider financial data.

The only interim evaluations are:

(1) Massachusetts reports a metric achievement rate of 95 percent in the first year but little other data.[46]

(2) California's interim evaluation has recently been completed[47] and thus far, reports the following findings:

- A project milestone achievement rate of 99 percent for Years 2-3;

State Snapshot

Mid-Program Results in California

Over the course of DSRIP, California's designated public hospitals have:

- Experienced an average 35.9% decrease in the Central Line-Associated Bloodstream Infection (CLABSI) rate per site in Acute Care Units and an average decrease of 59.7% in the ICU.
- Assigned more than 500,000 patients to a medical home and/or primary care provider
- Entered over one million patients into disease registries for care management purposes*

*California Health Care Safety Net Institute, *Aggregate Public Hospital System Annual Report on California's 1115 Medicaid Waiver's Delivery System Reform Incentive Program, Demonstration Year 7* (California Health Care Safety Net Institute, 2013). Available at: http://www.dhcs.ca.gov/Documents/DSRIP%20DY%207%20Aggregate%20Pub%20Hosp%20System%20Annual%20Report.pdf

- Related to the three CMS strategic goals, designated public hospitals reported higher impact on quality outcomes, but perceived a lower impact on cost;
- Hospitals reported that DSRIP led to systematic and major change;
- DSRIP is pushing the public hospitals to accelerate their building of EHRs systematically throughout the entire hospital system (inpatient and outpatient);
- The infusion of funds into the public hospitals served as an impetus to put measures in place and mobilize the organization to implement the projects; and
- The projects selected were generally consistent with hospital strategies, but DSRIP allowed these projects to be expanded across the system.

Finally, though Texas has not yet completed an evaluation, the state released some preliminary findings that reflect the ongoing development of the RHP structure. Evaluators have found increased collaboration among providers participating in RHPs on activities that improved access to care and services provided to disadvantaged populations.[48]

> *"DSRIP really brought everyone out of day-to-day survival mode and how to make costs work to an open table about healthy communities about helping everyone in the community."*
> -Texas DSRIP Provider

Ultimately, CMS will evaluate DSRIP as a tool to support the ability of Section 1115 demonstrations to transform care delivery processes. Although the specific DSRIP goals differ across states, there is a consistent theme of creating incentives to improve care for beneficiaries across systems.

KEY TAKEAWAYS

Given the purpose and genesis of DSRIP programs, it is critical to consider the key takeaways of this analysis with broader delivery system reform strategies and the role of supplemental payments. With the oldest DSRIP program now only in its fifth year, it is challenging to create a definitive list of “lessons learned.” However the following key themes emerged from interviews and site visits:

1. **While states view DSRIP programs as a way to preserve supplemental payments, CMS describes the primary purpose of DSRIPs as catalyzing delivery system transformation.**

   Although CMS describes DSRIP as a tool primarily intended to assist states in transforming their delivery systems to fundamentally improve care for beneficiaries, states have been candid that DSRIP programs have been pursued as a means to preserve hospital supplemental funding; with the introduction of DSRIP, states shift from a system where supplemental funding was designed to make up for Medicaid payment shortfalls toward a system where funding is earned when quality and improvement goals designed to support system transformation are met. The shift has been significant and continues to evolve.

   The relationship between DSRIP and supplemental payments is complicated and evolving, and extends to UC pools, which reimburse providers for uninsured care and Medicaid payment shortfalls and are viewed as another mechanism to sustain safety net systems. The linkage between UC pools and DSRIPs vary, with some operating as a subset of these pools, while others operate separately but tie increased DSRIP funding to decreased uncompensated care pool funding. Massachusetts, for instance, is required to assess the interplay between recent coverage expansions and future provider financing given uninsured care and Medicaid shortfall scenarios. Subsequently, the state must submit a report on how its program will look in the future. CMS views the future of DSRIP and uncompensated care pools as two distinct issues and plans to increasingly treat them separately. CMS noted that the expansion of health care coverage will influence the future of uncompensated care pools, and although DSRIPs do impact uncompensated care pools, they are not intended to be a vehicle to finance the safety net.

2. **DSRIP is not “one size fits all;” programs share common traits but vary based on state goals and needs for system transformation to improve outcomes for Medicaid beneficiaries, as well as federal and state negotiations.**

   Overall, DSRIPs were launched to improve care delivery for low-income uninsured and Medicaid beneficiaries and transform health systems. The DSRIP framework is explicitly based on the CMS strategic goals of better care, improved health, and lower costs. The basis for system transformation is to move away from episodic treatment to population health management—in other words, keeping people healthy and out of the hospital.

   As DSRIPs multiply and evolve, states typically look to the most recently approved state program for guidance on favored CMS policies; repeatedly, DSRIP states and providers note that they are “flying the plane, while building it.” Significant negotiation occurs between states and CMS on Section 1115 demonstration waivers generally, but also specific to DSRIPs, with core negotiation areas including funding, timeframe, types and number of eligible providers, and metrics. These are the key areas where DSRIPs differ from state to state. For example: (1) certain states attract funding above prior supplemental payments, while others receive level funding; (2) most states receive a five-year DSRIP

approval, while Oregon's program is two years; (3) eligible providers range from all hospitals in the state to only safety net hospitals to coalitions of providers; and (4) certain states work with hospitals to localize DSRIP project and metrics, while others use standardized projects and metrics statewide. States and CMS agree that DSRIPs should be individualized in order to propel and accelerate state efforts to improve care to Medicaid beneficiaries, reward value over volume, and move toward a more preventive, accountable model of care. With this understanding in mind, CMS plans to maintain the flexibility needed to continue to address state proposals individually and does not plan to issue formal guidance on DSRIP.

3. **While DSRIP policy is not one-size-fits all, as DSRIPs evolve, there is an increasing emphasis on standardizing metrics to demonstrate real improvements**.

   As DSRIPs shift over time, measuring performance is increasingly prescriptive, with DSRIPs seeking pre-defined outcome targets rather than providers defining improvement goals based on their facilities and patients. With these changes, DSRIPs gain the ability to compare and contrast results across providers and, potentially, across states. While recognizing the concern that the design of DSRIPs respect local nuance, flexibility, and innovation for projects to achieve improvements, DSRIPs must be able to demonstrate outcomes and ensure accountability for allocated funding, thus CMS' emphasis on ensuring accountability based on a parsimonious sets of metrics. This is particularly challenging in attempting to support innovation in areas where metrics may not yet be available. The outcomes DSRIPs measure may not be the best indicators of program success due to a lack of statewide, standardized metrics that accurately reflect progress in all facets of delivery system transformation. For example, a clinical panel across California's public hospitals reported that DSRIP has been instrumental in cultural transformation and making a real impact that is not completely captured in DSRIP metrics; in fact, one University of California health system official said that DSRIP has been the most important change agent in the organization.

4. **DSRIPs increase accountability for outcomes over the course of implementation.**

   Whereas prior supplemental payments were by and large distributed to providers based on their payer mix, DSRIP payments are made only after improvements are planned, executed, and achieved. DSRIP programs generally provide more funding for process and infrastructure improvements in earlier years, as they are necessary to achieve clinical improvements in later years. Distribution of funding formulas reflect this shift and increasingly allocate funding towards achieving improved clinical outcomes as DSRIP programs progress, while maintaining maximum valuation directly proportional to the number of Medicaid beneficiaries served. This makes incentive payments more challenging to attain; in all states, the bar rises over time.

5. **DSRIPs provide continued support for public and safety net hospitals via an incentive-based program; however, certain states have expanded DSRIP participants beyond hospitals.**

   Many states, and providers, have considered DSRIPs to be primarily targeted for public hospitals because DSRIP replaces supplemental payments that previously primarily supported hospitals that encountered a large share of Medicaid payment shortfalls given their payer mix. As a result, certain states exclusively focus DSRIP on safety net hospitals; however, others focus more broadly on safety net providers (e.g., outpatient clinics), and still others make DSRIP available to a host of health care organizations (e.g. mental health organizations). This reinforces conflicting perceptions among stakeholders regarding the goals of DSRIP; specifically whether the intent of DSRIP is to stimulate delivery system reform for all providers or to stabilize the safety net. It remains to be seen what

impact this approach has on safety net providers and how it continues to evolve, but it is necessary to monitor in order to evaluate safety net stability.

6. **DSRIP enables states to redesign hospital payment strategies to align with broader delivery system reform goals, thus supporting transition costs for the design of new systems.**

DSRIPs can complement other health system transformations within the state's Medicaid system, including managed care expansion, payment reform, coverage expansion, and other aspects of delivery system reform. DSRIP programs can help to catalyze community-based collaboration and increase providers' ability to take responsibility for the health of the populations served. In Massachusetts, the program worked to establish a provider-based ACO and proposed an accountable care framework as part of its renewed Section 1115 demonstration waiver. In New York, DSRIP established accountable-care-like networks, and in Texas, participants report that DSRIP has broken down barriers between providers that were previously competitors. Going forward, several participants raised DSRIP collaboration with Medicaid managed care plans as one potential reform strategy. Additionally, population health has become a greater focus with pay-for-performance metrics examining broader population health outside of hospital walls.

> *"We realized very early on that our DSRIP project is a population health project. We realized we needed to do everything we can to keep low-income patients healthy and that's the focus."*
> -New Jersey DSRIP Provider

7. **DSRIP implementation is resource intensive for states, providers, and the federal government.**

States, providers, and federal officials suggest that DSRIP accountability has produced results, but also created significant administrative burden. Most states have increased staff/consulting capacity and expertise in clinical quality and performance improvement; after DSRIP, California's Department of Health Care Services appointed the first-ever medical director to oversee quality in Medicaid, including DSRIP. Texas Health & Human Services Commission dedicated an additional 13 FTEs to support the administration of DSRIP alone. Providers, too, report adding staff/contractor time to successfully implement projects, comply with DSRIP reporting, and address data and technology limitations. CMS notes that the administration is challenging and requires the agency to think carefully about the desired number of DSRIPs, but the unique level of detailed reporting is important considering the investment. While participants understand the value of DSRIP reporting, they question whether there may be an equally valuable, but less resource intensive approach.

> *"[It's a] very labor intensive process. It's far more labor intensive than we were able to fathom when it first rolled out."*
>
> -California Medicaid Official

8. **States are challenged to produce a source for the non-federal share of DSRIP funding.**

DSRIP payments require a non-federal/state share that can be funded by sources such as state general revenue funds, provider taxes, or IGTs. Stakeholders noted that finding a source of non-federal share is difficult for states, and presents a host of complications (political, technical, and financial). States report federal inconsistency on policies such as DSHP and IGTs, which have been vehicles for the state non-federal share. In many states, the provision of the non-federal share is intricately connected to which participants qualify for DSRIP and can create scenarios where non-public providers go "shopping for IGTs" in order to participate. Furthermore, the entity providing the non-federal share is financially

and politically impacted and, in some cases, may net fewer DSRIP incentive payments than a privately-owned health care provider for comparable work.

9. **While lacking comprehensive DSRIP evaluation data, there are multiple examples of quality improvement and care delivery redesign.**

   Since DSRIP programs are relatively new and vary significantly in details, it is not yet possible to determine the efficacy of specific financing policies. Broadly, however, states with more mature DSRIPs report that significant improvements in care have been achieved for low-income (Medicaid and uninsured) patients, and that most likely these improvements would not have been achieved at comparable scale, speed, and success without the impetus of earning the accompanying DSRIP funding. For example, Texas Medicaid providers report the ability, via DSRIP, to provide services unreimbursed by their state's Medicaid program and note the care improvements made as a result of these investments.

10. **States and providers are concerned about the timeframe for DSRIP implementation and evaluation, demonstration of results for Medicaid beneficiaries, and the impact on waiver renewal requests.**

    All DSRIP implementation timeframes (post planning) are five years or less and, just recently, CMS approved the first DSRIP renewal (in October 2014, CMS approved Massachusetts's DSTI program for an additional three years). Providers expressed concern about upcoming renewal requests and the continuation and evolution of DSRIP. While these renewals should be informed by the program results and evaluation, both have shortcomings.

    First, DSRIP implementation only commences after a significant amount of time has been spent on program development, project planning, and startup. For example, Massachusetts providers received CMS approval of DSRIP projects nearly a full year into a three-year waiver, allowing only the latter two years for actual transformation work; this experience is shared among states.

    Second, state and provider interviewees noted that real transformation requires additional time, and that DSRIP programs are relatively short compared to the time needed to transform a system. In contrast, CMS noted that five years should be sufficient time for DSRIP implementation; officials do not view DSRIP as a long-term sustainable solution without addressing underlying care delivery issues in states. The agency is actively processing information from DSRIPs to identify their value and return on investment.

    Last, only New York's DSRIP was explicitly designed to be a one-time investment. While states and providers reported that some reforms are sustainable after an initial DSRIP (i.e. certain one-time investments in infrastructure), others are not (e.g. paying for aspects of better care not reimbursed under Medicaid). Some states see a continued need for such investment in transformation, as a DSRIP renewal or alternative arrangement, and are concerned that renewal requests precede the conclusion of the program, which means that final program results and evaluation data are not available. CMS points out that DSRIP is a demonstration. As such, it is not intended to serve as the mechanism for Medicaid delivery reforms long term, but rather to identify ways to better operate the Medicaid program going forward.

CONCLUSION

DSRIP programs can only be considered in their infancy; the oldest DSRIP program is just in its fifth year. There is wide variability across the eight states in their design, financing, and measurement. Nonetheless, they share two common goals of transforming the delivery system to meet the goals of better care, improved health, and lower costs; and incentivizing system transformation and quality improvements in hospitals and other providers that serve high volumes of low-income patients. In many states, they are also seen as a mechanism to preserve supplemental payments for safety net hospitals. The specifics of DSRIP financing policies, and the milestones and metrics for determining impact, are complex and evolving. As DSRIP programs continue to mature and evolve, it will be critical to evaluate their impact on state Medicaid and broader delivery system reforms, and on safety net providers.

ENDNOTES

1 As further described below, the framework put forth by CMS for the DSRIP is based on the Institute for Healthcare Improvement's (IHI's) "Triple Aim" goals of better care, lower costs, and better health. At the time of the creation of the first DSRIP, CMS was led by Dr. Donald Berwick, former head of IHI.

2 Many DSRIP programs repurpose prior supplemental payments to hospitals; Texas also included prior supplemental payments to other providers in its DSRIP pool.

3 While Florida includes a program similar to these states in its Section 1115 demonstration, Florida's program did not meet the criteria for this project due to its payment mechanism.

4 NASHP did not develop a fact sheet for Kansas, given the early stage of implementation and lack of available information.

5 Massachusetts' DSTI is the only program completed. The first round of DSTI was for three years and the next round has recently been renewed for an additional three years.

6 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 participate in California's DSRIP.

7 A prior waiver limited uncompensated care to costs and was set at a level that was below what the public hospitals felt was sustainable.

8 Julia Paradise, *Medicaid Moving Forward* (The Henry J. Kaiser Family Foundation, 2015). Available at: http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/

9 42 CFR 438.60

10 Aaron McKethan and Joel Menges, *Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion* (The Lewin Group, 2006). Available at: http://www.lewin.com/~/media/lewin/site_sections/publications/upl.pdf

11 Under a capitated managed care delivery system, supplemental provider payments directed at a particular provider are not permitted because of federal regulations that require managed care rates to account for the full cost of services under a managed care contract (42 CFR 438.60). While capitated Medicaid managed care organizations can spend up to 5 percent of their capitation rate on performance-based incentive payments to providers (42 CFR 438.6(c)(5)(iii)), states cannot direct these payments in the same manner that they can direct UPL payments.

12 The Centers for Medicare & Medicaid Services. "Section 1115 Demonstrations." Retrieved March 17, 2015. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html

13 Private providers play an important role in the Texas DSRIP program. A significant number of private hospitals are participating due to the state's system transformation goals and inclusion of private providers in the state's previous UPL program.

14 Two states, New York and Oregon, have not yet approved participating providers.

15 In New York, a PPS can be comprised of hundreds or thousands of health care organizations that are collectively responsible for an attributed population and for implementing projects to improve care for that population. In Texas, an RHP forms administratively in a geographic region of Medicaid providers who are individually responsible for their

own patients and their own DSRIP projects.

16 To watch a video overview of this program, please visit: http://texasregion7rhp.net. For more information on the Community Care Collaborative, please see: http://communitycarecollaborative.net.

17 DSRIPs are prohibited from paying for capital improvements, EHRs, housing, other services directed at social determinants of health.

18 Lisa Kirsch and Ardas Khalsa. "Texas Healthcare Transformation and Quality Improvement Program Waiver." Presented at the Texas DSRIP Learning Collaborative Summit on September 9, 2014. Retrieved March 17, 2015. Available at: http://www.hhsc.state.tx.us/1115-docs/DSRIP-summit/DSRIPSuccess.pdf

19 New York State Department of Health. "Redesigning New York's Medicaid Program." Retreived March 17, 2015. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/

20 For more information, see: http://www.alamedahealthsystem.org/about-us/news-press/news/hope-center-clinic-serves-super-users

21 California Association of Public Hospitals and Health Systems, Leading the Way: California's Delivery System Reform Incentive Program (DSRIP) (The California Association of Public Hospitals and Health Systems, 2014). Available at: http://caph.org/wp-content/uploads/2014/09/Leading-the-Way-CA-DSRIP-Brief-September-2014-FINAL.pdf For the full video, see: https://www.youtube.com/watch?v=zHyJ4DC8zdk.

22 Providers in New Jersey had the option of formulating their own project within existing clinical areas or in a new clinical area that was unique to their population.

23 The Center for Medicare & Medicaid Innovation within CMS has provided two rounds of State Innovation Model awards to support states as they develop and test new multi-payer delivery models that support Medicaid and CHIP beneficiaries. States receiving a SIM Design award are supported through the process of developing a delivery system transformation plan while states that receive a SIM Testing award are supported as they implement a new delivery system model. More information is available at: http://innovation.cms.gov/initiatives/state-innovations/

24 A Section 1115 demonstration must be budget neutral, meaning it cannot cost the federal government more than what would have otherwise been spent absent the waiver.

25 In New York, unlike in other DSRIPs, there is emergency relief funding for distressed hospitals to enable them to participate in DSRIP (up to $1 billion total, with a maximum of $500 million in federal funds) as well as DSRIP Design Grant funding (up to $200 million total, with a maximum of $100 million in federal funds) to support participating providers in forming provider networks and developing DSRIP plans.

26 California's DSRIP program, as the first of its kind, did not include funding for planning, nor do the DSRIP-like programs in New Mexico and Oregon.

27 This report uses each state's DSRIP program's individual definition of pay-for-performance, but that these definitions are not necessarily the same across states. Certain states may define pay-for-performance as payment for improvement in clinical outcomes and potentially preventable events; while other states may also provide performance payments for process improvements as well. This makes like-comparisons difficult.

28 For further details, please see http://aspe.hhs.gov/health/fmap.cfm.

29 Under §1905 (cc) of the Social Security Act, amended under the ACA, states are not allowed to require increased participation from political subdivisions.

30 Entities supplying IGT for DSRIP and participating in DSRIP project implementation only benefit from FFP

and not the full incentive payment. However, these providers typically find the ability to draw down FFP only is still advantageous.

31 Provider-related donations address certain types of public-private financing arrangements, and CMS has provided guidance to states on allowable and unallowable use of provider-related donations. Federal regulations at 42 Code of Federal Regulations (CFR) 433.52, which implement section 1903(w) of the Social Security Act, define a provider-related donation as "a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a state or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the state for administration of the state's Medicaid plan." As part of a program Year 2 financial and management review of Texas' funding pools, CMS has raised concerns about possible provider-related donations, which may affect DSRIP payments made to certain private providers. The State of Texas, the affected providers and CMS are working on those issues currently.

32 In DSRIPs, potentially preventable events encompass avoidable hospital use (admissions, readmissions and Emergency Department visits) as well as hospital-acquired complications/conditions and adverse events.

33 The definition of which ranges across states from prevention (e.g., California) to public health measures (e.g., New York).

34 Such as NCQA's Antidepressant Medication Management measure

35 The Texas DSRIP program requires at least either three process/access pay-for-performance measures or one clinical outcome/potentially preventable event/patient experience measure per delivery system reform project.

36 New Jersey and CMS have subsequently updated the list of approved DSRIP metrics for pediatric asthma projects in New Jersey.

37 Defined as patients who have visited the system's primary care clinic(s) at least twice in the past year.

38 Historically, CMS – at the time known as the Health Care Financing Administration (HCFA) – used to review managed care plans on structural standards that looked at a plan's infrastructure and capacity to improve care, as opposed to looking at whether the plan actually improved care. To demand more accountability within Medicare and Medicaid, HCFA working though NASHP in consultation with State Medicaid agencies and regulators, quality measurement experts, managed care plans and beneficiary groups to develop QISMC in the late 1990s.

39 As a simple example, if the provider's baseline rate for hemoglobin (Hb) A1c control is 50 percent and the benchmark (90th percentile) is 80 percent, then the gap is 30 percent (80% - 50%). The provider's improvement target is to close the gap by 10 percent, in other words improve HbA1c control by 3 percent (30% * 10%) over the baseline, or achieve 53 percent (50% + 3%) for HbA1c control.

40 Texas has only reported baseline rates, and other states have not yet reported baselines. DYs 4-5 in Texas will utilize QISMC methodology; the first report in DY4 for TX is April 2015.

41 DSRIPs may provide funding for HIT infrastructure but may not duplicate federal funding provided by the Medicaid EHR Incentive Program established through the Recovery Act/HITECH Act of 2009.

42 California Health Care Safety Net Institute, *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, 2013). Available at: http://www.dhcs.ca.gov/Documents/DSRIP%20DY%207%20Aggregate%20Pub%20Hosp%20System%20Annual%20Report.pdf

43 Ibid. p. 12.

44 Institute for Healthcare Improvement, *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement* (The Institute for Healthcare Improvement, 2003). Available at: http://www.ihi.org/resources/Pages/

IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

45 The evaluators of Oregon's DSRIP-like Hospital Transformation Performance Program (HTPP) program are planning to include comparisons between participating hospitals and non-participating hospitals on Coordinated Care Organization (CCO) metrics to see how HTPP is affecting CCO performance. No other state has yet to identify a comparable peer group.

46 Teresa Anderson et al., *MassHealth Section 1115(a) Demonstration Waiver 2011-2014 Interim Evaluation Report* (The University of Massachusetts Medical School (UMMS) Center for Health Policy and Research, 2013). Available at: http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/appendix-b-interim-evaluation-of-the-demonstration-09-2013.pdf

47 Nadereh Pourat et al., *Interim Evaluation Report on California's Delivery System Reform Incentive Payments (DSRIP) Program* (UCLA Center for Health Policy Research, 2014). Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCDSRIP.PDF

48 Monica L. Wendel and Liza M. Creel. "Evaluation of the Texas Healthcare Transformation and Quality Improvement Program: 1115(a) Medicaid Demonstration Waiver." Presented at the Texas Statewide Learning Collaborative Summit on September 10, 2014. Retrieved March 17, 2014. Available at: https://www.hhsc.state.tx.us/1115-docs/DSRIP-summit/WaiverEvaluation.pdf

Appendix

State Fact Sheets

The information presented in the following fact sheets summarizes NASHP's understanding of the DSRIP and DSRIP-like programs in California, Texas, Massachusetts, New Mexico, New Jersey, New York, and Oregon as of March 2015. They appear in chronological order of waiver approval. NASHP compiled this information from a variety of sources, including the Special Terms and Conditions and attachments of each state's Section 1115 demonstration waiver; available aggregate reports, evaluation plans, resources available on state websites, and information collected during interviews. For purposes of state-to-state comparison, each DSRIP program year begins with "Year 1," though states may refer to DSRIP years in terms of waiver demonstration years. Furthermore, the amounts provided in the following fact sheets are estimates based on an analysis of figures provided in each state's 1115 demonstration waiver. As with all DSRIP programs, funding is contingent upon: (1) the achievement of milestones, metrics, reporting and outcomes (in most cases, though some funding is for planning and administration); and (2) the provision of the non-federal share. Unless otherwise noted, all funding estimates (e.g. average project funding per year) are based on the STCs and total dollars allocated (gross total computable allocation, not net incentive payments received). Finally, the current FMAP is provided in each state although this number may have fluctuated in past years.

California

General Program Information and Context

California's 2010 Section 1115 demonstration renewal, known as the Bridge to Reform, created a Low Income Health Program (LIHP) to provide coverage through the end of 2013 for adults in certain counties who would be eligible under ACA coverage options come 2014; expanded the state's Safety Net Care Pool (including creation of the first DSRIP program); expanded the Medicaid ("Medi-Cal") managed care program to new populations; and provided state budget relief. The DSRIP in particular seeks to drive system transformation by providing support for infrastructure and quality improvements while bolstering the safety net for designated public hospitals (DPH) serving large numbers of Medi-Cal enrollees and uninsured Californians.

Under DSRIP, each of California's DPHs is undertaking several system transformation projects aimed at becoming an integrated delivery system. Each hospital system is required to undertake projects in each of 4 Categories (with an optional 5th Category - HIV Transition - added as a modification to the waiver), with significant flexibility for participants to tailor projects to meet local needs and goals.

General Information	**Program Length**	5 years
	Stage of Implementation	Year 5
	Date Submitted to CMS	6/3/2010
	Date Approved by CMS	11/1/2010
	Date Expires	10/31/2015
Funding	**Maximum Potential Pool Funding (federal)**	$3,336,000,000
	Maximum Potential Pool Funding (all funds)	$6,671,000,000
	Current FMAP	50.00%
	Source Of Matching Funds (Non-Federal)	IGT (provided by the designated public hospitals)
	Average Funding Available Per Year	$1.3 billion
	Relation of Total Funding to Prior Supplemental Payments	Exceeds prior supplemental payments
	Total Distribution of Payments	California does not include funding for planning. More funding is allotted to implementation milestones in earlier years, which decreases over time as funding is increasingly allotted to pay-for-reporting of population health measures and pay-for-performance of reduced hospital-acquired infections.
Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	Yes, total amount of UC pool is $8,050,508,827
	Corresponding Designated State Health Program (DSHP)	Yes, total limit of DSHP is $4,000,000,000; DSHP allocation is a percent of the UC pool. The state doesn't necessarily spend all of this money each year.

Providers	**Participating Providers**	All 21 designated public hospitals (DPHs) are participating (including 17 health systems).
Projects Being Funded	**DSRIP Project Domains**	Projects are identified within each of five categories (Categories 1-4 are required): • Category 1: Infrastructure Development • Category 2: Innovation and Redesign • Category 3: Population-focused Improvement • Category 4: Urgent Improvement in Care • Category 5: HIV Transition Projects
	Project Funding Per Year	Average project funding per year is $3.4 million.
	Approved Projects	388
	Minimum Number of Projects Required	A minimum of 12 projects are required per DSRIP plan (15 if participating in Category 5): • Category 1: minimum of 2 projects • Category 2: minimum of 2 projects • Category 3: 4 "projects": all must report all measures (70) across 4 domains[1] • Category 4: 4 projects: all must improve on 2 required projects and select 2 additional projects[2] • Category 5: participation in Category 5 optional; if participating, must select 3 projects No maximum requirements (except for Category 5, no more than 3 projects)
	Process for Reallocating Unused Funds	For Categories 1, 2, 4 and 5, DPHs are permitted partial payment for partial achievement of a milestone in 25% increments (i.e., if a milestone is 30% achieved, the DPH can receive 25% of the payment). For Categories 1, 2, 4 and 5, DPHs are permitted to carry forward a milestone and the associated payment for up to one DY. If a DPH is unable to meet a milestone in categories 1 or 2, they are able to submit additional project proposals to claim up to 90% of any remaining unclaimed funds for those milestones as part of a 90-day process. Categories 4 and 5 are not subject to this penalty. If the DPH is unable to propose sufficient additional milestones, the unclaimed funding becomes available to the other DPHs for additional milestones. For Category 3, DPHs may claim partial payment within the reporting year; however, they are unable to carry forward unclaimed funds for partial achievement. All remaining unclaimed funding will either remain unclaimed or be rolled into the Safety Net Care Pool, with CMS approval.
	Additional Funded Program Elements	Additional design elements are not required in CA, unless the DPH is participating in Category 5, which requires each plan to include activities related to shared learning. DSRIP requires the state to report each year on shared learning activities that occur. Additionally, the CA Health Care Safety Net Institute (SNI) provided learning collaboratives specifically for the DSRIP in which DPHs participated and partially funded at their option.

Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	Hospital safety measures are used for pay-for-performance except for measures where evidence is lacking in linking the process improvement to outcome improvement.
	Metrics and Benchmarked Improvement Targets	The improvement methodology is a combination of improvement over self and the Quality Improvement System for Managed Care (QISMC) methodology of closing the gap between baseline and benchmark.
	Denominator for Improvement	Denominators are specific to each participating health system. There is no attribution methodology utilized, since all denominators do not exceed the DPH's patient population and the DPHs tend to cover distinct geographic areas.
	Statewide Accountability Test	N/A for DSRIP
Reporting & Monitoring	**Provider Reporting**	DPHs are required to submit three reports to the state for review each year (two semi-annual reports and one annual report). DPHs are required to submit data on each milestone in addition to a narrative description of overall project implementation. Reports also must include a narrative on how projects contributed to system reform for the populations served as well as any shared learning that took place.
	State Reporting	The state must submit an annual aggregate report on DSRIP to CMS, which must include elements such as a description of progress made, metric reporting, outcome data, and shared learning activities that occurred. The state engaged SNI to conduct this report annually.
	Mid-Point Assessment Process	A mid-point assessment of DSRIP occurred in Year 3 that reviewed progress in each category. This process has occurred and was finalized, resulting in changes to the DSRIP protocols that apply to Years 4-5 of Category 4.
	Program Evaluation	UCLA Center for Health Policy Research is evaluating California's DSRIP. The goals of the evaluation are to assess DSRIP projects based on program requirements and milestones. In the interim evaluation hospitals reported that DSRIP has had a high impact on quality and outcomes but a lower impact on costs. Hospitals also reported that DSRIP led to systematic changes and new collaborations.
	External Audit/Review	Not required.

Texas

General Program Information and Context

The Texas Delivery System Reform Incentive Payment (DSRIP) program is part of the state's Healthcare Transformation and Quality Improvement Program Section 1115 demonstration. The major components of the waiver include the statewide expansion of Medicaid managed care and the development of two funding pools that support providers for delivering uncompensated care and for implementing delivery system reforms: the Uncompensated Care (UC) Pool and the DSRIP Pool. Savings generated from the managed care expansion, in addition to preserving prior supplemental payments to hospitals (Upper Payment Limit funding) under a new methodology, allow the state to maintain budget neutrality and establish the UC and DSRIP pools.

DSRIP incentivizes both hospital and non-hospital providers to implement multi-year projects that enhance access to health care, quality of care, experience of care, and the health-care system, with target populations including 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 other local governmental entity. Intergovernmental transfers (IGTs) from public entities such as hospital districts, counties, state-funded medical schools and community mental health centers finance the non-federal share of DSRIP.

General Information	**Program Length**	5 years
	Stage of Implementation	Year 4
	Date Submitted to CMS	7/12/2011
	Date Approved by CMS	12/12/2011
	Date DSRIP protocols approved	10/1/2012 (initial approval); 5/21/2014 (latest protocol modifications)
	Date Expires	9/30/2016
Funding	**Maximum Potential Pool Funding (federal)**	$6,646,000,000
	Maximum Potential Pool Funding (all funds)	$11,418,000,000
	Current FMAP	58.05%
	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.
	Average Funding Available Per Year	Available DSRIP funding fluctuates per year but averages about $2.28 billion per year.
	Relation of Total Funding to Prior Supplemental Payments	The $29 billion total DSRIP and UC pool funding exceeds prior supplemental payments (UPL funding). In FFY 2010, Texas made about $2.86 billion in UPL supplemental payments, according to CMS-64 data.
	Total Estimated Distribution of Payments	Funding was initially distributed to Regional Health Partnerships (RHP) based on the intensity of their Medicaid and low-income patient care. In Year 1 only, funding was available for submission of RHP Plans. Year 1 funding was based on the value of the DSRIP Category 1-4 projects (DY 2 – DY 5). Over the course of the remaining four years, funding for categories 1 and 2 decreases from no more than 85%, to no more than 75%. Category 3 funding increases from at least 10% to at least 15% and category 4 funding increases from at least 5% to at least 10%. Funding percentage requirements were applied to each provider at the time of plan submission.

Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	Yes, maximum UC pool funding is $17,582,000,000 over 5 years
	Corresponding Designated State Health Program (DSHP)	No
Providers	**Participating Providers**	A total of 309 providers were participating in DSRIP as of October 2014. Performing providers are hospitals and other eligible providers, including community mental health centers, local health departments, physician practice plans affiliated with an academic health science center, and other providers specifically approved by the state and CMS.
Projects Being Funded	**DSRIP Project Domains**	1. Infrastructure development 2. Program Innovation and Redesign 3. Quality Improvement 4. Population focused improvements
	Project Funding Per Year	Average project funding per year is $150,000.
	Process for Reallocating Unused Funds	Partial payment is only available for P4P Category 3 outcomes in 25% increments. Category 1 and 2 metrics must be fully achieved for payment and all measures within each Category 4 domain must be reported for payment. 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 DY2 funding was forfeited.
	Number of Approved Projects	1,491 projects have been approved and are active as of October 2014.
	Minimum Number of Projects Required	RHPs must select a minimum number of projects from Categories 1 and 2 (which all RHPs have exceeded). The minimum number of required projects varies for each RHP based on the volume of low-income patients they serve. RHPs serving the highest volume of low-income patients must select a minimum of 20 projects from Categories 1 and 2 while RHPs serving the lowest volumes of low-income patients must select a minimum of 4 projects from categories 1 and 2. A minimum level of participation by safety net hospitals and private hospitals was also required in order to be eligible to earn the RHP's full initial allocation.
	Additional Funded Program Elements	RHPs must participate in annual statewide learning collaboratives in Years 3-5. The first statewide learning collaborative was held in September 2014. In addition to statewide learning collaboratives, performing providers are also strongly encouraged to form regional learning collaboratives. Almost all RHPs are required to provide learning collaboratives.

Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	Quality Improvement outcomes are largely pay-for-performance. Additionally, Category 3 outcomes are divided into "standalone" clinical outcomes and "non-standalone" process outcomes. Projects must include at least one standalone measure (i.e. clinical outcome-focused measure) or at least three non-standalone measures (i.e. process measure).
	Metrics and Benchmarked Improvement Targets	The improvement methodology is a combination of improvement over self and the Quality Improvement System for Managed Care (QISMC) methodology of closing the gap between baseline and benchmark. Minimum Category 3 Requirements: Providers can either select a standalone measure, a non-standalone measure with a standalone measure, or at least 3 non-standalone measures.
	Denominator for Improvement	Category 3 outcome measures are based on evidence-based and/or endorsed quality measures and must be reported based on approved measure specifications as outlined in the project menu; these denominators are generally broader than the project intervention population. With approval from HHSC, performing providers may narrow the denominator based on one or more of the following factors: payer (Medicaid, Uninsured or both), gender, age, co-morbid condition, facility where services are delivered and race/ethnicity.
	Statewide Accountability Test	There is no statewide accountability test.
Reporting & Monitoring	**Provider Reporting**	In Year 1, RHPs must submit a state-approved RHP plan to CMS for the performing providers within that RHP to receive payment. In Years 2-5, providers report on project progress twice a year for payment. In addition to reporting for payment, each RHP anchor must submit an annual report in Years 2-5.
	State Reporting	The state must report quarterly and annually on DSRIP to CMS. DSRIP reporting is a component of the state's quarterly and annual waiver reporting requirements.
	Mid-Point Assessment Process	By early 2015, an independent assessor will work with HHSC to complete a mid-point assessment of RHPs. The mid-point assessment results could lead to modification of certain DSRIP projects and or/metrics to support successful implementation in later years of the current waiver period.
	Program Evaluation	The evaluation of the Texas Section 1115 demonstration is divided by the two distinct interventions: expansion of Medicaid managed care and RHP formation. The Strategic Decision Support unit of HHSC oversees the entire evaluation and specifically conducts the evaluation of intervention 1, managed care expansion. Texas A&M leads the evaluation of DSRIP.
	External Audit/Review	Texas is contracting with an independent assessor, Myers & Stauffer LC, to conduct the mid-point assessment and for ongoing compliance monitoring.

Massachusetts

General Program Information and Context

In 2006, Massachusetts dramatically shifted use of its Uncompensated Care Pool to combine it with funding previously used to support supplemental payments, creating the Safety Net Care Pool (SNCP). The SNCP continued to support uncompensated care payments to providers but also redirected a significant portion of funding to purchasing insurance coverage for low income individuals as part of Massachusetts' landmark state health care reform law that expanded access to affordable health care, which ultimately achieved near-universal coverage in the state. In its 2011-2014 Section 1115 demonstration waiver, changes to Massachusetts' SNCP continued, as the new DSTI program was created under the SNCP.

In Massachusetts, DSTI supports investments to promote delivery system and payment transformation within seven safety net hospital systems. DSTI initiatives were designed to provide incentive payments to support investments in eligible safety net health care delivery systems for projects that advance the CMS strategic goals of improving the quality of care, improving the health of populations and enhancing access to health care, and reducing the per-capita costs of health care. In addition, DSTI payments support initiatives that promote payment reform and the movement away from fee-for-service payments and toward alternative payment arrangements that reward high-quality, efficient, and integrated systems of care.

Massachusetts recently reached agreement with CMS on renewal of its Section 1115 demonstration waiver; this agreement includes continuation of DSTI for the first three years of the five-year waiver. Generally, it is expected that the renewed DSTI will follow a similar format to the initial DSTI, with increased requirements for participating hospital systems to demonstrate improvement on health outcome and quality measures; however, the renewal DSTI protocol and design have not yet been approved by CMS.

		Initial DSTI	Renewed DSTI
General Information	**Program Length**	3 years (7/1/11 – 6/30/14)	3 years (7/1/14 – 6/30/17)
	Stage of Implementation	Completed 6/30/14	Currently in Year 1 of a 3-year renewal period
	Date Submitted to CMS	Waiver submitted on 6/30/2010	Waiver extension submitted on 9/30/2013
	Date Approved by CMS	Waiver approved 12/20/2011. DSTI Master plan approved May 2012; Hospital projects approved June 2012.	Waiver approved 10/30/2014 Master plan approval pending; Hospital plan approvals pending.
	Date Expires	Initial DSTI completed on 6/30/2014; MA Section 1115 demonstration extended through October 30, 2014 during Massachusetts' negotiation with CMS.	6/30/2019 (current authorization for DSTI expires 6/30/17)

		Initial DSTI	Renewed DSTI
Funding	**Maximum Potential Pool Funding (Federal Funds)**	$314,000,000	$345,000,000
	Maximum Potential Pool Funding (all funds)	$627,000,000	$690,800,000[3]
	Current FMAP	50%	50%
	Source Of Matching Funds (Non-Federal)	The largest source of non-federal share is state appropriations. However, the source of non-federal share for the only public hospital (Cambridge Health Alliance) is an intergovernmental funds transfer.	The largest source of non-federal share is state appropriations. However, the source of non-federal share for the only public hospital (Cambridge Health Alliance) is an intergovernmental funds transfer.
	Average Funding Available Per Year	$209,333,333	$230,266,666
	Relation of Total Funding to Prior Supplemental Payments	Exceeded previous supplemental payments.	10% increase over initial DSTI
	Total Distribution of Payments	In Year 1, Massachusetts providers were eligible to receive half of DSTI funds based on CMS approval of a hospital-specific DSTI plan. The remaining half of Year 1 DSTI funds were awarded for hospitals that achieved metrics detailed in those hospital specific DSTI plans; in Years 2 and 3, 75% of DSTI funds were available to hospitals for achieved metrics in hospital-specific projects and 25% of the DSTI funds were available for reporting on Category 4 outcome Population Health metrics.	Not yet defined on a project specific basis. However, CMS retained the existing "pass/fail" funding accountability for metrics associated with project activities. Additionally, the percentage of DSTI funding at risk for improved performance on validated outcome or quality measures will gradually increase from 0% in SFY 2015 to 10% in SFY 2016 to 20 percent in SFY 2017 (averaging to 10% total over the three year period). This accountability structure is on a provider-specific basis.
Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	Yes; Massachusetts Uncompensated Care Pool was restructured and incorporated into the Safety Net Care Pool when state conducted its 2006 health reform. A portion of the SNCP authorized expenditure limits continues to be allocated to the Health Safety Net, which pays for uncompensated care. DSTI falls under SNCP.	SNCP approved for a 3-year period under waiver. DSTI falls under SNCP.
	Corresponding Designated State Health Program (DSHP)	Through December 31, 2013. Expenditure authority was $360 million in SFY 2012, $310 million in SFY 2013 and $130 million in SFY 2014.	Through June 30, 2017. Expenditure authority of $385 million in SFY2015; $257 million in SFY2016; and $127 million in SFY2017 for various state-funded programs. DSHP authority also used to support Connector subsidies (through June 30, 2019), Commonwealth Care transition, temporary coverage during Connector website challenges, outside of the expenditure authority caps listed above.

		Initial DSTI	Renewed DSTI
Providers	**Participating Providers**	Seven hospitals eligible for DSTI defined as public or private acute hospitals with a high Medicaid payer mix and a low commercial payer mix: Boston Medical Center, Cambridge Health Alliance, Steward Carney Hospital, Lawrence General Hospital, Signature Healthcare Brockton Hospital, Mercy Medical Center, and Holyoke Medical Center.	Seven hospitals eligible for DSTI defined as public or private acute hospitals with a high Medicaid payer mix and a low commercial payer mix: Boston Medical Center, Cambridge Health Alliance, Steward Carney Hospital, Lawrence General Hospital, Signature Healthcare Brockton Hospital, Mercy Medical Center, and Holyoke Medical Center.
Projects Being Funded	**DSRIP Project Domains**	Projects fall within each of four required categories **Category 1**: Development of a fully integrated delivery system **Category 2**: Improved health outcomes and quality **Category 3**: Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability. **Category 4**: Population-focused improvements	Projects fall within each of four categories: **Category 1**: Development of a fully integrated delivery system **Category 2**: Improved health outcomes and quality **Category 3**: Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments that promote system sustainability. **Category 4:** Population-focused improvements
	Eligible Project Funding Per Year	Average eligible funding per hospital, per year is $29 million.	Average eligible funding per year is $33 million.
	Number of Approved Projects	49	Not yet finalized
	Minimum Number of Projects Required	Hospitals are required to select a minimum of five projects across Categories 1-3. Each hospital must have at least one project in each of the three categories and at least two projects in two of the three categories. Hospitals are permitted to submit more than five total projects across Categories 1-3. For Category 4, hospitals are required to report on a specified number of population health metrics. Hospitals must also report on a minimum of six but no more than 15 hospital-specific metrics that link to projects in Categories 1-3.	Not yet finalized
	Process for Reallocating Unused Funds	Hospitals may carry forward unclaimed incentive payments in DY 15 and DY 16 for up to 12 months from the end of the Demonstration year and be eligible to claim reimbursement for the incentive payment under conditions specified in the master plan. No carry-forward is available for DY 17.	Not yet finalized
	Additional Funded Program Elements	Participation in a learning collaborative required; treated as a project in Category 3 with approved metrics.	Not yet finalized

		Initial DSTI	Renewed DSTI
Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	Metrics are pay-for-performance other than population-focused improvement metrics, which are pay for reporting.	Not yet finalized
	Metrics and Benchmarked Improvement Targets	For Categories 1-3, providers must report on between two and seven metrics per project per year. Metrics fall into two categories: 1) process and infrastructure metrics that are critical to project planning, design, and implementation; and 2) outcome metrics that demonstrate the results of the program. Category 4 metrics are comprised of two categories: population health metrics that all hospitals must report on and hospital specific metrics that link to projects.	Not yet finalized
	Denominator for Improvement	To the extent that denominators are included, they are specific to the project and unique metrics for each hospital.	Not yet established
	Statewide Accountability Test	N/A	Specifics of 5% aggregate potential penalty in SFY2017 not yet established.
Reporting &Monitoring	**Provider Reporting**	Hospitals must report twice a year for payment and are also required to submit an annual report that details progress, challenges, and lessons.	Hospitals must report twice a year for payment and are also required to submit an annual report that details progress, challenges, and lessons.
	State Reporting	Massachusetts reports to CMS on 1115 demonstration waiver quarterly and annually. DSTI is a component of the Massachusetts quarterly operational reports and annual reports for the 1115 demonstration.	Massachusetts reports to CMS on 1115 demonstration waiver quarterly and annually. DSTI is a component of the Massachusetts quarterly operational reports and annual reports for the 1115 demonstration.
	Mid-Point Assessment Process	There is no state mid-point assessment process.	There is no mid-point assessment of DSTI. However, because DSTI is approved for three years in a five-year waiver, Massachusetts must reach agreement with CMS on the restructuring of the SNCP and DSTI.
	Program Evaluation	The UMass Medical School Center for Health Policy and Research completed a draft interim evaluation report of the 1115 demonstration on September 26, 2013. The state has a committee comprised of members across agencies to examine each semi-annual report to ensure hospitals have achieved their milestones and to provide feedback on progress.	An independent evaluator must be retained to assess hospital performance for DSTI payments. In addition, an independent evaluator must be retained for overall waiver evaluation. In the context of this evaluation, evaluator must address the following question: "What is the impact of DSTI on managing short and long term per-capita costs of health care?"
	External Audit/ Review	No external audit or review; however the UMass Medical School Center for Health Policy and Research issued interim evaluation described above.	

NEW MEXICO

GENERAL PROGRAM INFORMATION AND CONTEXT

New Mexico's Hospital Quality Improvement Incentive (HQII) program is part of the state's Centennial Care 1115 demonstration waiver. The Centennial Care waiver establishes a comprehensive managed care system, consolidating a number of previous 1915(b) and 1915(c) waivers and expanding access to care coordination for Medicaid enrollees. The waiver also establishes a Safety Net Care Pool (SNCP) that is comprised of an Uncompensated Care (UC) Pool and a Hospital Quality Improvement Incentive (HQII) pool. HQII is available in years two though five of the waiver. Consistent with CMS' strategic goals, New Mexico's HQII program was designed to incentivize hospitals to improve the quality of care for and health of Medicaid and uninsured populations while lowering costs.

New Mexico has designated 29 hospitals (sole community provider (SCP) hospitals and the state teaching hospital) that are eligible to participate in the program by improving on measures of clinical events or health status that reflect high need for the Medicaid and uninsured populations they serve.

General Information	**Program Length**	5 years
	Stage of Implementation	Year 1 (planning only)
	Date Submitted to CMS	4/25/2012
	Date Approved by CMS	9/4/2012, effective 1/1/2014
	Date Expires	12/31/2018
Funding	**Maximum Potential Pool Funding (federal)**	$21,000,000
	Maximum Potential Pool Funding (all funds)	$29,000,000 (plus any unclaimed funds from UC pool)
	Current FMAP	69.65%
	Source Of Matching Funds (Non-Federal)	Intergovernmental transfers (IGTs) from local counties and from the University of New Mexico hospital plus state general funds to fill gap.
	Average Funding Available Per Year	$7 million; gradually increases from $2.8 million to $12 million in DY 2-5
	Relation of Total Funding to Prior Supplemental Payments	Same as prior supplemental payments, no "new" money; some prior supplemental payment funding was incorporated into a rate increase for hospitals, as described in STC 105.
	Total Distribution of Payments	Hospitals qualify for HQII funds by achieving outcome metrics in two domains: Urgent Improvements in Care; and Population-Focused Improvements. All HQII funding is directed towards achievement on outcome measures (i.e., no funding for DSRIP projects or project plan development) so 100% of total funding is considered pay-for-performance (meeting improvement targets).

Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	Yes, UC and HQII pools combine to make up the SNCP, valued at $373,873,201 total. The maximum potential funding for the UC Pool is $344,446,615; unclaimed UC funds go into HQII pool. The state has limitations on the FFP it can claim for the SNCP that fluctuate each year such that the state increasingly claims funds from the HQII pool (however, the limits on UC pool funding remain consistent throughout the waiver at $68,889,323/year). Over the course of the five years the UC pool shrinks from 100% to 85% while the DSRIP pool increases from 4% to 15%.
	Corresponding Designated State Health Program (DSHP)	No
Providers	**Participating Providers**	There are 29 eligible hospitals; these include sole community providers (SCPs) and the state teaching hospital. Hospitals had to be eligible to receive SCP and UPL supplemental hospital payments at the time of the demonstration approval. All 29 hospitals have submitted their intent to participate.
Projects Being Funded	**DSRIP Project Domains**	Unlike other DSRIP programs, HQII does not include funding for "projects" or interventions; only for outcome measures. Outcome measures are divided into two domains: 1. Urgent Improvements in Care (Required) 2. Population-Focused Improvements (Optional) Participating hospitals are required to report and improve on (and be paid based on) a set of ten measures from Domain 1; they may also choose to report on measures related to Population-Focused Improvement (Domain 2).
	Additional Funded Program Elements	The program does not appear to include funding for additional elements, such as shared learning (although shared learning is encouraged through STC 83.d.v)
Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	Domain 1 includes 10 measures of safer care that align with the CMS Partnership for Patients initiative (hospital-acquired conditions and readmissions). Domain 2 includes population-focused improvements that align with the AHRQ prevention indicators.
	Metrics and Benchmarked Improvement Targets	The state uses standardized metrics and the Quality Improvement System for Managed Care (QISMC) methodology of closing the gap between baseline and benchmark. The state establishes high performance levels (HPL) and minimum performance levels (MPL) based on state or national benchmarks for each outcome measure; this was submitted in March 2014. Hospitals then use the state MPLs and HPLs to set their own improvement targets for each outcome measure. HPLs should be generally set to the 90th percentile of the state or national performance and MPLs should be set to the 25th percentile of state or national aggregate performance. The provider-set improvement targets must continuously close the gap between the provider's current performance/baseline and the state HPL in DYs 3, 4, and 5. Specifically, for DYs 4 and 5, the provider improvement target cannot be lower than the state MPL.
	Denominator for Improvement	Denominators are not specifically identified in the STCs, but will likely be provided in the state's allocation and payment methodology (APM) document due July 1. STC 83.d.ii requires the state to consider small denominator issues for smaller hospitals.
	Statewide Accountability Test	None

Reporting & Monitoring	**Provider Reporting**	Participating hospitals must submit annual reports, although the state is looking to use existing data (e.g., hospital inpatient discharge data) for the majority of measures. For those measures that cannot be captured with existing data, the state will develop a standard hospital-reporting template for all participating hospitals that includes sections on hospital interventions, challenges, and mid-course corrections and successes. The state must also be able to aggregate hospital reports for CMS and shared learning among all hospitals.
	State Reporting	The state must share HQII reporting results on its website
	Mid-Point Assessment Process	A mid-course review will be conducted prior to DY 4. It will be a joint effort between the state and CMS designed to examine hospitals' progress in meeting their specified improvement targets and to assess the success of the project in achieving its goals. If a hospital performs above the HPL on an outcome measure in DY 3, the hospital may be required to report on an additional measure in DY4 and demonstrate improvements on that measure in DY 5. The state or CMS may propose adjustments to hospital interventions or other aspects of the demonstration based on the mid-year review findings.
	Program Evaluation/External Audit and Review	The APM document was submitted on July 1 and includes operational requirements on monitoring and evaluation.

General Program Information and Context

- DSRIP is part of the New Jersey Comprehensive Waiver, that seeks to provide comprehensive health care benefits to 1.3 million New Jersey citizens, including Medicaid beneficiaries and other specified populations. Through DSRIP, New Jersey aims to transition safety net hospital payments from the previous supplemental payment system (Hospital Relief Subsidy Fund) to an incentive-based model for all New Jersey hospitals where payment is contingent on achieving quality improvement goals.
- Each participating hospital submits 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. Hospital projects are selected from a menu of focus areas that include: asthma, behavioral health, cardiac care, substance abuse, diabetes, HIV/AIDS, obesity, and pneumonia. Each project consists of a series of activities drawn from a predetermined menu of activities grouped according to four project stages. Hospitals may qualify to receive DSRIP payments for fully meeting performance metrics (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care. All acute care general hospitals in New Jersey are eligible to participate.

General Information	**Program Length**	5 years
	Stage of Implementation	Year 3
	Date Submitted to CMS	9/14/2011
	Date Approved by CMS	10/1/2012
	Date Expires	6/30/2017
Funding	**Maximum Potential Pool Funding (federal)**	$292,000,000
	Maximum Potential Pool Funding (all funds)	$583,000,000
	Current FMAP	50.00%
	Source Of Matching Funds (Non-Federal)	Provider tax
	Average Funding Available Per Year	Available DSRIP funding fluctuates per year but averages to about $146 million per year.[4]
	Relation of Total Funding to Prior Supplemental Payments	Same as prior supplemental payments (Hospital Relief Subsidy Fund)
	Total Distribution of Payments	In Year 1, 100 percent of DSRIP funding is provided as a transition payment. In Year 2, 50 percent of DSRIP funding is provided as a transition payment; 25 percent is paid to hospitals that develop a hospital specific plan; the remaining 25 percent is paid for progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. Over time, funding gradually shifts from project improvements to quality improvements (first as pay-for-reporting and then to pay-for-performance).
Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	No. The waiver does, however, authorize transition payments in DY 1-DY2.
	Corresponding Designated State Health Program (DSHP)	No.

Providers	**Participating Providers**	All acute care hospitals are eligible to participate in DSRIP. Total of 63 eligible hospitals; 50 have approved DSRIP projects; 13 are not participating.
Projects Being Funded	**DSRIP Project Domains**	Each hospital must select one project from a menu of focus areas that include: 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
	Project Funding Per Year	Average project funding per year is $3.26 million.
	Number of Approved Projects	50
	Minimum Number of Projects Required	Each participating hospital has selected one project from a menu of focus areas.
	Additional Funded Program Elements	New Jersey has a Universal Performance Pool (UPP) which is made up of the following funds: • For DY2, 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 DY2. • For DY3-5, 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 demonstration year in favor of the hospital. Hospitals are also required to participate in learning collaboratives as part of the stage 2 metrics.
Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	For DY4 and DY5, over half of quality improvement metrics will be pay-for-performance.
	Metrics and Benchmarked Improvement Targets	Incentive payment during the pay-for-performance demonstration years is based on hospitals making a measurable improvement in a core set of the hospital's quality improvement performance measures. For measures with a national or publicly available benchmark, a measurable improvement is a minimum of a 10 percent reduction in the difference between the hospitals baseline performance and improvement target goal. For hospitals working with project partners, this gap is reduced from 10 percent to 8 eight percent. For measures without a national or publically available benchmark, a measureable improvement is a 10 percent rate of improvement over the hospital's baseline performance (per year).
	Denominator for Improvement	Performance measurement for both Stage 3 and 4 metrics will measure improvement for specified population groups, including the charity care, Medicaid and CHIP populations, collectively referred to as the low income population. An attribution model to link the low-income population with DSRIP hospitals and project partners for Stage 3 and 4 performance measurement has been developed by the Department with the input and support by the hospital industry.
	Statewide Accountability Test	N/A

Reporting & Monitoring	**Provider Reporting**	DY2: Hospitals are required to submit the DSRIP plan (covers 50% of DY2 Target Funding amount), and submit the DY2 Progress Report (covers the other 50% of DY2 Target Funding) DY3-DY5: Hospitals are required to submit an annual DSRIP application renewal for DY3-5 and quarterly DSRIP Progress Reports for DY3-5 that are based on stage-specific activities/milestones and metrics achieved during the reporting period.
	State Reporting	The Department and CMS will use a portion of the Monthly Monitoring Calls for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.
	Mid-Point Assessment Process	A mid-point assessment of DSRIP will be completed by June 2015 by the independent DSRIP evaluator to provide broader learning both within the state and within the national landscape. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.
	Program Evaluation	• The Rutgers Center for State Health Policy is conducting the evaluation of New Jersey's waiver. The quantitative portion of the evaluation consists of analysis of Medicaid claims data and payer data in addition to hospital reported measures. The qualitative portion consists of a survey and key informant interviews with hospitals. • Interim Evaluation Report: The state must submit a draft interim evaluation report by July 1, 2016, or in conjunction with the state's application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report. • Final Evaluation Report: The state shall submit to CMS a draft of the final evaluation report by July 1, 2017.
	External Audit/Review	• The Center for State Health Policy at Rutgers University is conducting both the mid-point assessment and final evaluation.

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 1115 demonstration waiver. As described in demonstration Amendment 13, the state plans to invest 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 ACO-like structures called Performing Provider Systems (PPSs) that collectively implement 5-11 quality improvement projects designed to create regional integrated delivery systems able to accept value-based payments for attributed populations.

New York's DSRIP program was created to incentivize provider collaboration at the community level to improve the care for Medicaid beneficiaries while lowering costs and improving health. Participating PPSs receive DSRIP funding for achieving specific project milestones, metrics and outcomes.

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."

General Information	**Program Length**	6 years
	Stage of Implementation	Year 1 (planning only)
	Date Submitted to CMS	8/6/2012
	Date Approved by CMS	4/14/2014
	Date Expires	12/31/2019 (assuming renewal of the Partnership 1115 demonstration 12/31/2014)
Funding	**Maximum Potential Pool Funding (federal)**	$6,919,000,000
	Maximum Potential Pool Funding (all funds)	$13,837,000,000
	Current FMAP	50.00%
	Source Of Matching Funds (Non-Federal)	Intergovernmental transfers (IGTs) from major public hospitals, supplemented by some state general revenue funded by DSHP.
	Average Funding Available Per Year	Available DSRIP funding fluctuates per year.
	Relation of Total Funding to Prior Supplemental Payments	No relation to prior supplemental funding; NY DSRIP funding comes from Medicaid Redesign Team (MRT) savings and no prior supplemental payments were rolled into DSRIP.
	Total Distribution of Payments	New York includes $140 million in funding for planning in Year 1/DY 0 and then has 5 years of DSRIP implementation activities. Funding for Domain 1, Project Program milestones, is highest (80% and 60% of total DSRIP funding,) in DY 1 and 2, respectively, and steadily declines to 0% in DY5. Funding for Domains 2 and 3 steadily increases throughout the program and reaches 55% and 40%, respectively, in DY 5. Domains 2 and 3 are a combination of P4P and P4R and in each case; more funding is based reporting in earlier years and on performance in later years. New York also has a population health domain, which remains consistently at 5% of total DSRIP funding every year.

Corresponding Pools	**Corresponding Uncompensated Care (UC) Pool**	No (although the F-SHRP 1115 demonstration does include an indigent care pool for clinics that is not related to the DSRIP)
	Corresponding Designated State Health Program (DSHP)	Yes; $4 billion related to DSRIP (total, all funds); Additional DSHP had previously been approved as part of other initiatives
Providers	**Participating Providers**	Eligible providers form regional coalitions known as Performing Provider Systems (PPSs) led by major public hospitals or other eligible safety net providers; PPSs can include health care providers, health services, community-based organizations, and others. Twenty-five PPSs have been identified as of March 2015. Eligible hospitals are public hospitals, Critical Access Hospitals or Sole Community Hospitals, or hospitals that served a minimum number of Medicaid or uninsured patients. Eligible non-hospital based providers must also meet requirements for volume of Medicaid/uninsured patients. The state and CMS may also approve certain non-qualifying organizations for participation in a PPS.
Projects Being Funded	**DSRIP Project Domains**	1. Overall Project Progress 2. System Transformation and Financial Stability 3. Clinical Improvement 4. Population Health
	Project Funding Per Year	Average project funding per year is $900,000.
	Number of Approved Projects	258
	Minimum Number of Projects Required	PPSs must include a minimum of five projects and a maximum of 11 projects per DSRIP plan with specific criteria for each project category.
	Additional Funded Program Elements	$1 billion total computable in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term. DSRIP Design Grants are available in CY2014 to support providers in developing DSRIP project plans. They amount to up to $200 million total computable. A high performance pool is available for PPSs that close the gap between baseline and benchmark by 20% and/or exceed the 90th performance percentile on a subset of metrics related to avoidable hospitalization, behavioral health and cardiovascular disease. Funding is composed of up to 10% of annual DSRIP project funds and any unclaimed project funding. The DSRIP budget includes $600 million total computable for state administration of the program over 6 years. As part of these duties, the state will lead learning collaboratives at the regional and state levels that are required for all PPSs.

Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	A standard set of metrics is required for each domain and project. Many of these measures are pay-for-reporting in earlier program years, and transition to being pay-for-performance in later years.
	Metrics and Benchmarked Improvement Targets	All quality improvement targets are closing the gap between the PPS' baseline and the state or national benchmark of the 90th percentile by 10% year-over-year.
	Denominator for Improvement	Population of attributed Medicaid beneficiaries (minimum of 5,000 Medicaid members in outpatient settings) for most projects. One project is for the uninsured and Medicaid non/low utilizing population, and uses that attributed population for the denominator for that project's metrics.
	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%, 10%, and 20% respectively. If penalties are applied, CMS requires the state to reduce funds in an equal distribution, across all DSRIP projects.
Reporting & Monitoring	**Provider Reporting**	PPSs must report twice a year for payment purposes though they may only be eligible for payment at the end of the year report. PPSs will also report quarterly to support New York's quarterly assessments.
	State Reporting	The state will publish project-by-project updates on a quarterly basis.
	Mid-Point Assessment Process	All plans initially approved by the state must be re-approved by the state in order to continue to receive funding in Years 5-6 (DYs 4 and 5). The state will submit draft mid-point assessment criteria and checklist to review plans to CMS, which will be modified in consideration of learning and new evidence.
	Program Evaluation	The state is currently developing its evaluation plan: it submitted an evaluation proposal and received public input. Will have an interim and final independent evaluation.
	External Audit/Review	New York is contracting with an independent assessor, Public Consulting Group (PCG), to serve as an external auditor and reviewer.

Oregon

General Program Information and Context

Through the Hospital Transformation Performance Program (HTPP) diagnosis-related group (DRG) hospitals, defined as "urban hospitals with a bed capacity of greater than 50," will earn incentive payments by meeting specific performance objectives designed to advance health system transformation, reduce hospital costs, and improve patient safety. The program lasts for two years and payments are made for reporting baseline data in the first year and for meeting benchmarks or improvement targets in the second year.

The major goal of the program is to accelerate Oregon's health system transformation activities among a targeted group of providers. Oregon currently operates a statewide accountable care model that consists of a network of Coordinated Care Organizations (CCOs). These community-level entities provide coordinated and integrated care to Oregon Medicaid beneficiaries and are held accountable for the populations they serve by operating under a global budget. The HTPP seeks to "create a mutually beneficial system for both hospitals and Coordinated Care Organizations (CCOs) by reducing costs and improving quality." The state specifically hopes to use HTPP, in part, as a vehicle to accelerate transformation and quality improvements in CCOs.

General Information	**Program Length**	2 years
	Stage of Implementation	Year 1
	Date Submitted to CMS	6/26/2013
	Date Approved by CMS	6/27/2014; HTPP effective 7/1/2014
	Date Expires	6/30/2016
Funding	**Maximum Potential Pool Funding (federal funds)**	$191,000,000
	Maximum Potential Pool Funding (all funds)	$300,000,000
	Current FMAP	64.06%
	Source Of Matching Funds (Non-Federal)	Provider tax; the state's portion of HTPP money is funded through an increase of one percentage point to the state's hospital assessment rate.
	Average Funding Available Per Year	$150 million
	Relation of Total Funding to Prior Supplemental Payments	Exceeds prior supplemental payments (i.e., no supplemental payment diversion to fund HTTP)
	Total Distribution of Payments	Hospitals were awarded $150,000,000 for submitting baseline data in Year 1. In Year 2, hospitals are eligible for an additional $150,000,000 contingent upon achievement of incentive measures.
Corresponding 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. Specified state programs are eligible to received DSHP payments to support health system transformation goals in DY 11-DY 15 of waiver. Maximum potential pool funding is $704,000,000, FFP only, 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	**Participating Providers**	All 28 diagnosis-related group (DRG) hospitals (urban hospitals with a bed capacity of greater than 50) are participating.
Projects Being Funded	**DSRIP Project Domains**	Unlike other DSRIP programs, HTPP does not include funding for projects or interventions; only for meeting reporting and benchmark requirements on hospital-specific metrics.
	Additional Funded Program Elements	N/A
Outcomes	**Types of Outcomes Being Used for Pay-for-Performance**	All 11 measures are pay-for-performance in Year 2. All measures have either a hospital only or hospital-CCO collaboration focus. Measures then fall into domains including readmissions, medication safety, patient experience, healthcare-associated infections, sharing ED visit information, and behavioral health.
	Metrics and Benchmarked Improvement Targets	OHA will use its CCO methodology to calculate hospital improvement targets, which require a ten percent reduction in the gap between baseline and benchmark to earn incentive payments.
	Denominator for Improvement	The denominator for improvement is specific to each measure and participating hospital.
	Statewide Accountability Test	HTPP payments will be included in Oregon's calculations of total expenditures under the waiver. If Oregon fails to meet trend reduction targets, the state faces reduced federal funding for DSHP
Reporting & Monitoring	**Provider Reporting**	All HTPP measures will be reported on the OHA website at least once a year and will be available at the hospital level.
	State Reporting	The state must provide quarterly reports to CMS that detail payments and progress.
	Program Evaluation	The state will conduct an interim independent evaluation of HTPP, due March 31, 2016, to assess how the goals of the program are being met. Evaluation questions will focus on how participating providers are performing on metrics and include comparisons between participating hospitals and non-participating hospitals on CCO metrics to see how HTPP is affecting CCO performance.
	External Audit/Review	The Hospital Metrics and Incentive Payment Protocol may include more on this.

(Footnotes)

1 For purposes of this fact sheet, each Category 3 domain set of measures counts as a "project."

2 If a DPH baseline value on a measure meets or exceeds the high performance goal, the provider is considered to have achieved "top performance" on the measure and must select a different stretch measure (in the same intervention) to improve upon for DY 9 and 10.

3 The renewal DSTI transitions $660,000,000 in historical funding to the state's only public hospital to the Cambridge Health Alliance Public Hospital Transformation and Incentive Initiative. Up to 30% of this incentive pool will be at risk based on performance on outcome measures.

4 In New Jersey, DSRIP transition payments were made in DY 1 (7/1/2012 to 6/30/2013) and for half of DY 2 (7/1/2013 to 12/31/2013). Funding tied to the DSRIP program (approval of application and progress reports) did not begin until the second half of DY 2 (1/1/14). Accounting for the transition payments, the total 5-year program funding is $833 M, or $166.6M per year.