Improving Care through DSRIP 1115 Medicaid Waivers:
An Analysis of the Delivery System Reform Incentive Payment Program across Six States

2nd Edition 2017

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EXECUTIVE SUMMARY

Fourteen states have included incentive-based system transformation programs in their Section 1115 Medicaid Waivers since 2010[1]. These are most commonly known as Delivery System Reform Incentive Payment (DSRIP) programs, although some states take on different names and approaches. Each waiver provides incentive funding following providers' achievement of improved care for low-income patient populations. These programs continue to be adapted and refined by federal and state governments to promote better care at lower costs within the states by directly linking waiver funding to health care quality and total cost of care, as opposed to uncompensated care costs or reimbursement for Medicaid services. They are designed to support safety net providers take steps to transform care delivery and better compete in a reformed health system. Many of the notable programs since 2014 are making advanced strides to transition the funding streams within the Medicaid program to be paid through value-based payments (VBP) through their program requirements.

The paper discusses crucial decision points for Medicaid agencies, health plans and providers developing or considering a waiver to transform payment and/or delivery systems. Aspects examined include: aligning the improvement program with waiver goals, understanding evolving priorities in Washington D.C., securing the local matching dollar to finance the program, determining DSRIP participants, establishing and distributing available funds, incorporating improvement potential, conducting program planning, understanding data and reporting, defining the network patient population and developing strategy and implementation plans. For states with DSRIP or DSRIP-like programs, these initiatives are transforming the way providers work together to deliver care and impacting state Medicaid agencies, participating providers and their patients.

As important as understanding how DSRIP programs influence transformation across the care continuum, it is equally important to understand how the Trump administration and policymakers in Washington view the role of Medicaid and seek to influence 1115 waiver designs. Beyond Congressional bills, the current administration continues to modify the Medicaid program and unwind various aspects of the Affordable Care Act (ACA) through executive orders and other administrative actions. As the current Trump administration and GOP leadership contemplate new cuts to Medicare and Medicaid, understanding how these issues impact the design of Medicaid programs and supplemental waivers is becoming increasingly more critical. Here, we examine what these priorities may be and how they will impact current and future 1115 waiver DSRIP programs and the current actions of the administration that provide insight into what their future strategies may be.

We conclude this paper by describing 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 that is embraced by the federal government and expected to be utilized as a vehicle to drive long-term infrastructure improvements and payment reform.

This paper provides an update to a previous 2013 comparative analysis of the current DSRIP, and DSRIP-like, programs across several states and identifies a number of key decision points for states and providers who may be considering, developing or beginning implementation work for waivers with DSRIP programs. The appendices focus on a comparative analysis of state DSRIP programs, including key contextual influences, the investment dollars available within each waiver, the size and scope of the DSRIP program.

OVERVIEW

Section 1115 Medicaid Waivers – A Vehicle for Transformation

Medicaid is a historic federal-state partnership established in Title XIX of the Social Security Act to provide a safety net for low-income populations. It is administered by the states and funded jointly between the state and federal government. Medicaid programs must adhere to federal rules in the management of their programs, unless they have been granted exemptions or flexibility to vary from state to state either through a state plan amendment or through waivers.

Section 1115 in Title XIX 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").

Since the 1990s, 1115 waivers have become increasingly utilized by the state to implement innovative programs to meet current needs. As a result, they are important policy levers providing significant funding streams that are evolving various aspects of Medicaid programs and changing safety net delivery systems. Through waivers, states are expanding the use of Medicaid managed care as an alternative to the traditional fee-for-service system, helping providers shift towards value-based payments, extending health care coverage and developing new partnerships and integrated networks while demonstrating new ways to deliver health care. 1115 waivers are a negotiation impacted by the goals, strategies and key policies of each federal administration, the goals and needs of the state applying for the waiver and influenced by the successes and challenges of previous states implementing similar waiver programs.

[1] https://www.chcs.org/resource/delivery-system-reform-incentive-payment-mapping-state-programs/

DSRIP and DSRIP-like programs continue to evolve, and there is a momentum for more of these waivers by states seeking systems change. As policy objectives of the new administration of President Trump become clearer, these goals will create challenges and questions states must address to achieve new 1115 waiver programs or renewal programs. Initial indications inform the industry that the Centers for Medicare and Medicaid Services (CMS) will want waivers that are designed to reduce cost and financial risk, may contain requirements for the target population to contribute to health savings accounts (HSAs) and focus on co-pay requirements for covered individuals, in addition to other key priorities of the administration.

History of the Delivery System Reform Incentive Payment Program

The Institute for Healthcare Improvement's (IHI's) concept of the Triple Aim has always been an inspiration for the framework of DSRIP – better care that improves population health at a lower cost[2]. Additionally, the delivery system reforms inspired by the Affordable Care Act (ACA) and the Triple Aim helped shape the structure of DSRIP programs – 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.

Since the concept of DSRIP was first developed in California in 2010, other states have sought to use the program structure as a framework to stimulate transformation in the delivery system from fragmented silos of episodic treatment to integrated systems of coordinated and proactive care focused on improving health outcomes. Section 1115 waivers with a DSRIP or DSRIP-like component not only push providers and health systems to reshape the way they think about and deliver clinical care, but also how the care is financed and payment is distributed amongst payors, including those in the community setting (Table 1). Following the initial launch in California, Massachusetts was the first to modify the program for the states' needs, followed by Texas, New Jersey, New York and many others.

Accordingly, the DSRIP program structure 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 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 varies among states.

Each DSRIP program is governed by state and federally negotiated protocols, making each program unique and complex in its own way. Based on these protocols, participating providers develop multi-year plans with milestones and specific quality outcomes. A key hallmark of DSRIP programs is that they are outcomes based incentives by nature – federal funds do not flow to states unless providers demonstrate that they have done the work and achieved metrics and milestones. Providers can receive incentive payments if and after they achieve their milestones or surpass clinical quality benchmarks. Depending on the state waiver, providers earn their funds based on their individual performance (e.g. California and Texas) or their combined performance across partners (e.g. New York and Washington). 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 often used to implement population-based and patient-centered care in a deliberate manner that focuses on health and wellness instead of treating illness; however, it is important to note that each program is designed based on the issues state and local stakeholders are trying to improve. As a result, many participating providers are expanding primary care, partnering with community-based organizations (CBOs), 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[4].

Table 1: Timeline of DSRIP and DSRIP-like Program Application and Approval

STATE[3]	APPROVAL PERIOD(S)
California	Initial waiver approved 2010, current extension approved from January 2016-December 2020
Massachusetts	Initial waiver approved in 2011, current extension approved July 2017-June 2022
Texas	Initial approval September 2012-September 2017, current 15-month extension in place through 2018
New Jersey	Approved October 2012-June 2017
Kansas	Approved January 2014-December 2017
New Mexico	Approved January 2014-December 2018
New York	Approved January 2014-December 2019
New Hampshire	Approved January 2016-December 2020
Washington	Approved January 2017-December 2021
Virginia	To be determined
Arizona	Extension approved September 2016-September 2021 with new DSRIP-like component
Oregon	In renewal negotiations for July 2017-June 2020
Florida	Extension approved July 2014-June 2017
Rhode Island	To be determined

Key: DSRIP | DSRIP-like

[2] http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
[3] http://www.chcs.org/media/DSRIP-State-Program-Tracking-120516-FINAL.pdf
[4] 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.

In DSRIP programs such as New York, the state and CMS have specific requirements that all participating primary care doctors establish themselves as Level 3 Patient Centered Medical Homes (PCMH) by the third year of their waiver[5]. Many providers are also working to improve the patient experience and important health indicators. In a number of states, such as New York and Washington, providers are encouraged to come together to build integrated networks to fundamentally change relationships across the care continuum for providers serving Medicaid and low-income patients.

The appendices of this paper focus on a few distinct state DSRIP programs. We begin with the states currently implementing DSRIP programs – California, Texas, New York and Massachusetts, concluding with an analysis of two states who are working to develop their DSRIP program protocols – Washington and Arizona.

To highlight one distinguishing but critical difference in each program is the regional structure and organizational authority developed for each state. This variation is demonstrated by single individual hospitals as sole participating providers to complex networks of clinical and community-based providers. The table below (Table 2) details some of the key structural differentiators in some programs.

Table 2: Regional and Organizational Structure

	CALIFORNIA PRIME[6]	TEXAS[5]	NEW YORK[5]	WASHINGTON[7]
REGIONAL STRUCTURE	• Only public hospital systems involved, no other provider types • No additional regional structure • 21 public hospital systems (DPH) and 58 district and municipal hospital (DMPH) systems participating as DSRIP entities	• DSRIP entities are Regional Health Partnerships (RHP) • RHPs align to geographic boundaries across the state (multi-county collaboratives) • 20 RHPs participating as DSRIP entities	• DSRIP entities are Performing Provider Systems (PPSs) • PPSs are arbitrary regions across the state, based on providers involved and attribution • PPS overlap in densely populated areas (e.g., New York City) • 25 PPSs participating as DSRIP entities	• DSRIP entities are pre-existing Accountable Communities of Health (ACH) • ACHs align to Medicaid regional service areas across the state • 9 ACHs participating as DSRIP entities
ORGANIZATIONAL AUTHORITY	• No additional organizational authority outside of hospital system structure • Hospital systems are the entities that interface with the state and lead administration and implementation of projects (DPH) • Hospital systems can contract with MCOs (DMPH)	• RHPs are the entities that interface with the state and lead administration and collaboration within their region • Each RHP consists of a public, county, or district hospital that coordinates as the lead entity (anchor) and a number of other clinical providers • The state encourages regional collaboration • RHPs cannot contract with MCOs	• PPSs are the entities that interface with the state and lead administration and implementation of projects • Each PPS consists of a lead entity (generally an anchor hospital), associated clinics and a number of other clinical and community-based providers • The state encourages both inter- and intra-PPS collaboration, especially in densely populated areas • PPSs cannot contract with MCOs	• ACHs are the entities that interface with the state and lead administration and implementation of projects • Each ACH consists of a lead entity and a number of other clinical, community-based and tribal providers • ACHs cannot contract with MCOs

[5] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/domain_1_project_requirements_milestones_metrics_6-18-2015.pdf

[6] COPE Health Solutions: Section 1115 Medicaid Waiver – Select State Comparison Placemat

[7] http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach; Washington State Medicaid Transformation Project Special Terms and Conditions; COPE Health Solutions: Key Special Terms and Conditions of the Washington Waiver

[8] Attribution is the process used in the New York DSRIP program to assign a member to a Preforming Provider System (PPS), it assures that each Medicaid member is assigned to one and only one PPS. Attribution uses geography, patient visit information and health plan PCP assignment to “attribute” a member to a given PPS. Attribution was used to provide the maximum value available to a PPS to earn (attribution for valuation) and also uses a certain attributed population to measure the movement of health outcomes over time (attribution for performance).

As mentioned previously, the design of each DSRIP or DSRIP-like program is impacted by previous 1115 waivers as federal and state policymakers learn from prior states. These applied lessons learned are evident in the differences and evolution of the categories, domains or focus of each program structure (depicted in Table 3). Generally, at the end of the day, each unique organized set of domains or categories is ultimately focused on similar goals – developing appropriate infrastructure and networks to enable transformation across the continuum of care, while increasing quality of care and reducing the total cost of care.

Table 3: Program Structure (Project Categories)

CALIFORNIA PRIME[9]	TEXAS[10,11]	NEW YORK
1. **Domain 1:** Outpatient Delivery System Transformation, including a major focus on prevention 2. **Domain 2:** Improving care for targeted high-risk or high-cost populations 3. **Domain 3:** Reducing overuse and misuse of identified high-cost services, eliminate use of ineffective or harmful services and address inappropriate underuse of effective services	1. **Category 1: Infrastructure Development:** investing in technology, tools and human resources (e.g., primary and specialty care capacity) 2. **Category 2: Program Innovation and Redesign:** testing and replicating care models (e.g., behavioral health interventions, care navigation) 3. **Category 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. **Category 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, and emergency department[12]	1. **Domain 1:** Project requirements and milestones (e.g. achieving PCHM level 3 status, earning Meaningful Use certification, etc.) 2. **Domain 2:** System Transformation Projects (e.g. creation of integrated delivery systems, implementation of care coordination and transitional care programs) 3. **Domain 3:** Clinical Improvement Projects (e.g. Behavioral Health integration, cardiovascular health, asthma, perinatal care, etc.) 4. **Domain 4:** Population-wide Projects (based on New York State prevention agenda e.g. chronic disease prevention, prevention of HIV and STDs)

[9] http://www.dhcs.ca.gov/provgovpart/Documents/DHCSStateInitiativesCrosswalk3-16-16.pdf

[10] These four categories represent the categories for DY1-DY6 with DY6 representing the 15 month extension granted in 2016.

[11] If a renewal is approved, the Texas DSRIP program will move to a measure-bundled focused program and rename/ redefine their Categories: A) Core activities, Alternative Payment Model (APM) arrangements, costs, savings and collaborative activities, B) Medicaid and Low-income Uninsured Patient Population by Provider C) Measure Bundles D) Statewide Reporting Measure Bundles. https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-waiver/draft-dsrip-dy7-8-prm-protocol-webinar.pdf

[12] 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.

A noteworthy observation is that the more dollars awarded through the DSRIP program, the more numerous and onerous the administrative, policy and programmatic issues and requirements. Requirements have become more prescriptive, with less provider flexibility. Transparency, consistency and quantifiable justification are also increasing from one program to the next. Overall, the bar is raised from state to state as CMS and state policymakers look for providers to achieve higher levels of success sooner, Tables 4 and 5 below shows similar DSRIP program properties across states and the evolution of requirements.

Table 4: Evolution of the Program

	CALIFORNIA PRIME	TEXAS	NEW YORK
First program year activities	Program year 1 (July 2015-June 2016) focused on plan development for DMPH and achievement of infrastructure milestones while DPHs focused on outcome measurement and reporting (100 percent of years incentive payments)	Plan development (100 percent of year 1's incentive payments)	50 percent for Domain 1 awarded for approved DSRIP plan, 15 percent paid upon delivery of first semiannual report and outlined achievement, 15 percent upon delivery of second semiannual report and outlined achievement, 20 percent for other process measures (100 percent of year 1's incentive payment)
Target Populations	Medicaid beneficiaries	Medicaid beneficiaries and low-income uninsured under 200 percent FPL, however all patients eligible	Medicaid beneficiaries
Plan components	Participating entity information, organization and community landscape, executive summary including community needs, project selection/ narratives, project metrics and reporting requirements, data integrity, valuation and certification	Regional community health needs assessment, public input process, summary of projects, project narratives with several required sub-sections (including community needs addressed by project, valuation methodology and related outcomes) and milestones by year table that includes the number of patients impacted	Executive summary, governance, community needs assessment, project selection, workforce strategy, data sharing/ confidentiality/ rapid cycle evaluation, cultural competency and health literacy, budget and funds flow, financial sustainability plan, bonus points and attestation
Project options and requirements	No cap on projects: • Only 18 projects on menu • 9 required projects for public hospitals (DPH) • 1 project minimum for district/municipal public hospitals. (DMPH)	No cap on projects: • 130 project options on menu • Over 1500 projects implemented	5 to 10 projects within PPS across all providers: • 44 project options on menu • Only 39 of 44 on menu selected among all PPS • Maximum 10 projects per entire PPS, with exception of Project 11 (patient engagement) for public hospitals and PPS with no public hospital
Learning collaboratives	Required to participate in at least one face-to-face statewide learning collaborative per PRIME year	Required; each region operates a learning collaborative based on CMS definition	Required; developed regionally or at the state level organized geographically, by the goals of DSRIP or by specific DSRIP projects
Pre-implementation funding available	N/A	$500 million	$100 million
Funding structure	Funds flow to individual providers performing projects.	Funding dependent upon available IGT funds and commitments from entities, funds flow to individual providers performing projects.	Joint budgets and funding distribution plan through public hospitals. Funds flow to providers unique per PPS structure.

	CALIFORNIA PRIME	TEXAS	NEW YORK
Project values	Funding for district hospitals split based on formula accounting for size of Medicaid population served and bed size	Region had flexibility to design valuation model, but must address specific criteria, most importantly the number of patients impacted	Total valuation of PPS based on member attribution, projects selected, application score, and extra points for public hospitals for uninsured
Partial payment for partial achievement	Permitted to reflect that quality improvement does not always occur "on time"	Permitted only for partial achievement of outcome improvement targets	Not permitted
Improvement year over year	Required	Required	Required
Carry forward of unearned incentives up until the last program year[13]	Permitted	Permitted until the end of the following year with narrative description and plan to achieve missed milestones/outcomes	Not permitted
Alignment with value-based payment (VBP)	DPHs participating in PRIME will be required to contract with at least one Medi-Cal Managed Care Provider (MCP) in the MCP service area that they operate using APM methodologies as part of their PRIME Project Plan by January 1, 2018.	Not applicable for initial waiver period, but under proposed requirements for two year renewal	90 percent of Medicaid contracts by conclusion of Year 5

[13] This differs from partial payments as this allows a provider to achieve an outcome or metric outside of the program year it was supposed to be earned. Partial payments allow for a provider to earn funding on a sliding scale, e.g. earn 50 percent of funding associated with a metric if you achieve 50 percent of the goal.

Table 5: Average Provider Workload Comparison

	CALIFORNIA PRIME	TEXAS	NEW YORK
Total DSRIP dollars	$7.5 billion	$11 billion	$6.4 billion
Total number of providers	57	309	64,099[14]
Types of providers	District and District Municipal Public Hospitals	Medicaid providers: public and private hospitals, medical schools, private physician groups, public health departments and mental health agencies	All safety net and vital access providers; non-safety net providers can participate (but have funding restrictions); hospitals, clinics, physicians, medical groups, mental health providers, substance use providers, health home/care management agencies, skilled nursing facilities, nursing homes and other community-based organizations that provide social and wraparound services
Most selected projects	Care transitions, Complex care management for high-risk populations, Ambulatory care redesign	Primary care capacity; Specialty care capacity	Integration of primary and behavioral health; creation of integrated delivery systems; implementation of care transitions intervention models
Total number of projects across state	261	1,451	258

	CALIFORNIA PRIME	TEXAS	NEW YORK
Total number of projects across state	261	1,451	258
Average number of process milestones per provider	76	40[15]	N/A[16]
Number of pay-for-reporting (P4R) on menu	99[17]	102	131[18]
Number of pay-for-performance (P4P) on menu	99[13]	254	131[14]

References [2, 19, 20, 21]

KEY CONSIDERATIONS FOR STATES AND PROVIDERS

At a high level, states considering the inclusion of a DSRIP program in a waiver must weigh the benefits and drawbacks. While a DSRIP program may offer incredible potential for improved care and financing, it takes investments in staffing and manpower to develop and implement from the state and its implementation partners. 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. It is again worth noting that 1115 waivers can, and do, exist without a DSRIP program element and can be leveraged for the smallest of demonstrations to large-scale efforts (e.g. Indiana using an 1115 waiver to expand Medicaid).

As a comprehensive program, a DSRIP focused waiver contains many elements, and several key considerations are discussed below. These considerations can be from the perspective of the state health care authority (e.g. Department of Health in New York, Health and Human Services in Texas), from the lead entity perspective or from the individual provider perspective. Many of these considerations relate to one another and should be deliberated and considered collectively.

Aligning the DSRIP Program with Waiver Goals

A DSRIP program may help a state achieve its overarching waiver goals. It is key to consider whether the DSRIP program goals complement larger state waiver initiatives and can be supported by decision makers and stakeholders. For example, in New York, the DSRIP program has facilitated more patient engagement and an energized shift towards value-based payment. In Texas, the participating providers projects indirectly helped develop better care delivery models for the population as the state moved to broader managed Medicaid coverage.

Understanding the Priorities in Washington D.C.

Just as active DSRIP or DSRIP-like programs influence the development of new waiver programs, one of the most influential factors of 1115 waiver design and approval is the impact of an administration in Washington D.C. It is difficult to know exactly how the Trump administration will view DSRIP programs and how they will interact with states who currently have 1115 waiver DSRIP programs or are seeking approval for one. Initial indications

[14] Represents provider number based on individual NPI numbers, not organizations. New York estimated unique providers across the 25 Performing Provider Systems (PPS) but not individual provider organizations (e.g. hospital and physician groups) as other states normally would. New York is also the first state to allow non-traditional care providers (e.g. transportation community-based organizations) to participate in DSRIP.

[15] Around 10 milestones per project per provider.

[16] This is described as not applicable because of how New York State structured their process measures. Each PPS is responsible for ensuring all projects process measures are met across their PPS and all provider types by developing their own contracting and funds flow models. Thus, while all PPS across the state have the same process measures to meet per project, each PPS may develop a different process measures for each participating provider type to meet DSRIP requirements. One PPS may have five process measures while another may create 50. Numbers illustrate examples only.

[17] PRIME utilized a total of 99 outcome measures for the 5-year program, each year a number of measures converted from P4R to P4P.

[18] New York DSRIP utilized 131 defined outcomes for Domains 2, 3 and 4 with a gradual shift towards P4P each year. For example, a PPS may have 57 P4R outcomes and 24 P4P in DY2-3 and then 14 P4R outcomes and 47 P4P outcomes in DY4-5.

[19] https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf

[20] http://www.dhcs.ca.gov/provgovpart/Documents/PRIME/PRIMEProjectSelections-Web.pdf

[21] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/DSRIP-summit/Cat3Baseline.pdf

from the administration indicate an interest in program elements focused on increasing individual beneficiary responsibilities. The concept of DSRIP was introduced when the Affordable Care Act (ACA) was approved and a number of DSRIP programs were approved during the Obama administration. The current members of the administration may see 1115 waivers, especially with states like Texas seeking renewals, as an opportunity to undermine or undercut efforts of the previous administration.

It will be important for states seeking new approvals or renewals of existing waivers to tap into the priorities and platforms of Washington to inform the design and approach of their waiver and DSRIP or DSRIP-like program. States should consider aligning their applications and implementation efforts to demonstrate alignment with the administration in office. Early signs point to a focus on continued cost reduction and financial risk within the industry. There may be more interest by the new administration to approve programs that align with their goals, such as implementing health savings accounts (HSAs) for covered members or spreading co-pay requirements within the Medicaid population. Current actions of the administration suggest heavier scrutiny on "blue states" such as California, is more likely.

Securing the Local Matching Dollar

As a joint state and federal program, Medicaid requires a federal funding match to be provided. Given this, the way that states provide the non-federal share is an important consideration for states seeking DSRIP programs under 1115 waivers. DSRIP funds flow has historically been made through local government, public hospital intergovernmental transfers (IGTs) or state appropriations. This non-federal portion of the payment is sent by the state to the federal government first, and then this is matched by the federal government with federal funds. The combined local match and federal match is then sent back to states as the entire payment (total computable funds). Typically, the entire 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 portion or some other portion[22].

Recent actions by the Trump administration reinforce the importance of this key consideration for states and providers. In some states, like Texas, local funds are provided in a number of ways, such as by public hospitals, provider donations or local tax dollars. Recent actions by CMS suggest increased scrutiny on provider donations, as evidenced by New Hampshire which funded their Medicaid expansion through provider donations. The administration has imposed sanctions on the IGT design (provider donations) of the New Hampshire waiver, informing the state that these types of local matches will no longer be allowed, effective immediately. New Hampshire has been provided calendar year 2018 to attempt to design a solution for these sanctions; however, if they are not able to do this, their expansion program would essentially have to be rolled out and halted altogether. Should CMS's ruling hold, it may set a precedent that may have a trickle-down effect on allowable sources of local match throughout the country on Medicaid programs, not limited to DSRIP.

Understanding the Funds Flow

As time passes, each DSRIP program's funds flow structure has changed, from funding the non-federal share to the distribution to providers. As discussed, there are vast differences between programs. For example, in New York and Washington, lead entities determine the contracting and funds flow methods to disperse earned funds, while California and Texas providers earn funds on their own behalf. As more Medicaid programs shift towards Medicaid Managed Care and value-based payment, the flow of dollars are shifting for DSRIP waivers as well. Arizona serves as an example of this, where all incentive dollars that are earned by providers will flow through Managed Care Organizations (MCOs) instead of through the state to a lead entity or provider. Payments will be made to Arizona provider participants annually by MCOs to the tax identification number (TIN) in the approved plan.

Determining DSRIP Participants

In defining pool participants, states may base eligibility on ownership (e.g., public hospitals), share of low-income care (Medicaid and uninsured) or a set of specific qualifications. Each existing DSRIP program has taken vastly different approaches towards defining participant eligibility (refer to Table 5) based on the payment and delivery models that states seek to achieve. Given the nature of the program, it is critical to consider which providers are a good fit and how much funding is available as a meaningful incentive. Key providers in current DSRIP programs tend to be safety net organizations (public hospitals, academic medical centers, private safety net hospitals, community-based organizations).

Texas' DSRIP program includes a host of other organizations (such as local public health departments and mental health agencies), while New York has the most inclusive program developed to date, embracing community-based organizations and entities focused solely on supporting social determinants of health. In programs engaging providers and stakeholders outside of traditional health care providers, additional emphasis and focus on stakeholder engagement modalities are critical as any social service provider as stakeholders operate under different goals and assumptions and use different languages when compared to mainstream health care providers and players.

Establishing and Distributing Available Funds

The total potential available funding for any 1115 waiver is based on budget neutrality calculations. Section 1115 waivers are required by federal law to be budget neutral, meaning the proposed waiver programs must be revenue neutral to the federal government. This means that states must convince CMS that waiver programs, once implemented, bend the cost curve. The delta between what the program costs would have been versus what it might be once waiver programs are implemented, represents ongoing savings that the state would share with CMS. In return, CMS provides a share of those savings up front to fund proposed waiver programs.

A larger pool of funds will be able to offer better incentives to providers to advance care improvement. The funds pool size

[22] 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.

should support key providers' ability to be successful in achieving the major change sought by the program. Funding pools should be large enough for providers to reasonably reinvest their earned incentive funding in long-term sustainability strategies. It is important to ensure that key participating providers are eligible for enough funding to realize the desired transformation. For example, a diluted pool may produce less change than a more concentrated one because the diluted dollars may not support large-scale reforms.

DSRIP dollars will need to be allocated among participants, or regional entities such as RHPs or PPSs, based on a methodology (e.g. low-income volume, uncompensated care costs, Medicaid share, application scores, etc.) that is viewed as logical and equitable. As programs continue to mature, we anticipate seeing more DSRIP programs structured like New York and Washington, where lead entities will be responsible for establishing a fair and equitable approach to distributing earned dollars to individual providers, such as through performance-based contracts. This is anticipated because it forces providers and health systems to learn to work together and encourages building strong, full-continuum care networks in states to take care of vulnerable populations. DSRIP programs like those in New York and Washington push providers closer to value-based payments and working within a full network of providers to accomplish the transition together.

Incorporating Improvement Potential

A DSRIP program is supposed to be ambitious but achievable. Providers are encouraged and asked to develop stretch goals, so 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 time interval to demonstrate improvement 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. A provider's starting point makes a difference, such as whether they have electronic medical records[23] 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 consistent visions and if they are starting from adjacent or disparate points on their transformation path.

Using DSRIP Funds to Advance Outcome Metrics

Providers must prepare for a shift to payment for value and quality, which begins more rapidly within each new program. This is due to elevated expectations within each program, especially in states who are in renewal terms of their DSRIP program. For example, under the PRIME renewal in California, the public hospitals were measured against health outcome improvement in program year 1 and were not allowed to earn funding for infrastructure building. DSRIP programs should use their available incentive funding to advance the quality of care provided within their state as measured by specific, targeted outcome metrics. These metrics should be monitored at the individual provider level, the regional level and ultimately, at the state level as one element in which the success of the program can be measured.

Conducting Program Planning

A new program should be tailored to the unique needs of the state and be flexible enough to accommodate CMS' evolving vision for the program. When developing a new or renewal program, an important step may be an analysis of the program elements from other states to identify those that can be adopted, those that would need further refinement and any that might be 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. In addition, the state-federal politics and policies that may influence scope, focus and participation should be considered[24]. In many states, regional variance is also taken into account during the first year of DSRIP by integrating assessments, like community health needs assessments and environmental and resource scans, into the planning phase.

Understanding Data and Reporting

Data and reporting are crucial components of DSRIP programs, as a provider or regional entity cannot earn incentive funds without demonstrating achievement of milestones and metrics first. All DSRIP programs are subject to audit, requiring program leads and providers to ensure their documentation and reporting are honest, clear and detailed. Existing programs have approached the reporting of clinical outcomes differently, while some require providers to report on their own behalf (Texas and California), others utilize statewide claims data to measure clinical improvement (New York). As states design DSRIP programs, or as providers become participants in one, it is important to understand how process and clinical measures are expected to be reported to states and CMS as some programs place a higher reporting burden on providers. With each state approaching clinical outcome reporting differently, it makes it difficult to compare programs and provider success side by side.

Defining the Network and Patient Population

Another important consideration is the approach to define the demonstration population and network. 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 (e.g., 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. From the network perspective, it is important not to define the network or system too narrowly. New York was encouraged to emphasize partnerships with other systems (social services, criminal justice, local governments, education, etc.) as they worked together to benefit the most

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

[24] 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 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.

vulnerable patients. Delivery system transformation is not easy, but the best way to move forward is through integration of systems and incentives focused on improving quality and cost.

Developing the Strategy and Implementation Plans

Based on the negotiated DSRIP protocols, each participating provider or regional entity submits a plan committing to milestones for incentive payments. In most cases, these plans describe governance and sustainability plans in addition to outlining the provider's commitment to other key initiatives like workforce development and improving the provision of culturally competent care. Plans must describe the transformation being undertaken and justify the dollars being requested. Key considerations for states include stakeholder processes, policies, communications and coordination, as well as the development of standard templates and forms. Provider should consider 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.[25] Regions implementing projects must consider the mix of providers that comprise their network and have strategic insight into what role each of those providers can play during implementation. Project management and communications across provider entities and external stakeholders must also be established to coordinate and achieve goals. Defining clear roles and responsibilities for transformation efforts is important, as it will directly impact how downstream providers earn incentive funding from lead entities based on their role, activities or clinical outcomes.

From the development and submission of initial DSRIP applications, it is important for providers or regional entities to define their personal strategy for implementation, ensuring they work diligently and in a timely fashion to draw down their maximum available dollars. When it comes to implementation, it is important that all participants are well educated and have access to clear and consistent communications, both from the state agencies and lead entities in regional set ups like New York and Texas. Successful initial plans are built with collaboration and consideration for all stakeholders and community needs. Successful organizations choose DSRIP projects or initiatives that are aligned with their core business functions and competencies. Implementation of these projects and initiatives will enable reinvestment of dollars for sustainability and transformation purposes.

BROAD IMPACTS OF DSRIP POLICY

For states with DSRIP or DSRIP-like programs, these initiatives are transforming the way providers work together to deliver care and impacting state Medicaid agencies, participating providers and their patients. The policy impacts of these programs may influence health care markets and trends as well. Overall, the program construct appears to be achieving one of its key goals of connecting health care quality with Medicaid financing regardless of the unique implementation requirements each state chooses to utilize. State Medicaid agencies have had to harvest new quality and clinical departments to develop and oversee these programs. 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, proactive health care[26].

Including a DSRIP program in an 1115 waiver offers tremendous opportunity to alter the state's health care landscape and directs the focus of its safety net delivery system during the industry's transition toward value. Additionally, a DSRIP program can support safety net system financing – as long as those providers are willing to work hard for the funding and intelligently reinvest funds in key strategic initiatives. Safety net organizations are typically funded by local, state and federal dollars and are charged with providing care to patients regardless of their ability to pay. These systems generally have low operating margins and rely on subsidies to offset costs for uncompensated care; but, programs like DSRIP allow providers an opportunity to earn key additional dollars to invest in their infrastructure, technology and clinical care to advance the quality of care provided to their vulnerable populations. The customizability of DSRIP programs allows each states to focus its DSRIP program on particular state goals (for example, the New York DSRIP is focused specifically on payment reform). For providers with vision, the program offers the opportunity to achieve transformation with financial support along the way.

As the DSRIP structure is a risk-based program and funding is not guaranteed – payments are made if and only after milestones or outcomes are accomplished – this flexibility and opportunity for systems transformation must be balanced with a provider or group of providers' ability to manage the incentive nature of the program. 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.

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. Furthermore, providers spend significant time and resources to develop their plans, and the implementation of the program for a provider can be very time 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 and ensure accurate and timely audits are conducted. Finally, as a public program, accountability and transparency are needed, and there is a risk of audit recouping funds from providers if further investigation demonstrates that achievement was not fully completed.

All-in-all, 1115 waivers with DSRIP programs have cemented the idea that broad incentive based payments must be earned. Shaped by the federal government, it is seen as a pathway to continue focusing on and implementing key aspects of the Affordable Care Act and a way to bend the Medicaid spending curve, while incentivizing providers to focus on building cohesive

[25] 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.

[26] Based on COPE Health Solutions DSRIP clients across the country and our experiences in each state.

and cooperative integrated networks, provide higher quality care at a lower cost and prepare to succeed long-term in a value-based payment environment.

APPENDICES

APPENDIX 1: CALIFORNIA — THE PIONEER AND INNOVATOR

The Launch of DSRIP

California's 2010 waiver was designed to serve as a bridge to health reform. Worth $10 billion, its key components included early coverage expansion for 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. Don Berwick's appointment to director of 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[27], 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 with a desire to tie funds to performance. 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 results of an eight-month process of policy development and negotiations were 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. The initial DSRIP program included 21 public hospitals and because the public hospitals were financing the non-federal share, the program was valued at $6.5 billion gross[28], or $3.3 billion net for 21 public hospitals.[29]

The initial DSRIP program marked very high achievement rates of milestones across the public hospitals and substantial efforts to spark initial transformation in the Medicaid space. By the end of the first five years (2010-2015), public hospitals (DPH) had[30]:

- Empaneled more than 680,000 patients into medical homes
- 11 public hospitals implemented and utilized disease registries, adding over one million patients
- Decreased the rate of hospitalizations for diabetics with short-term complications by more than 20 percent and reduced by more than five times the percentage of diabetics with a diagnosis of uncontrolled diabetes (0.18 percent from 1 percent)
- Increased primary care by 18.5 percent by offering more weekend and evening appointments and improving panel management
- Across seven DPHs, 36 clinics successfully integrated primary and behavioral health services at the same location
- Increased mammography screenings by 14.2 percent or 42,000 women who did not previously receive this service
- Achieved a decrease in Central Line Associated Blood Stream Infections (CLABSI) by an average of 17 percent in acute settings and 22 percent in intensive care across all DPHs, as well as a 61 percent increase in sepsis bundle adherences resulting in a 17 percent decrease in sepsis mortality
- Reduced surgical site infections (SSI) from 3.4 percent to 1.4 percent, well below the national average of 1.9 percent

The Evolution to PRIME and Whole Person Care (WPC)

In December of 2015, California and CMS reached an agreement for another renewal of the state's 1115 Medicaid waiver, entitled Medi-Cal 2020. Medi-Cal 2020 is expected to guide California through the next five years via transformation efforts to improve the quality of care, access and efficiency of health care services for over 13 million Medi-Cal members[31].

The renewal brought a new name and approach to California's DSRIP program, building on this foundation, the state created the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program and another targeting cross-sector collaboration to address vulnerable populations the Whole Person Care Pilot (WPC). PRIME is charged to build upon the foundational DSRIP framework, expand coverage and increase access to primary care. In PRIME, new participating entities were introduced, the District/Municipal Public Hospitals (DMPHs) joined the ranks of the Designated Public Hospitals (DPHs), which were all tasked to focus on changing care delivery models to maximize health care value and prepare themselves to perform successfully under risk-based alterative payment models (APMs).[32]

During the initial launch of DSRIP when only DPHs were considered participating entities, individual hospitals submitted five-year transformation plans in compliance with the program requirements, each tasked with achieving an average of 76

[27] Includes County and University of California owned hospital systems.

[28] 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).

[29] This means that the designated public hospitals have committed to spending up to $3.2 billion to participate in the program.

[30] http://caph.org/wp-content/uploads/2015/10/CA-DSRIP-2010-2015-Successes-to-Build-On.pdf

[31] http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

milestones within seven major delivery system improvement projects. The most common projects included 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 reported on the same 21 population-based care measures as well as outcomes across four provider preventable conditions, two of which are required for all – sepsis and central line-associated bloodstream infections.

In PRIME, the first two years of the program looked substantially different for DPHs and DMPHs. Due to their participation and achievement in the initial DSRIP program, DPH entities immediately faced requirements to report performance on clinical quality outcomes, setting their baselines in the first year and expected to earn funds by reporting performance in the second year. DMPH entities were provided two years to achieve infrastructure metrics, which means that they were provided opportunities to earn incentive funds while building their programs and laying the foundation to meet the requirements set forth in each project in the form of pay-for-performance outcomes.[33] These infrastructure metrics such as project planning and initial process improvements, are foundational to care improvements, population health and clinical outcomes in later program years.

California's PRIME program completed its first year (DY11) in June of 2016. Total payments to entities equaled $1,597,997,857[34], a disbursement equal to 99.8 percent of program year 1 (July 2015-June 2016) available dollars to earn[35] . The public hospitals continue to work with CMS in the program's "mid-point assessment," which includes 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[36].

Also part of Medi-Cal 2020 is the Whole Person Care (WPC) pilot, which is a five-year program focused on providing more efficient, high-quality, integrated care through improved coordination of physical and behavioral health with social services for Medi-Cal patients. The program focuses on Medi-Cal patients who are high users of multiple health care systems yet continue to have poor health outcomes. The pilot provides $300 million annually in federal funds; total funding, including the local match, is not to exceed $3 billion over the five-year program. The WPC pilot stresses the need to improve coordination of care across multiple systems to more efficiently address external factors that affect the health of individuals. WPC encourages collaborations among various stakeholders focused on infrastructure development and attempting to prevent duplication in program costs addressing patient needs.

WPC pilots focus on the following activities:

• Providing payments for services otherwise not reimbursed by Medi-Cal, this includes housing services such as Individual Transition Housing Services and Individual Housing & Sustaining Services; in order for federal financial participation, local housing authorities and programs must be involved. Payments in this category will only be made for patients who are Medi-Cal beneficiaries;

• Building infrastructure for service integration, such as a Health Information Exchange (HIE); and

• Implementation of strategies that support integration, reduce health care utilization and improve health outcomes

WPC pilots require a lead agency - a county, city, health or hospital authority, designated public hospital, a district/municipal public hospital or a combination of these entities - to lead and coordinate the effort across participating organizations. WPC pilots must include one managed Medi-Cal plan from the same geographic area, in addition to local health services or specialty mental health agencies and at least two other community-based organizations who have experience meeting the needs of the target population. By integrating the work of all of these organizations, WPC pilots are expected to develop an infrastructure that will enable sustainable collaboration post program funding. WPC pilot infrastructure can include sharing best practices among local organizations, expanding data management practices, developing effective case management and patient monitor programs and on-going performance improvement. Where possible, WPC pilots are encouraged to explore options to improve support services and housing for individuals who are homeless or at-risk of becoming so. As an important part of the Medi-Cal 2020 program, the WPC pilot program provides a wonderful opportunity for health systems and community-based organizations to align and develop sustainable programs to continue to serve high-risk populations in an integrated fashion.

APPENDIX 2: TEXAS — THE INITIAL AMPLIFIER

Texas received approval of its five-year waiver in 2011, driving the expansion of Medicaid managed care statewide. However, that expansion meant that a significant source of supplemental funding to Medicaid providers through their Upper Payment Limit (UPL) program would discontinue. In order to maintain funding levels, the $29 billion waiver established two programs, one that reimburses providers for uncompensated care (UC) costs and a DSRIP program worth up to $11.4 billion. The percentage of funding assigned to the uncompensated care pool was structured to decrease over the five years proportional to the increase in

[32] http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx

[33] PRIME contained 18 unique project options, all selected. (http://www.dhcs.ca.gov/provgovpart/Documents/PRIME/PRIMEStakeholderWebinar.pdf)

[34] http://www.dhcs.ca.gov/provgovpart/Documents/PRIME/PRIME_DY_11_payments.pdf

[35] http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentII_PRIMEFundingMechanics.pdf

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

DSRIP funding during that time in order to take into account ACA implementation and to shift priority to a pay-for-performance financing model. While Texas and the Perry gubernatorial administration at the time had been vocally opposed to national health reform and the state chose not to expand Medicaid coverage, the waiver brought a renewed focus to improving the quality of care provided to the Medicaid population.

Previous supplemental funding programs (UPL and UC) widely impacted the financial statements of Medicaid providers across the state; many providers relied heavily on these programs to provide care to the target populations. With the opportunity for more than public hospitals to participate in the Texas DSRIP program, 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 care provided to Medicaid and uninsured individuals significantly varies across these participants, which is seen now in their reporting of impact on Medicaid/ Low-income/ Uninsured (MLIU) individuals in semi-annual reports. This led to the requirement that some project options must serve a minimum percentage of Medicaid individuals for a provider to be eligible to implement that particular project (e.g. specialty expansion projects).

Taking the opportunity to bring the impact of the DSRIP program beyond the four walls of one organization and do system transformation at the community level, the participating providers were organized into 20 regional groupings or Regional Healthcare Partnerships (RHPs) across the state, marking the first DSRIP program to structure regional organization as a requirement for participation. Each RHP is "anchored" by a public hospital or, if the RHP did not include a public hospital, a local government entity[37] that serves as the region's single point of contact ("anchor") with the state and CMS and is responsible for coordinating the RHP's activities for the duration of the waiver.

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 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) for an independent entity to monitor the accuracy of milestones and metrics reporting as well as the integrity of financing the non-federal share.[38] 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.

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 –state funds are not used to finance the program.

For the first five years of their DSRIP program and during an 15-month extension granted in 2016, Texas drew inspiration from the original California program and started with similar California projects from Categories 1-2 (Infrastructure Development and Program Innovation and Redesign) but made several important changes:

• Texas added a number of projects from which providers can select, most notably projects related to behavioral health[39]

• 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)

• Many interventions require the project to address a set of core components

• Each project must specify the number of patients directly impacted ("quantifiable patient impact or QPI")

• Each project must result in at least one improved clinical outcome from Category 3 (Quality Improvements) which is a list of outcomes from which providers could select for DYs 1-6a

• All hospital participating providers were required to report measures in Category 4 (Population-Focused Improvements). These measures are all inpatient measures which indicates that many of the hospital participating providers are not positioned toward integrated delivery systems with outpatient clinics[40]

Despite a lengthy approval process of RHP plans and project valuations, Texas providers began transformation work as soon as plans were submitted, wasting no time getting projects off the ground and focusing on improving clinical outcomes. Texas providers who selected "off-menu" or customized projects initially had trouble obtaining approval for their projects; this challenging approval process for CMS led to the requirement of more structured and narrow project menu options in subsequent DSRIP and DSRIP-like programs in other states. Many specialty care projects required the providers to demonstrate a significant impact on low-income patients, and projects that selected a patient experience outcome instead of a clinical outcome were approved but generally with reduced valuations. Another lesson learned by CMS was to pre-assign clinical outcomes to each project on menu, an evolution that is seen in New York, California's PRIME and in Washington program structures.

[37] Either a hospital district, hospital authority, county or State University.

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

[39] Behavioral health became a large focus of the waiver (greater than 25 percent of the 1,451 active projects), especially with MHMR entities as providers, some might say one of the greatest aspects of the Texas waiver has been the transformation efforts and new services provided to the behavioral health population across the state

[40] For more information, please see Texas 1115 Waiver: Texas Healthcare Transformation and Quality Improvement Program, No. 11-W-00278/6.

In September of 2015, Texas submitted a request to CMS to extend their 1115 waiver for five additional years. CMS approved a 15-month extension in October of the same year, allowing Texas to maintain DY5 funding levels through December 2017. With hopes to continue the DSRIP and UC programs, Texas submitted an application for a 21-month extension creating DYs 7 and 8, which will provide the same level of funding as seen in DY5 of the original waiver for each program pool beginning in January 2018. Negotiations with CMS are still ongoing, and Texas has had to develop a ramp-down plan for funding if a formal extension is not approved. As stated in a prior footnote, if approved[41], the extension would change the goals and focus of the Texas DSRIP program for DYs 7-8. The program would evolve to focus on measure bundles and will introduce the first requirement for movement towards value-based payment (VBP) in Texas.

The initial DSRIP program marked very high achievement rates of milestones and clinical metrics across providers. The formal evaluation conducted at the end of DY5 provides insight into a number of these successes[42]. By the end of the first five years (2011-2016), providers had[43]:

• Increased access to primary and preventive care, emergency department (ED) diversion and enhanced behavioral health services by implementing 1,451 DSRIP projects and measuring 2,111 outcome metrics

• Over 10.8 billion dollars earned across Categories 1-4 in all regions

• Provided over 14 million encounters serving over 8 million additional individuals (reporting from DYs 3-5) compared to reported service levels prior to the waiver

• Expressed satisfaction with the RHP structure and the performance of their Anchor, noting 95 percent of survey respondents satisfied with their Anchor's level of commitment to listen to the ideas and options of stakeholders and 94 percent satisfaction with increased collaboration

• 81 percent of outcomes reported achievement in the first reporting period of DY5

• 56 projects reported on risk-adjusted hospital readmission reduction in DY5, with a median 15 percent reduction compared to baseline for that individual year

• 107 projects reported on diabetes HbA1c poor control (>9 percent) with 74 percent reporting improvement over their prior year and a median improvement rate of HbA1c control of 17 percent

• 30 projects reported on 7 and 30-day follow up after hospitalization for mental illness, with 100 percent of those reporting at least one year of performance receiving incentive payments for improving over their baseline with an median improvement in 7-day follow up rates of 12 percent

• Data from the External Quality Review Organization shows a reduction of potentially preventable admission expenditures for the Texas Medicaid/ CHIP population decreasing from $6,966 per 1,000 member months in calendar year 2013 to $5,831 in calendar year 2015, or a decrease of 16 percent per member month over two years

APPENDIX 3: NEW YORK — MOVING PROVIDERS INTO INTEGRATED DELIVERY SYSTEMS AND VALUE-BASED CONTRACTING

New York received approval for its DSRIP program in April of 2014, set to expire in December 2019. New York built upon the Texas regional structure and organized providers into Performing Provider Systems (PPSs), emphasizing the need for collaboration among multiple types of providers. PPPs evolved the Texas RHP model in a number of ways, most notable through formal governance requirements, establishment of a number of new collaborations resulting in new contracting entities and allowing the PPS leads (equivalence to the term Anchor in Texas, see Table 2) to establish their own strategies to flow funds to their providers. New York's program has explicit statewide goals to reduce avoidable hospital use by 25 percent over five years, and if certain targets are not achieved throughout the program, total available incentive dollars will be reduced for all providers. Specifically for DSRIP, New York has $6.42 billion available for planning grants, performance payments and state administrative costs (the DSRIP program is one part of a larger overall Medicaid redesign waiver). New York State is very focused on defining and achieving key principles to govern their DSRIP program, the development of the PPS, specific project menu and ongoing waiver operations align to be[44]:

• Patient-centered: improving patient care and experience through a more efficient, patient-centered and coordinated system

• Transparent: decision making process takes place in the public eye and that process is clear and aligned across providers

• Collaborative: collaborative process reflects the needs of the communities and inputs of stakeholders

• Accountable: providers are held to common performance standards, deliverables and timelines

• Value-driven: focus on increasing value to patients, community, payors and other stakeholders to achieve better care at a lower cost

As noted in the table below, New York has prioritized bringing a high number of providers across the care continuum together to build integrated delivery systems (IDSs). Each PPS is required to implement strategic initiatives focused on building an IDS through

[41] https://hhs.texas.gov/sites/default/files//documents/laws-regulations/reports-presentations/2017/leg-presentations/house-appropriations-committee-july-25-2017.pdf

[42] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf

[43] https://hhs.texas.gov/sites/default/files//documents/laws-regulations/policies-rules/1115-docs/Evaluation-Companion-Document.pdf

[44] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/chcs_presentation_slides.pdf

one targeted project and up to nine supporting projects across three domains. Each IDS is focused on utilizing evidenced-based medicine to achieve key population health initiatives[45]. PPSs are required to "create an integrated, collaborative and accountable service delivery system that incorporates the full continuum of care, eliminating service fragmentation while increasing the opportunity to aligned provider incentives. The facilitation of the build should incorporate the medical, behavioral health, post-acute, long-term care, social service organizations and payors to transform the current service delivery system from one that is institutional-based to one that centers on community-based care. Each organized integrated delivery system is accountable for delivering accessible evidence-based, high quality care in the right setting, at the right time, at the appropriate cost. These organized IDSs will commit to devising and implementing comprehensive population health management strategies and be prepared for active engagement in New York State's payment reform efforts"[41].

In partnership with CMS, New York defined core components for the IDS each PPS is building under the DSRIP program. Each PPS clearly articulated a governance model for the IDS incorporating provider, consumer and patient representation. Health Homes and accountable care organizations were encouraged to incorporate their activities into each IDS while PPSs worked to re-balance the health care delivery system in ways consistent with health care needs of their specific community. Each PPS, through their IDS, must ensure that patients receive care coordination, including discharge planning, and appropriate health care across the continuum. Health Information Technology (HIT) is important in the development of the IDS; each PPS must have or develop the ability to share relevant patient information in a timely manner. Part of the HIT expectation is that health systems should track care outside of the hospital to ensure all critical follow-up services are in place and recommendations are followed. The PPS must establish monthly meetings with Medicaid managed care plans to discuss utilization trends, performance issues and payment reform as the entire state works towards very targeted value-based payment goals. Each PPS must focus on workforce development and ensure all care is provided in a culturally competent manner and issues of health disparities are addressed through targeted interventions.

Through its DSRIP program and building IDS, New York was the first DSRIP program to require a focused and intentional shift to value-based payment. By 2019, 80-90 percent of Medicaid payments are expected to be tied to quality or value. This focus on value requires PPS and all participating providers to develop appropriate strategies to achieve state defined targets and remain financially viable in an ever-changing health care environment. New York proved to be a pioneer in their effort to utilize their DSRIP funds to enhance the opportunity for providers and payors to make this critical shift towards value.

According to the governing documents of the waiver, each PPS must develop an equitable approach to funds flow from the PPS lead to providers. Funds are distributed once the PPS has collectively achieved pre-defined process measures and clinical outcomes together as an integrated delivery system. Unlike Texas where funds were earned based on an individual organization's performance, New York PPS providers must work together collectively and demonstrate success as a cohesive IDS. CMS and New York provided limited guidance to PPSs in how funds flow strategies and arrangements should be structured, only mandating specific rules around the percentage of funds that may be distributed to safety net and non-safety net providers. Each PPS has taken a different approach to budgeting funds to be distributed each year and the construct of performance-based contracts to providers.

In December of 2016, the Independent Assessor released their report on the mid-point assessment for the New York DSRIP program. The report included general organizational recommendations and brief recommendations on select projects across the state. It will be critical for PPS leads and their partners to focus on these recommendations and initiate focused improvement efforts in these areas for the remaining years of the waiver to ensure the state reaches all of its statewide goals and is eligible to earn all incentive funding available. Some of the observations from the Independent Assessor include[46]:

Organizational:

• Governance: Most PPSs developed efficient and effective governance structures to oversee the DSRIP initiatives, a small number should focus more on sub-regional implementation and ensuring Board of Directors understand PPS and project priorities

• Financial sustainability and value-based payment: The report indicates that many PPSs have not focused on detailed arrangements for sustainability and more education to partners in their role for value-based payments was required

• Partner engagement: Many PPSs were behind partner engagement goals at the time of the assessment and were encouraged to focus their attention and funding to engage key partners

• Funds flow: The lead project management offices and hospitals had received over 70 percent of DSRIP funds at the time of the assessment, PPSs will need to fund their full network of partners at a meaningful level going forward

Project:

• The assessor notes the need for more and continued education to patients regarding the appropriate use of the emergency department and available alternative sites of care

• More PPSs need to increase outreach and educational materials to partners with respect to patient activation measures

• PPSs should focus on improving the interoperability of electronic health records, with special focus on the integration of primary care and behavioral health care records

The New York program sets the tone for the expectations of many future DSRIP programs by formalizing regional provider structures, requiring a move to value-based payment and

[45] https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

[46] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/docs/final_companion.pdf

authorizing each PPS to develop their own strategy and contracting structures to flowing funds to thousands of providers.

At this point in New York's DSRIP journey there are many opinions about what is working well and what is not, but most can agree that New York embarked on a substantial and ambitious journey to transform its Medicaid delivery system in both clinical and payment design and operation. It is undoubtable that what New York is able to achieve as a state by 2019 will influence future DSRIP and DSRIP-like programs in structure, goal definition, funds flow and so much more.

APPENDIX 4: MASSACHUSETTS — A FOCUS ON ACCOUNTABLE CARE ORGANIZATIONS

The 2011 Renewal and Delivery System Transformation Initiatives

Massachusetts' first Section 1115 waiver implemented near universal health care coverage to cover almost an additional 400,000 residents[47] and was first renewed in December 2011, several months after the ACA had been signed into law. The focus of the 2011 waiver renewals for both the state and CMS was to maintain the coverage expansion, and 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 not grow faster than the state economy[48].

This 2011 renewal provided $26.7 billion to MassHealth and included two programs: (1) children's/parent's health care coverage and services; and (2) the Delivery System Transformation Initiatives (DSTI), a DSRIP-like program. While the waiver was large, it was limited to up to $628 million gross, making it a significantly smaller program than the existing California program and the Texas program which was in development at the time. The renewal was only a three-year waiver renewal and focused participation on seven safety net hospitals who had the largest low-income and lowest commercial payor mixes[49] and included the state's only public hospital. These systems serve the poorest, most diverse and multi-lingual areas of the state. Given the key contextual influencers on the development of the Massachusetts waiver, the focus of the DSTI program was on restructuring health care payment as part of delivery system reform.

Given Massachusetts' payment reform and previously-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 investments in the absence of the DSTI program. As a result of universal coverage in the state, these hospitals saw a 30 percent increase in Medicaid volume from 2006 to 2010[50]. 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 of them are competitors, which differs from California's program participants, who each covered a distinct geographic area. Because the DSTI program was only three years, as opposed to five, most of the milestones were process-oriented. Over three years, the participating providers, on average, worked to achieve 93 metrics within seven major delivery system improvement project areas. 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, a requirement that has continued to be utilized in other state programs since 2011[51].

The 2016 Renewal, DSRIP and Accountable Care Organizations

On November 4, 2016 CMS approved to amend and extend the MassHealth Section 1115 waiver demonstration which supports the restructuring of the MassHealth program to provide integrated, outcome-based care to 1.9 million Massachusetts residents[52]. This renewal moves Massachusetts from its current fee-based model to a system of Accountable Care Organization (ACO) models who will work in close partnership with community-based organizations (CBOs) to better integrate care for behavioral health, long-term services and supports health related social needs. The renewal became effective in July of 2017 and authorized $52.4 billion of expenditures over five years and generates $29.2 billion of federal revenue for the state during the timeframe. The waiver renewal includes $8 billion of funding over the five years to support[53]:

- $1.8 billion over five years to mature the DSTI program to a more recognizable DSRIP program which will support the move to ACOs, invest in community partners for behavioral health and encourage innovative ways to address social determinants of health

[47] Commonwealth of Massachusetts Health Policy Commission Report to the Massachusetts Legislature, "A Report on Consumer-Driven Health Plans" (April 2013).

[48] 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.

[49] 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.

[50] Massachusetts 1115 Waiver: MassHealth, No. 11-W-00030/1, Attachment J: Master DSTI Plan (March 18, 2012).

[51] For more information, please see Massachusetts 1115 Waiver: MassHealth, No. 11-W-00030/1.

[52] https://www.mass.gov/service-details/previous-waiver-documents

[53] https://www.mass.gov/files/documents/2017/11/03/ma-1115-waiver-factsheet.pdf

• In addition to the DSRIP funding, the waiver also authorizes $4.8 billion for additional safety net care payments over five years to hospitals and the health care safety net for the uninsured and underinsured

• $1.3 billion over the waiver timeframe for subsidies to assist consumers obtain affordable coverage on the Massachusetts Health Connector

• Expand substance use benefits to address the opioid epidemic and secure important investments to strengthen the community-based health care system for behavioral health services and long-term supports

• Allows more safety net hospitals to participate, for a total of 15 participating organizations

The 2017 DSRIP program is not a one-size fits all approach towards the movement to ACOs; the program provides different model options that reflect the range of provider capabilities and leverages MCO partnerships. Under the waiver, MCOs will work with MassHealth to implement ACO contracts and other value-based payment arrangements and will partner directly with ACOs to deliver coordinated care (Table 6)[54].

Table 6: MassHealth Accountable Care Models

MODEL	DETAILS
A: Integrated ACO/MCO	• Fully integrated: ACO joins with MCO to provide full range of services • Includes administration (e.g. claims payment) and care delivery/coordination • ACO/MCO receives a prospective capitation payment and is at full risk
B: Direct to ACO	• ACO provider contracts directly with MassHealth • Full MassHealth/ MBHP provider network, but ACO may have preferred provider relationships • ACO accountable for total cost/quality and integration of care • MassHealth/MBHP pay claims up-front, retrospective reconciliation of ACO for total cost of care
C: MCO-administered ACO	• ACOs contract and work with MCOs • MCOs play larger role to support population health management • MCO pays claims, contracts provider network • ACO accountable for total cost/quality and integration of care, with varying levels of risk (all levels include two-sided performance risk)

In December of 2016, six (6) pilot ACOs were launched, DSRIP funding starts at the beginning of the state's fiscal year 18 and implementation of the full ACO model with behavioral health/ long term support services (BH/LTSS) community partners will launch in December 2017. To receive DSRIP funding, ACOs must partner with BH and LTSS community partners. Community-based organizations who become BH and LTSS community partners will also be eligible to earn DSRIP dollars. Massachusetts has committed to annual targets for performance improvement over five years (e.g. reducing in total cost of care trend, reduction in avoidable utilization and improvement in quality metrics). In order to access new funding, providers will have to partner to better integrate care.

Table 7: MassHealth DSRIP investments[50]

DSRIP INVESTMENTS		
ACO transition + social determinants	Certified BH and LTSS Community Partners	Statewide Investments
• Contingent on ACO adoption • Funding based on lives covered • Must meet annual milestones or metrics • Funding to invest in certain defined, currently non-reimbursed 'flexible services' to address social determinants	• State certifies BH and LTSS Community partners to develop scaled infrastructure and capacity • ACOs incented to partner with existing community resources (i.e. buy not build) • Direct funding available to community partners under a performance accountability framework	• Health care workforce development and training • Targeted technical assistance for providers • Improved accommodations for people with disabilities • Other state priorities, including ED boarding

[54] MassHealth 1115 Waiver Proposal Slides 160624

The 2016 waiver renewal continues to push Massachusetts to new areas of focus and improvement in providing care to their residents. In addition to the investments in DSRIP and building functional ACOs focused on value-based payment arrangements, the waiver also stresses the integration of physical and behavioral health, long-term services and supports and health-related social services. Explicit goals of this waiver are to create a behavioral health system that improves outcomes, experiences and coordination of care including members with complex needs (substance abuse, dual diagnosis, etc.) Further, the renewal includes the safety net care pool redesign with funding for both DSRIP and uncompensated care (which includes disproportionate share and uncompensated care pools). Payments made to safety net providers within the UC pool are not time-limited and are tied to DSRIP accountability measures.

As the country faces the reality of the growing opioid challenges, the 2016 waiver renewal in Massachusetts places the state as one of the leading states to focus on this public health concern through 1115 waivers. The waiver expands MassHealth substance abuse coverage to address the opioid crisis to include the full continuum of medically necessary 24-hour community-based rehabilitation services. Capacity will expand by nearly 400 beds in fiscal year 17 and an additional 450 beds in fiscal year 18 in addition to providing members with substance abuse disorders care management and recovery support services, including support navigators and recovery coaches.

APPENDIX 5: LOOKING AHEAD — WASHINGTON AND ARIZONA

Washington and Arizona both received approved 1115 waivers in January of 2017 either containing DSRIP or DSRIP-like programs. Both programs are focused on incentivizing providers to focus on delivering care through integrated models, reducing costs, increasing quality and preparing for the industry shift towards value-based payments.

Similar to New York, Washington has structured their waiver and DSRIP program to be implemented through regional collaborations known as Accountable Communities of Health (ACH). An ACH is a regional coalition consisting of multidisciplinary organizations charged with working together to improve population health[55]. There are nine ACHs across the state, broken up by Medicaid service delivery areas and include both traditional Medicaid providers and a variety of other entities and community-based organizations, including Tribal Nations. The ACH governance structure utilizes workgroups comprised of ACH member representation, for some ACHs the lead entity is a local public health agency while others are led by a non-profit organization with a history of promoting regional health reform. The waiver in Washington is comprised of three initiatives, which together will receive up to $1.5 billion in total computable funding over five years; the DSRIP program will have access to $1.125 billion total computable.

Staying with recent trends in DSRIP programs, Washington will operate under a limited project menu (eight (8) projects) with required components for capacity building, financial sustainability, workforce and systems for population health management. Similar to New York and California programs, there is a required set of pre-defined clinical quality metrics that transition from pay-for-reporting to pay-for-performance aligned with each project. These projects are intended to support broader systems change goals already being contemplated by ACHs. Moreover, Washington aligned their DSRIP program with efforts to integrate behavioral health with physical health, putting 100 percent of DY4-5 total DSRIP funds ($327 million) at-risk based on local county ability to integrate behavioral health[56]. This is very similar to New York's goal to reduce avoidable hospitalizations by 25 percent by program year three or statewide funding available to the DSRIP program would be reduced. Goals like this are important because they directly integrate payment and delivery levels which require county systems to change. The Washington DSRIP program is challenged with a low valuation to begin, and if the state is not able to achieve its goals of integration, their overall program funding will be reduced.

Washington also developed a value-based payment roadmap as part of their DSRIP waiver which will be updated annually; the roadmap includes value-based payment attainment goals, details for financial incentives available for MCOs and ACH partnering providers for achieving targets and summary information for how managed care will transform to support new models of care. By DY4-5, providers participating in each ACH should be able to exhibit project fulfillment, prepare for project evaluation and sustainability efforts and will be eligible to receive funding based on the achievement of fully integrated care measured by process measures, outcome measures and value-based payment milestones[57].

Table 8: Washington Waiver Overview

INITIATIVES	HIGH-LEVEL WAIVER GOALS
Transformation through Accountable Communities of Health (DSRIP)	Reduce avoidable use of intensive services and settings
Long-term Services and Supports	Improve population health
Foundational Community Support Services	Accelerate the transition to value-based payment
	Ensure that Medicaid per-capita cost growth is below national trends

[55] https://www.hca.wa.gov/assets/program/achfactsheet_0.pdf

[56] https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf

[57] https://www.hca.wa.gov/assets/program/demonstration-stcs.pdf

Arizona's Targeted Investments Program (TIP) is part of the 1115 waiver renewal for the state and is similar to the California DSRIP and PRIME model in that individual providers will implement projects and improve clinical outcomes on their own, not required to operate in a regional model like a New York PPS or Washington ACH. Arizona was approved for $300 million, total computable, over five years with a focused promotion of the integration of physical and behavioral health while increasing efficiencies in care delivery and improving health outcomes. Of the programs described in this piece, Arizona has the least amount of incentive funding available, providing additional challenges to providers to not only work to ensure they draw down all available dollars but also begin planning their strategic long-term investments for their TIP dollars early in the program.

Arizona will allow only four provider types to participate - primary care providers, behavioral health providers, integrated clinics and hospitals[58]. There are two concentration areas for projects (ambulatory and hospital) with five sub-concentration areas under ambulatory, creating only six (6) options available to providers. This is important because it shows the continuation of more narrow project options and menus in each subsequent waiver (e.g. New York had less than Texas, Washington had less than New York, etc.) Narrower project options and menus force providers to focus on similar efforts across the state and allow providers less flexibility in the design of their transformation initiatives. In years 2-3, providers will be required to complete required core components within their chosen area of concentration, moving to clinical outcome metrics in years 4-5. An interesting and unique aspect of the TIP program is the funds flow structure to participants. Annual TIP payments will flow through managed care organizations and regional behavioral health authorities, together referred to as "MCOs", to provider organizations. This will be accomplished by the Arizona Health Care Cost Containment System (AHCCCS) amending current MCO contracts to include making payments to TIP participants. MCOs will then generate the payments based on AHCCCS calculation of the funds earned from TIP participants based on programmatic requirements of a specific demonstration year[59]. A limited number of TIP participants will be approved to participate in a project focused on the transition of adults from the criminal justice system. These providers will be required to align with a regional behavioral health authority and implement the adult ambulatory primary care project. At this time Arizona is still compiling their list of clinical quality outcomes for performance measures. The first set of payments is expected to flow by December 2017 for approved applications from participants.

Table 9: Arizona Waiver Aims

AIMS
Reduce fragmentation that occurs between acute care and behavioral health care
Increase efficiencies in service delivery for members with behavioral health needs
Improve health outcomes for affected populations

[58] https://www.azahcccs.gov/PlansProviders/TargetedInvestments/

[58] https://www.azahcccs.gov/PlansProviders/Downloads/TI/Stakeholder%20Meeting%202017%206-9.pdf

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1st Edition

This paper was first developed in 2013 by Natalie Chau and Allen Miller and has been edited and adapted based on current and relevant information.

ABOUT COPE HEALTH SOLUTIONS

COPE Health Solutions has developed and implemented innovative strategic plans and integrated delivery models across a broad set of providers in health care markets across the country, including extensive experience in California, Texas and New York with 1115 Medicaid waivers and DSRIP. We are pioneers in this work and have a proven history of working with multiple stakeholders within communities to define a best-fit solution, implement the design and manage ongoing operations and performance.

The firm has unparalleled national experience with Medicaid 1115 Waivers, from early design and planning, to implementation, to extremely successful drawdown of dollars and investment/alignment with long-term sustainable Medicaid and all-payor value-based payment driven networks. Our success in supporting our clients is underscored by a commitment to collaboration and joint planning with our clients and key stakeholders. This approach allows us to understand the current state of care delivery and true realities (e.g., resources, politics and culture) of each system. Most importantly, it enables the collaborative development of a solution that is responsive, timely and practical. To best leverage our expertise and impact, COPE Health Solutions coordinates with client project teams and leadership in order to synthesize vision, strategic objectives, available resources and operational needs to bring the organization closer to a comprehensive solution.

Our team includes experts in the areas of clinical integration, managed care systems design, ambulatory network development, strategic planning, care coordination and health care finance – including value-based payment methodologies, Medicare and commercial Accountable Care Organizations (ACOs) and Medicare Access and CHIP Reauthorization Act (MACRA), Medicaid waivers, provider and health plan contracting and population health. This expertise and bench strength has enabled us to lead our clients through the challenging process of transformation, in light of the implementation of health reform and local market realities, in multiple settings. COPE Health Solutions has developed a cadre of core subject matter experts with deep experience within the industry, allowing us to readily organize resources around strategic issues, operational challenges and pertinent policy and regulatory changes.

COPE Health Solutions' roots are as a community-based organization committed to supporting the diverse needs of homeless families. Having worked for years to help transform safety net and all-payor health systems, our firm understands the unique challenges faced by traditional safety net organizations, including the need for a diverse and culturally competent workforce. We are committed to investing in and developing the communities that our clients serve.

We are a national firm, one of only a few that can combine deep experience with Medicaid waiver transformation projects across multiple states and a variety of provider systems, payors, and community-based organizations with expertise in helping health systems and providers transition from volume to value across all lines of business whether through MACRA, ACOs, Independent Physician Associations (IPAs), health plans or innovative commercial and direct to employer arrangements. Our firm is a pioneer in leveraging government incentive programs, such as DSRIP and Medicare ACOs, to develop population health management systems and value-based payment arrangements.

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