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Key Themes From Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States

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Executive Summary

Introduced originally in California and followed by Texas, Massachusetts, New Jersey, Kansas and New York, “Delivery System Reform Incentive Payment” or DSRIP programs are a key feature of the dynamic and evolving Medicaid delivery system reform landscape. DSRIP initiatives are part of broader Section 1115 Waivers and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals, specifically maintaining supplemental payments for safety-net hospitals. Reflecting a growing emphasis at the Centers for Medicare & Medicaid Services (CMS) to strengthen accountability for Medicaid waiver dollars, a defining feature of these waivers is that they require providers – and, recently, states – to meet benchmarks as a condition of receiving Medicaid funds.

This analysis provides an early look at the impact of DSRIP waivers on Medicaid payment and delivery systems. Building on an earlier [brief](#) that provides an overview of the DSRIP waivers, it relies on interviews with stakeholders to identify emerging trends and themes. It is based on interviews conducted with state officials, providers and advocates in three states that have adopted the Medicaid expansion (California, Massachusetts, and New York) and one state that has not adopted the expansion (Texas). While each of the four programs is different, a number of major themes emerged across the four states that highlight the opportunities and challenges with DSRIP:

DSRIP initiatives are promoting collaboration, supporting innovation, and bringing renewed attention to social services. DSRIP initiatives are sparking new collaboration among providers, such as urban teaching hospitals and rural health care providers or primary care and mental health providers. With the funds that they make available, providers are pursuing innovative approaches to improving care that they have been considering for years. In addition, DSRIP waivers are increasing the focus on the role that social services play in the health of Medicaid beneficiaries, including stable housing, jobs, transportation, food, and other “non-medical” resources. At the same time, providers are struggling with the scope and complexity of the organizational, financial and cultural change needed to implement DSRIP initiatives in some states.

It is critical but challenging to design appropriate DSRIP measures. With significant federal funding on the line in DSRIP waivers, it is vital to design measures that capture whether providers are using DSRIP funds to improve care for beneficiaries. The effort is complicated by the vast number of DSRIP projects in

some states, as well as by the inherent tension between providers wanting the flexibility to design projects that address community-specific needs (as allowed in the initial waiver approved in California) versus the need for some standardization of projects and metrics (more like the recently approved waiver in New York). States and other stakeholders also face many of the classic issues that confront most measurement efforts, including the burden that it can impose on providers to gather and report standardized data, the risk that measures will over-incentivize providers to focus too heavily on specialized activities or populations, and that providers will employ problematic strategies to meet performance benchmarks.

DSRIP's role in broader delivery system reform and relationship to Medicaid managed care remains unclear. A major issue in all four states is how DSRIP fits into other efforts to transform the Medicaid delivery system. In particular, DSRIP waivers often share many of the same goals as Medicaid managed care programs – slowing the rate of growth in spending, improving care and offering greater accountability. DSRIP offers providers – rather than health plans – the opportunity to change the way that they provide care, but, even so, the relative roles of DSRIP-funded provider networks and managed care plans remains unclear in many instances. New York reported the most progress in articulating the relative roles as a result of the work it has done on planning (required in the waiver) to ensure that managed care companies work more over time with the provider networks established by the DSRIP waiver.

The financing structure behind DSRIP waivers can dramatically affect how they are implemented. States typically rely on contributions from state and local public hospitals to finance their share of DSRIP payments. Not surprisingly, this has an effect on the role that providers are expected to play in DSRIP. For example, California currently reserves its DSRIP funds for the state's 21 public hospital systems because they finance the non-federal share of DSRIP payments, as well as of some of the state's other Medicaid spending. In Texas, large public hospitals finance the bulk of the state's share of DSRIP expenses, but, a number of other public entities including community-based mental health centers also contribute and some stakeholders believe it has increased their influence over DSRIP implementation.

The complexity and rapid pace of DSRIP implementation poses challenges to providers, advocates, and state officials. It often takes an extended period – two years for New York – to negotiate a DSRIP waiver with CMS, and once approval is secured, states typically want to implement rapidly to jump start delivery system reform and allow providers to begin earning DSRIP payments. At the same time, the work is complex, often requiring providers to build relationships with new partners and make fundamental changes in their organizational culture and approach to the delivery of care. The complexity and pace of change creates challenges for all stakeholders, but has proven particularly challenging for consumer advocates. They generally are enthusiastic about the role that DSRIP can play in improving care for Medicaid beneficiaries, but, already have numerous ACA issues to address and limited resources. As a result, they struggle to keep track of and actively participate in DSRIP implementation.

Looking ahead, DSRIP waivers are becoming an increasingly important tool for driving Medicaid delivery system reform in states that have approved waivers. However, there are a number of questions about the future of these waivers, such as concerns about the sustainability of projects implemented using DSRIP funds and the extent to which CMS will allow or even encourage other states to pursue DSRIP plans in the future and how states' decisions on Medicaid expansion may affect future DSRIP waiver awards.

Introduction and Background

States are in the midst of transforming the way they provide care to Medicaid beneficiaries, tapping tools ranging from Medicaid managed care contracts to the establishment of health homes and Accountable Care Organizations to demonstrations focused on better care coordination for individuals dually eligible for Medicaid and Medicare. Increasingly, a number of states also are employing Medicaid waivers often referred to as “Delivery System Reform Incentive Payment” or “DSRIP” waivers. Authorized under Section 1115 of the Social Security Act, these initiatives are generally part of broader reform waivers and allow states to make payments to eligible providers supporting the state’s Medicaid delivery system reform agenda. The payments can be used to strengthen the infrastructure needed for delivery system reform; promote new and innovative partnerships among providers; and build stronger connections between health care providers and social services agencies. Reflecting a growing emphasis at the Centers for Medicare & Medicaid Services (CMS) to strengthen accountability for Medicaid waiver dollars, a defining feature of these waivers is that they require providers – and, recently, states - to meet benchmarks as a condition of receiving Medicaid funds.

Building on an earlier [brief](#) that provided an overview of the components of DSRIP waivers, this analysis relied upon interviews with stakeholders to identify emerging trends and themes from DSRIP waivers in four states – California, Massachusetts, New York and Texas. It highlights that DSRIP waivers are spurring major change in relationships among providers; allowing providers to launch new initiatives aimed at improving care and reducing costs; and fostering a stronger focus on the social service needs of Medicaid beneficiaries. At the same time, the rapid pace of implementation is straining the ability of stakeholders to keep pace, including consumer advocates who are hard-pressed to track and respond to the DSRIP-driven changes that are fundamentally re-shaping the way that care is delivered to Medicaid beneficiaries. Looking ahead, as DSRIP implementation continues and waivers come up for renewal, there will be an increasing focus on the need to ensure the long-term sustainability of the DSRIP improvements, including in states like Texas where the challenge may be even greater because of the decision not to adopt the Medicaid expansion.

Overview of DSRIP Waivers in Four States

This analysis is based on interviews with key stakeholders in California, Massachusetts, New York and Texas, including state officials, providers, consumer advocates, foundation staff and other experts. The states were selected to be geographically diverse, as well as to reflect trends emerging from some of the earliest DSRIP waivers (e.g., California and Massachusetts) that have been in place for at least a few years, as well as waivers approved more recently (e.g., New York) that reflect CMS and states’ emerging priorities for delivery system reform. Texas was included based on these factors, but, also to ensure that the issue brief would reflect the experiences of a DSRIP state that has not yet adopted the Medicaid expansion to low-income adults up to 138% of the federal poverty line (FPL). Interviewees were asked to provide their perspective on a range of topics, such as opportunities and challenges created by DSRIP waivers; the role of DSRIP waivers in broader delivery system reform; consumer engagement in the development of the waivers; and implications of DSRIP waivers for beneficiaries. (For a full list of interviewees and interview questions, see Appendix A.)

To provide context for the emerging themes and trends, this section provides a brief overview of the key features of each state’s DSRIP initiative. (Table 1)

Table 1: Key Elements of DSRIP Waivers in Four States

| State | Waiver Timeline | Eligible Institutions | Approach to Budget Neutrality | Funding (All Funds) | Projects/Metrics |
|---------------|--|---|--|--|---|
| California | Approved: 2010-2015, currently seeking renewal | 21 public hospital systems | Repurposed supplemental payments to hospitals | \$6.67 billion | Public hospitals determine own projects and must meet defined metrics |
| Massachusetts | Originally approved: 2011-2014 DSTI Portion Renewed: 2014-2017 | 7 hospitals with high Medicaid and low commercial payer mix | Relied on savings accrued from existing Medicaid 1115 waiver | (2011-2014): \$0.63 billion; (2014-2017): \$0.69 billion | Hospitals must develop projects and meet metrics defined by internal work groups |
| New York | Approved: 2015-2019 | 25 Performing Provider Systems (PPSs) that include hospitals and community-based providers | Relied on savings accrued from existing Medicaid 1115 waiver | \$8 billion/ \$6.42 billion for incentive payments | Performing Provider Systems must meet metrics; State also must meet statewide accountability measures; PPSs must select at least 5 projects from a list of 44 |
| Texas | Approved: 2011-2016, currently considering options to renew/extend | 20 Regional Healthcare Partnerships (RHPs) that include hospitals and community-based providers | Managed care expansion savings and repurposed supplemental payments to hospitals | \$11.4 billion | Providers must meet performance benchmarks; close to 1,500 projects throughout the state |

CALIFORNIA

In 2010, California was the first state to secure a DSRIP waiver, effectively establishing the basic framework for future DSRIP waivers – the distribution of funds to providers that agree to meet defined metrics and goals. California pursued a DSRIP initiative because it was at risk of losing the authority to make critical supplemental payments to its 21 public hospital systems. The state and CMS settled on the DSRIP framework as a means for continuing the payments to these providers while also ensuring a level of accountability for the funds. The DSRIP initiative was included in a larger Medicaid 1115 waiver, known as the “Bridge to Reform,” which was primarily used to expand Medicaid to low-income adults in advance of the January 1, 2014 requirement in the Affordable Care Act. By including the DSRIP initiative in the Bridge to Reform, California was able to retain critical funding for the state’s public hospital systems, but, at the same time, to “jump start” the public hospitals in preparing for broader health reform implementation.

California’s \$6.67 billion dollar DSRIP initiative is financed entirely by the state’s 21 public hospital systems and the federal government. The public hospital systems make intergovernmental transfers to the state, which, in turn are used to draw down federal Medicaid matching funds. These funds are then sent to the public hospital systems for implementing delivery system reform projects and meeting performance measures. In

recognition that California’s public hospitals were at different starting points along the spectrum of delivery system reform, the waiver gave each hospital system broad flexibility to decide the nature of the projects that they would pursue and benchmarks they would attempt to meet. Unlike more recent DSRIP initiatives, it does not require these public hospitals to establish new partnerships with community clinics or social services agencies, but, the state’s public hospitals already have relatively extensive relationships with such entities and, in some instances, even operate their own Medicaid managed care plans.

On March 27, 2015, California submitted a renewal application for its Medicaid 1115 waiver, which is being renamed “Medi-Cal 2020.” The renewal requests authority for a series of delivery system transformation and alignment programs, including a continuation of DSRIP funding for public hospital systems. However, the proposed waiver expands the scope of DSRIP-eligible institutions to 42 safety net institutions run by health care districts (referred to as “non-designated public hospitals”). These institutions are predominantly located in rural areas and are often the only hospitals serving their communities. The application requests a funded planning period of up to one year for these safety-net hospitals to build the infrastructure necessary to participate in the program. The delivery system transformation and alignment programs also seek to transform and improve managed care system; improve the fee-for-service system used to pay for dental and maternity care; spur workforce development; increase access to supportive services and housing; and promote regionally-based “whole-person” integrated care pilot projects.

MASSACHUSETTS

The Massachusetts DSRIP initiative – referred to as the “Delivery System Transformation Initiative” or “DSTI” within the state – has its origins in an 1115 Medicaid waiver originally approved by the federal government in the mid-1990s. The original waiver established a safety net care pool that enabled Massachusetts to dramatically expand coverage and continue supporting safety net hospitals that were significantly impacted by the growth in Medicaid membership. In more recent years, some of the funding available for safety net institutions has been incorporated into a DSRIP-type incentive payment program for selected providers implementing projects and meeting performance metrics. In order to be potentially eligible for DSRIP payments, hospitals must have both a high share of Medicaid patients and a low share of commercially-insured patients. As a result, seven hospitals within the state are eligible for DSRIP payments. In order to secure funding, they must develop projects, largely of their own choosing, and meet metrics established by internal work groups.

Spurred on by the passage of landmark legislation in 2012 (often referred to as “Chapter 224”) that requires significant progress on cost containment and quality improvement, the state is currently in the midst of a major push on delivery system reform and the state’s DSRIP waiver can be expected to play a significant role in those efforts. In the fall of 2014, Massachusetts secured a \$0.69 billion dollar renewal of its DSTI program, through 2017. The state has advised CMS that it will use this time to develop a plan for linking DSRIP payments to more standardized and outcome-based measures, as well as to foster stronger linkages with community providers and make greater use of value-based purchasing.

NEW YORK

The New York DSRIP waiver has its origins in a budget crisis confronting Governor Andrew Cuomo when he first took office in January of 2011. In response, he created a Medicaid Redesign Team charged with lowering costs and improving quality. It produced a number of initiatives that reduced the rate of growth in Medicaid spending, including through cuts to hospitals. New York began negotiating with CMS in the spring of 2012 for an amendment to its existing Medicaid 1115 waiver. It was able to do so in large part because the existing Medicaid 1115 waiver, which was used to implement Medicaid managed care, had generated significant federal Medicaid savings, creating the opportunity for the state to “tap” those savings and reinvest them in the state’s Medicaid program.¹

Arising out of extensive negotiations with CMS, the New York DSRIP is an \$8 billion 1115 waiver approved in April of 2014 that will run from 2015 through 2019. Of this amount, \$6.42 billion will be used for payments to provider networks that implement delivery system reform projects and meet accountability metrics, while the remainder is for transitional payments to critical safety net facilities and for current and new care management initiatives by the Medicaid Redesign Team. At the heart of the waiver are “Performing Provider Systems” or “PPSs.” These newly-created partnerships of providers can receive DSRIP payments for implementing at least 5 delivery system reform projects from a list of 44 and meeting performance metrics. By design, the 25 new PPSs are required to include a broad array of providers, not just hospitals, reflecting the strong interest in New York in moving care into community-based organizations. To date, some PPSs have formed, and, while most are headed by hospitals, this is not a requirement and a few are headed by community-based clinics or primary care physicians.

The New York waiver is notable for including a number of new features. First, the terms and conditions of the waiver require New York to develop a plan for integrating DSRIP initiatives into Medicaid managed care by ensuring 90 percent of managed care payments to providers use value-based methodologies. Many stakeholders view the requirement as CMS’s effort to encourage states to find ways to integrate DSRIP-driven changes into their delivery systems on a permanent basis. Second, New York is the first state that will be held accountable at a statewide level for ensuring that its DSRIP investments are effective. It faces a reduction in DSRIP funding if it cannot hold per capita Medicaid spending to target levels; demonstrate that providers have met a majority of all of their project goals; and show progress toward the goal of integrating DSRIP initiatives into Medicaid managed care.

TEXAS

The Texas 1115 waiver was developed to allow the state to expand the managed care delivery model statewide for Medicaid and retain historical supplemental funds, known as upper payment limit (UPL) payments, to its hospitals. (As discussed in “DSRIP Waivers: An Overview,” states cannot make UPL payments to hospitals on behalf of Medicaid managed care beneficiaries. As a result, greater use of Medicaid managed care diminishes the capacity to make these payments to hospitals). The Texas 1115 waiver, approved for 2011-2016, includes two supplemental funding pools, the Uncompensated Care (UC) pool, which replaced the previous UPL program, and the DSRIP pool. The \$11.4 billion dollar DSRIP pool allows DSRIP payments to providers implementing delivery system reform projects and meeting performance benchmarks. Public entities provide

intergovernmental transfers (IGTs) to the state to finance the state share of UC and DSRIP payments, much as they previously did to finance the supplemental payments the waiver replaces.

As in New York, the Texas DSRIP waiver is specifically designed to promote stronger collaborative relationships among DSRIP performing providers, including hospitals (public and private), physician groups, community mental health centers, and local health departments. (In fact, as the Texas DSRIP initiative predates the New York waiver, it is widely viewed as providing a model for some of New York's activities.) Under the waiver, the state of Texas allocates funds to these performing providers that participate in "regional healthcare partnerships," or "RHPs," which, in turn, must have a regional plan to identify and address community needs, and create and implement proposed projects. Each partnership includes one or more public entities – including local public hospital districts, academic health science centers, community mental health centers, counties and others – that can make an intergovernmental transfer to the state, allowing performing providers to draw down federal Medicaid matching funds for DSRIP payments. In total, there are 20 RHPs covering the 254 counties in Texas and each selects projects from a menu of project options, with a minimum number of projects in each region related to Infrastructure Development and Innovation/Redesign. There are close to 1500 projects that are implemented by over 300 performing providers throughout the state, many of which focus on behavioral healthcare, access to primary care, and chronic care management and helping patients with complex needs navigate the health care system. The primary target populations for projects include Medicaid beneficiaries and low-income uninsured individuals.

Notably, Texas secured its DSRIP waiver before the Supreme Court ruling on the Affordable Care Act made it optional for states to adopt the Medicaid expansion to adults below 138 percent of the FPL. As a result, CMS did not address in Texas whether it will require states to cover low-income adults before making available federal Medicaid matching funds for investments in delivery system reform. The issue, however, is likely to arise in the near future. In Florida, CMS officials already have advised the state that it cannot continue "in its present form" a nearly \$2 billion uncompensated care fund for hospitals. The uncompensated care pool is not a DSRIP initiative, but, the debate over its future may offer some insight into how CMS will approach Texas and other non-expansion states seeking to secure a new DSRIP waiver.

Key Findings

While DSRIP waivers vary based on how long they have been in effect, specific goals and objectives, eligible providers, projects and organization and financing, a number of common themes and early "lessons learned" emerged from stakeholder interviews. Overall, DSRIP is spurring major change in the way that providers serve Medicaid beneficiaries.

1. DSRIP IS CHANGING THE WAY CARE IS DELIVERED BY PROMOTING COLLABORATION, SUPPORTING INNOVATION, AND FOCUSING ON SOCIAL SERVICES.

In Texas and New York, the DSRIP waivers have unleashed a range of new collaborative partnerships, spurring what one stakeholder characterized as "never-before-had" conversations among providers. The DSRIP waivers are clearly changing the dynamic among providers, promoting new

relationships, and breaking down traditional silos between behavioral health and physical health providers, large hospitals and community clinics, and more. In Texas, for example, the DSRIP waiver has fostered new relationships between large urban teaching hospitals and rural health care providers, allowing rural residents to receive care in their own communities for complex conditions. For example, in Childress, TX, a small town of 6,000 mostly low-income residents, the DSRIP waiver sparked a new relationship between the community's small rural hospital (Childress Regional Medical Center) and one of the state's teaching hospitals in Lubbock, TX (University Medical Center). With the assistance of UMC, the Childress Regional Medical Center was able to establish an on-site chemotherapy option for cancer patients who previously had been required to routinely travel over 100 miles for such care.

In New York, the state placed coordinated networks of providers (Preferred Provider Systems or PPSs) at the heart of its DSRIP waiver, reflecting the belief that delivery system reform will occur only if hospitals work together with community-based partners to change the way that care is delivered. State leaders repeatedly emphasize the importance of collaboration when describing DSRIP. Perhaps more importantly, New York has developed an algorithm for distributing DSRIP funds that rewards PPSs for contracting with community-based providers serving large numbers of Medicaid beneficiaries. As a result of the strong focus on collaborations, New York providers have spent significant amounts of time building partnerships with one another and finding ways to strengthen their joint efforts.

At the same time, the changing provider relationships inspired by DSRIP also raise new challenges. Some interviewees, for example, pointed out that it is challenging for providers to figure out how to collaborate for purposes of serving Medicaid beneficiaries, while continuing to compete against each other for Medicare and private-pay patients. Others raised the concern that the new partnerships could prove anti-competitive and, indeed, commercial managed care companies in New York have filed a lawsuit against the state charging that the new performing provider systems are anti-competitive. Some interviewees view hospitals as continuing to hold too much power within the integrated delivery networks set up in New York, in particular, muting the effectiveness of DSRIP as a tool for promoting more community-based care. Finally, a number of consumer advocates expressed concern that new partnerships could increase existing financial incentives for providers to refer patients to one another even when it is not necessarily in their patients' best interest. Although these issues are a feature of any delivery system reform effort, it is clear that they are likely to continue to arise in the DSRIP context as providers wrestle with the complex organizational, financial and cultural issues raised by their changing relationship to one another.

DSRIP is allowing providers to try out innovative approaches to improving care that they have been considering for years, or, in some instances to take innovative pilot projects and implement them broadly. The significant funding opportunity created by DSRIP has been enough to “fracture routine,” as one interviewee put it, and promote cultural and environmental change in the way that care is delivered to Medicaid beneficiaries. For example, in Texas one project helps to train paramedics as community health workers. They help “frequent flyers” avoid unnecessary ER visits by checking in with them regularly, helping them fill prescriptions, getting groceries, and offering companionship to socially isolated individuals.

DSRIP waivers are bringing renewed attention to the importance of the social issues confronting Medicaid beneficiaries, but, some stakeholders remain disappointed. States are

using DSRIP waivers to revisit the question of the role that Medicaid can and should play in providing people with social services that directly affect their health, including stable housing, jobs, transportation, food, and other “non-medical” resources. In New York, performing provider systems are explicitly given the choice of implementing a DSRIP a project aimed at ensuring that people have supportive housing. The state also has invested significant state dollars outside of its DSRIP waiver in housing stock to ensure that a better supply of appropriate housing is available. In Texas, some DSRIP performing providers have used DSRIP funds to install refrigerators in homeless shelters so that people can get access to insulin without having to visit a clinic. The California DSRIP waiver has increased the extent to which the public hospital systems focus on coordination with social services agencies and county-level welfare offices. In its renewal application, California is seeking to go even further by providing funding for housing-based care management strategies, as well for respite care, housing subsidies, and other supportive services.

At the same time, some stakeholders expressed concern about the depth of the commitment to connecting Medicaid beneficiaries to social services. In some instances, states reported that they were interested in pursuing more aggressive connections to social services, but, that CMS imposed constraints. In New York, for example, stakeholders noted that the final terms and conditions of the state’s DSRIP waiver imposes a five percent cap on the share of DSRIP funds that can go to non-Medicaid providers, creating a limit on the DSRIP funds that can go to community-based organizations with arguably the strongest ability to connect people to social services (though they could also potentially be funded indirectly at higher levels if a provider that is in a PPS network decides to share some of the DSRIP dollars with them). On a related note, some stakeholders were concerned that there is no obligation for the PPSs to contract with social service agencies, and they may be relatively weak partners as a result.

2. IT IS CRITICAL, BUT CHALLENGING TO DESIGN APPROPRIATE MEASURES OF THE IMPACT OF DSRIP

The issue of how to measure the progress of providers in meeting DSRIP goals is a major source of debate and discussion in states with DSRIP waivers. With significant federal Medicaid funding on the line in DSRIP waivers, CMS is pushing states to adopt robust, meaningful measures and metrics that capture whether providers and states are making meaningful changes that improve care for beneficiaries and slow the rate of growth in spending. Indeed, these are the primary tool that CMS has to hold providers and states accountable for the Medicaid funds they are investing in delivery system reform. As a result, it is not surprising that a number of state officials reported that it took months to negotiate their DSRIP measures with CMS. In turn, providers (particularly smaller providers) frequently raise concerns about the level of resources and time associated with pulling and reporting the data needed for measurement. On the other hand, stakeholders across the board pointed out that it will be difficult to establish the worth of DSRIP waivers and to explain what they have accomplished in the absence of strong, clear data.

At a more granular level, the four states ran into many of the classic issues that confront any effort to measure performance, including whether the measures can be implemented; the risk that measures will incentivize providers to focus on what is being measured (rather than what most needs to be done); and the prospect that providers will employ problematic strategies to meet performance benchmarks. For example, some stakeholders in New York pointed out that the decision to condition the continued flow of DSRIP funds on

reductions in avoidable hospitalizations could create incentives for providers to reclassify their hospitalizations. Others expressed concern that critical measures were missing from DSRIP initiatives, such as measures aimed at addressing disparities and at the quality of care provided to children. Some providers felt that measures inappropriately held them responsible for the care of individuals not subject to DSRIP intervention (e.g., one Texas provider noted that it must report data on all diabetics that it treats, not just those that are the beneficiaries of its DSRIP-funded program for super-utilizers). Finally, California has faced issues because all of the public hospital systems have met the performance metric that they established for themselves, suggesting to some that the standards should be more rigorous.

A major tension in DSRIP waivers is how much to standardize the projects and related measures versus allowing providers to develop their own projects within general parameters.

The chance to allow individual hospitals and/or provider systems to select projects within broad parameters helps to ensure that the projects are connected with each local community's needs and priorities. However, a plethora of projects can make it difficult to measure and explain the impact of DSRIP funding, as well as increase the challenge that states face in overseeing and implementing DSRIP waivers. California stakeholders, in particular, noted that because each public hospital system has developed an individualized implementation plan, it is hard to tell a statewide story of how much DSRIP has accomplished, as well as to assess the impact of the projects in advancing the state's broader vision for delivery system reform. In Texas, a large state with over 300 DSRIP performing providers, and CMS requirements for a cap on the maximum valuation of projects, resulted in close to 1,500 DSRIP projects, making it difficult to evaluate and quantify the effect of DSRIP funds.

3. DSRIP'S ROLE IN BROADER DELIVERY SYSTEM REFORM AND MEDICAID MANAGED CARE REMAINS UNCLEAR

A major issue in all four states is how their DSRIP initiatives relate to other efforts to transform the delivery system for Medicaid. DSRIP is distinguished by its focus on helping hospitals and their provider partners – as opposed to issuers or other parties – prepare for and implement Medicaid delivery system reform. And, DSRIP waivers often are embedded in or closely connected to broader initiatives aimed at delivery system reform. In Massachusetts, for example, the state's renewal of its DSRIP pool was negotiated as the state was in the midst of implementing broad efforts to contain costs and improve quality in light of the enactment of Chapter 224, landmark legislation to reform the state's delivery system. The DSRIP pool plays the role of helping several of the state's major safety net institutions prepare for more value-based purchasing in Medicaid, but it is far from the state's only delivery system reform initiative. California's DSRIP program also is aimed at strengthening the ability of the state's public hospital systems to treat Medicaid beneficiaries, but the state has sought to connect DSRIP with related initiatives, such as its Medicaid quality strategy. In its renewal application, California places even greater emphasis on coordinating and strengthening its various initiatives to transform the delivery system and has outlined a more detailed plan for building connections among them.

Of particular interest to stakeholders is the question of how DSRIP waivers relate to a state's Medicaid managed care program. In general, the DSRIP projects that providers are undertaking are designed to slow the rate of growth in Medicaid spending; improve quality; and promote greater accountability for the care of Medicaid beneficiaries. Medicaid managed care also is designed to promote these same

objectives, raising the question of the relationship between a state's Medicaid managed care program and its DSRIP initiative.

The New York DSRIP waiver comes closest to tackling the issue directly – the waiver requires the state to develop a plan for incorporating DSRIP into its approach to Medicaid managed care contracting. By April 15, 2015, the state must submit the plan to CMS and it cannot receive federal Medicaid matching funds for managed care payments for state fiscal year 2015 until the plan has been approved. At a minimum, the plan will address how the state will ensure that 90 percent of managed care payments to providers are made using value-based payment methodologies; how it will modify rates to reflect changes in the cost of care attributable to DSRIP; and how it will ensure that Medicaid managed care plans are pursuing and reporting on DSRIP objectives and metrics. In Texas, some stakeholders suggested that the state is likely to identify promising practices emerging from DSRIP projects, and eventually to consider integrating them into its Medicaid managed care contracting process (although, unlike New York, it is not required to do so under its waiver).

Ultimately, the DSRIP waivers could end up strengthening a state's Medicaid managed care program by offering MCOs a larger pool of more sophisticated providers with which to contract and manage care. On the other hand, there is a risk of redundancy as managed care organizations and providers both work toward building stronger networks of care that can provide integrated, cost-effective, high-quality services.

4. THE FINANCING STRUCTURE UNDERPINNING DSRIP WAIVERS CAN DRAMATICALLY AFFECT HOW THEY ARE USED

DSRIP initiatives are heavily influenced by how they are financed. As described in the background section on each of the four states, the original impetus behind the DSRIP waivers was a state desire to hold onto or maximize federal Medicaid matching funds for payments to providers. And, the more hospitals or certain hospitals (e.g. public hospitals) finance the non-federal share of the Medicaid DSRIP funding, the more DSRIP funds are allocated to these providers. Although they have become a surprisingly important driver of change, DSRIP waivers and the way that they are being operationalized continue to reflect the financing incentives that underlie them.

For example, California's decision to focus its DSRIP payments on the state's 21 public hospital systems (which some stakeholders suggest might be revisited at renewal) reflects the reality that these integrated systems finance the state share of DSRIP payments and even additional payments to the state's other hospitals through intergovernmental transfers and/or certified public expenditures. In New York, where some public hospitals are responsible for financing the state share of DSRIP payments, some stakeholders raised the concern that the implementation of the waiver is being affected by the need to ensure that these public hospitals receive a significant share of the available DSRIP funds. In Texas, stakeholders noted that the ability for community-based mental health centers to finance a portion of the state share created relationships between primary care providers and mental health centers and increased the influence of mental health centers on DSRIP implementation.

5. COMPLEXITY AND RAPID IMPLEMENTATION OF DSRIP PROGRAMS POSE CHALLENGES TO PROVIDERS, ADVOCATES, AND STATE OFFICIALS.

A number of stakeholders reported concern about the rapid pace of DSRIP implementation given the complexity of delivery system reform. Once states secure approval for their DSRIP initiatives, they typically feel enormous pressure to implement quickly in order to start the flow of DSRIP funds to providers. In New York, for example, the state’s DSRIP waiver took over two years to negotiate, but, since approval, providers have been expected to work rapidly to build integrated delivery networks and create DSRIP implementation plans. The work is complex, requiring providers to build relationships with new partners and create a single, unified delivery system; establish a governance structure; and develop a methodology for distributing DSRIP funds among participating providers. As a result, it can be difficult for consumer advocates, beneficiaries and others who sit outside of the process in New York and other DSRIP states to provide input. Several stakeholders across the four states also raised that it is difficult to achieve the cultural and environmental change that is needed to make DSRIP work when rushed – such change relies on carefully and thoughtfully engaging the leadership of provider organizations and changing the way that the people on the front lines of delivering care do their jobs.

Most consumer stakeholders are enthusiastic about their state’s DSRIP waiver, but struggle to keep track of what is happening and remain concerned about whether beneficiaries’ interests are well-represented. Since Medicaid beneficiaries are disproportionately affected by multiple chronic conditions and behavioral health issues, consumer advocates are particularly appreciative of DSRIP-driven efforts to improve care coordination; integrate physical and behavioral health; and connect people to social services. On the other hand, they struggled to track what was happening with their state’s DSRIP waiver. They have been occupied with implementation of the Affordable Care Act and find it difficult to monitor and respond to the complex and often voluminous details of DSRIP implementation. One notable exception was Massachusetts, which has a robust consumer advocacy community and a high-profile delivery system reform agenda. A broad array of stakeholders noted that consumer advocates were able to consistently track and provide productive insights into DSRIP developments in Massachusetts. While advocates in California were focused on the broader coverage provisions in the Bridge to Reform Waiver, it appears as though consumer advocates will be more focused on the DSRIP issues as the California waiver goes through the renewal process.

Beyond the process and timing issues, consumer advocates also raised concerns about the extent to which beneficiaries are aware of the changes going on around them. Specifically, in both Massachusetts and New York, the issue was raised that consumers do not necessarily know when they are part of a network of providers and so may be unaware of any financial incentives that a provider might have to refer within the integrated delivery network. (Although it should be noted that a number of other stakeholders pointed out that this is an issue not unique to DSRIP initiatives.) On the other hand, a few stakeholders argued that improvements should be happening “behind-the-scenes,” out of the eye of consumers who will benefit from improved care without needing to follow the details of the changes. Consumer advocates also were concerned that community-based organizations were not getting enough funding, as well as that consumer advocates were being asked by providers and states to provide a consumer perspective on DSRIP, without the resources to track and develop positions on waiver developments.

Looking Ahead

In all four of the states reviewed for this analysis, major questions are arising about the sustainability of DSRIP initiatives. The challenge is exacerbated by the reality that DSRIP initiatives often are replacing supplemental payments to hospitals, and, the providers receiving them do not view them as short-term transitional help. At the same time, Medicaid 1115 waivers are intended to be demonstrations, not to become permanent fixtures of a state's Medicaid program, and CMS increasingly is pressing states to articulate their plans for what will happen when their DSRIP waivers expire. One emerging approach to sustainability is apparent in New York's DSRIP waiver, which requires the state to develop and implement a plan for ensuring that 90 percent of managed care payments to providers eventually are made using value-based payment methodologies. In effect, the state and CMS appear to be envisioning that Medicaid managed care plans will play a key role in continuing the progress initiated by DSRIP waivers.

There currently are DSRIP waivers in 7 states, and an open question is the extent to which CMS will allow or even encourage other states to pursue them. It is unlikely that Congress will take action on Medicaid and delivery system reform in the near future, which means that states and the Administration have a strong incentive to use existing tools, such as the 1115 waiver authority, to pursue delivery system reform. On the other hand, 1115 waivers are a relatively cumbersome tool for adopting change; they are time-intensive to negotiate and must be budget neutral to the federal government. To date, all states with DSRIP waivers have recycled supplement payments to hospitals or, as in New York, "tapped" savings from an existing waiver to finance their DSRIP initiatives. If it wants to allow more states to pursue DSRIP waivers, CMS will need to work with states to identify additional ways to establish and ensure the budget neutrality of DSRIP waivers even if they do not happen to have savings from an earlier Medicaid 1115 waiver or supplemental payments that can be re-configured as DSRIP funding.

For states that have not yet adopted the Medicaid expansion, a key question will be whether CMS will grant them a DSRIP waiver even though they have elected not to provide care to many low-income adults. In Texas, the one non-expansion state in this analysis, most stakeholders agreed that the decision not to expand has left a coverage gap that makes it significantly harder to engage in delivery system reform. It is far more challenging to coordinate and improve the care of uninsured individuals, and the lack of coverage for many Texans means that providers must divert energy and resources away from delivery system reform and toward providing uncompensated care. Moreover, while many Texas providers have pushed hard for the state to expand coverage, a number of stakeholders noted that they might have been even more aggressive in their expansion advocacy if DSRIP funds were no longer available. At the same time, the DSRIP waiver has brought about important and beneficial changes in the way that many providers deliver care. Florida, which faces similar issues with respect to its low-income pool, may offer early insight into the likely future of DSRIP in states that have not expanded Medicaid. If it fails to secure renewal of its low-income pool, it is a clear sign that Texas and other similarly-situated states may find it difficult to continue their DSRIP initiatives in the absence of a Medicaid expansion.

Conclusion

Based on the four states investigated for this analysis, it is clear that DSRIP waivers are becoming an increasingly important tool for driving Medicaid delivery system reform. They have spurred major change, often surprising even the state officials who designed them in the extent to which they have broken down silos among providers and unleashed new initiatives. The waivers have prompted sweeping changes in relationships

among providers, as well as played a role in changing the way that care is provided to individuals with specific conditions; increased coordination of care; promoted integration of physical and behavioral health services; and deepened coordination between health care providers and social services organizations. At the same time, because the waivers can include a range of projects carried out by multiple providers (or provider networks), it is difficult to accurately assess the impact of DSRIP waivers on states' delivery system and to quantify and explain the role that they play. This complexity and the rapid pace of implementation also has made it challenging for consumer advocates to track and respond to changes brought about by DSRIP waivers, even though they have the potential to fundamentally re-make the way that care is provided to low-income Medicaid beneficiaries.

Looking ahead, there are a number of open questions about the future of DSRIP waivers, including the fundamental issue of whether CMS will allow or even encourage more states to use DSRIP waivers as a tool for delivery system reform. States such as Alabama, Illinois and New Hampshire have recently submitted DSRIP waiver applications, but, CMS has not yet provided a public response. The issue may prove particularly challenging to resolve in non-expansion states where the coverage gap makes it more difficult to reform the delivery system. CMS, states and other stakeholders will continue to face questions about how to track and evaluate the impact of the DSRIP waiver; how to integrate the waiver with Medicaid managed care and other delivery system reform efforts; how to ensure the long-term sustainability of DSRIP initiatives; and how to ensure that consumer advocates have the resources with which to track and respond to DSRIP developments. Regardless of how these issues are resolved, DSRIP waivers are likely to become an increasingly important part of the delivery system reform landscape for Medicaid beneficiaries in the months and years ahead.

This brief was prepared by Jocelyn Guyer and Naomi Shine from Manatt Health and Robin Rudowitz and Alexandra Gates from the Kaiser Family Foundation. The authors would like to thank all of those interviewed for this study.

Appendix A: List of Expert Interviewees and Interview Guide

California:

Toby Douglas, Mari Cantwell, Neal Kohatsu, California Department of Health Care Services (November 17, 2014)

Peter Harbage, Harbage Consulting (November 13, 2014)

Erica Murray, California Public Hospital Association (November 24, 2014)

Massachusetts:

Amanda Cassel Kraft, Laxmi Tierney, Taya Mashburn, MassHealth (December 12, 2014)

Brian Rosman, Health Care For All (November 12, 2014)

New York:

Jason Helgerson, New York State Department of Health (November 14, 2014)

Andy Cohen and Chad Shearer, United Hospital Fund (October 23, 2014)

Elisabeth Benjamin, Community Service Society of New York (October 28, 2014)

Melinda Dutton and Patricia Boozang, Manatt Health (November 3, 2014)

Texas:

Lisa Kirsch and Ardas Khalsa, Texas Health and Human Services Commission (December 11, 2014)

Melissa Rowan, Texas Council of Community Centers (December 1, 2014)

Anne Dunkelberg, Center for Public Policy Priorities (December 2, 2014)

Maureen Milligan, Teaching Hospitals of Texas (December 10, 2014)

High Level Questions

1. What are the strengths of your State's DSRIP waiver?
2. What are the weaknesses?
3. What are the biggest challenges and barriers related to implementation of your DSRIP program/to delivery system and payment transformation?
4. What would you tell CMS or other States to do differently in future DSRIP waivers?
5. How does the DSRIP initiative relate to other delivery system reforms in your State?

For State Officials

1. Why did your State pursue DSRIP?
2. What was your role in the design and/or implementation of your State's DSRIP waiver?
3. What are the key features of your State's DSRIP waiver? What distinguishes your initiative from other States'?
4. How did your State approach transparency and opportunities for public input? Were these activities focused at the State level, the provider level, or both?
5. What are the two or three top goals your waiver is meant to achieve?
6. How did you decide which providers could receive DSRIP funding?
7. How is funding tied to waiver goals and how are funds allocated across providers?
8. What are some of the key metrics to demonstrate progress in meeting goals? Are there some DSRIP projects or initiatives that have proven to be more successful than others and why?
9. What oversight and evaluation processes do you have in place to measure progress in meeting goals? Do you think the evaluation/oversight mechanisms, from a State perspective, are sufficient?
 - o What has been the experience in providers meeting metrics?
10. How does your DSRIP waiver relate to the current delivery system infrastructure and other delivery system reforms (i.e., managed care, pay for performance, SIM grants, etc.)?
11. What are the biggest challenges you've faced implementing DSRIP (operationally, administratively, etc.)?
12. How do you see the DSRIP waiver playing out over the next 5 years?
13. Do you think this model is sustainable in the long run? What changes would you make for a renewal?
14. What can you say about how DSRIP is affecting outcome measures (i.e., population health, clinical improvements, access to primary care, etc.)?
15. What is the effect of the Affordable Care Act and the Medicaid expansion on DSRIP?

Financing

16. What are the allowable uses of DSRIP funding in your state?
17. How do you control how DSRIP money is spent?
18. How does DSRIP fit in to the aggregate budget neutrality calculations for the waiver? What challenges arose in establishing budget neutrality? How are you ensuring budget neutrality over the course of the waiver?
19. What did you use as State matching funds?
20. What have been the financial implications of implementing DSRIP in your State?

For Providers

1. Please tell us a little about your organization—how big are you, who are your key patient populations, what is your service area?
2. Please tell us about your participation in your State's DSRIP waiver:
 - o Are you leading an application, or partnering with a leading hospital? What were the criteria for participation in your State's waiver?
 - o What governance structures are in place between the different partners in your program? How closely are you working together on program planning and implementation?
 - o What are the goals and focus areas of your DSRIP program?
 - o How many enrollees do you expect it will reach?
 - o How much funding are you expecting to get or have you received?

- How far along are you in planning and/or implementation?
 - What are the major metrics being used to evaluate your program's performance? How are those metrics tied to DSRIP funding?
3. Are there specific DSRIP initiatives or projects that have proved to be more successful than others?
 4. What actions were necessary to implement DSRIP (i.e. new systems, staff training, new staff, coordination across stakeholders, etc.)?
 5. What have been the major challenges and opportunities with DSRIP?
 6. How do you think your practice will be impacted when DSRIP funding ends? How are you preparing for this?
 7. What is the effect of the ACA and the Medicaid expansion on DSRIP?

For Advocates

1. What are the implications for beneficiaries regarding DSRIP waivers in your State?
2. What opportunities have you had to participate in the decision-making process concerning implementation?
3. From a beneficiary's perspective, what are areas that are working well and what could be changed to make DSRIP work better?
4. How do you see DSRIP connecting with other delivery system reforms in your state?
5. What additional tools do you think advocates need to ensure DSRIP waivers help beneficiaries? How much access and how easy to understand are the reports on meeting various metrics?
6. What is the effect of the ACA and the Medicaid expansion on DSRIP?

For Texas Stakeholders

1. How does the DSRIP waiver intersect with Texas's decision to not expand Medicaid?
2. How do you think this decision will play out in the long run?

¹ Under the budget neutrality rules for Medicaid 1115 waivers, states and the CMS agree upon a "without waiver" baseline that represents the amount a state would have spent on Medicaid in the absence of the waiver. The state is then allowed to receive federal Medicaid matching funds for amounts up to the without waiver baseline level, including for activities that otherwise would not be matchable but for the Medicaid 1115 waiver. If a state's actual spending comes in below the without waiver baseline, it may be allowed to "bank" those savings and potentially use them to finance activities for future Medicaid 1115 waivers.