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Delivery System Reform Incentive Payments

History and Evolution of the Program

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Delivery System Reform Incentive Payments (DSRIP)

- Background and Overview of DSRIP Transformation Funding Programs
- Program Characteristics Over Time
- State Implementation
- Trends for Future Investment

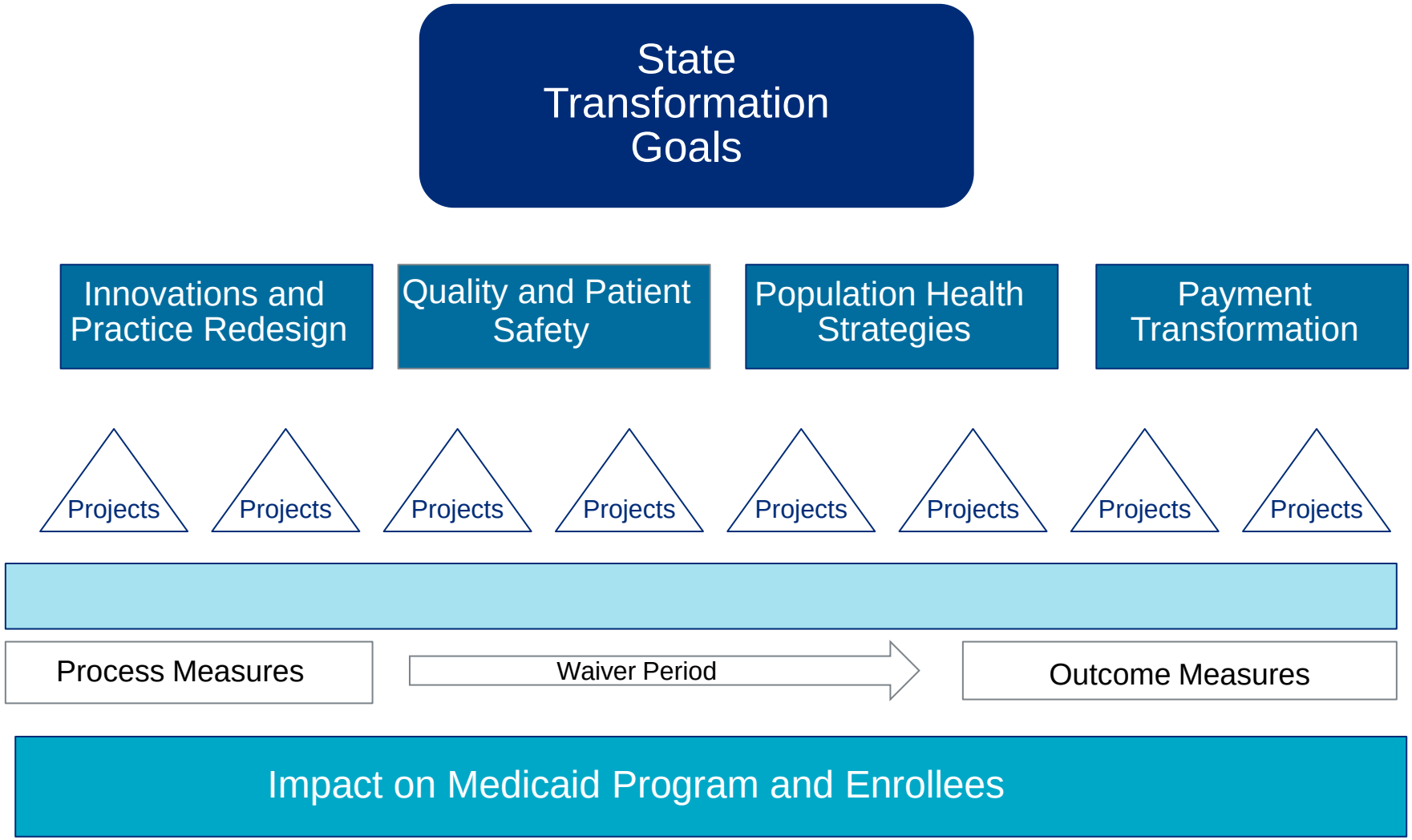
DSRIP Background

- Federal investment in Medicaid transformation using 1115 demonstration waivers.
- Opportunity for states to incentivize providers and provider systems to invest in transformational activities supporting broader state goals for developing higher-performing Medicaid programs.
- First DSRIP: The California Bridge to Reform Waiver (2010).
- Second group: MassHealth and Texas Transformation Waivers (2011).
- Centers for Medicare & Medicaid Services (CMS) approved additional transformation and reform initiatives in four other states.

DSRIP Overview

- Payments are made to providers based on the achievement of defined metrics or milestones associated with projects designed to move providers and systems of care along a continuum of delivering high quality and high value services.
- States generally focus projects on four general “domains” identifying different categories of investment and transformation.
  - Innovations and Practice Redesign.
  - Population-Based Health.
  - Health Quality Improvement.
  - Payment Transformation.
- Participants identified “projects” within these categories of transformation. The development of the projects often took between six months and one year.

Program Design Characteristics



Overview of DSRIP Programs

- Select DSRIP Programs as of December 2015.

State	DSRIP/DSTI Approval Period	Total Funding
California	2010 – 2015	$6.5 billion
Texas	2011 – 2016	$11.4 billion
Massachusetts	2014 – 2017*	$1.35 billion
New Jersey	2014 – 2017	$666.4 million
Kansas	2014 – 2017	$99.8 million
Oregon	2012 – 2017	$1.9 billion**
New York	2014**	$6.4 billion***

* Massachusetts waiver renewed 10/2014 – 2019 – only 3 years of funding approved.
** Oregon expenditures are based on available DSHP funding.
*** New York currently negotiating final extension details.

Program Characteristics Over Time

- Early DSRIP or transformation programs focused on individual hospitals or hospital systems.
  - California – Designated public hospitals (initially 14 systems).
  - Massachusetts – 7 safety net hospitals.
  - New Jersey – 66 hospitals.
  - Kansas – 2 university hospitals.
  - Oregon – Urban hospitals with more than 50 beds, added in 2014.

Program Characteristics Over Time

- Exceptions are Oregon, Texas, and New York.
  - Oregon utilizes Coordinated Care Organizations (CCOs) rather than "projects".
    - CCOs are the next evolution in health delivery and financing in Oregon and are defined in state statute.
    - CCOs have required benchmarks and metrics in quality and access to meet "global budget" risk payments for enrolled populations.
    - Funding is part of the CCO payments through rate development, withholds, and incentive payments.
    - Oregon is at risk for other hospital funding based on performance on quality and cost measures defined in the terms and conditions.

Program Characteristics Over Time

- Exceptions are Oregon, Texas, and New York.
  - Texas has self-determined Regional Health Partnerships (RHP).
    - 20 RHPs including 300+ hospitals, as well as other entities including public health entities.
    - RHPs include an anchoring entity and government funding entities.
    - Projects are specific to RHP community needs.
  - New York has Performing Provider Systems.
    - 25 partnerships developed.
    - Incentive payments paid to provider systems.
    - Developing APM and value-based payment methodologies.

State Implementation

- DSRIP can be very complex and lengthy to implement.
  - Require descriptions of qualified participants.
  - Require development of project, plans, clinical metrics, and population metrics.
  - Requires identification of data requirements.
  - Requires development of appropriate metrics to inform payments.
  - A year (or more) to implement.
- Requires providers to organize within sub-organizations (RHPs and Prospective Payment Systems) or within their own organization to select projects, train staff, and enable data collection.

Emerging Trends – CMS

- CMS is being more strategic in its approach to developing and managing these investment programs. Key concepts emerging in new waivers and recent renewals:
  - **Sustainability**: How does the program become self supporting over time eliminating the need for continued federal subsidy?
  - **Measurement**: Developing meaningful metrics directly correlated with program objectives. Population attribution to measure impact of change.
  - **Systemic Approach**: Focusing on health systems rather than individual providers, measuring aggregate impact on populations, expenditures, quality, and future payment systems based on data feedback.
  - **Accountability**: Requiring a continuum of accountability from the state to insurers and providers. Accountability metrics that measure the success of the program's impact on cost, quality, and beneficiary satisfaction.

Emerging Trends – CMS

- Massachusetts' renewal is only authorized for three of the five total waiver years approved.
  - Requires a strategy to address viability of the pool funding over time.
- Recent programs/renewals focus on system change and a preference for qualifying entities working together rather than individual provider investments.
- States are held accountable for performance.
- Protocols for DSRIP programs are developed during the negotiations for the waiver rather than post approval as much as possible.
- Upcoming renewals will further inform the evolution of transformation investment.
  - New York, California, and Texas.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