Improving Care through 1115 Medicaid Waivers:

An Analysis of the Delivery System Reform Incentive Payment Program across Five States

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Executive Summary

Five states have included a new pay-for-performance program to improve care delivery in Section 1115 Medicaid Waivers since 2010. These Delivery System Reform Incentive Payment (DSRIP) programs provide funding following providers' achievement of improved care for low-income patient populations. The program is being adopted and refined by the federal government to promote better care at lower costs within the states by directly linking waiver financing to health care quality, as opposed to uncompensated care costs or reimbursement for Medicaid services. It is designed to support safety net providers that take steps to transform how care is delivered and compete in a reformed health system.

This paper provides a comparative analysis of the current DSRIP programs across several states and from that, identifies a number of key decision points for states and providers developing or considering waivers with DSRIP programs. Section I provides general background on Section 1115 Medicaid Waivers and the development of the DSRIP program.

Section II conducts a comparative analysis of state DSRIP programs, including key contextual influences, the size and scope of the waiver, the size and scope of the DSRIP program, providers participating in the program, the structure of each program, and a summary of the providers' DSRIP plans and projects. In addition to this information, Section II draws similarities and differences among programs as well as tracks the evolution of the program from one state to the next.

Section III discusses crucial decision points for Medicaid agencies and providers developing or considering a waiver with a DSRIP program: aligning the program with waiver goals, determining pool participants, financing the program, establishing the size of the pool, distributing pool funds, determining improvement potential, conducting program planning, assembling the program development team, defining the patient population, and developing the provider plans.

Finally, the conclusion describes key high-level impacts of the program on states, providers, patients, health policy, and the health care market. Overall, there are challenges and opportunities associated with implementing a DSRIP program; yet, it is proving to represent a model being fully embraced by the federal government to be replicated as well as revised across more states.

Section I: Overview

Section 1115 Medicaid Waiver Gaining Momentum

Medicaid is a federal-state program that is administered by the states and funded jointly. Medicaid programs have flexibility to vary from state to state as long as they meet a substantive set of federal requirements.

Section 1115 of the Social Security Act allows the federal government to waive some of these requirements for a state to demonstrate innovation. As such, waivers can provide financing for

state Medicaid programs and health care providers in new ways – as long as the federal government does not spend more than it would have in the absence of the waiver ("budget neutrality").

These waivers have become increasingly utilized, and as a result, they are steering policy development and significant funding streams in Medicaid. Through waivers, states are expanding the use of Medicaid managed care as an alternative to the traditional fee-for-service system, extending health care coverage, and demonstrating new ways to deliver health care.

Rise of the Delivery System Reform Incentive Payment Program

Recent waivers have tested changes to the traditional model of delivering care to low-income people as well as how to finance it. Spreading among states is the DSRIP program as a model to transform the delivery system from fragmented silos of episodic treatment to integrated systems of coordinated and proactive care. It was first developed in California, then modified by Massachusetts, then expanded and refined by Texas, and is now being developed or contemplated by a number of states nationwide.

The Institute for Healthcare Improvement's (IHI's) concept of the Triple Aim is the framework for the DSRIP – better care that improves population health at a lower cost. Additionally, the delivery system reforms enveloped in the Affordable Care Act (ACA) helped shape the program – reward value instead of volume; incent coordinated care; promote prevention, primary care and chronic care through models of care management and patient empowerment; improve quality; and reduce cost.

Accordingly, the DSRIP program provides incentives for providers who have demonstrated improvements in care as measured by quality, access, patient experience and efficiency, as well as better population health outcomes.

The program is governed by state and federally negotiated protocols. Based on these protocols, participating providers develop multi-year plans with milestones. Providers can receive incentive payments if and after they achieve their milestones. The milestones comprise infrastructure development, process redesign, implementation of best practices, improved care and outcomes, and reporting on a set of metrics intended to measure the efficacy of the state's DSRIP program.

The DSRIP program is a model to provide population-based and patient-centered care in a deliberate manner that is focused on health and wellness instead of on treating illness. As a result, many participating providers are expanding primary care, providing chronic disease management and reporting on population health metrics. Large safety net hospital systems are implementing medical homes in the ambulatory care setting, improving quality and safety in the inpatient setting and establishing connections for patients among the various settings that

ultimately center on the patient's medical home.[1] Many providers are also working to improve the patient experience and important health indicators.

Section II: Comparative Analysis of State DSRIP Programs

The overall focus of the DSRIP program has common elements across states, but it is tailored to the unique needs and goals of each state and its participating providers. In addition, it has evolved from state to state and is becoming more prescriptive and focused. The size of the program funding has ranged from hundreds of millions to billions of dollars. The scope of the program is vast, and providers with more potential DSRIP dollars tend to have larger scope plans. In addition, provider eligibility and the number of providers participating in the program vary among states.

The below subsections describe state DSRIP programs. The first three subsections focus on the states currently implementing DSRIP programs – California, Massachusetts and Texas. The last subsection discusses two states working to develop their DSRIP program protocols – New Jersey and Kansas.

California: The Pioneer

Renewed amidst the development of the ACA, California's 2010 waiver was designed to serve as a bridge to health reform. Worth $10 billion, its key components include early coverage expansion to low-income adults, moving seniors and persons with disabilities from Medicaid fee-for-service to managed care, state budget support, and delivery system reform. In particular, the development of the ACA (particularly the accountable care organization program), Dr. Berwick being appointed director of the federal Centers for Medicare and Medicaid Services (CMS) from IHI, and the California budget crisis were contextual influencers on the waiver.

Due to financing limits and issues from the previous waiver for designated public hospitals[2], California sought a new financing model in this waiver. In initial discussions with CMS, it became clear that a new program would need to marry finance and quality. Hence, the DSRIP program was first conceived. The public hospitals proposed specific care improvement models based on their experiences in quality improvement since 2000, and CMS provided a framework (the Triple Aim) and the program structure (four categories of improvement projects: Infrastructure Development, Innovation and Redesign, Population-Focused Improvement, and Urgent Improvement in Care).

The result of an eight-month process of policy development and negotiations was the program requirements and financing mechanics, including a lengthy menu of projects based on care improvement models and best practices. From a financing perspective, the program offered new funding opportunities for the public hospitals through risk- and performance-based incentives.

[1] A medical home is a health care setting (typically primary care) that is responsible for and coordinates the continuum of a patient's care, serves as the primary point of contact for the patient's health care needs and establishes a long-term relationship with the patient.
[2] Includes County and University of California owned hospital systems.

Because the public hospitals are financing the non-federal share, the program is worth up to $6.5 billion gross[3], or $3.3 billion net for 21 public hospitals.[4]

The public hospitals drove the development of the program.[5] For the most part, they are a fairly homogenous group of providers as major teaching safety net hospital systems that provide the full suite of health care services, from primary to tertiary care. Their payer mix is largely Medicaid and uninsured. Close collaboration on the program was organized through their statewide provider association, the California Association of Public Hospitals and Health Systems, and based on programs run by the California Health Care Safety Net Institute, which since 1999 has worked to help the public hospitals improve patient care. As a whole, the public hospitals saw the DSRIP program as an opportunity to take to scale the kinds of improvements they had tested, despite its significant risks and high demands.[6]

Based on its participants, the focus of the program is on transforming care delivery across public hospitals. Designated public hospitals individually submitted five-year transformation plans in compliance with the program requirements. Over five years, the designated public hospitals are each on average working to achieve 76 milestones within seven major delivery system improvement projects. The most common projects include expanding medical homes, implementing and utilizing disease management registry functionality, expanding primary care capacity, expanding chronic care management models and integrating physical and behavioral health care. In addition, they are reporting on the same 21 population-based care measures as well as achieving outcomes across four provider preventable conditions, two of which – sepsis and central line-associated bloodstream infections – are required for all.

The first two years of the program marked very high achievement rates of milestones across the public hospitals. By the end of the second program year (June 30, 2012), public hospitals had:

- Increased primary care encounters by almost 30,000;
- Opened 40 exam rooms;
- Hired more than 35 primary care staff;
- Assigned more than 300,000 patients to a medical home; and
- Entered more than one million patients into disease registry systems to enable population health-based care management of chronic diseases (among other achievements).[7]

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[3] The technical term for the gross program amount is "total computable," which includes both the federal and non-federal share. Government-owned providers are able to put up their own non-federal share, which means that they net only the non-federal share of the incentive payment. The amount of the payment that is federal is determined by the state's federal Medicaid assistance percentage (FMAP).
[4] This means that the designated public hospitals have committed to spending up to $3.2 billion to participate in the program.
[5] Forty-six non-designated public hospitals (district and municipal hospitals) were approved to participate in the last three years of the waiver for up to $330 million gross, and the waiver also allowed for the participation of private safety net hospitals. However, these other hospitals opted not to participate.
[6] For more information, please see California 1115 Waiver: California Bridge to Reform Demonstration, No. 11-W- 00193/9.
[7] 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*, (Revised March 26, 2013).

On the one hand, the first two years represent milestones that should be largely achievable (project planning and initial process improvements that are foundational to care improvements, population health and clinical outcomes in the later program years). On the other hand, because many milestones were achieved earlier than was projected by the plans, it laid the groundwork for setting an even higher bar in future state DSRIP programs.

California's DSRIP program will soon complete its third year; results will be reported by September 30, 2013. The public hospitals are also continuing to work with CMS in the program's "mid-point assessment," including setting higher achievement targets for their outcomes. A key takeaway from their experience mid-way through the program is that system-wide transformation requires cultural change and a consistent, organization-wide approach to performance improvement.[8]

Table 1: Program Structure (Project Categories)

California	Massachusetts	Texas
1. **Infrastructure Development:** investing in people, places, processes and technology (e.g., chronic disease registries, primary care clinics) 2. **Innovation & Redesign:** testing and replicating care models (e.g., medical homes, care management models) 3. **Population-Focused Improvement:** reporting on 21 common measures across four domains: patient experience, care coordination, prevention and at-risk populations 4. **Urgent Improvement in Care:** improving outcomes for four provider preventable conditions, with sepsis and central line-associated bloodstream infections required	1. **Further Development of a Fully Integrated Delivery System:** investing in foundations of the medical home model (e.g., primary-specialty care networks) 2. **Improved Health Outcomes & Quality**: implementing innovative care models (e.g., care management, care transitions) 3. **Ability to Respond to Statewide Transformation to Value-Based Purchasing and to Accept Alternatives to Fee-For-Service Payments that Promote System Sustainability:** preparing for payment reform and alternative payment models (e.g., capacities to accept global payment) 4. **Population-Focused Improvements**: reporting on: (1) 12 common measures across three domains: better care, better health and cost-effective care; and (2) at least one outcome measure for each	1. **Infrastructure Development**: investing in technology, tools and human resources (e.g., primary and specialty care capacity) 2. **Program Innovation and Redesign**: testing and replicating care models (e.g., behavioral health interventions, care navigation) 3. **Quality Improvements**: improving at least one outcome for each Category 1 and 2 project, including clinical events, recovery and health status, patient experience and cost 4. **Population-Focused Improvements**: reporting on 83 measures across five domains: potentially preventable admissions, potentially preventable readmissions, potentially preventable complications, patient satisfaction and medication management,

[8] For example, utilizing the Lean methodology; otherwise, systems are simply undergoing simultaneous initiatives that run the risk of spreading the organization too thin.

	of the Categories 1-3 projects[9]	and emergency department[10]

Massachusetts: The Reformer

Massachusetts renewed its Section 1115 Waiver in December 2011, several months after the ACA had been signed into law and following the state's previous waiver, which had implemented near universal health care coverage to cover almost an additional 400,000 residents.[11] Thus, the focus of the 2011 waiver for both the State and CMS was to maintain the coverage expansion. In order to do this, Massachusetts recognized that it had to reduce per capita health care costs, particularly in its Medicaid program. As the 2011 waiver was being developed, it was clear that a law would soon be enacted to make Massachusetts the first state to cap overall health care spending, both public and private, so that it would grow no faster than the state economy.[12]

This $26.7 billion waiver included two programs: (1) children's/parents health care coverage and services; and (2) the Delivery System Transformation Initiatives (DSTI), a DSRIP-like program. While the waiver is large, the DSTI is limited to up to $628 million gross, making it a significantly smaller program than the one in California. It is also only a three-year waiver. The seven safety net hospitals that participated had the largest low-income and lowest commercial payer mixes.[13]

Given the key contextual influencers on the development of the Massachusetts waiver, the focus of the DSTI program is on restructuring health care payment as part of delivery system reform. The categories are: (1) Fully Integrated Delivery System; (2) Improved Health Outcomes and Quality; (3) Value-Based Purchasing and Alternatives to Fee-For-Service Payments; and (4) Population-Focused Improvements.

The participating hospitals are major safety net providers in the region, including the state's only public hospital. They serve the poorest, most diverse and multi-lingual areas of the state. As a result of universal coverage in the state, these hospitals saw a 30 percent increase in Medicaid volume from 2006 to 2010.[14] Most of them provide primary through tertiary care and comprise health systems with full service acute care hospitals and emergency departments, employed or affiliated physicians, community-based health centers and psychiatric inpatient services. Some

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[9] Except for the required project to participate in a learning collaborative.
[10] Hospitals also had the option to report on a sixth domain, CMS Initial Core Set of Measures for Adults and Children in Medicaid/CHIP, for an increased percentage of the provider's total DSRIP payments going toward reporting.
[11] Commonwealth of Massachusetts Health Policy Commission Report to the Massachusetts Legislature, "A Report on Consumer-Driven Health Plans" (April 2013).
[12] Massachusetts Acts of 2012, Chapter 224, Section 263: An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation.
[13] Public or private acute hospitals with a Medicaid payer mix more than one standard deviation above the statewide average and a commercial payer mix more than one standard deviation below the statewide average, based on FY 2009 cost report data.
[14] Massachusetts 1115 Waiver: MassHealth, No. 11-W-00030/1, Attachment J: Master DSTI Plan (March 18, 2012).

of them are competitors, which differed from California's program participants, who each covered a distinct geographic area.

Given Massachusetts payment reform and already-implemented state health reform, for the most part, these systems were already advancing toward an accountable care organization model that assumes the risk and responsibility for a population of patients. Like the California participants, Massachusetts program participants needed to develop electronic data systems to enable population management, but tended to lack the resources for such substantial investment in the absence of the DSTI program.

Because the DSTI program is only three years, as opposed to five, most of the milestones are process-oriented. Over three years, the participating providers are each on average working to achieve 93 metrics within seven major delivery system improvement projects. The most common projects are implementing care management for patients with chronic diseases, establishing patient-centered medical homes, developing capacities for payment reform, developing integrated primary-specialty care networks and improving care transitions. All of the hospitals are reporting on the same 12 population-based care measures, as well as reporting on an average of eight outcome measures for each of their Categories 1-3 projects.

Apart from the programmatic focus on payment reform and shorter timeframe, a key difference in Massachusetts from California is that the approval of a hospital's DSTI plan is worth 50 percent of the first year's total incentive payments. Also, the method of financing the non-federal share is mainly through state appropriations, with the exception of the public hospital which provides its source of non-federal share. While in California providers had flexibility in valuing incentive payments for Categories 1-2 projects and used formulas to value projects in Categories 3-4, each of the Categories 1-3 projects in a Massachusetts provider's plan was valued equally.[15] Furthermore, while the California public hospitals did establish several learning collaboratives for the DSRIP program, Massachusetts' was the first program where participation in a learning collaborative became required.[16]

Because Massachusetts' current waiver renewal is only three years, it will be the first state to have the opportunity to develop a sequel DSRIP program.

Table 2: Average Provider Workload Comparison

	California (5 years)	Massachusetts (3 years)	Texas (5 years)
Total # of Providers	21	7	309
Types of Providers	County and University of California owned public hospital systems	6 private and 1 public major safety net hospital systems	Medicaid providers: public and private hospitals, medical schools, private physician

[15] Except for the learning collaborative project, which was worth less than other Categories 1-3 projects.
[16] For more information, please see Massachusetts 1115 Waiver: MassHealth, No. 11-W-00030/1.

				groups, public health departments and mental health agencies
Category	Per Provider Averages			
Pay-for-Improvements[17]	**# Projects**	7	7	4
	# Milestones/Metrics	76	93	40[18]
	Most Picked Projects	Medical Homes; Disease Registries; Primary Care Capacity	Care Management; Medical Homes; Capacities to Accept Alternative Payment	Primary Care Capacity; Specialty Care Capacity
Pay-for-Reporting[19]	**# Reporting Measures**	21	20	83
Pay-for-Outcomes[20]	**# Outcomes**	4	0	4[21]

Texas: The Amplifier

Texas also received approval of its five-year waiver in 2011 with plans to expand Medicaid managed care statewide. However, that expansion meant that a significant source of supplemental funding to Medicaid providers through their Upper Payment Limit program would discontinue. In order to maintain funding levels, the waiver establishes two new pools of $29 billion, one that reimburses providers for uncompensated care costs and a DSRIP program worth up to $11.4 billion. The percentage of funding assigned to the uncompensated care pool will decrease over the five years proportional to the increase in DSRIP funding during that time in order to take into account ACA implementation and to shift priority to a pay-for-performance financing model, even though the Perry Administration has been vocally opposed to health reform and the State will not be expanding Medicaid coverage.

Because the previous supplemental funding program had widely impacted Medicaid providers, 309 providers are participating in the Texas DSRIP program – public and private hospitals, medical schools, private physician groups, public health departments and mental health agencies. The amount of low-income care provided by these participants significantly varies.

Consequently, the participating providers are organized into 20 regional groupings, or Regional Healthcare Partnerships (RHPs). Each RHP has a public hospital or, if the RHP does not contain a public hospital, a local government entity[22] that serves as the region's single point of

[17] Categories 1-2 in California and Texas; Categories 1-3 in Massachusetts.
[18] About 10 milestones per project
[19] Category 3 in California, Category 4 in Massachusetts and Texas.
[20] Category 4 in California and Category 3 in Texas.
[21] One outcome per project
[22] Either a hospital district, hospital authority, county or State university.

contact with the State and CMS and coordinates the RHP's activities for the duration of the waiver ("anchor").

Another legacy of the prior supplemental funding program was the precedent of public entities providing non-federal share for private institutions. In this waiver, private providers had to come up with a source for their non-federal share; providers unable to secure this were ineligible to participate because – like in California – no state appropriations are being used to finance the program.

Texas started with the California projects from Categories 1-2 (Infrastructure Development and Program Innovation and Redesign) but made several important changes:

(1) they added a number of projects from which providers can select, most notably projects related to behavioral health;

(2) each project identifies permissible interventions, from which the provider had to select one (for example, if the provider selected the project to expand primary care, within that project, the provider must also select whether a new clinic will be established or an existing clinic will have expanded hours);

(3) many interventions require the project to address a set of components;

(4) each project must specify the number of patients directly impacted; and

(5) each project must result in at least one improved outcome. Category 3 (Quality Improvements) is a list of outcomes from which providers could select. Category 4 (Population-Focused Improvements) specifies the measures on which all hospital participating providers must report, though it varies from California's and Massachusetts' in that it has the high number of measures. They measures are all inpatient measures to reflect that many of the hospital participating providers are not positioned toward integrated delivery systems with outpatient clinics.[23]

The first year of the DSRIP program was spent on developing the DSRIP plans. Each provider's DSRIP projects were rolled up into the larger RHP plan, which also included a community health needs assessment as the basis for the selection of those projects. The implementation of the program will demonstrate whether the regions' identification of common community health needs resulted in their providers working more closely together on improving population health.

The Texas DSRIP program has nearly completed its second year; however, the project review and approval process will not be completed until September 2013. The first year incentive payments were based solely on submission of the RHP plans.[24] Plans have been under State and CMS review since January 2013. So far, CMS has completed an initial review of DSRIP projects for years 2-3, and has approved about 80 percent of associated funding. Any projects that were "off-menu" or customized as "other" projects were not initially approved. Many

[23] For more information, please see Texas 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program, No. 11-W-00278/6.
[24] First year funding associated with projects not approved will be recouped.

specialty care projects were not approved unless the provider could demonstrate a significant impact on low-income patients, and projects that selected patient experience instead of a clinical outcome tended to be approved, but with reduced values. Since March 2013, the program has been undergoing a four-phase process to revise projects, with a final date for project approval of March 31, 2014. In the meantime, providers will soon begin to report on achievement of Year 2 milestones. Many providers are facing having to report a year's worth of implementation activities in the absence of knowing whether a project will be approved, and if so, whether it will be at a high enough value to make the effort worth the while.

A noteworthy observation is that the larger the program, the more numerous and onerous the administrative, policy, and programmatic issues and requirements. The role of the anchoring public hospitals, the State, and CMS in making sure a high number and wide variety of providers comply with the program requirements in both letter and spirit has resulted in a substantively higher number of obligations. Furthermore, CMS is requiring the State to monitor the providers throughout the program, resulting in the State proposing to spend up to $10 million per year (out of the DSRIP program non-federal share being provided) for an independent entity to monitor the accuracy of milestones and metrics reporting as well as the integrity of financing the non-federal share.[25] Significantly longer time periods are being spent on State and CMS review and approval of plans (from December 2012 to September 2013), with considerable numbers and values of projects not being fully approved. Furthermore, the regional governance model creates additional layers of bureaucracy and requires substantial administrative and reporting responsibilities on the part of the public hospital anchors as well as on the State and CMS.

Table 3: Evolution of the Program

Overall, the bar has been raised from state to state, demanding higher levels of achievement sooner. Requirements have become more prescriptive, with less provider flexibility. Transparency, consistency, and quantifiable justification are also increasing from one program to the next.

	California	Massachusetts	Texas
First program year activities	Plan development and achievement of planning milestones	Plan development (worth 50% of year's incentive payments) and achievement of initial milestones	Plan development (100% of year's incentive payments)
Plan components	Executive summary, project narratives and milestones by year table	Executive summary, community context, project narratives and milestones by year table, incentive payment amount calculations (based on master statewide plan with community needs)	Regional community health needs assessment, public input process, summary of projects, project narratives with several required sub-sections (including community

[25] Texas Health and Human Services Commission Chapter 355, Subchapter J, Division 11, Proposed Rule Section 355.8204 (June 2013).

			needs addressed by project, valuation methodology and related outcomes) and milestones by year table that includes the number of patients impacted
Project results	Expected results described	At least one outcome measure reported for each project	At least one outcome must be improved for each project
Learning collaboratives	Not required, though the public hospitals conducted several	Required	Required; each region must submit a learning collaborative plan based on CMS definition and template
Project values	Provider flexibility to prioritize Categories 1-2 projects within guidelines; Categories 3-4 project values formula-driven	Every project equal value (except for learning collaborative); formula-driven[26]	Region had flexibility to design valuation model, but must address specific criteria, most importantly the number of patients impacted
Partial payment for partial achievement	Permitted to reflect that quality improvement does not always occur "on time"	No	Permitted only for partial achievement of outcome improvement targets
Improvement year over year	Required to improve over the span of the program, but permitted to maintain an improvement from one year to the next to reflect that quality improvement is cyclical	Required	Required
Carry forward of unearned incentives up until the last program year	Permitted	Permitted for up to 12 months	Permitted until the end of the following year with narrative description and plan to achieve missed milestones/outcomes

Looking Ahead: New Jersey and Kansas

New Jersey and Kansas both received approved waivers in 2012 that include DSRIP programs, the requirements for each of which are currently under development. Like in Texas, they are

[26] Program allows some provider flexibility some adjustment to the formula to account for provider priorities.

replacing supplemental payment programs. Unlike other existing DSRIP programs, Kansas will only have two participating hospitals. Its DSRIP program will focus on improving access to services, population health management through information technology, integration of the delivery system, health literacy, health and wellness programs, and chronic and complex care management models. Each of the six possible related projects spans four categories of milestones: (1) Infrastructure Milestones (program year 2 only); (2) Process Milestones; (3) Quality and Outcomes Milestones (hospital-specific outcomes); and (4) Population Focused Improvements (reporting of performance indicators). This structure represents the full shift from categories organizing types of projects to projects spanning categories, or types, of milestones. Each hospital must adopt a process for continuous performance improvement, or rapid cycle evaluation.[27]

The New Jersey program is much larger, with up to 66 public and private hospitals, like Texas. However, state appropriations will be the source of the non-federal share and no regional organization will be required. The program will be structured around eight disease areas: behavioral health, HIV/AIDS, chemical addiction/substance abuse, cardiac care, asthma, diabetes, obesity, pneumonia, or a medical condition unique to the hospital. Importantly, instead of implementing multiple system-wide transformative initiatives simultaneously, New Jersey hospitals will likely focus on making improvements in just one of these areas. In other words, hospitals will likely select one project designed to address to one of these disease areas, and that project will include a series of activities organized into four progressive stages: (1) Infrastructure Development (program years 2-4); (2) Chronic Medical Condition Redesign and Management (beginning in year 3); (3) Quality Improvements (years 4-5); and (4) Population Focused Improvements.[28] Furthermore, consistent with the evolution of the program, it is possible that the New Jersey hospitals will need to: (1) achieve a high level of improved outcomes, with a higher share of funding attached to them; (2) adopt pre-defined achievement targets for outcomes (as opposed to providers defining their own improvement goals); and (3) improve population-based measures (as opposed to simply reporting on them).[29]

In both of these programs, providers are encouraged to take a more focused approach, but realize more significant and stringent improvements in health outcomes. The stakes are higher: no partial payment is possible for partial achievement and the timeframe has been condensed to four years.

Section III: Key Considerations for States and Providers

At a high level, states considering including a DSRIP program in a waiver must weigh the benefits and drawbacks. While a DSRIP program may offer incredible potential for both

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[27] For more information, please see Kansas 1115 Waiver: KanCare, No. 11-W-00283/7, including Attachments F and G (draft May 31, 2013).

[28] The first year of the New Jersey DSRIP program served as a transition year and included the development of the program requirements and plans. Plans are due in the second year, which began on July 1, 2013, for up to 50 percent of that year's funding per hospital.

[29] For more information, please see New Jersey 1115 Waiver: New Jersey Comprehensive Waiver Demonstration, No. 11-W-00279/2.

improved care and financing, it will take manpower to develop and implement. Additionally, the context in which the state is contemplating a DSRIP program matters – it may be complementary and enhance other waiver initiatives, or it may run up against larger state politics and strategies.

As a comprehensive program, a DSRIP contains many elements. Therefore, several key considerations are discussed below. Many of these considerations relate to one another and therefore should be deliberated collectively.

Aligning the DSRIP with Waiver Goals

A DSRIP may help a state achieve its waiver goals. Key considerations are whether the DSRIP program goals (described in Section I above) complement larger state waiver goals and can be supported by decision makers and stakeholders. In California, for example, the DSRIP program has facilitated a more successful early coverage expansion by increasing access to primary care.

Determining DSRIP Participants

In defining pool participants, states may base eligibility on ownership (for example, public hospitals), share of low-income care (Medicaid and uninsured) or a set of qualifications. Considerations include which providers – given the nature of the program – are a good fit and how much funding is available as a meaningful incentive (see funding considerations below). Key providers in current DSRIP programs tend to be safety net hospital systems (public hospitals, academic medical centers, private safety net hospitals). However, Texas' DSRIP includes a host of other organizations (such as local public health departments and mental health agencies). It is important to note that a provider that is not yet system-oriented (working toward an integrated delivery model that spans primary to tertiary care) may be limited in its ability to "fit" into the DSRIP model that emphasizes ambulatory care and "systemness".

Finding Funding Share

As a state-federal program, Medicaid requires a match to be provided for federal funding. Given this, who will provide the non-federal share is an important consideration for states seeking DSRIPs. DSRIP payments have historically been made through local government or public hospital intergovernmental transfers or state appropriations. The non-federal portion of the payment is sent by the state to the federal government first, and then the federal government sends back the entire payment. Typically, the whole incentive payment must be received by the DSRIP-participating provider who has achieved the milestone – a non-participating government entity has not been allowed to retain the non-federal or some other portion.[30]

Establishing the Size of the Pool

The total pool funding is based on budget neutrality calculations aside other waiver financing. A larger pool will be able to offer higher and/or more incentives to providers to advance care

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[30] Specifically, IGTs must consist of non-federal public funds in the control of the government entity. A government entity that is not a provider cannot receive incentive payments, and a provider that receives incentive payments has not been permitted to return any portion of those payments to the government entity providing the IGT.

improvement. The pool size should support key providers' ability to be successful in achieving the major change sought by the program.

Distributing Pool Funds

DSRIP dollars will need to be allocated among participants based on a methodology (such as low-income volume, uncompensated care costs, Medicaid share). The methodology should be viewed broadly as logical and equitable. It is important to ensure that key participating providers are eligible for enough funding to realize the transformation desired. For example, a pool spread too thinly may produce less change than one more concentrated because the diluted dollars may not support large-scale reforms.

Incorporating Improvement Potential

A DSRIP program is supposed to be ambitious, but largely achievable. Hence, it should bear in mind what is possible for providers to achieve within the program timeframe from a quality improvement standpoint. The bar is high and the interval is short. History suggests that other systems (e.g., Denver Health, Geisinger Health System, Kaiser Permanente) took close to a decade to achieve the type of results the DSRIP program demands in about half that time. Providers' starting point makes a difference, such as whether they have electronic medical records[31] and how much quality improvement work they have conducted to date. Additionally, a state should consider the variance among its providers – whether they are tackling similar challenges, share corresponding visions and are starting from adjacent or disparate points on their transformation path.

Conducting Program Planning

Three DSRIP programs have already been designed, each with protocols covering hundreds of pages. Two of these are about halfway through implementation. A lot of work and thinking has already been done – literature reviews, identification of best practices and refinement of metrics. Nevertheless, a new program should be tailored to the unique needs of the state and be flexible to accommodate CMS' evolving vision for the program. An important step may be an analysis of the program elements from other states that can be adopted, those that would need further refinement and what is missing. This work should take into account unique state and local issues, the larger context of state waiver goals and strategies, population health needs, provider challenges and CMS thinking. Also, the state-federal politics and policies that may influence scope, focus, and participation should be considered (for example, whether the state is expanding Medicaid).[32]

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[31] How data will be collected and what data are available are important considerations given the massive reporting requirements of the program.

[32] Other states have used most of the first year of the waiver to negotiate the protocols with the Centers for Medicare and Medicaid Services, leaving even less time for providers to begin to make improvements. It is possible that as more states adopt the DSRIP, the time period for this activity could shrink. On the other hand, it may be in the state's best interest to use the first year for planning, where incentive payments are based on DSRIP plan approval.

Assembling the Program Development Team

Program development requires the right resources. All five states have involved key providers in some capacity – from having three-way negotiations to using expert advisory boards. More alignment between the state Medicaid agency and its participating providers could be beneficial in developing a program that is mutually beneficial in a timely manner. These states have also leaned on the know-how of clinical, quality improvement, and subject matter experts.

Defining the Patient Population

Another consideration is how to define the demonstration population. Because the low-income population is not a stable cohort, measuring improvement over time becomes complicated. In other words, the patients receiving the intervention may or may not compose the group measured later on to see whether the intervention worked (such as whether diabetics who received regular blood tests actually improved their blood sugar control). California sought to address this challenge by defining its population as patients with two or more visits per year in an effort to capture patients receiving ongoing care within the provider's organization.

Developing the Provider Plans

Based on the negotiated DSRIP protocols, each participating provider submits a plan committing to milestones for incentive payments. Plans must describe the transformation being undertaken and justify the dollars being requested. Key considerations for states include state-provider processes, policies, communications and coordination, as well as the development of standard templates and forms. Provider considerations include how to form a multi-disciplinary plan development team, manage time and resources, and develop a plan that will achieve transformation in a way that is sustainable and impactful.[33]

Conclusion: Broad Impacts of DSRIP Policy

The DSRIP program is impacting state Medicaid agencies, participating providers and their patients; its policy impacts may even influence health care markets and trends. Overall, the program appears to be achieving one of its key goals of connecting health care quality with waiver financing. State Medicaid agencies have had to harvest new quality and clinical departments to develop and oversee this program. Many of the large safety net providers participating in the program have adopted their DSRIP plans as their organizational strategic plans. As a result, low-income patients are receiving higher quality and more coordinated and proactive health care.

Hence, including a DSRIP program in a waiver offers tremendous opportunity to alter the state's health care landscape and direct the focus of its safety net delivery system. Additionally, a DSRIP can support safety net system financing – as long as those providers are willing to work hard for the funding. Because a DSRIP can be customized, a state may focus its DSRIP on particular state goals (for example, the Massachusetts DSRIP is focused specifically on

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[33] Many providers have developed their plans using processes similar to those for organizational strategic planning. It is recommended that providers consider projects that yield high value for patients, are top organizational priorities, build on existing work and maintain room for improvement.

payment reform). For providers with vision, the program offers the opportunity to achieve transformation with financial support.

However, the DSRIP is a risk-based program and funding is not guaranteed – payments are made if and after milestones are accomplished. A participating provider may invest in the project upfront, but fail to achieve a milestone and therefore not be able to receive the full incentive payment amount on the back end.

In fact, it takes tremendous effort and resources to develop, implement, and participate in the program. These programs often require months of negotiation between state and federal agencies just to develop the elements and requirements. Providers spend significant time and resources to develop their plans, and the implementation of the program for a provider can be all-consuming, including reporting multiple times per year on sometimes hundreds of metrics. In addition to administering the program, states must report on providers' aggregate achievements as well as evaluate the program. Finally, as a public program, accountability and transparency are needed, and there is a risk of audit recovery.

All-in-all, DSRIP policy has cemented waiver safety net financing as something that must be earned. Shaped by the federal government, it is seen as a pathway to ACA implementation, a potential fix to the fragmented U.S. health care system, and a way to bend the Medicaid spending curve.

About the Authors

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