



## Building Provider Capacity for Delivery System Transformation: The Role of Section 1115 Delivery System Reform Incentive Payment Demonstrations

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### Executive Summary

Ten state Medicaid programs have implemented Delivery System Reform Incentive Payment (DSRIP) demonstrations, authorized under section 1115 demonstration authority, to improve health, lower costs, and enhance patient care experience (quality and satisfaction). The size and scale of these demonstrations vary across states—for example, the total amount of federal and nonfederal funding allocated to DSRIP demonstrations ranges from \$150 million (New Hampshire) to \$14.7 billion (Texas). Nonetheless, to achieve demonstration goals, all DSRIP demonstrations aim to encourage participating provider entities to build capacity in three core domains: (1) data use and management, (2) care coordination and redesign, and (3) value-based payment. All DSRIP demonstrations have included early investments in infrastructure and capacity building, reducing the percentage of funds tied to infrastructure over the course of the demonstration as providers transition to pay-for-performance incentive structures. A central question for evaluating these demonstrations is the degree to which these infrastructure investments help Medicaid and safety net providers build the capacity required to achieve the demonstration goals.

This brief examines the role of DSRIP infrastructure investments and requirements in advancing health care providers' and systems' capacity to reform care delivery and transition to value-based payment. Based on 20 interviews with state Medicaid agency policymakers and provider representatives in spring 2019 and a review of state demonstration documentation, we find that DSRIP has spurred progress, but gaps remain:

- Provider entities have used DSRIP funds to build their health information technology infrastructure, expand their workforce capacity, and partner with other providers to improve care coordination.
- In demonstrations in which multiple providers participate as a single accountable entity, providers are gaining experience with population health management, a foundational skill for success in value-based payment.
- Participating entities have built upon initial infrastructure investments to expand their capacity to use and manage data, coordinate and redesign care, and participate in value-based payment programs.

### THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some states have used section 1115 waiver authority to implement delivery system reform incentive payment (DSRIP) demonstrations. Since the first DSRIP demonstration was approved in 2010, the breadth and specific goals of these demonstrations have evolved, but each aims to advance delivery system transformation among safety net hospitals and other Medicaid providers through infrastructure development, service innovation and redesign, and population health improvements. More recent DSRIP demonstrations have also emphasized increasing provider participation in alternative payment models, which are designed to reward improved outcomes over volume.

- Not all demonstrations explicitly incentivize infrastructure development. Instead, some states expected provider capacities and infrastructure to develop organically, driven by providers' need to meet DSRIP reporting, implementation, and performance targets.
- Gaps remain at the provider and system levels related primarily to health information exchange, population health management, and value-based payment. Furthermore, progress in these areas is slower for certain providers, such as small, rural, or community-based providers and those with low Medicaid volumes that may not be able to participate in risk-bearing value-based payment arrangements.

As providers transform their care delivery systems and participate in more mature stages of value-based payment, their infrastructure needs appear to evolve to more sophisticated tools and processes necessary to manage population health and financial risk, which are required for success under advanced value-based payment models. Looking ahead, efforts to transform the delivery system for Medicaid beneficiaries could require a mix of targeted infrastructure supports and performance goals to meet diverse levels of provider readiness.

## Introduction

Several state Medicaid programs are implementing delivery system reform incentive payment (DSRIP) demonstrations, authorized under section 1115 authority, to improve quality, enhance access to care, and lower costs among providers serving Medicaid and low-income uninsured patients. DSRIP demonstrations provide a unique opportunity for states to access federal matching funding for provider infrastructure investments that might not otherwise be available (Artiga et al. 2016), supporting their transition from volume-based payment to value-based payment (VBP) by gradually ramping up performance expectations as these infrastructure investments are made (Heeringa et al. 2018).

Prior qualitative studies conducted as part of the national evaluation of section 1115 demonstrations found that DSRIP investments helped providers prepare for performance-based payment. However, these studies also consistently pointed to obstacles in health information technology (HIT), workforce capacity, and effective provider collaborations that inhibit performance measurement, care coordination, and physical and behavioral health integration (Baller et al. 2017; Heeringa et al. 2017; Lane et al. 2020). Further, the 2018 interim national DSRIP evaluation, based on data from early demonstration years in California, New Jersey, and Texas, detected only minimal or insignificant demonstration effects on select outcome measures. One possible explanation for the lack of progress on these indicators of long-term clinical and utilization outcomes is that providers initially focused their efforts on building infrastructure

and capacity to establish the foundation for delivery transformation in the later stages of the demonstration (Baller et al. 2018). Given these findings, this brief sought to understand whether and to what extent DSRIP has enabled providers to build infrastructure and expand their capacity for delivery system reform and VBP.

## VALUE-BASED PAYMENT AND ALTERNATIVE PAYMENT MODELS

Alternative payment models (APMs) tie provider payment to quality—and sometimes cost—performance, with the goal of shifting from a volume-based payment model, as exists under fee for service, to a value-based payment model. APMs aim to engender greater provider accountability for the care of defined populations by assigning patients to providers and tying payment to outcomes. The Health Care Payment Learning & Action Network created an APM framework that arrays APMs in four categories distinguished by the amount of risk shifted to providers—Category 1 is limited to fee for service and Category 4, the final category, is population-based or global APMs, in which providers assume the greatest risk and responsibility for population health (HCP-LAN 2017).

The term value-based payment encompasses a broad set of strategies, which includes APMs that tie provider reimbursement to outcomes. DSRIP demonstrations aim to prepare providers for value-based payment, in part, by tying incentive funding to quality and cost targets. They also directly encourage provider entities to participate in value-based payment contracts by tying a portion of incentive funding to value-based payment participation goals (Lipson et al. 2019).

## Roadmap to the report

This brief focuses on the following topics:

1. How states promoted infrastructure development through their DSRIP designs
2. How providers used DSRIP funding to develop HIT, workforce, and organizational infrastructure
3. To what extent these infrastructure investments affected provider entities' capacity to manage and report data, coordinate and redesign care, and participate in VBP
4. Lessons learned that could inform future efforts to expand capacity for delivery system reform and VBP among Medicaid and safety net providers.

We examine DSRIP demonstrations operated in seven states from 2011 to 2019: California, Massachusetts, New Hampshire, New Jersey, New York, Texas, and Washington. California, Massachusetts, New Jersey, and Texas have each operated two DSRIP demonstrations, and the demonstration designs

in California, Massachusetts, and Texas changed considerably between the first and second demonstration periods. We synthesize findings from a review of state demonstration documentation and 20 interviews with state Medicaid agency policymakers and provider representatives, conducted between March and April 2019.

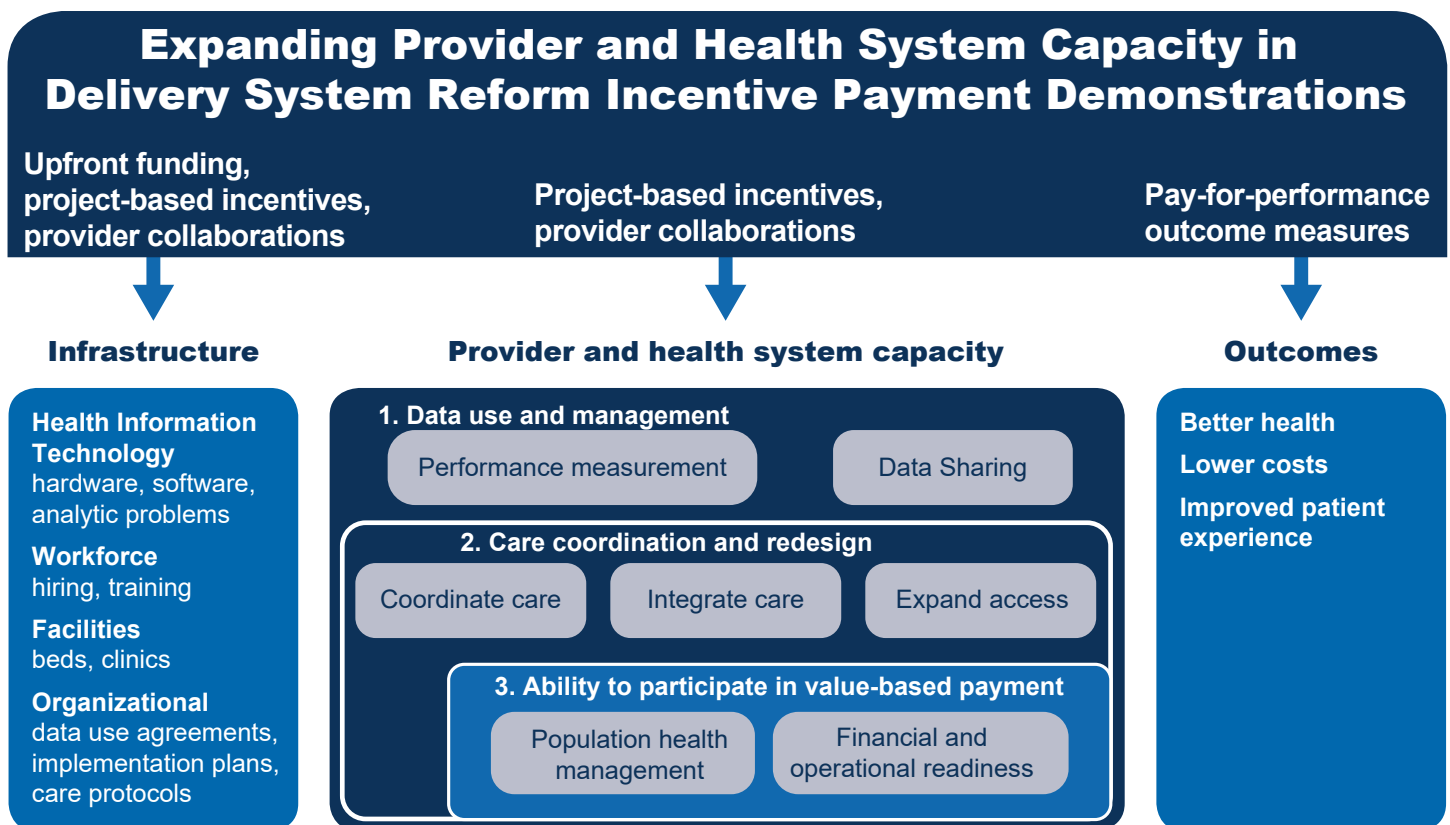
### Framework for expanding provider and health system capacity in section 1115 DSRIP demonstrations

In the context of DSRIP, developing infrastructure is a means to build and expand provider capacities to achieve the goals of transforming care delivery systems: improved health, lower costs, and better patient care experience.

Figure 1 presents a logic model portraying how DSRIP infrastructure investments support provider and system capacities. For the purposes of this brief, a provider refers to an entity that provides health care treatment or related services. Providers might include hospitals, individual practices, nonhospital-based physicians, nurses, and paraprofessionals such as care coordinators. A health system includes multiple providers who collaborate, either contractually or informally, to deliver health care in a coordinated manner (Enthoven 2009). Infrastructure falls into four categories:

- 1. HIT.** HIT refers to the electronic systems health care professionals and patients use to store, share, and analyze health information. Most prominently, this includes electronic health records (EHRs), which store and securely share patients' medical and treatment records. HIT development is a primary focus in DSRIP to expand data use activities, including data sharing, performance measurement, and population health management.
- 2. Workforce.** Workforce includes hiring and training staff that support the adoption, use, administration, or implementation of health care services and technology. Demonstrations target workforce development to expand overall access to care and help implement new care delivery models.
- 3. Facilities.** This category can include supplies and buildings for new primary care clinics, community mental health and behavioral health centers, and other health facilities.
- 4. Organizational infrastructure.** Organizational infrastructure includes the necessary business, legal, and technical requirements for health care operations and administration of the DSRIP program. This infrastructure can include data use agreements for data sharing; memorandums of understanding (MOUs), governance, and business associate agreements that establish provider partnerships; and value-based contractual arrangements with managed care plans.

**Figure 1. Logic model of expanding delivery system reform capacity**



In turn, the infrastructure built with DSRIP investments is intended to expand and strengthen provider and system capacity in three core areas:

- 1. Data use and management.** The effective use of patient, clinical, and service data to improve care outcomes and manage population health is foundational to delivery system transformation. Because DSRIP ties incentive payments to reporting measures and improving performance, participating provider entities must be able to capture and share necessary data, including patient- and population-level data, and leverage them for performance measurement (HCP-LAN 2016a). Data sharing is the process of promoting and encouraging the availability and use of comprehensive patient- and population-level data and information across the full continuum of care (HCP-LAN 2016a). Data sharing is necessary to implement performance measurement, in which provider entities use data to calculate indicators of health care and coordinate care. Performance measurement might include assessments of clinical processes (for example, whether evidence-based care was followed), patient health outcomes, patient care experiences, and cost-of-care (HCP-LAN 2016c). These capabilities are also central to care coordination and VBP because they enable providers to analyze, coordinate, and manage care delivery across providers and settings.
- 2. Care coordination and redesign.** Care coordination and redesign involves systematic changes to improve the quality, efficiency, and effectiveness of patient care (AHRQ 2018). All demonstrations encourage expanded access to care and greater care coordination across providers through care redesign activities, though the specific target of care redesign varies across states (Lane et al. 2020; Heeringa et al. 2017).<sup>1</sup> Under DSRIP, redesign activities include expanding the workforce and implementing new care delivery models, often involving new protocols, workflows, and staff, such as the patient-centered medical home. These activities also involve

integrating physical and behavioral health care services and efforts to shift treatment from the emergency department and inpatient settings to ambulatory and primary care settings.

- 3. Ability to successfully participate in VBP.** To successfully participate in VBP and alternative payment models, provider entities must be able to monitor and improve performance, oversee the health care (and sometimes social service needs) of defined patient populations, and develop the financial and operational capacity to manage financial risk. For example, participation in accountable care organizations (ACOs) requires providers to partner to expand their service delivery capacity, determine how funds will flow among partners, and target interventions to high-risk patients. DSRIP demonstrations support movement towards VBP with a number of strategies that vary by state, including incentives for developing population health management systems and meeting established cost and quality pay-for-performance targets.

## POPULATION HEALTH MANAGEMENT

Population health management involves the aggregation and analysis of patient data across multiple health information technology resources in a manner that provides action-oriented clinical and financial information. To help providers target their clinical activities, population health management includes stratifying risk, tracking patient cohorts, and benchmarking finances—core capabilities for participating in value-based payment (HCP-LAN 2017).

## State strategies to build delivery system reform infrastructure

State DSRIP demonstrations promote infrastructure development through a mix of incentives and requirements, including (1) upfront funding, (2) project-based incentives, (3) provider collaborations, and (4) pay-for-performance incentives (Table 1).

**Table 1. DSRIP participation and performance accountability**

	HIT	Workforce	Organizational
<b>Upfront funding</b>	Upfront funding for providers to develop necessary infrastructure for participating in DSRIP		
<b>Project-based incentives</b>	Incentives for completing projects and milestones for HIT development	Incentives for completing projects and milestones for workforce hiring and training	Incentives for completing projects and milestones for establishing protocols, care plans, or Quality Improvement Plans.
<b>Provider collaborations</b>	n.a.	Incentives, requirements, or both for creating provider partnerships	Requirements to develop memorandums of understanding, data use agreements, and other governance for provider partnerships and data exchange
<b>Pay-for-performance</b>	Indirectly promotes development as participants build HIT, workforce, and organizational infrastructure that is necessary to meet pay-for-performance targets for health outcomes		

**Sources:** Mathematica analysis of section 1115 demonstration special terms and conditions.

Note: Facilities is not included because it is not a focus of state strategies.

DSRIP = delivery system reform incentive payment; HIT = health information technology; n.a. = not applicable.

**Upfront infrastructure funding.** Most state DSRIP demonstrations fund an initial planning and development phase upfront, a phase that precedes a project's implementation. To access these funds, states sometimes require participating entities to develop needs assessments, gap analyses, and implementation plans that outline how they will implement necessary infrastructure.<sup>2,3</sup> For most demonstrations, funding for infrastructure development is significant, especially in the beginning years, tapering in later years (see Table 2). Second generation DSRIP demonstrations continue this evolution and have largely shifted from any infrastructure funding and requirements.<sup>4</sup> Massachusetts'

DSRIP demonstration is an exception, because a significant amount of infrastructure funding is still available through prospective funding streams for ACOs and community partners, which are new entities in this version of the demonstration, and community service agencies that are also participating. In addition to funding directed to participating entities, Massachusetts provides additional statewide funding opportunities through the Statewide Investments initiative. The initiative accounts for six percent of total DSRIP funding and is designed to address statewide gaps in workforce, technical assistance, and technology.

**Table 2. Percentage of DSRIP funding allocated to infrastructure development, by state**

States	Demonstration	Total DSRIP demonstration funding (in millions)	Percentage of DSRIP demonstration funding allocated to infrastructure by demonstration year				
			1	2	3	4	5
California	DSRIP	\$6,671	47	35	30	15	5
	PRIME	\$7,646	25*	0	0	0	0
Massachusetts	DSTI	\$1,318	< 100**	< 75	< 75	< 85**	< 80
	DSRIP (ACOs)	\$1,800	77	77	77	73	54
	DSRIP (CPs, CSAs)		63	27	27	23	20
	DSRIP Statewide Investments		6	6	6	6	6
New Hampshire	DSRIP	\$150	100**	50	50	30	20
New Jersey	DSRIP	\$583	100**	< 90	< 75	< 50	< 25
	DSRIP (Renewal)	\$499	< 25	0	0	—	—
New York	DSRIP	\$8,250	80	60	40	20	0
Texas	DSRIP hospitals	\$11,418	100*	≤ 85	≤ 80	≤ 75	≤ 57
	DSRIP non-hospital providers		100	≤ 100	≤ 90	≤ 90	≤ 80
	DSRIP (Renewal)	\$14,700	0	0	0	0	0
Washington	DSRIP	\$1,125	***	***	***	***	***

**Source:** Mathematica analysis of section 1115 demonstration special terms and conditions.

**Notes:** For California, percentages for the DSRIP demonstration represents Category 1 "Infrastructure Development" projects. We identified additional infrastructure projects outside this domain for which funding percentages were not available; thus, the presented percentages understate the total funding tied to infrastructure in this demonstration. For PRIME, Designated Public Hospitals and District Municipal Public Hospitals had 25 percent of funds (\$350 million) for the first year tied to submitting an implementation plan in the first year. District Municipal Public Hospitals also had 75 percent of funds (\$150 million) tied to infrastructure milestones in the first year.

New York funding estimates are based on the percentage of funds allocated to achieving "Domain 1" infrastructure milestones.

Massachusetts' DSTI, Texas' initial DSRIP, and New Jersey's DSRIP demonstrations overestimate incentives tied to infrastructure. New Jersey's DSRIP funding for both demonstrations includes incentives for Stage 1 (Infrastructure Development) and 2 (Chronic Medical Condition Redesign and Management) milestones; funding amounts specific to infrastructure development milestones are unavailable.

For Massachusetts ACO and CP/CSA funding, percentages are of the total funding available to the respective entities (ACOs, CP/CSA). Percentages are state estimates of anticipated funding for infrastructure-related funding streams and sub-streams and not final.

Texas DSRIP funding includes Category 1 (Infrastructure Development) and 2 (Program Innovation and Redesign), which may include milestones that are not be directly related to infrastructure. DSTI funding includes incentives associated with all infrastructure and care redesign projects (Categories 1-3) and submitting implementation plans; funding for infrastructure-specific projects is unavailable.

Texas' DSRIP has extension years, which are excluded from the table to illustrate design change between demonstrations. Massachusetts' DSTI received an extension in year 4 and was active for six total years. The final year, not reflected in the table, had at most seventy-five percent of demonstration funding tied to infrastructure (a maximum of \$172,700,000).

ACOs = accountable care organizations; CPs = Community Partners; CSAs = Community Service Agencies; DSRIP = delivery system reform incentive payment program; DSTI = Delivery System Transformation Initiative; NA = not available; PRIME = Public Hospital Redesign and Incentives in Medi-Cal

Sources for DSRIP total funds include: (1) State demonstration STCs; (2) The Commonwealth of Massachusetts Executive Office of Health and Human Services 2016; (3) MACPAC 2015; (4) MACPAC 2018; and (5) Bachrach et al. 2016.

— = Demonstration not active in year.

\* Percentage includes upfront funding tied to completing an implementation plan.

\*\* Percentage includes upfront funding from submitting an implementation plan and incentives for reporting and/or achieving infrastructure projects and milestones.

\*\*\* For Washington, the amount of funding dedicated to infrastructure was not available. Washington outlines a set primarily infrastructure-related implementation and sustainability milestones under Domain 1 (Health Systems and Community Capacity Building). Accountable Communities of Health (ACHs), entities that participate in DSRIP, specify a set projects and corresponding Domain 1 milestones they plan to address. The state determined each ACH's allocation of DSRIP funding based on several factors, including project selection. For each ACH, Washington allocated 20 percent of each ACH's funding for in the first year for submitting and gaining state approval of an implementation plan.

**Project-based incentives.** Most state demonstrations tie financial incentives directly to infrastructure development through a mix of projects and milestones (see examples in Table 3). Project-based incentives were a primary infrastructure development strategy in the initial demonstrations in California, Massachusetts, New Hampshire, and Texas.<sup>5</sup> States also specify milestones that are tied to either (1) infrastructure-specific projects or (2) projects focused on care redesign or VBP. For example, New York and New Jersey specified milestones that require infrastructure development for each project or activity.

Infrastructure projects and milestones primarily target HIT and workforce, though providers do have flexibility. Common across

all states are projects or milestones to enhance clinical data collection, documentation, and quality improvement. To support efforts on improving outreach, health literacy, and culturally competent care, some states, including California and Texas, also included incentives for collecting race, ethnicity, and language data. Incentives also target capabilities of population health management, especially through risk stratification or disease management systems that can identify patients by disease and complexity. Beyond HIT investments, DSRIP demonstrations create incentives to expand the number, type, and expertise of the health care workforce (see Table B.2 in the Appendix). Demonstrations most often encouraged hiring and training primary care and specialty care providers and care coordinators.

**Table 3. Infrastructure project and milestone examples**

Project Names	Milestones
<ul style="list-style-type: none"> <li>Enhance Performance Improvement and Reporting Capacity (California DSRIP)</li> <li>Strengthen Mental Health and SUD Workforce (New Hampshire DSRIP)</li> <li>Enhance Service Availability (that is, hours, locations, transportation, mobile clinics) to Appropriate Levels of Behavioral Health Care (Texas DSRIP)</li> <li>Develop Risk Stratification Capabilities for Patient Populations and Alternative Payment Models (Massachusetts DSTI)</li> </ul>	<ul style="list-style-type: none"> <li>Clinically Interoperable System is in place for all participating providers (New York DSRIP)</li> <li>Develop a health assessment or risk stratification tool to help identify the health risk of project participants (New Jersey DSRIP)</li> <li>Completion and approval of quality improvement plan (Washington DSRIP)</li> <li>Community health workers and community-based organizations used an integrated delivery system for outreach and navigation activities. (New York DSRIP)</li> </ul>

**Source:** Mathematica analysis of section 1115 demonstration special terms and conditions.

**Note:** This table contains example projects and milestones and is not a comprehensive list of all projects and milestones.

**Provider collaborations.** Besides direct financial incentives for development, demonstrations promote infrastructure through requirements for provider collaborations. All study states, except California and New Jersey, required regional provider collaborations, which are composed of multiple health care providers. In their designs, states specify eligibility criteria for participation, which can engage a broader range of providers that help expand the service mix, improve care coordination, or jointly manage attributed patient populations (Heeringa et al. 2018). Massachusetts, New Hampshire, New York, and Washington also created incentives to encourage participation from community-based and social service providers. Because these collaborations support care coordination and integration, we consider them to be a component of the infrastructure developed for delivery system reform. Through collaborations, providers may also establish data sharing and governance agreements, which enumerate standards and practices for data sharing among partnering providers.

**Pay-for-performance and VBP participation targets.** Not all demonstrations explicitly incentivize infrastructure development. Instead, some states expected provider capacities and infrastructure to develop organically, driven by providers' need to meet DSRIP reporting, implementation, and performance

targets. Further, all DSRIP demonstration require providers to report and improve on process and outcome measures to qualify for funding—a strategy that may require providers to build capacity to achieve the performance targets. To encourage VBP advancement, some demonstrations have tied DSRIP incentive funding to VBP participation targets, often encouraging providers to ramp up the level of risk they assume as the demonstration progresses (Lipson et al. 2019). In all states, VBP arrangements with Medicaid managed care plans are the primary mechanism intended to sustain delivery system reform achieved through DSRIP. Although reporting, performance, and VBP requirements do not exclusively target infrastructure, providers must develop infrastructure to support the care models and services that enable them to report and meet these outcomes.

### Provider use of DSRIP funds to build delivery system reform capacity

In this section, we describe how providers used DSRIP infrastructure funds and the extent to which they built the capacities required to manage and use data, redesign care, and participate in VBP arrangements.

## Data use and management

To transform delivery systems and participate in performance-based payment, provider entities must first be able to collect, share, and use data for performance measurement. Stakeholders across states described significant investments in infrastructure to facilitate measure reporting, performance measurement, care coordination, and high-level program monitoring. Policymakers and providers also indicated that participants met or are meeting DSRIP reporting and measurement requirements.

For completed or mature demonstrations, performance measurement required providers to improve their clinical data collection and incorporate other data sources. State interviewees said much of their infrastructure development was directed to strengthening interoperability across EHRs and modifying EHRs by adding previously missing fields and documentation processes to capture data necessary to report clinical quality measures. Stakeholders in California, Massachusetts, and New York mentioned development of data systems to integrate data from disparate sources, calculate performance measures, and perform data analysis. Providers and policymakers also noted that state aggregation and calculation of claims-based measures helped lessen providers' reporting burden.<sup>6</sup> Besides HIT enhancements, respondents also noted that measurement and analytics required new expertise, which necessitated hiring and training additional staff.

Interviewees identified two infrastructure components as necessary conditions for facilitating data sharing across provider entities: (1) data use agreements and related data security documents, which established clear guidelines for sharing data across providers and (2) interoperable EHRs.

### HEALTH INFORMATION TECHNOLOGY DEVELOPMENT: HITECH

Distinct from DSRIP, grant and funding opportunities have helped support infrastructure development. The federal Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 was designed to promote interoperability of clinical data, information security, and public health departments' HIT use (U.S. Congress). HITECH provided funding for health information technology infrastructure, including health information exchanges, electronic health records, and telemedicine.

Providers in all states said they invested DSRIP funds to improve interoperability, though to varying degrees. California interviewees mentioned that there was limited investment in interoperability through DSRIP as providers were already working on interoperability in the Meaningful Use program. However, Massachusetts described important DSRIP investments in

interoperability for ACOs serving Medicaid beneficiaries; these ACOs include providers not eligible for Meaningful Use incentives, such as behavioral health providers, and community-based providers, so the DSRIP funds filled gaps left by other funding sources.<sup>7</sup>

Regional health information organizations and exchanges such as New York's helped to give providers a head start with data sharing. Overall, state policymakers across states said that investments in HIT were not only beneficial for expanding data use capabilities, but also important for engaging providers in the demonstration.

"The focus on health information exchange is really important and really engaged a lot of our smaller providers who would probably never engage in a statewide health information exchange, and we had money to support them to do it."

—New York provider

## Remaining gaps in data use and management

Despite progress in sharing data and measuring performance, many providers, especially nonhospital-based providers, lack the capacity to participate in data exchange.

Siloed, non-enterprise-wide EHRs, which are still prevalent, inhibit data standardization, collection, and interoperability. Although supportive, DSRIP funding and the relatively short implementation timeline are sometimes viewed as insufficient to cover costs of acquiring and implementing new EHRs for multiple providers. Interviewees stressed that data exchange is difficult or impossible when providers do not use the same EHR. Some respondents also mentioned limitations in executing data sharing agreements. In instances in which health care systems were competitors or a DSRIP region was county-led, providers were less likely to complete these agreements and share data.

Stakeholders across states said that non-claims data have been difficult to consistently collect and bring into operation, especially substance use disorder (SUD) data. Even with vetted guidelines and processes, providers are hesitant to share SUD data because of concerns about violating privacy regulations.<sup>8</sup> New Hampshire was one of the few states to note some progress in using SUD data, attributing progress to provider boot camps that shared information and trained participants on how to comply with 42 CFR part 2 requirements governing the sharing of such information. Another respondent said there was little progress on collecting reliable race, ethnicity, and language data. Claims-based data and analytic resources that some states provided were also of mixed benefit to providers, in part because of data lags, which make it of limited value for managing patient clinical care.

**Table 4. Infrastructure for data use and management: design and implementation**

Infrastructure	Emphasis in design	Essential infrastructure (implementation)	Facilitators (implementation)	Gaps
<b>Health information technology</b>	+++	<ul style="list-style-type: none"> <li>Development of electronic health records systems and enhancements for interoperability and clinical data collection</li> </ul>	<ul style="list-style-type: none"> <li>Regional and state health information infrastructure</li> <li>Analytic dashboards</li> <li>Provider participation in Meaningful Use</li> </ul>	<ul style="list-style-type: none"> <li>Interoperability and information exchange, especially with small, community-based providers</li> <li>Collection of behavioral health, social determinants of health, and race, ethnicity, and language data</li> </ul>
<b>Workforce</b>	+	<ul style="list-style-type: none"> <li>Hiring new measurement and analytic staff</li> <li>Training and technical assistance to build providers' performance measurement and analytics capabilities</li> </ul>		
<b>Organizational</b>	++	<ul style="list-style-type: none"> <li>Data use agreements and memorandums of understanding between providers</li> </ul>	<ul style="list-style-type: none"> <li>State guidance and technical assistance</li> </ul>	<ul style="list-style-type: none"> <li>Data use agreements among competitors, county-led entities</li> <li>Guidance for sharing and using behavioral health data</li> </ul>

**Source:** Mathematica analysis of section 1115 demonstration special terms and conditions, state documentation, and key informant interviews.

+++ = A common focus of infrastructure incentives and requirements across demonstrations based on review of projects, milestones, and participation requirements

++ = A focus in select demonstrations

+ = Rarely incentivized or a required infrastructure component in demonstrations

Throughout the interviews, respondents described providers' disparity in health information infrastructure and data capabilities. Hospitals have more developed infrastructure and resources, but many smaller and community-based providers have only recently begun building the necessary capacity for measurement and reporting. Because they sometimes have to rely on manual processes, reporting requirements are more burdensome for smaller providers.

### Care coordination and redesign

Policymakers across states reflected that a primary goal of the infrastructure investments was to expand access and implement care delivery models that improve care coordination and integrate behavioral and physical health care.

Across states, interviewees described expanding care coordination capacity as the primary focus of their infrastructure development. Provider entities successfully built HIT solutions to achieve this goal. For example, state policymakers and provider representatives stated that a central activity was developing care coordination features in HIT systems. Provider groups invested in event notification systems, shared care plans, and empanelment systems to track patients, share information between different provider types, and coordinate care across different health care settings. For example, New Hampshire invested in an Event Notification System that helped providers share information about patients in the emergency department. Providers also invested in telemedicine to expand access to primary and behavioral health care.

“The most impactful thing is the real-time notification of admission, discharge, and transfer. If everything else in this project goes away and that stays, we have the ability to impact 95 percent of the health outcomes we want to impact.”

—New Hampshire provider representative

Beyond HIT, provider entities hired and trained staff to improve care delivery. Providers and states often mentioned staff development for the patient-centered medical home model, which was widely implemented in California, Massachusetts, New York, and Washington. Across states, respondents said that hiring care coordinators, community health workers, and patient navigators addressed longstanding shortages, expanded care coordination capabilities to social resources, and helped improve cultural competency. Provider organizations also hired to fill gaps across many different health care service areas, including primary care, behavioral health, and palliative care. Some respondents described these investments as having directly translated to outcomes—one New York Performing Provider Systems (PPS) representative attributed the PPS's success in reducing avoidable emergency department use, in part, to its investments in care coordinators. Interviewees also discussed training programs for providers to better understand and promote behavioral health needs.

DSRIP participants emphasized trust and governance as a linchpin to redesigning care delivery. A California provider stressed the benefit of establishing MOUs for care coordination between partnering outpatient and inpatient settings. Besides governance,



**Table 5. Infrastructure for data use and management: design and implementation**

Infrastructure	Emphasis in design	Essential infrastructure (implementation)	Facilitators (implementation)	Gaps
Health information technology	++	<ul style="list-style-type: none"> <li>• HIT for sharing data across providers</li> <li>• Event notification systems and alerts</li> </ul>	Telemedicine	Limited interoperability and information exchange
Workforce	+++	<ul style="list-style-type: none"> <li>• Provider partnerships</li> <li>• Care coordinators, patient navigators</li> </ul>	<ul style="list-style-type: none"> <li>• Hiring primary care, behavioral health providers</li> <li>• Provider training and certification for health care delivery models (for example, patient-centered medical home model)</li> <li>• Community health workers</li> <li>• Learning collaboratives</li> </ul>	<ul style="list-style-type: none"> <li>• Low or no reimbursement for some activities</li> <li>• Endemic provider shortages</li> </ul>
Organizational	+++	Governance for provider partnerships (business associate agreements, memorandums of understanding)		Guidance for co-location of physical and behavioral health providers

Source: Mathematica analysis of section 1115 demonstration special terms and conditions, state documentation, and key informant interviews.

+++ = A common focus of infrastructure incentives and requirements across demonstrations based on review of projects, milestones, and participation requirements

++ = A focus in select demonstrations

+ = Rarely incentivized or a required infrastructure component in demonstrations

most states have also encouraged provider relationships through learning collaboratives, networking events, and webinars.

### Remaining gaps in care coordination and redesign

Respondents in all states noted that remaining data use and management disparities are impeding effective care coordination between various types of facilities and service lines. Providers and policymakers in Massachusetts, New Jersey, New York, and Washington stated that more time and, in some instances, more incentives are necessary to support smaller providers' capacity for effective care coordination and sustained partnerships with hospitals. Although there was consistent feedback that some of the largest infrastructure and capacity gains under DSRIP were among community-based and rural providers, many are still limited in their ability to collect, report, and share data. Respondents across states stated that gaps in interoperable EHRs prevent information exchange necessary for care coordination and integration. Further slowing coordination, especially among primary and behavioral health providers, are legislative and regulatory concerns such as the Health Insurance Portability and Accountability Act of 1996 and 42 CFR part 2. Even in the presence of patient consent, providers are reluctant to share SUD-related information because of perceived regulatory barriers and fear of violating regulations.

Respondents across states also stated that care coordination and redesign are limited by endemic provider shortages. Systemic issues in hiring and retention limit network capacity. Providers in New Hampshire, New York, and Texas mentioned the difficulty of rural payment disparities in hiring staff and the challenge of completing licensing requirements. These barriers lead to persistently high demand relative to supply for services such as primary care and behavioral health, which threatens the sustainability of care rede-

“If a patient is admitted and the primary diagnosis is a substance use diagnosis, we don’t get that information. That patient, who could really use care management services, is basically lost to us.”

–Massachusetts provider representative

sign. Respondents further stated that care coordination activities and staff might also not be sustainable, because related services such as care management are sometimes not directly reimbursed.

### Participation in VBP arrangements

Provider representatives across states conveyed that DSRIP infrastructure investments helped prepare providers for VBP. Many viewed the initial infrastructure investments as foundational to building providers' capacity to monitor and improve performance.

As discussed previously, DSRIP HIT investments have furthered data availability at the point of care and driven performance improvement strategies. Several provider representatives viewed DSRIP as a tool for building on these data capabilities to enable population health management. DSRIP investments in population health tools include investments in EHR-based analytic tools to monitor specific patient populations and complex care management programs. Risk stratification was described as an especially important capability, because it facilitated targeting interventions to the most complex patients. Population health management and analytics are also useful for engaging managed care plans in VBP. A California provider representative reflected that data analytics has helped to better position the provider to partner with its health plan because it enabled them to analyze the managed care population and share information with the plan.

**Table 6. Infrastructure for value-based payment: design and implementation**

Infrastructure	Emphasis in design	Essential infrastructure (implementation)	Facilitators (implementation)	Gaps
<b>Health information technology</b>	+++	Population health management	HIT development for data sharing, performance measurement	<ul style="list-style-type: none"> <li>Population health management capabilities are not widespread</li> <li>Limited data on financial performance and attributed population</li> </ul>
<b>Workforce</b>	++	<ul style="list-style-type: none"> <li>New care models</li> <li>Provider partnerships</li> <li>Expertise in performance improvement, risk management, contracting, and financial analysis</li> </ul>	<ul style="list-style-type: none"> <li>Workforce investments related to new care models</li> <li>Engagement of social service providers</li> <li>Provider training on value-based payment</li> </ul>	<ul style="list-style-type: none"> <li>Provider understanding of value-based payment and performance improvement</li> <li>Provider measurement fatigue</li> <li>Challenges addressing social determinants of health</li> </ul>
<b>Organizational</b>	++	Risk-based contracting with managed care plans		<ul style="list-style-type: none"> <li>Limited engagement from managed care plans</li> <li>No standard data sharing agreements or value-based payment contracts across managed care plans</li> </ul>

**Source:** Mathematica analysis of section 1115 demonstration special terms and conditions, state documentation, and key informant interviews.

+++ = A common focus of infrastructure incentives and requirements across demonstrations based on review of projects, milestones, and participation requirements

++ = A focus in select demonstrations

+ = Rarely incentivized or a required infrastructure component in demonstrations

Stakeholders also viewed investments in care redesign as facilitators of VBP readiness, because these investments helped lay the groundwork for provider collaboration necessary to achieve success under VBP arrangements. For example, a New York PPS representative noted that investments in nursing care to prevent avoidable emergency department use helped an ACO move to more advanced VBP models. Another reflected that adoption of the patient-centered medical home model was the first step toward VBP readiness.

“Without the infrastructure payments, we would just be going into risk contracts with no new interventions to try to manage the cost of care.”  
 —Massachusetts provider representative

### Remaining gaps to participate in VBP arrangements

Important gaps remain in building provider capacity for VBP. Providers’ most prominent challenges are in engaging managed care plans and building out advanced data use capabilities to support population health management.

Stakeholders expressed mixed views regarding the extent to which DSRIP had spurred providers and managed care plans to establish VBP contracts. Interviewees noted a lack of engagement from managed care plans in VBP implementation and data sharing, a cause for concern among stakeholders who are unclear on whether and how DSRIP infrastructure investments will be sustained post-DSRIP. Cost data are important for understanding VBP, which is built upon baselines and benchmarks that inform performance targets and ultimately payment. But the

availability of these data is limited among DSRIP participants. One stakeholder mentioned that this is, in part, because of providers’ reliance on information from managed care plans, and information exchange with managed care plans can be limited and burdensome.<sup>9</sup> A policymaker stated there is also little standardization in data sharing agreements across managed plans, creating significant burden for individual providers who need to review and execute agreements with each managed care plan.

Stakeholders across states pointed to limitations in population health management capabilities. Some shortfalls are attributable to persistent challenges with data sharing. One state policymaker reflected that they are just beginning to understand how to leverage HIT infrastructure to support population health monitoring.

DSRIP has supported various providers types, but stakeholders from several states noted that larger hospitals and health systems were better positioned to invest in infrastructure and prepare for the transition to VBP. Meanwhile, progress lags for providers that are smaller, reside in under-resourced areas, are geographically dispersed, are relatively new to Medicaid, and have limited Medicaid volume. Some providers, especially rural and community-based providers, lack the volume of Medicaid covered lives to participate in VBP.<sup>10</sup>

“We have the care teams in place, and we’re hoping that would be sustainable through value-based care with the [managed care organizations], but that seems not to be the case. Having that infrastructure is important to support those contracts, but sustainability is what we are focusing on now to make sure [the infrastructure] can stay in place for those contracts.”  
 —New York provider representative

Lastly, views were mixed regarding how to best support providers' transition to VBP. Policymakers and provider representatives across states alike view infrastructure investments as being necessary for the transition to VBP. However, some respondents questioned whether states needed to specify a roadmap with prescribed infrastructure milestones. Instead, some speculated that pay-for-performance alone could have better encouraged providers to build the necessary infrastructure for more advanced VBP models. While providers and states emphasized the importance of funding for infrastructure development, some noted that prescriptive pay-for-reporting infrastructure milestones were burdensome and incentivized providers to make investments that did not directly improve their capacity to achieve pay-for-performance metrics. Instead, they suggested that giving providers flexibility in how to use infrastructure funding may help them prioritize the activities needed to achieve pay-for-performance goals more efficiently, given their individual resources and local context.

### Implications for future medicaid delivery system reform efforts

Nearly all respondents agreed that DSRIP motivated delivery reform infrastructure that has helped expand provider and system capacities to use and manage data, redesign care, and participate in VBP arrangements. Many gaps remain despite this progress, but the following takeaways from DSRIP can inform future investments in delivery reform infrastructure that yield the greatest value:

**Striking the right balance between prescriptiveness and flexibility in use of DSRIP funds.** Although tying incentive funding to specific infrastructure investments and milestones gives providers clear direction on how to use funds to create and expand infrastructure, some respondents viewed the state requirements as being too prescriptive. They noted that these requirements often diverted DSRIP funds from other infrastructure or capacity investments that could address local needs or gaps to help providers meet pay-for-performance metrics. Further, many stakeholders described pay-for-performance as being the primary driver of infrastructure development.

Alternatively, if participants begin implementing DSRIP demonstrations with underdeveloped HIT, workforce, or organizational capacities, they might not make enough progress by the end of the demonstration to qualify for performance-based payments or participate in VBP arrangements with managed care plans. This ultimately jeopardizes the sustainability of prior investments. These considerations are especially significant because of consistent disparities in providers' infrastructure and capacity. For example, hospitals and large health systems generally start out with more capacity and resources to reform delivery systems than community-based providers, rural providers, or small physician practices. If DSRIP funds are targeted toward improving interoperable HIT, providers with established EHRs

might not be able to efficiently use these funds. But if funds are available to establish partnerships with community-based organizations in early stages, providers who join the DSRIP demonstration in later years might not be able to take advantage.

This highlights a fundamental tension in designing DSRIP demonstrations: balancing prescriptiveness and flexibility in the use of demonstration funds. If states are overly prescriptive regarding required implementation milestones, participants might invest funds in data systems, workforce training, or partnerships that are not directly related to pay-for-performance metrics. On the other hand, if states grant entities too much flexibility, providers might use the funds in ways that have questionable value to state and federal delivery system reform goals.

Although there is no clear path, states should seek input from all stakeholders in striking the right balance between provider accountability and latitude in using the available funds to meet infrastructure and capacity needs and progress towards the ultimate goals of delivery system reform. States should consider how to set targets that are tailored to specific providers' needs and starting points to help address persistent infrastructure and capacity disparities across community-based, rural, and hospital providers.

**Evolution of provider infrastructure needs for delivery system reform and VBP.** As providers transform the delivery system, their infrastructure needs evolve. For example, in the initial stages of delivery reform, many stakeholders must acquire or modify EHRs to be able to monitor and report performance metrics, invest in IT systems to share data across providers, and hire care coordinators. In later stages of delivery system reform, provider entities shift to developing systems and tools to manage population health and financial risk, which are required for success under advanced VBP models. If states target DSRIP funds to certain types of infrastructure investment each year of the demonstration, they might be out of sync with the needs of different providers at different stages of delivery system reform. This progression suggests the importance of reassessing state requirements related to infrastructure over the course of demonstration periods to ensure funds are directed effectively.

### Conclusion

This study sought to understand the role of DSRIP infrastructure investments in advancing provider and system capacity to redesign the delivery system and support providers as they transition to VBP. We found that participating provider entities built their HIT infrastructure, expanded their workforce capacity, and partnered with other providers to coordinate care through DSRIP. In turn, these initial infrastructure investments have helped to expand providers' and systems' capacity.

Consistent with other aspects of DSRIP demonstration design, we identified an inherent tension between tying incentives to prescriptive reforms versus broader performance goals. We also found that providers' infrastructure needs appear to evolve as they move along the continuum of delivery system reform and VBP, suggesting a need to continually develop infrastructure to support increasingly sophisticated population health and risk management. Further, certain providers appear to be lagging behind others in terms of their readiness for VBP.

Our findings have implications for future efforts to build capacity among Medicaid and safety net providers. Specifically, policymakers seeking to improve the delivery system for Medicaid beneficiaries

need to be able to identify and account for wide-ranging readiness among providers. States should consider how incentives are targeted to providers at different levels of sophistication—from community-based providers and those who did not participate in prior DSRIP demonstrations to large, hospital-based systems that have greater capacity. For example, among providers with developed capacities, incentives tied to pay-for-performance targets rather than upfront funding may be more effective at spurring infrastructure development for VBP arrangements. In contrast, providers lagging behind may still require performance goals and incentives tied to specific infrastructure changes that enable initial engagement in delivery system transformation.

## DATA SOURCES AND METHODS

This issue brief summarizes qualitative data obtained from key informant interviews, states demonstrations' special terms and conditions (STCs), and related attachments and program documents available on state Medicaid websites.

Between February and March 2019, Mathematica conducted 20 semi-structured telephone interviews with state Medicaid agency policymakers, lead provider entities, and state provider associations. We selected seven states with ongoing delivery system reform incentive payment (DSRIP) demonstrations: California, Massachusetts, New Hampshire, New Jersey, New York, Texas, and Washington. We asked interviewees from states that have implemented two DSRIP demonstrations (California, Massachusetts, New Jersey, and Texas), to discuss both their initial and subsequent demonstrations. Interview questions focused on demonstration design and implementation, including incentives, program requirements, and examples of infrastructure development. Questions also assessed the role of infrastructure investments in supporting provider and system capacity for data use and management, care redesign, and participation in value-based payment. We recorded interviews, with the interviewees' consent, transcribed the notes, and extracted data from the notes into analytic tables, organized by factors in the conceptual framework.

We also collected data from each of the states' section 1115 demonstration special terms and conditions and other demonstration documentation to assess the range of strategies states used to promote provider and system infrastructure and capacity development.

This study has several limitations. First, because this study is qualitative and intended to examine DSRIP demonstration implementation, it does not examine how capacity changed among non-DSRIP participating providers. Therefore, this study does not compare DSRIP to other strategies for building capacity among providers and is not evaluative. Second, we did not interview managed care entities; in states with demonstrations that encourage providers to enter into managed care value-based payment (VBP) arrangements, these entities may also have encouraged or directed infrastructure investments that support VBP. Finally, state documentation inconsistently describes infrastructure activities. Although states require providers to report activity, much of the reporting on infrastructure is narrative and not standardized. Combined with the number of providers and latitude with which they can implement infrastructure projects, it is difficult to synthesize across providers the specific types of infrastructure that were implemented. For example, in Texas over 1,400 different projects are being implemented across the 20 different Regional Health Partnerships. See Appendix A for a full list of state resources reviewed for this brief.

## ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica, IBM Watson Health, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) demonstrations, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports informed an interim outcomes evaluation in 2018 and a final evaluation report in 2020.

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## Endnotes

<sup>1</sup> For example, most participants in California's Public Hospital Redesign and Incentives in Medi-Cal program are participating in a project entitled, "Care Transitions: Integration of Post-Acute Care," and six of nine Accountable Communities of Health in Washington State selected projects focused on care coordination. Further, all but one Performing Provider System in New York are implementing the patient-centered medical home model. Compared to other demonstrations, Massachusetts and Washington include greater emphasis on expanding access to social services through their projects. New Jersey has a narrower focus for care redesign than other demonstrations, organizing care redesign around specific clinical conditions.

<sup>2</sup> Similar planning activities are also included as a milestone for some projects. For example, New Hampshire's statewide information technology project requires that each Integrated Delivery Network will develop a health information technology implementation plan and timeline that will be approved by the state in order for the Integrated Delivery Network to be eligible for incentive payments associated with this project.

<sup>3</sup> In New York, the required implementation plan includes organizational requirements for information technology systems and processes and governance.

<sup>4</sup> Some DSRIP demonstrations that followed an earlier DSRIP demonstration, however, expand eligibility to new provider participants that can elect to participate and receive infrastructure development funding. In California's Public Hospital Redesign

and Incentives in Medi-Cal demonstration, newly participating district/municipal public hospitals can earn funding for achieving infrastructure metrics that they design and report.

<sup>5</sup> Although most demonstrations require infrastructure development, providers have latitude to determine which areas of infrastructure they will develop. Initial DSRIP demonstrations in California, Massachusetts, and Texas all required infrastructure project selections but prescribe no specific project (there were 15 infrastructure projects in California, 23 in Texas, and 11 in Massachusetts). Providers were required to report multiple milestones and metrics for each of the projects, along with a set of standard metrics, twice a year. For each project, providers were required to report corresponding milestones from a menu. As a result, providers were able to satisfy requirements and earn incentives for infrastructure development in various ways.

<sup>6</sup> In DSRIP, states use their systems and databases, including all payer databases and Medicaid Management Information Systems, to calculate some measures, provide claims files to participating entities, and create analytic dashboards. For example, New York sends claim-based extracts to providers and has public-facing utilization dashboards (available at <https://dsripdashboards.health.ny.gov/>).

<sup>7</sup> As part of the section 1115 HIT Toolkit, the Centers for Medicare & Medicaid Services has indicated that section 1115 demonstrations should consider whether funding is available for EHR adoption and health information exchange for providers who are not eligible for meaningful use. See [https://www.healthit.gov/sites/default/files/1\\_1115\\_HIT\\_Toolkit-Qs\\_with\\_Detailed\\_Background.pdf](https://www.healthit.gov/sites/default/files/1_1115_HIT_Toolkit-Qs_with_Detailed_Background.pdf).

<sup>8</sup> 42 CFR part 2 governs the confidentiality of SUD patient records and is intended to protect patients' personal health information. This federal statute outlines the limited circumstances under which a patient's treatment for SUD might be disclosed with and without the patient's consent. (American Psychiatric Association n.d.)

<sup>9</sup> States can add contractual requirements for managed care plans around data sharing and other activities to support VBP. For example, Texas includes a requirement for managed care plans to share data necessary to support VBP with providers (Lipson et al. 2019).

<sup>10</sup> Small population sizes inhibit the ability to reliably measure outcomes of care as well as the extent to which risk for adverse events can be mitigated by others in the population who are attributed to the same provider or entity.

## Appendix A: State Documentation

All links listed below were accessed between February 2019 and June 2019.

### CALIFORNIA

“Attachment Q: PRIME Projects and Metrics.” Amended March 2, 2016. Available at [http://www.dhcs.ca.gov/provgovpart/Documents/MC2020\\_AttachmentQ\\_PRIMEProjectsMetrics.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_AttachmentQ_PRIMEProjectsMetrics.pdf).

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“PRIME Project Selection Matrix.” Amended May 23, 2017. Available at <https://www.dhcs.ca.gov/provgovpart/Documents/PRIME/PRIMEProjectSelections-Web.pdf>.

### MASSACHUSETTS

Attachment M: Massachusetts Delivery System Reform Incentive Payment (DSRIP) Protocol.” Amended June 27, 2019. Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-protocol-edits-20190627.pdf>

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### NEW HAMPSHIRE

“Building Capacity for Transformation: New Hampshire’s DSRIP Waiver Program.” March 2016. Available at <https://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrrip-waiver-overview-20160304.pdf>.

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### NEW JERSEY

“Attachment 1: New Jersey Delivery System Reform Incentive Payment (DSRIP) Toolkit.” n.d. Available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-dsrrip-toolkit.pdf>.

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### NEW YORK

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## Appendix B: Detailed tables on infrastructure in delivery system reform incentive payment demonstrations

**Table B.1. Overview of infrastructure design in delivery system reform incentive payment demonstrations**

State (demonstration)	Demonstration effective dates	Design summary			
		Project-based incentives	Provider collaborations	Upfront funding	Summary of primary infrastructure design
California (DSRIP)	November 1, 2010, to October 31, 2015	X		X	California requires DPHs to select projects in Category 1 Infrastructure Development. Infrastructure projects and milestones are also listed in Category 2 Innovation & Redesign Improvement. For each project, providers must report a corresponding narrative with milestones and measures.
California (PRIME)	December 30, 2015, to December 31, 2020	X		X	DPHs no longer receive incentives for specific infrastructure activities, though projects include optional core components that describe workforce and HIT activities to help achieve project metrics. Newly participating district and municipal public hospitals are able to earn funding for the achievement of provider-designed infrastructure metrics.
Massachusetts (DSTI)	October 30, 2014, to June 30, 2019	X		X	DSTI includes infrastructure projects and milestones from which providers may choose across all four of the demonstration's project categories. Category 2 includes projects on building workforce and HIT infrastructure to improve care coordination. Category 3 includes projects on HIT infrastructure and processes to help providers transition to value-based payment.
Massachusetts (DSRIP)	July 1, 2017, to June 30, 2022		X	X	The demonstration shifts away from project implementation to implementing ACOs. Infrastructure funding is available to ACOs, Community Partners, and Community Service Agencies through prospective infrastructure funding streams. A separate funding stream, Statewide Investments, supports statewide recruitment and training of primary and behavioral health providers.
New Hampshire (DSRIP)	January 5, 2016, to December 31, 2020	X	X	X	All New Hampshire integrated delivery networks are required to participate in two state infrastructure projects: A1 Assessing Workforce Capacity and A2 Assessing Health IT Infrastructure. New Hampshire also has additional, optional HIT and workforce infrastructure projects.
New Jersey (Initial DSRIP)	October 1, 2012, to June 30, 2017	X		X	Each project in New Jersey's demonstration includes an infrastructure development stage (Stage 1), which specifies infrastructure milestones, such as procuring data needs and establishing provider education.
New Jersey (Renewal DSRIP)	July 1, 2017, to June 30, 2020			X	New Jersey demonstration participants continue projects started in the initial demonstration. However, funding for the infrastructure development stage is only available for the first year of the second DSRIP demonstration period.
New York (DSRIP)	December 7, 2016, to March 31, 2021	X	X	X	New York incentivizes infrastructure development through required milestones for each project, known as Domain 1 Infrastructure Development. New York also ties funding to reporting plans and progress on five organizational requirements related to infrastructure: governance, financial sustainability, cultural competency, health literacy, and workforce.
Texas (Initial DSRIP)	December 12, 2011, to December 31, 2017	X	X	X	Texas requires performing providers to select projects across two categories, which emphasize infrastructure development. Performing providers must report associated infrastructure-related milestones and metrics for each selected project. Some projects also include infrastructure-related core components for which providers must qualitatively report progress.

(continued)

		Design summary			
State (demonstration)	Demonstration effective dates	Project-based incentives	Provider collaborations	Upfront funding	Summary of primary infrastructure design
Texas (Renewal DSRIP)	January 1, 2018, to September 30, 2022	X	X	X	Texas's second demonstration shifts away from infrastructure-related projects. Instead, providers receive funding for performance on measure bundles composed of clinical outcome measures.
Washington (DSRIP)	January 9, 2017, to December 31, 2021	X	X	X	As part of a domain of activities, Washington's DSRIP demonstration requires providers to develop needs assessments and task forces for workforce, HIT, and value-based payment infrastructure. Washington provides optional project guidelines describing HIT and workforce infrastructure and activities supporting other projects.

**Source:** Mathematica's analysis of section 1115 demonstration special terms and conditions.

ACO = accountable care organization; DPH = Designated Public Hospital; DSRIP = Delivery System Reform Incentive Payment Program; DSTI = Delivery System Transformation Initiatives; HIT = health information technology; IT = information technology; PRIME = Public Hospital Redesign and Incentives in Medi-Cal; RHP = Regional Health Partnerships

**Table B.2. Targeted workforce expansion in DSRIP demonstrations**

State	Demonstration	Primary care	Specialty care	Behavioral health	Care coordinators, patient navigators	Dental	Interpreters
California	DSRIP	X	X	X	X	X	X
	PRIME						
Massachusetts	DSTI	X			X		
	DSRIP	X	X	X*	X*		
New Hampshire	DSRIP	X	X	X	X		
New Jersey	DSRIP			X	X		
	DSRIP (Renewal)						
New York	DSRIP	X	X	X	X		
Texas	DSRIP	X	X	X	X	X	X
	DSRIP (Renewal)						
Washington	DSRIP	X		X	X	X	

**Source:** Mathematica's analysis of section 1115 demonstration special terms and conditions and state documentation

X = State demonstration included projects, milestones, or funding programs that explicitly note expanding the provider category.

\*As part of the 1115 demonstration, Massachusetts procured Community Partners and received infrastructure funding to support existing Community Services Agencies that are responsible for care management for beneficiaries with serious or complex behavioral health conditions.