Medicaid Innovation: Delivery System Reform Incentive Pools

States across the country are taking up the charge for delivery system and payment reform. A sustainable Medicaid program will require more efficient and effective health care delivery that improves health outcomes. Through Medicaid-led initiatives, federal grants and programs, and multi-payer efforts, Medicaid directors are actively engaged in efforts to improve quality, contain costs and increase the value of the Medicaid investment. These efforts range in size from small focused pilots around specific communities or disease states, while others are more sweeping in scope and impact.

One such tool for system reform is the Delivery System Reform Incentive Pool (DSRIP). In DSRIP, states procure a Section 1115 waiver that allows the state to reward providers for implementing successful delivery system and payment reform projects. This is a hospital-based effort and is financed by redirecting supplemental payments that have traditionally only been available to hospitals for the provision of uncompensated care. States pool a portion of their existing uncompensated care funds (and supplement with additional resources at times) to target and reward specific quality improvement goals.

To date, seven states have created a DSRIP, including California, Kansas, Massachusetts, New Jersey, New Mexico, New York, and Texas. While these programs differ in scope (two hospitals are participating in Kansas verses 21 public hospitals in California), the programs have similarities, including:

- States establish a framework for projects and objectives that Center for Medicare and Medicaid Services (CMS) approves.
- Entities eligible for DSRIP funds then must select targets and approaches from this framework, and shape a tailored plan on how their entity (typically a hospital) will meet those goals. This entity plan must receive state and federal approval.
- Entities then assemble a reporting structure, conduct activities, and provide data on their progress to the state.
- Although eligible entities are typically hospitals, some DSRIPs require hospitals to partner with other providers to be eligible for funds. This establishes a common financial interest and alignment across providers to affect change.

1 Alabama’s recently proposed 1115 waiver also includes a DSRIP.
- All DSRIPs have been created through Section 1115 waivers.

The specific design of DSRIP projects vary broadly within and across states, as CMS has allowed states to tailor this program considerably. Below is a description of the current DSRIP state efforts. It is important to note that the future of this program remains uncertain as CMS has not provided guidance on DSRIPs, nor have they indicated how many Section 1115 waiver demonstrations they will permit to include a DSRIP.

**CALIFORNIA**

As part of the Bridge to Reform waiver, the state created a DSRIP in 2010 to support public hospital systems’ work to increase access, quality, and efficiency. Up to $6.67 billion in incentive payments ($3.4 billion in federal funds) were made available through this program over five years, and the state share is provided by the public hospitals through an intergovernmental transfer (IGT). To participate, public hospitals had to receive state and CMS approval for a plan outlining the hospital’s projects and milestones in the project categories: infrastructure development, innovation/redesign, population-focused improvement, urgent improvement in care, and HIV transition projects. In addition, all participating hospitals had to implement certain types of initiatives, such as sepsis detection and Central Line-Associated Bloodstream Infection (CLABSI) Prevention. The state’s 21 designated public hospitals are participating in the demonstration, and each entity is implementing 12 to 19 projects simultaneously. In an effort to drive high performance and quality improvement within the program, participating hospitals face potential penalties tied to their funding pool for low achievement values and incomplete milestone bundles.

**KANSAS**

The state’s DSRIP was created through the KanCare waiver in 2013, making available up to $60 million in funds through 2017 for hospitals that implement delivery system reform projects and reach the corresponding milestones. The state share of DSRIP payments is funded with a combination of state funds and IGTs. Only large public teaching hospitals or border city children’s hospitals are eligible for the funds, resulting in two hospitals qualifying. These hospitals must develop a plan and implement at least two projects from the focus areas developed by the state and approved by CMS. Hospital DSRIP plans must be submitted to CMS for approval in the second half of 2014, and CMS is slated to approve these plans by Jan. 1, 2015.

**MASSACHUSETTS**

The state’s DSRIP, called the Delivery System Transformation Initiatives (DSTI) program, was created in 2011 to support hospital efforts to enhance access, improve quality, and develop payment reform strategies. The program makes available $628 million over three years to the seven hospitals that are eligible due to their high Medicaid patient volume. The goals of DSTI are to develop an integrated delivery system; improve outcomes and quality; move toward value-based purchasing and alternatives to fee-for-service; and institute population-focused improvements. The state’s master plan for DSTI, which was approved by CMS, outlined the funding categories,
objectives, and evaluation metrics. Based on this document, eligible hospitals submitted their own plans to the state and CMS outlining their projects and metrics for success.

Authority for the program is set to expire June 30, 2014. The state is seeking CMS approval to continue DSTI as part of their pending waiver extension request for SFY 2015-2019.

NEW JERSEY
New Jersey’s DSRIP was created in 2012 through the state’s Comprehensive Medicaid Waiver to improve care and population health while reducing costs. The DSRIP makes available $583.1 million for hospital efforts to implement delivery reform and for achieving metrics of success. Prior to the waiver, this funding was available to hospitals as supplemental payments.

All acute care hospitals are eligible for funds through DSRIP, which is available over a period of four years. A hospital’s initiative may focus on one of eight chronic conditions: HIV/AIDS, cardiac care, asthma, diabetes, obesity, pneumonia, and behavioral health or substance abuse conditions. Hospitals may choose another medical condition that is unique to it, but this must be approved by CMS. The agency approved 49 DSRIP plans in April 2014.

NEW MEXICO
The state’s DSRIP, the Hospital Quality Improvement Incentive (HQII) pool, was created through the Centennial Care waiver in 2014. Beginning in 2015 and continuing through 2018, the HQII funds will be available to incentivize provider improvement in the health and quality of care. Up to $29 million in funding will be available over the demonstration. Funds will support providers that achieve specific milestones, as outlined in the allocation and payment methodology, which must be approved by CMS. Entities eligible to participate in this program include sole community provider and state teaching hospitals that were eligible for certain supplemental payments at the time of the waiver’s approval.

NEW YORK
In 2014, New York created a DSRIP through an amendment to its Medicaid Reform Transformation waiver. Through the DSRIP, the state will leverage savings generated from earlier transformation efforts to pursue delivery reform and reduce avoidable hospital use by 25 percent over five years. The state share of DSRIP will be funded through an IGT, and $6.92 billion in federal funding will be made available for this program. In conjunction with this program, the state will implement changes in the managed care contracts to promote DSRIP objectives.

Safety net providers must collaborate to form a Performing Provider System (PPS) to be eligible for DSRIP, and the PPS will be evaluated as a single unit, which may receive full funding if process and outcome metrics are met. If a public hospital providing IGT funds is participating in a PPS, that hospital will generally be the lead provider. Each PPS must implement 5 to 10 projects that focus on system transformation, as well as clinical and population health improvement. These projects must
be outlined in a plan approved by the state and subject to CMS review. DSRIP project plan applications are due Dec. 2014.

TEXAS
In 2011, the state’s DSRIP was created through the Transformation and Quality Improvement Program waiver, which made available up to $11.4 billion over five years. Twenty Regional Health Partnerships (RHPs) were created under this waiver to bring together providers to plan for and implement delivery reforms that enhance access, quality, and the health of patients. RHPs are anchored by a public hospital or other public entity and comprised of other providers. Local and state public entities, including public hospitals, contribute the state share of DSRIP funding through an IGT. In addition, RHPs must pursue projects that are included in CMS-approved project menu. Individual RHP plans must also be approved by the state and CMS.

<table>
<thead>
<tr>
<th>State</th>
<th>Years</th>
<th>Program Funding</th>
<th>Eligible Providers</th>
<th>Requires Hospital/Provider Coalition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>2010-2015</td>
<td>$6.67 billion</td>
<td>Public hospital systems</td>
<td>No</td>
</tr>
<tr>
<td>Kansas</td>
<td>2013-2017</td>
<td>$60 million</td>
<td>Large public teaching hospitals or border city children’s hospitals</td>
<td>No</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>2011-2014</td>
<td>$628 million</td>
<td>Hospitals with high Medicaid volume</td>
<td>No</td>
</tr>
<tr>
<td>New Jersey</td>
<td>2014-2017</td>
<td>$583.1 million</td>
<td>All acute care hospitals</td>
<td>No</td>
</tr>
<tr>
<td>New Mexico</td>
<td>2014-2018</td>
<td>$29 million</td>
<td>Sole community providers; state teaching hospitals</td>
<td>No</td>
</tr>
<tr>
<td>New York</td>
<td>2014-2019</td>
<td>$6.92 billion (FFP only)</td>
<td>Safety net providers that have formed a PPS</td>
<td>Yes</td>
</tr>
<tr>
<td>Texas</td>
<td>2012-2016</td>
<td>$11.4 billion</td>
<td>Providers participating in a RHP (led by public hospital or other public entity)</td>
<td>Yes</td>
</tr>
</tbody>
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While there have been early struggles to measure the impact of DSRIP, notable improvements are beginning to emerge as a result of these state programs. Some states, consequently, are looking to continue their DSRIP program, while other states are pursuing a DSRIP for the first time (such as Alabama). Though the long-term outlook of this program is unclear – due to lack of CMS guidance and uncertainty that accompanies the waiver approval process – ongoing success of this program will make it likely that DSRIP will continue to be a tool available for states to deliver value in Medicaid.