

**A Review of Select State DSRIP Programs and  
Implications for California’s Medi-Cal 1115 Waiver Renewal**

**Prepared by Peter Harbage, Ingrid Aguirre Happoldt, and Jennifer Ryan  
Harbage Consulting, LLC**

In 2010, California established the nation’s first Delivery System Reform Incentive Payment (DSRIP) program. Approved as part of a Medicaid waiver by the Centers for Medicare & Medicaid Services (CMS) under Section 1115 of the Social Security Act, California’s DSRIP makes federal incentive payments available to public hospitals for demonstrating progress in several areas, including building infrastructure and achieving performance outcomes. California’s DSRIP program was the first of its kind, and only five other states have received CMS approval to operate DSRIP programs: Kansas, Massachusetts, New Jersey, New York, and Texas.<sup>1</sup>

Against a backdrop in which California is currently renegotiating its 1115 waiver with CMS, this brief examines the DSRIP programs in four of these states, describes their key design features, discusses how these programs have developed and evolved, and considers what lessons and questions these experiences hold for California and others states as they look to the future.

**DSRIP Models**

There is no formal CMS guidance regarding how to design a Medicaid DSRIP program. As such, states interested in establishing DSRIP programs can look to recently approved waivers in other states as a precedent.<sup>2</sup> One approach is to examine the major project categories of each DSRIP (Table 1).

**Table 1. DSRIP Project Categories, Selected States**

<b>California 2010</b>	<b>Texas 2011</b>	<b>New York 2014</b>	<b>Massachusetts 2014</b>
Infrastructure Development	Infrastructure Development	Overall Project Progress	Development of a Fully Integrated Delivery System
Innovation and Redesign	Program Innovation and Redesign	System Transformation	Improved Health Outcomes and Quality
Population-Focused Improvement	Population-Focused Improvement	Clinical Improvements	Transformation to Value-Based Purchasing
Urgent Improvement in Care	Urgent Improvement in Care	Population-Wide Strategy Implementation	Population-Focused Improvements
HIV Transition for the Low Income Health Program			

Source: Authors' analysis

A closer examination of each DSRIP reveals two distinct models: one that emphasizes transformation within a hospital system and another that emphasizes regional health care transformation.

### 1. Hospital System Transformation

Generally, in the Hospital System Transformation model, CMS evaluates and monitors projects within individual hospitals, both in and across inpatient and outpatient settings. The focus is on building infrastructure and programs that improve hospital systems' operations around a set of specific functions. California's 2010 DSRIP is an example of this model, but it has typically been used in smaller states, including New Jersey, Kansas, and most recently in Massachusetts, whose seven-hospital Delivery System Transformation Initiative was renewed in November 2014. Examples of Hospital System Transformation projects include:

- *Expanded Medical Home Model.* In California, this project sought to reorganize medical staff into primary care teams to promote internal coordination. One of the benchmarks includes documenting the number of providers working in, and patients being served by, a medical home.
- *Improving Chronic Disease Management – Diabetes.* Among other activities, the Cambridge Health Alliance in Massachusetts implemented a nursing staff-led diabetes education initiative that included setting up pilot sites, creating interdisciplinary care teams, and training nurses on diabetes education.
- *Central Line-Associated Bloodstream Infection (CLABSI) Prevention.* Under this program, California hospitals worked to reduce infection caused by central lines through better data reporting, training, and protocols.

### 2. Regional Transformation

The Regional Transformation model moves beyond a single hospital system to try to foster coordination and improve population health at a regional level. This model involves the establishment of regional collaboratives that are expected to drive regional planning, align providers to address local gaps, and be the local entity responsible for aggregating data and reporting. New York and Texas, both large states, are the best examples of this approach.

The following examples from the 44 project categories in the New York DSRIP illustrate this regional approach:<sup>3</sup>

- *Create an Integrated Delivery System.* The goal is to reduce avoidable hospital utilization by building “a new vision, with the formation of an integrated delivery system that is community-oriented and that incorporates the full continuum of patient care needs including medical, behavioral, long term care, post-acute, and social.”<sup>4</sup>

- *Care Transitions Intervention Model.* To reduce 30-day readmissions for chronic health conditions, “hospitals, partnering with a home care service or other appropriate community agency, will develop standardized protocols to assist patients...to ensure discharge directions are understood and implemented by the patients at high risk of readmission.” In addition, the hospital and its partners will help ensure that social services are provided, including food services.
- *Expansion of Asthma Home-Based Self-Management.* Under this project, providers will work together to implement a program that teaches “asthma self-management skills, including home environmental trigger reduction, self-monitoring, medication use, and medical follow-up” to reduce unnecessary Emergency Department (ED) and inpatient utilization.<sup>5</sup>

## **Discussion of Models**

Both DSRIP models require extensive collaboration in order to be successful. The Hospital System Transformation model requires collaboration internal to the hospital system, while the Regional Transformation approach requires collaboration across a range of providers that may or may not share the same incentives or interests. As such, the regional approach brings with it a greater amount of political and financial complexity, and requires significant effort in aligning providers and provider incentives. Regional incentive dollars need to be spent beyond the hospital, and may be available to a range of providers as well as community-based organizations. This often requires hospitals to develop new types of relationships in their communities.

While the two DSRIP models are clearly different, they need not be mutually exclusive within a state. Although such a hybrid model does not currently exist, it could be possible to have two different DSRIP pools functioning concurrently in a state, with each separately supporting Hospital System and Regional Transformation. Joint planning across providers in the two incentive pools would be essential. If the two incentive pools operate as independent and “siloesd” programs, systemic problems are not likely to be resolved, and duplication of efforts could occur.

## **Key Design Issues**

When considering the design of a DSRIP program, states must make a number of critical design decisions. This brief examines five issues: participating providers, vision and goals, evaluation and metrics, role of managed care, and sources of non-federal share.

### **1. Participating Providers**

One of the most significant design questions is which types of providers should be able to participate in a state’s DSRIP program. Every state has a range of providers that needs to improve health outcomes, making the process of deciding who is eligible for DSRIP dollars challenging but critical.

California's DSRIP is the only one that has been focused solely on public hospitals; all other DSRIP states include private hospitals. The public hospital focus in California emerged partially out of a history in which public hospital systems have had to self-fund the DSRIP and other waiver payments with Intergovernmental Transfer (IGT) dollars, since no state General Fund is provided as the non-federal share in California.

California has included a proposal in its Medi-Cal 1115 waiver-renewal concept paper<sup>6</sup> to expand its DSRIP program beyond the 21 existing large Designated Public Hospitals (DPHs) to include the 42 non-designated public District Hospitals. Some of these hospitals are large urban facilities; however, many District Hospitals are smaller hospitals that have their own taxing authority. By doing so, California's Department of Health Care Services would expand the reach of DSRIP while keeping the "public" nature of DSRIP intact in California.

Additional types of providers that states have included in DSRIP are:

- *Non-Hospital Providers.* States may want to consider whether or not their DSRIP should extend beyond hospitals, which by definition means selecting the Regional Model. Texas and New York both used this approach to include a vast array of provider types and classes to help improve health outcomes.
- *Safety Net or All Providers.* California's DSRIP was created to help support and strengthen the state's 21 public hospital systems, which provide 40 percent of all hospital care to the state's uninsured population and primary care providers for over a half-million of the state's newly eligible Medicaid enrollees.<sup>7</sup> States should consider how they are supporting goals of broad transformation of delivery systems and supporting providers that play essential safety-net roles in their communities. Though delivery system transformation might require the inclusion of all providers, safety-net providers are traditionally underfunded and arguably have higher needs. A state could take steps toward directing a higher percentage of funds to safety-net providers or providers who see a higher percentage of Medicaid patients, as New York has done.
- *Services Beyond Medical Care.* Social service providers can play a critical role in achieving health outcome goals and making progress on the social determinants of health. New York's waiver includes social service providers in its DSRIP.
- *Specialty Providers.* States may want to consider including specialty providers, such as behavioral health providers, in their DSRIPs. Poor mental health status can affect overall patient treatment compliance and may contribute to inappropriate use of the ED and inpatient care. California could take advantage of the opportunity to build partnerships between DSRIP hospitals and the private behavioral health providers funded by the counties. This would be a Regional Transformation approach bounded to this single provider class.

## 2. DSRIP Vision and Goals

What change does the state want to incentivize? Is there a broader vision or goal that the state wants to meet? A shared vision of what needs to be transformed in the system is key to a successfully designed DSRIP project. California's vision for its 2010 DSRIP was to help support underfunded public hospital systems and catalyze delivery system improvements to help them prepare for the implementation of the Affordable Care Act. As such, California designed its initial DSRIP categories to meet the improvement needs of public hospitals. Specific goals included the following:

- *Systems Redesign* is the core focus on transforming the way care is delivered and financed, including redesigning ambulatory care, improving care transitions, and integrating behavioral health (both mental health and substance use disorders) and primary care services.
- *Care Coordination for High-Risk/High-Utilizing Populations* will focus on improving care management, expanding access to health homes, and palliative care.
- *Resource Utilization Efficiency* will seek to decrease inappropriate use of antibiotics, high-cost imaging, and pharmaceuticals.
- *Prevention* will a focus on core areas such as cardiovascular health, obesity, cancer, and perinatal care.
- *Patient Safety* strategies are designed to improve safety in ambulatory care (e.g., medication reconciliation) and create an overall culture of safety.

The goals are carried forward in California's Medi-Cal 1115 Renewal concept paper, and the state has increased its overall focus on delivery system transformation.<sup>8</sup>

The driving vision for DSRIP programs across the country is most consistently about payment reform. In Texas, the goal of payment reform was a particularly acute motivator, as inpatient spending had long been carved out of managed care, and the state was considering a full reversion to a fee-for-service model. DSRIP in large part was designed to transform Texas' inpatient care system by helping to reduce unnecessary utilization and create a more efficient system that is well-positioned for a transition to capitation.

Similarly, New York is preparing for greater capitation, including delegation-of-risk models. As such, New York and Texas are both focused on reducing unnecessary institutional utilization – New York's key statewide metric is a 25 percent reduction in unnecessary inpatient utilization. Massachusetts, which is further along than most states in expanding capitation, is using DSRIP to prepare for Medicaid to move to a 100 percent managed care model. Capitation strategies will help promote efficiency, bring down state health care costs, and prepare for the certainty and stability that capitation payments make. California has already achieved many of these improvements, due to the extensive use of managed care and capitation that already exists in California.

Recently, CMS started asking for DSRIP programs to also meet broad state public health or outcome improvement goals. This is reflected in New York, where the statewide goal is to reduce preventable hospital admissions by 25 percent. (New Jersey also has a number of statewide goals.) California has committed to developing similar goals in conjunction with its waiver-renewal process.

### 3. Project Planning, Evaluation, and Metrics

What performance measures and evaluation methodology will be used to assess the outcomes of these projects? CMS has increased its focus on this element of its 1115 waiver review, and states should expect to include specific, outcomes-based goals and metrics in their proposals in order to achieve approval. DSRIP projects must have well-developed and thought-out plans to address key health provider and system needs, and they must have evaluation metrics that both accurately assess progress and drive progress toward the intended goal. Generally speaking, within state guidelines, each eligible provider submits for approval both process-oriented metrics (for the early years) and outcome-oriented metrics (for later years) for each category to be approved by the state and CMS. CMS has expressed to states that they need to have “stretch” goals that are “truly transformative.”<sup>9</sup>

Indeed, while the structures and requirements of each DSRIP initiative vary by state, CMS has instituted a set of expectations for performance measurement in order to qualify for the DSRIP funds. There is a focus on meeting process-based metrics in the early years of the waivers, such as system redesign or infrastructure development, with the focus shifting to outcome-based metrics in later years, such as clinical health or population-based improvements.

In support of these milestones and metrics, CMS imposes extensive data collection and reporting requirements on DSRIP providers. For example, Texas DSRIP plans can number well over 1,000 pages and include an extreme level of detail. One DSRIP project plan that involved a Texas hospital expanding specialty access to gastrointestinal services by 1,800 patients per year simply by adding two specialty physicians lasts for 12 pages. The evaluation for the project involves 20 different metrics over five years.<sup>10</sup>

Massachusetts’ planning and evaluation requirements have been more rigorous than in California but not so expansive as those in Texas. In a review of Massachusetts’ 2011 DSRIP plans, the DSRIP applications to apply for DSRIP dollars are roughly double the length of California’s plans, with hospitals needing to expand their data analysis efforts to meet CMS detail and uniformity requirements.<sup>11</sup> However, the primary source of data for Massachusetts continues to be their internal hospital electronic medical record and billing data.

As the first DSRIP program, California was at the cutting edge of Medicaid pay-for-performance. The 21 public hospital systems had been engaging in a number of small, piecemeal quality improvement efforts but nothing on the scale of the DSRIP. They used their experience with those prior efforts to propose DSRIP plans that complemented their own strategic plans. At the time, CMS expressed general goals for the DSRIP but had not yet formulated or articulated

its desired level of detail for California reports. Four years later, CMS' increased focus on data and performance measurement ensures that California will need to have more-aggressive goals and metrics as part of its 2015 waiver.

In conjunction with the more rigorous requirements, CMS has also provided more support for states in meeting these requirements. For example, New York has received tens of millions in federal planning dollars as well as an extended approval period for the waiver. California may benefit from offering to follow protocols as developed in other states while asking the federal government for the resources needed to conduct the planning, as well as create and maintain new data collection systems to support more-robust evaluations. A funded planning period may be a critical element of a successful expansion of DSRIP in California to include the District Hospitals, as these hospitals likely need more intensive technical assistance and preparation for participation in DSRIP.

#### 4. Role of Managed Care Plans

What is the role, if any, of managed care in DSRIP? California has a well-established Medi-Cal managed care program and is an example of DSRIP being designed to operate separately from managed care. Generally, the managed care programs of other states with DSRIP programs are not as well developed. Unlike California, those states are using DSRIP to prepare their providers for increased managed care. For example:

- Massachusetts affirmatively decided to use Delivery System Transformation Initiatives (DSTI) for Hospital Transformation and to prepare for a 100 percent Medicaid managed care model. However, the Commonwealth's Hospital Transformation model leaves little room for managed care plans to play a role. The Commonwealth has suggested an accountable care organization (ACO) be created for Regional Transformation (although to date, no progress has been made on that plan).
- In New York, a condition of participating in DSRIP is that the regional collaborative is preparing providers to accept capitation in five years. The New York DSRIP application asks about building relationships between the Performing Provider System and managed care, and drives providers to create integrated delivery systems where one of the requirements is to participate in value-based contracts. Plans are having discussions with the regional collaborative about how they can participate in specific projects. However, working with plans is a goal and outcome of New York DSRIP, not a part of current operations.
- The Texas DSRIP is specifically designed to transform inpatient care by helping to reduce unnecessary utilization and create a more efficient system that can tolerate capitation.

In California, a key question is what role managed care plans might be able to play. Under California's Coordinated Care Initiative (CCI), for example, the state sought to promote care integration for those in Medicare and Medicaid (dual eligibles) by expanding the reach of managed care. All of those care dollars run through health plans, so each plan operates much like

a regional collaborative. There is no obvious reason why managed care plans could not play a broader care integration role in Medi-Cal beyond CCI, but there would need to be a financial incentive for plans and providers to act together.

## 5. Sources of Non-Federal Share

Financing drives much of the thinking on how waiver proposals should be designed. As a component of a Medicaid waiver, DSRIPs must have appropriate sources of non-federal share. If there is no non-federal match, the program cannot be funded.

California has a decades-long history of limiting the contribution of state General Fund to Medi-Cal. Prior to 2005, California public hospital IGTs were used as a source of funding for both public and private hospitals for certain Medi-Cal supplemental payments. During that period, public hospitals were also receiving General Fund support that has since been discontinued, replaced by, in 2005, Certified Public Expenditures (CPEs), in which public hospitals incur allowable expenses and receive a 50 percent reimbursement from the federal government, with no state General Fund support for most waiver payments. In 2010, CMS allowed IGTs to be used to finance the non-federal share of DSRIP payments, in addition to the CPE structure for other waiver payments. Upon achievement of performance milestones, the public systems send an IGT to the state. The IGT is matched and returned to the public hospital systems, also at a 50 percent matching rate. In contemplating alternative sources of non-federal share for a successor DSRIP, the state has indicated its position not to provide General Fund as a match.

Other states have varied in their approaches:

- Massachusetts uses a combination of IGTs and state General Fund to finance DSRIP.
- New York uses public hospital IGTs to support the entire program.
- Texas uses a combination of IGTs from a number of sources, including local government entities such as hospital districts, counties, and cities, as well as state mental health spending. In some places, there have been insufficient sources of local match to finance the DSRIP.

In states where General Fund is used sparingly, there is a labyrinth of caps and spending limits on how supplemental (non-General Fund) dollars can be used. If there is no General Fund forthcoming for a successor California DSRIP, even given the proposed inclusion of the District Hospitals, California needs to give deep consideration to the financial sustainability of DSRIP projects and the future role of uncompensated care pools. CMS will likely be focused on long-term sustainability in its waiver negotiations with California.

## Conclusion

While Section 1115 waivers offer states tremendous flexibility, they also include important controls. CMS and the federal Department of Health and Human Services (HHS) have no obligation to approve a state's waiver request. The first step in successfully seeking a state

waiver is setting a vision and goals to be achieved, and then to consider how to align those goals with those of the federal government so that there is a mutual investment in a successful outcome. Once shared goals are established, the process of designing a programmatic and financial system becomes much easier between the state and federal government, with a greater likelihood of obtaining needed federal support.

## **Appendix A: State DSRIP Summaries**

### **California**

California is in the fourth year of its DSRIP program using the Hospital System Transformation model. Fifteen counties have DSRIP plans, which cover all 21 eligible public hospitals (Designated Public Hospitals). Each DSRIP plan sets its own measures within the set of categories. During the first two years of California's DSRIP, the hospitals had to reach process metrics for developing infrastructure and new models of care, as well as improving the patient experience. California has had great success in meeting these goals and is in the process of pursuing a five-year renewal of the Medi-Cal Section 1115 waiver that includes DSRIP as a key element. The current waiver expires on October 31, 2015.

### **Massachusetts**

Massachusetts has a seven-hospital innovation program, and each hospital is expected to have six or seven projects. The Commonwealth's version of DSRIP, called Delivery System Transformation Initiatives (DSTI), was renewed for three years in November 2014. The new extension is structurally similar to the amendment approved in January 2014 to comply with requirements of the Affordable Care Act. Massachusetts used its initial three-year CMS approvals, for the first waiver and a subsequent renewal, to argue that a population health approach was not possible – that regional change would require a full five-year waiver. It took almost a full year of the initial three-year waiver period to develop operational protocols. For the renewal, CMS wanted the Commonwealth to go beyond the seven hospitals and hospital transformation, but Massachusetts refused on both counts. The Commonwealth's goal continues to be to prepare providers for the complete elimination of fee-for-service Medicaid.

### **New York**

New York is in the process of developing a number of Performing Provider Systems (PPSs), which are generally multi-county in size. Acknowledging the importance and amount of time needed for appropriate planning, CMS took the uncommon step of approving a 5.5-year waiver in 2014. The projects are all regional in nature, and both population health and statewide measures will be used; there are no options for addressing hospital-specific operations – cross-provider collaboration is required in every case. There are tens of thousands of non-hospital providers involved – including physicians, pharmacies, clinics, social service providers, and other provider types. The primary goal of the waiver is to prepare providers for capitation payments, and to reduce unnecessary utilization of emergency departments by 25 percent over 5 years.

## Texas

Texas operates its DSRIP with 20 Regional Health Partnerships (RHPs), which are generally multi-county in size. The five-year waiver was approved in 2011 with a strong focus on population health. Much of the negotiation was driven by CMS, including the focus on a regional approach and the inclusion of both public and private providers. Neither the state nor the public providers were interested in private hospital participation. Some of the 1,400 projects underway are hospital-specific, but most are regional in nature, with a range of provider types able to participate. The primary goal of the Texas waiver was to prepare hospital providers for carving inpatient care into managed care, which had historically been left out for state financing reasons. The state has relied on IGTs and state behavioral health funding as the sources of the non-federal share.

There have been some ongoing financing issues, CMS recently issuing a deferral on some of the state's IGTs. DSRIP has helped alleviate the initial distrust between public and private providers in Texas by helping both provider classes realize that all providers are needed to make the safety net work.

Texas RHPs are locally developed confederations that convene to develop Regional Healthcare Plans. The plans identify strategies to address uncompensated care and delivery system reform. Participants in the partnership include county medical associations/societies, community mental health centers, public and private hospitals, county health departments, academic health science centers, Department of State Health Services regional public health directors, and consumers and advocates.

## Endnotes

---

<sup>1</sup> In this brief, the term DSRIP is used to refer to any such incentive program, except as noted when it refers specifically to California's program.

<sup>2</sup> Peter Harbage and Jennifer Ryan, "Examining the 2005 California Hospital Waiver," California HealthCare Foundation, April 2006, <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20ExaminingThe2005MediCalWaiver.pdf>.

<sup>3</sup> Excerpts from the New York Department of Health DSRIP Project Toolkit, September 2014, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/dsrip\\_project\\_toolkit.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf)

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*

<sup>6</sup> California Department of Health Care Services, "Medi-Cal 2020: Key Concepts for Renewal," March 16, 2015, <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FinalDraftMediCal2020WaiverRenewal.pdf>.

<sup>7</sup> California Association of Public Hospitals, <http://caph.org/caphmemberhospitals/fastfacts/>.

<sup>8</sup> DHCS, *op cit.*

<sup>9</sup> Author interviews, November-December 2014.

---

<sup>10</sup> Texas RHP 7 DSRIP plan, <http://texasregion7rhp.net/wp-content/uploads/2013/09/307459301.1.6-Revised-Project.pdf>.

<sup>11</sup> R. Seifert, M. Grenier, and J. Sullivan, “The MassHealth Waiver Extension for State Fiscal Years 2015–2019: Foundation for Coverage, Engine for Innovation,” Center for Law and Economics, U. of Mass Medical School, February 2015, [http://bluecrossfoundation.org/sites/default/files/download/publication/MassHealth\\_Waiver\\_report\\_FINAL.pdf](http://bluecrossfoundation.org/sites/default/files/download/publication/MassHealth_Waiver_report_FINAL.pdf).