



## Advancing Value-Based Payment in Medicaid Section 1115 Delivery System Reform Demonstrations: The Role of Hospital Supplemental Payments

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### Summary

To contain costs and improve care outcomes, many state Medicaid agencies are encouraging delivery system changes that will lead to higher value care without reducing access to essential services. Nine states obtained section 1115 demonstration waiver authority to implement delivery system reform incentive payment (DSRIP) demonstrations. These demonstrations were designed to serve as a temporary bridge to value-based payment for safety net providers who serve Medicaid beneficiaries and low-income uninsured populations. States have historically used a combination of disparate Medicaid hospital payment streams, including supplemental payments, to support this health care safety net. Yet recent policy changes have reduced the amount, or placed greater restrictions on, the use of certain types of hospital supplemental payment streams in order to strengthen the link between payment and value. Simultaneously, the shift from volume to

value-based payment is raising questions about how to best align payment strategies to achieve broader policy goals.

Key findings from this study of five state DSRIP demonstrations, including both first- and second-wave program designs, reveal that DSRIP has spurred safety net hospitals to start reforming their delivery systems and building their capacity to participate in value-based payment models. Over the course of the DSRIP demonstrations, state Medicaid agencies began to align payment models across Medicaid hospital funding streams, including supplemental payments, to encourage the adoption of performance or value-based payment methods. However, state policymakers and safety net hospital representatives contend that inadequate Medicaid base payment rates (relative to the costs of providing services), persistent uninsurance, and gaps in funding to address the social determinants of health warrant the continued use of supplemental payments to safety net hospitals to ensure beneficiaries' access to essential services.

### 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.

## The role of section 1115 delivery system reform incentive payment demonstrations in driving value-based payment

As of 2019, nine states had implemented section 1115 DSRIP demonstrations, which tied incentive funding to infrastructure investments, delivery system transformation, population health improvement, and value-based payment (VBP) participation for providers serving Medicaid and uninsured individuals. VBP and alternative payment models (APMs)<sup>1</sup> are designed to stem rising health care costs and improve population health by tying payment to provider performance on quality metrics, and sometimes to cost, so as to reward value instead of volume. Some state DSRIP demonstrations primarily offer payment incentives to hospitals and hospital systems, whereas others offer them to both hospital and nonhospital providers.

One of the primary goals of DSRIP demonstrations is to help safety net hospitals transition from volume-based to value-based payment models. Compared with hospitals serving fewer Medicaid and uninsured patients, safety net hospitals face more challenges making this transition. For example, they have more limited access to the capital needed to make upfront investments in information technology, outpatient clinics, and staff, all of which make care delivery models more efficient (Bachrach et al. 2012; Burns and Bailit 2015; Government Accountability Office 2016; Witgert and Hess 2012). In addition, safety net hospitals have little cushion to cover short-term losses that can result if they miss the quality and cost targets used in APMs. Consequently, states used DSRIP to support safety net hospitals in making the transition to VBP.

DSRIP demonstrations were intended to be time-limited initiatives that would catalyze broader changes in the delivery system and build provider capacity to participate in alternative payment models. However, the movement to VBP raised questions about the influence of supplemental payments on incentives for hospitals to participate in VBP arrangements. Historically, states have used a variety of payment streams to reimburse hospitals, including a combination of base payments—reimbursing them for the health services they provide to individual patients—and supplemental payments, which are lump-sum payments that are intended to augment base payments for hospitals serving disproportionate shares of low-income and uninsured patients. Some analysts have argued that supplemental payments, disbursed on the basis of volume, could weaken the incentive to improve quality by delivering more cost-effective care (Mann et al. 2016).

In this brief, we examine whether and how states implementing DSRIP demonstrations are changing their policies on hospital supplemental payments in response to the movement toward VBP, and the role of DSRIP in catalyzing or facilitating those changes. The Centers for Medicare & Medicaid Services (CMS) and states implementing DSRIP demonstrations view VBP as a strategy for

sustaining delivery system reforms after the demonstrations end by replacing DSRIP payments to hospitals with VBP payments by Medicaid managed care plans. But an outstanding question is whether and how states' hospital payment policies are evolving to support the broader movement to VBP.

To understand how states' policies on Medicaid hospital supplemental payment have changed during DSRIP, we selected five states for in-depth case studies: California, Massachusetts, New York, Texas, and Washington. We reviewed federal and state demonstration documents and relevant literature on Medicaid hospital payment policies. We also interviewed state policymakers and hospital representatives, separately, in each of the study states, holding a total of 16 interviews, and we analyzed changes in state Medicaid expenditures on base, supplemental, and DSRIP payments over the course of the demonstration periods, using data from 2011 to 2017. We built on research conducted as part of the national evaluation of section 1115 DSRIP demonstrations that examined DSRIP incentive design (Heeringa et al. 2018) and the intersections between DSRIP, managed care, and VBP progress (Lipson et al. 2019). See the box, Methods and Data Sources, at the end of the brief for more information.

In the section that follows, we summarize the historic role of hospital supplemental payments and the policy changes affecting these payments. We then describe the context that motivated states to pursue DSRIP demonstrations, the major changes in hospital payment policies that took effect concurrently with DSRIP, and the catalysts for these changes. Next, we review the role of DSRIP in driving delivery system reform and preparing hospitals for VBP and conclude with a discussion of the role of supplemental payments following the end of the DSRIP demonstrations.

## Policy context influencing hospital supplemental payment policy and value-based payment

### Historical use of supplemental payments to support safety net hospitals

Federal law requires all Medicare-participating hospitals (virtually every hospital in the United States) to provide emergency services to all individuals, including pregnant women in active labor, regardless of their ability to pay.<sup>2</sup> Thus, the higher the rate of uninsurance in a state or region, the greater the potential need for Medicaid disproportionate share hospital (DSH) and other supplemental payment streams to compensate hospitals that serve higher shares of the uninsured.

Hospitals that treat a high volume of low-income and uninsured patients are commonly known as safety net hospitals, and they often incur costs that exceed the payments they receive for their care—referred to as uncompensated care costs.<sup>3</sup> These hospitals

typically operate on tight margins in service of their mission to serve low-income populations. State Medicaid programs provide both base and supplemental payments to Medicaid providers, using a mix of financing sources to fund the nonfederal share of payments, including state general revenue, local government funds, and provider taxes (see box, Nonfederal Financing Dynamics, for more information). Unlike base payments, supplemental funding streams often are paid in lump-sum amounts at regular intervals, are not tied to individual patients or services, and can be targeted to safety net hospitals, which typically need them more to remain financially viable than hospitals serving fewer Medicaid and uninsured patients do.

Historically, states have used supplemental payments to bring total Medicaid hospital payments closer to actual costs. Supplemental payments continue to play an important role in compensating hospitals for shortfalls in the Medicaid base payment rate. For example, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that state Medicaid fee-for-service (FFS) base payment rates were, on average, 78 percent of Medicare payments for a set of 18 conditions, corresponding to diagnosis related groups, examined in 2011 (MACPAC 2017). But when supplemental payment rates were factored in, Medicaid net payment on average was 6 percent higher than Medicare payment across the 18 conditions, although it varied by state: Medicaid net payment was higher than Medicare for 25 states and lower than Medicare for 22 states (MACPAC 2017).<sup>4</sup> Supplemental payments often help safety net hospitals maintain positive operating margins.<sup>5</sup>

States use two primary streams of supplemental payment: (1) Medicaid disproportionate share hospital (DSH) payments and (2) upper payment limit (UPL) payments.<sup>6</sup> Both of these payment streams offset Medicaid shortfalls, but only Medicaid DSH payments are intended to cover the costs of treating uninsured patients. Since 1987, the federal government has required states to direct Medicaid DSH payments to hospitals serving a disproportionate share of low-income patients. In 1991, Congress established state-specific allotments for federal DSH funds. States cannot make DSH payments to an individual hospital that exceed the hospital's allowable costs of caring for Medicaid and uninsured patients. Beyond this requirement, states have broad discretion in how they disburse Medicaid DSH payments.

Under UPL programs, states are able to make supplemental payments up to the amount Medicare pays for specific classes of providers, with Medicaid UPL payments representing the difference between the Medicaid FFS rate and the Medicare rate. Federal rules (42 CFR 447.272 and 447.321) require that UPLs be computed based only on FFS days in hospitals and other institutions, excluding stays for Medicaid managed care enrollees. As states expanded Medicaid managed care programs to cover more people and services, however, the number of Medicaid FFS claims reported by hospitals declined, lowering the total allowable amount for UPL payments.<sup>7</sup>

## NONFEDERAL SHARE FINANCING DYNAMICS

States have broad discretion in how they finance the nonfederal share of Medicaid payments, with the constraint that at least 40 percent of the payments must be financed by state general revenue ((§1902(a)(2) of the Social Security Act). States use a variety of local sources of funding to finance the nonfederal share, including provider assessments and intergovernmental transfers or certified public expenditures from local governmental entities or public hospitals. The Government Accountability Office (2014) reported that the use of local sources of financing increased by 21 percent between state fiscal years 2008 and 2012 nationwide.

The mechanisms for financing the nonfederal share influence the continued use of supplemental payments (Marks et al. 2018). For example, among the five states examined by Marks et al. (2018), many providers preferred to direct their nonfederal share contributions to supplemental payments instead of base payment streams because of the certainty and predictability of payments and the ability to direct increases to certain providers (Marks et al. 2018).

In this study, stakeholders expressed mixed opinions about the role of nonfederal financing in hospital payment policy. On the one hand, they noted that states face budget constraints and competing policy priorities, limiting the ability or willingness of state policymakers to direct state general revenue to Medicaid. Thus, the ability to leverage local sources of financing creates an opportunity to draw down federal funds. On the other hand, they cited the financial burden on public hospitals, hospital systems, and local governments that is associated with financing the nonfederal share via provider taxes or intergovernmental transfers. As one provider representative noted, "The pro is we haven't necessarily left any federal funds on the table ... The con is if private hospitals and public hospitals [are both contributing funds], you need to figure out a way for both those entities to share in the federal funds."

On the subject of what role nonfederal financing might play in hospital supplemental payment policy going forward, most stakeholders are still considering the best ways to direct non-state sources of financing. One state policymaker described how the state was actively working with public hospitals and systems to assess whether and how non-state financing can be directed to VBP more globally after the DSRIP demonstration ends. Provider representatives did not have a strong preference for directing non-state financing to base versus supplemental payment. One representative of a health system that serves a high number of uninsured people stressed the importance of tying payment streams directly to the patients served by each system. About the transition to VBP and non-state financing, a representative of large, urban health systems said, "We've been thinking about shifting that relationship so we don't always assume that it needs to be a supplemental payment ... [as long as] some portion of the supplemental funding is incorporated into our base rate."

## Policy changes influencing hospital supplemental payments in 2010–2019

During the DSRIP demonstration periods, a host of federal and state policy changes took place, affecting the amount and type of hospital supplemental payments that states could direct to safety net hospitals.

**Coverage changes and their intersection with Medicaid DSH policy.** The Affordable Care Act of 2010 (ACA) enabled states to expand Medicaid eligibility (starting in 2014) to adults without dependents whose incomes were up to 133 percent of the federal poverty level—a change that was expected to reduce the number of uninsured. Because the number of uninsured was projected to decline, the ACA set a timetable to reduce Medicaid DSH payments, based on the assumption that hospitals would incur fewer uncompensated care costs as more people enrolled in Medicaid.<sup>8</sup> After the U.S. Supreme Court ruled in 2012 that states could not be required to expand Medicaid eligibility to low-income adults, many states opted not to do so; thus, uninsurance rates have not declined to expected levels in certain states. Congress has delayed scheduled Medicaid DSH reductions several times, and they are now slated to begin in federal fiscal year (FFY) 2021 (MACPAC 2019b; CRS 2020).

**Federal and state initiatives to transform the care delivery and payment systems.** Since 2010, momentum has built at the federal and state levels to implement care delivery and payment models that reward providers for high-value care. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which changed how Medicare paid physicians under Part B, replacing the FFS model with a new payment model that ties payment to performance. That same year, CMS announced ambitious goals for value-based payment across the Medicare FFS system.

Meanwhile, state Medicaid agencies launched a variety of initiatives, including DSRIP demonstrations, patient-centered medical homes, accountable care organizations, and episode-of-care payment methods. They also began to set VBP goals for Medicaid managed care organizations, requiring the plans to make a specified share of total payments to providers each year through APMs. For example, all five study states require managed care plans to pay an increasing portion of Medicaid provider payments through APMs, or to have a plan to establish such requirements in the future (Lipson et al. 2019). In some states, these targets are part of the section 1115 waiver demonstration terms and conditions.

**New federal Medicaid managed care requirements affecting state delivery and payment methods.** As part of a sweeping overhaul of federal Medicaid managed care regulations in 2016, CMS sought to reinforce the shift to VBP and broader delivery system reforms through state contracts with managed care plans. One of the provisions in the new rule limits

states from making supplemental pass-through payments to providers via managed care plans. Because pass-through payments have no link to the amount, quality, or outcomes of services delivered to Medicaid managed care enrollees, federal policy-makers believed these types of supplemental payments could diminish providers' incentives to participate in VBP arrangements with managed care plans. Consequently, the 2016 federal Medicaid managed care rules set limits on the use of new or increased pass-through payments and required states to phase out these payments over a 10-year period.<sup>9</sup>

At the same time, the federal managed care rule established a new mechanism, known as “state-directed payments.” This mechanism allows states to direct their managed care plans to make payments to providers to support their overall goals for delivery system and payment reform and performance improvement (Neale 2017). States may specify how managed care plans pay providers, as long as such requirements are based on the use of services provided to Medicaid beneficiaries covered under the contract and are tied to outcomes and quality. All state-directed payments must advance at least one of the goals in a state's quality strategy.<sup>10</sup> Under this new regulation, states can direct managed care plans to: (a) implement specific types of VBP models, such as bundled payments, episode-based payments, or other methods that recognize value or outcomes instead of volume; (b) participate in multi-payer or Medicaid-specific delivery system reforms, such as pay-for-performance, quality-based payments, or population-based payment models; and (c) provide minimum fee schedules, a uniform dollar or percentage increase, or maximum fee schedules.

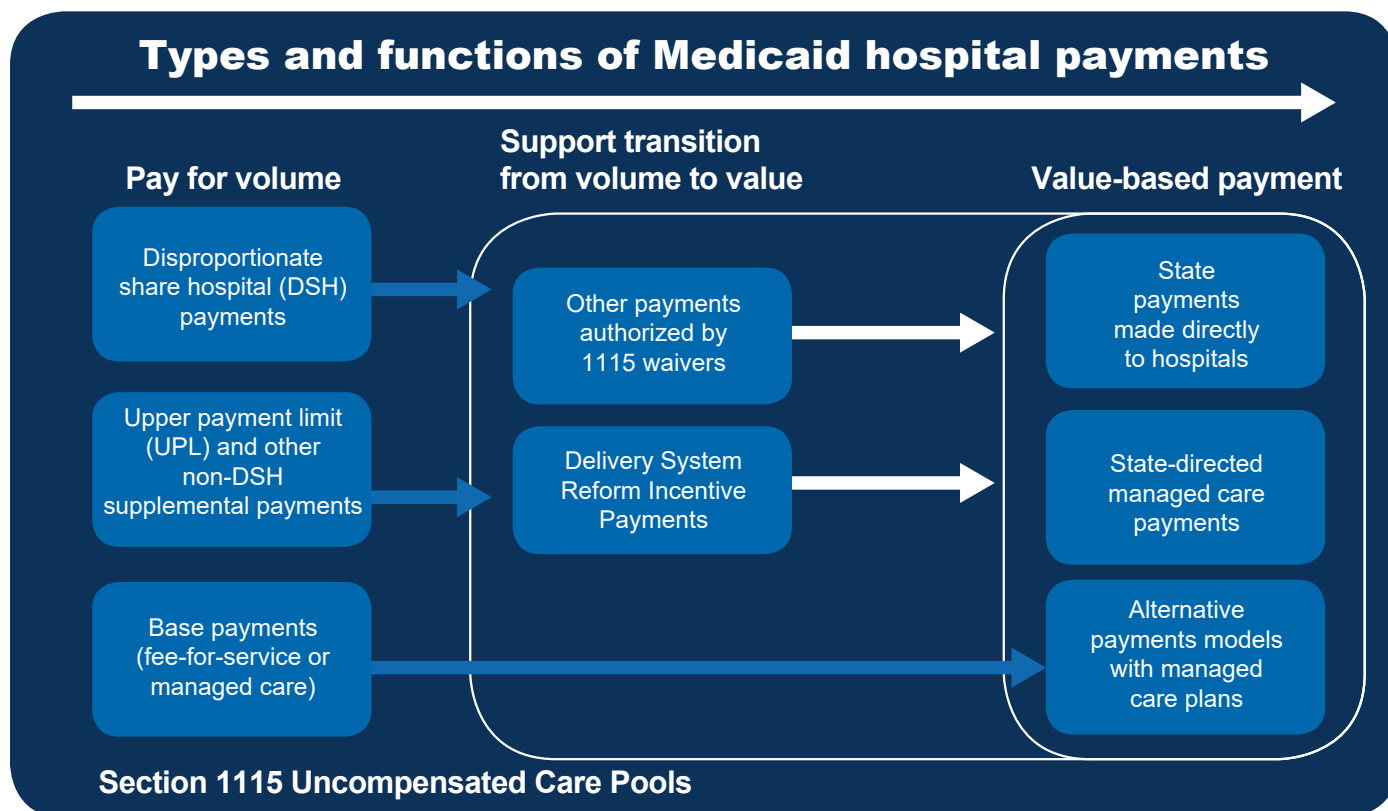
## Findings: Evolution of hospital payment policy in five DSRIP states

### DSRIP as a bridge to VBP

In the context of these broader Medicaid policy changes, DSRIP demonstrations provided an additional lever to help safety net hospitals transition to VBP models. Interviews with policymakers and safety net hospital representatives in the five study states highlighted the importance of DSRIP funds in helping them make this transition. They also underscored how hospitals' supplemental payment policies have evolved toward performance or value-based payment models over the course of state DSRIP demonstration periods, reinforcing the incentives for providers to shift to VBP. Table A.1 in the Appendix has more details about the contextual factors motivating states to pursue DSRIP demonstrations.

Exhibit 1 presents a framework showing the transformation of Medicaid hospital payment from volume to value and the central role played by DSRIP in the process. On the left side of the continuum are hospital payments made for DSH, UPL, and other types of supplemental payments, as well as base rates, which traditionally have not been connected to provider performance or quality. Three study states—California, Massachusetts, and

**Exhibit 1. Transformation of Medicaid hospital payment from volume to value**



Texas—have also used section 1115 demonstration waiver authority to operate uncompensated care pools that supplement provider payments.<sup>11</sup> In the middle of the continuum are DSRIP and other payments authorized by section 1115 demonstrations, or state-only payment streams designed to support the transition from volume to value. On the right are VBP models, including APMs between Medicaid managed care plans and hospitals, state-directed payments through managed care plans, and other payment streams that flow directly from states to hospitals.<sup>12</sup>

### Changes in states' hospital payment policies

By 2019, the five study states were operating a mix of supplemental payment programs, many of which tied a portion of the payments to quality performance or value (see Table 1 and Appendix Table A.2 for details). Depending on where states are in the transition from volume- to value-based payment, they may use a subset, or all types, of Medicaid hospital payments in the framework at a point in time. For example, under its section 1115 demonstration, California converted Medicaid DSH payments to a Global Payment Program (GPP), which ties payment to the provision of specific services with the goal of encouraging public health care systems to deliver high-value services in appropriate settings. Other states continue to use DSH as they have in the past—by making lump-sum payments to eligible hospitals based on incurred costs. Although all states share the goal of shifting more

funds to value-based payment models, this study revealed that they are setting different timelines for this transition and might not shift all hospital payments to value-based models.

Below, we discuss four major themes that characterize changes in Medicaid hospital payment policies in the study states during their DSRIP demonstration periods. These themes are: (1) repurposing supplemental payments to support the goals of DSRIP demonstrations; (2) targeting additional supplemental payments to hospitals at risk of financial insolvency during the transition to VBP; (3) establishing state-directed payment policies for Medicaid managed care plans; and (4) increasing the share of Medicaid base payments made through managed care plans to VBP, and revising FFS base payments to encourage greater efficiency.

**Repurposing supplemental payments to DSRIP.** First-wave DSRIP demonstrations in California and Massachusetts repurposed historical supplemental payments for DSRIP in order to support safety net hospitals' delivery system reforms.<sup>13</sup> Unlike previous supplemental payments, the payments made through DSRIP were tied to delivery system changes that were intended to reduce use of inpatient hospital care, shift care to outpatient and community-based settings, improve care quality, and promote population health outcomes. Policymakers in these early demonstrations carefully calibrated their expectations for providers to attain the performance targets required to earn DSRIP funding, balancing ambition with achievability (Heeringa et al. 2018).

**Table 1. Overview of state Medicaid supplemental hospital payment policies, 2019**

States	Supplemental hospital payments tied to quality or value				Supplemental hospital payments based on costs			
	DSH	Non-DSH	UC pools	Directed pay-ments	DSH	Non-DSH	UC pools	Directed pay-ments
CA	X		X	X	X		X	X
MA	X	X	X	X	X	X	X	X
NY		X	n.a.	n.a.	X	X	n.a.	n.a.
TX		X		X	X	X	X	X
WA	X	X	n.a.	n.a.	X	X	n.a.	n.a.

**Source:** Authors' analysis of state documentation. See Appendix Table A.2 for a detailed listing of state-specific non-DSH funding streams.

**Notes:** Under its section 1115 demonstration, Massachusetts diverted its Medicaid DSH allotments to the state's Safety Net Care Pool, which funds uncompensated care and supplemental payments. Massachusetts' UC Pool, referenced in this table, is a component of its broader Safety Net Care Pool.

DSH = disproportionate share hospital; n.a. = not applicable; UC = uncompensated care.

In contrast, certain second-wave demonstrations, beginning with New York's DSRIP demonstration in 2014 and Washington's in 2017, had no link to prior supplemental payments.<sup>14</sup> They also have broader goals in terms of reforming the delivery system, and they create stronger incentives for advancing VBP. This broader focus is reflected in the states' inclusion of hospital and nonhospital providers and their more ambitious performance requirements (MACPAC 2018a).

Under its current demonstration, California also realigned its Medicaid DSH payments to support broader delivery system reform goals. Specifically, under its 1115 demonstration, the state directs its Medicaid DSH allotments to its GPP, operated under section 1115 waiver authority. Funded at \$2.9 billion annually, the GPP makes payments to designated public health care systems if they deliver an increased share of care (relative to historic service levels for inpatient and emergency care) to uninsured individuals for high-value services such as primary and preventive care. The GPP also provides funding for nontraditional health care services such as health coaching and telehealth consults (CAPH 2019). The shift of DSH funding into the GPP was in part a reflection of the misalignment of incentives between DSH and concurrent reforms. As one policymaker stated, "The way the DSH funding had worked, it was really hard for [the public health care systems] to invest in non-hospital outpatient primary care, because it meant they would lose DSH." The state also designed the GPP and the second DSRIP demonstration, renamed Public Hospital Redesign and Incentives in Medi-Cal (PRIME), as complementary programs, leveraging the infrastructure and capacity created through both DSRIP demonstrations to improve GPP-funded care provided to the uninsured.

Massachusetts is also using Medicaid DSH funding to finance a supplemental payment program called Safety Net Provider Payments to support broader VBP goals. Hospitals are eligible for these payments only if they participate in a Medicaid ACO, while an increasing percentage of their payments are at risk based on their ACO's DSRIP performance over the demonstration period.<sup>15</sup>

As a Massachusetts policymaker explained, "We think about how aligned the incentives are with every dollar that [the hospitals] get, whether it's a service dollar [base payment], a supplemental dollar, or a DSRIP investment dollar. We should be pulling in the same direction with every single one of those."

**Targeting supplemental payments to financially distressed hospitals.** New York set aside \$500 million in grant funding for an Interim Access Assurance Fund (IAAF) to support financially distressed hospitals for the initial eight months of the DSRIP demonstration. These funds were intended to keep the doors open for some of the most financially fragile safety net providers by alleviating the financial pressure associated with reengineering care delivery systems. In addition to the IAAF, New York established two other supplemental payment streams to provide temporary subsidies that support financially vulnerable safety net providers over the six-year demonstration period. In 2016, the state began the Vital Access Provider Assurance Program, which initially made available \$245 million in state funding for 28 private hospitals that qualified as financially distressed. The state transitioned that program into the VBP Quality Improvement Program (QIP). Total QIP payments in 2018 were about \$539 million. Massachusetts also set aside nearly \$113 million of its DSRIP funding for the seven safety net hospitals that participated in the state's first DSRIP demonstration, contingent on their participation in a Medicaid ACO.

**Establishing state-directed managed-care payments.** California, Massachusetts, and Texas are using directed payments through managed care as a mechanism for directing supplemental payments to hospitals (Table A.2). Although the state-directed payment mechanism emerged in response to the new managed care regulations, DSRIP also catalyzed the use of

"The VBP QIP program is an example of a bridge program, where it was really targeting financially distressed hospitals, but distributing funds on a value basis."

—Provider representative

directed payment programs in some states because they allow states to re-direct supplemental funds into a payment stream linked to quality and value. As one provider representative said: “Through the [state’s directed payment program] you have increased alignment with the managed care delivery system. We don’t think about our financing in terms of individual streams as much as we think about which delivery system are we operating in, and how are we ensuring we have the right incentives to do delivery system transformation at the hospital system level.”

**Increasing the share of Medicaid base payments made through managed care plans to VBP and revising FFS base payments.** In parallel with changes to supplemental payments, all five study states are requiring the Medicaid base payments that managed care plans make to hospitals to use a VBP framework. DSRIP infrastructure and practice transformation investment are deemed critical to delivering value, which is ultimately tied to the sustainability and improvement through VBP. These states expect managed care plan contracts with providers using VBP models to help sustain DSRIP reforms after the demonstrations end. For example, under California’s section 1115 demonstration, the state requires designated public hospital systems to use VBP arrangements with managed care plans for at least 50 percent of Medicaid patients assigned or attributed to each hospital system in 2018, rising to 60 percent in 2020. In the other four states—Massachusetts, New York, Texas, and Washington—Medicaid agency contracts with managed care plans require the plans to use VBP arrangements for a minimum percentage of their total payments to providers, ranging from 10 percent to 50 percent in 2018 and increasing to 39–85 percent in 2020.<sup>16</sup>

On the FFS side, Massachusetts and Texas changed their hospital base payment methods to introduce incentives for efficiency simultaneously with their DSRIP demonstrations. Both states adopted methods that pay an adjusted fixed rate per inpatient discharge, and Massachusetts pays an enhanced adjusted payment per episode of outpatient service.<sup>17</sup> These changes are mirrored by those in other states adopting Medicaid hospital base payment rate-setting methods that are more rational and equitable and that use prospective payment systems like those used by Medicare and commercial payers, which give hospitals incentives to be more efficient (Marks et al. 2018).

### Impacts of DSRIP on safety net hospitals’ progress toward VBP

It is difficult to attribute changes in hospitals’ readiness to participate in VBP to DSRIP alone. DSRIP funds are only one of many Medicaid hospital payment streams, and for most hospitals, the funds received from DSRIP comprise a small share of total Medicaid revenue. It is also challenging to disentangle the role of DSRIP in driving payment changes from states’ broader commitments to VBP.

However, there was consensus among the policymakers and provider representatives we interviewed for this study that DSRIP was a major factor driving delivery system change and that it strengthened hospitals’ readiness for VBP. At the same time, they said that DSRIP is not a remedy for larger forces that increase financial vulnerability for certain types of hospitals, and those hospitals will continue to need Medicaid supplemental payments to survive.

**DSRIP drove hospitals to change their delivery systems, at least in the short term.** Several provider representatives believe that DSRIP incentives had a strong influence in driving delivery system changes. Tying DSRIP payments to the achievement of performance targets led providers to “pay attention to what keeps us afloat for our mission,” according to one provider. Some hospitals have cut certain types of specialty inpatient services, and others have tried to develop new modes of delivering services—for example, through telehealth.

However, some design features of the DSRIP demonstration did not consider how the incentives could be sustained in the long run. In Texas, for example, one provider respondent believed that the initial DSRIP demonstration should have been designed to require the providers in a region to share accountability in order to earn DSRIP funds, which would have created more incentives for data sharing and the development of a systems-level approach to population health management. A Washington provider representative noted that DSRIP has supported initiatives to address the social determinants of health, but there is great uncertainty about how non-health care services will be paid for or rewarded in VBP arrangements after the DSRIP demonstration ends.

**DSRIP helped prepare providers to participate in VBP arrangements, but progress has been uneven.**

Although considerable progress has been made in reforming hospital delivery systems, some hospitals’ progress has not been fast enough for them to fully engage in or succeed under VBP arrangements after their DSRIP demonstration ends. Many study respondents believe DSRIP demonstrations did not last long enough to help providers with the least capacity to make the transition to VBP. For example, some respondents said that some small rural hospitals were still using paper records, so it took them much longer to develop the ability to measure their performance. Even large providers with data analytics capacity said that it took a long time to get clinicians to use the data to assess their performance and develop strategies to improve. Although many hospitals and health systems took advantage of DSRIP funds to transform their business models, some hospitals viewed the demonstration as a short-term initiative that would go away at the end of five years, so they did not have to change the way they did business. For providers in the latter group, it is not clear whether more time would have induced them to revise their business model.

**DSRIP alone cannot alleviate financial vulnerability for certain safety net hospitals.** Declines in total inpatient revenue from Medicaid, Medicare, and other payers have applied intense financial pressure on safety net hospitals. As one provider representative put it, “Hospitals’ financial models are built on taking care of people who are unwell, and they generate revenue from serving them. But if you’re trying to keep patients out of the hospital, it’s totally contrary to the providers’ financial model at present.” Safety net hospitals that cannot make these changes quickly are the most susceptible to financial distress. According to one safety net provider representative: “Hospitals are trying to figure out how to transform the system from one based on inpatient care to improving the health of the people we serve. [But the challenge is] how to do that in such a way to preserve our margins, which are pretty tight and will always be tight, because we’re a dominant Medicaid/uninsured provider.”

### Looking ahead: the role of hospital supplemental payment post-DSRIP

Many respondents referred to Medicaid hospital payment as a mosaic—a set of interconnected pieces that collectively support the financial viability of safety net hospitals. As one policymaker noted, “We have not had an assertive preference of one funding stream over another. [Instead] we try to actively braid together these resources, including Medicaid and various indigent care pools, to expand coverage as best we can ... and then wherever there was a gap, covering the cost either through emergency Medicaid or other funding pools in such a way that facilities would not have to make strategic choices to close their doors.” These comments echo findings from MACPAC’s ongoing examination of Medicaid DSH and UPL payments: “From a hospital’s perspective, the total amount of Medicaid payments received is more important than the amount received from DSH or any other Medicaid payment stream” (MACPAC 2019b).

Consequently, regardless of how supplemental funds are paid, there was broad consensus among the state policymakers and provider representatives interviewed for this study that if Medicaid base payment rates do not cover hospitals’ actual costs, the need for supplemental payments will remain after DSRIP demonstrations end. Such payments are critical for: (1) compensating for shortfalls in Medicaid base payments, which occur when such payments do not cover providers’ costs for delivering care to Medicaid beneficiaries; and (2) directing additional payments to hospitals with higher shares of Medicaid and uninsured patients.

#### Addressing inadequate Medicaid base payment.

Although the base payment methodology can be designed to encourage delivery system change, Medicaid base payment rates remain low relative to actual costs, which creates challenges for broader delivery system transformation and VBP. According

“We don’t want a fragmented payment system, but the value-based payment structure needs to recognize the full value of both base and supplemental payments. We’re comfortable moving to a value-based world as long as the package of funding available to support the value system includes the funding available now through [both payment streams].”

—Provider representative

to provider representatives, inadequate base payment causes hospitals to remain reliant on supplemental payment streams. It also creates little room for the financial risk required by more advanced APMs. Provider representatives also spoke to the uncertainty and operational challenges posed by changes to base payment methods and rates. For example, one provider said: “We’re taking risk on [attributed beneficiary] lives, and the baseline economics of the Medicaid program are shifting, so you take risk on one set of assumptions and then the payment changes.”

In addition, even if safety net hospitals make effective use of DSRIP funding to build more efficient delivery systems and improve population health management, respondents point out that continued supplemental payments are likely necessary to ensure total Medicaid revenue is large enough to sustain the reforms required to succeed in Medicaid VBP arrangements. If the VBP payments to hospitals that are paid by managed care plans, or by the state directly, are held to Medicaid base payment rates that are lower than costs, then DSRIP funds, other supplemental funds, or state-directed payments via Medicaid managed care plans have critical roles to play in supporting the safety net. These roles, discussed below, include: (1) ensuring access to critical services; (2) directing funds to hospitals serving higher shares of Medicaid and uninsured patients; and (3) sustaining delivery reforms.

**Ensuring access to critical services.** According to respondents, when Medicaid base payment rates do not cover hospitals’ actual costs, continued supplemental payments are critical for maintaining access to essential inpatient services such as obstetrical and newborn care, trauma units, and emergency departments, which are particularly expensive and often not covered in full by Medicaid base payments. Medicaid now pays for nearly half of all births in the country, and deliveries and newborn care accounted for about one-quarter (27 percent) of total Medicaid spending for inpatient hospital care (MACPAC 2018b). State policymakers recognize the dilemma posed by moving to value while also needing to create structures to sustain certain hospitals. As one policymaker shared, “When you strip away inpatient volume from community hospitals, you’re still left with a set of ‘24/7/365’ services. Under the current federal and state regulatory standard, that is expensive, because some of those things are absolutely critically necessary



to provide quality care. I think, as a matter of policy, we have to recognize what minimum set of acute care does a community need, and what is a payment system to fund that?”

Policymakers and provider representatives frequently cited rural hospitals as being particularly vulnerable to financial losses in Medicaid APMs. Current Medicaid DSH allotments have often not been enough to compensate for the cost of care for the uninsured, and because the rate of uninsurance is higher in rural areas<sup>18</sup> some respondents said uncompensated care costs were among the factors that have led to rural hospital closures. Policymakers and hospital executives in Washington State said they might pursue a global budget model for rural hospitals, like the one being tried in Pennsylvania, to sustain access to care in rural areas.<sup>19</sup>

### **Targeting supplemental payments to hospitals serving higher shares of Medicaid and uninsured patients.**

Despite gains in Medicaid coverage over the past decade, substantial numbers of people still lack insurance. Among the five study states, the problem is most acute in Texas. Although the rate of uninsured Texans ages 18–64 dropped from 25.5 percent in 2013 to 17.9 percent in 2016 (Marks et al. 2016), the uninsured rate was estimated to increase to 19 percent in 2018, the highest in the nation (Buettgens et al. 2018). One provider representative’s hospital had significantly expanded care for the uninsured under DSRIP, and the provider said that “without sustained funding, we would really have to cut the services to the [uninsured] population.”

Although hospitals in states that did expand Medicaid coverage under the ACA report lower uncompensated care costs for uninsured individuals since 2014, they had higher Medicaid shortfalls compared with hospitals in states that did not expand Medicaid. In a subset of hospitals that were subject to Medicaid DSH audits in state plan rate years 2013 and 2014, the increase in the Medicaid shortfall (\$4.0 billion) exceeded the decline in uncompensated care costs for uninsured individuals (\$1.6 billion) in DSH-designated hospitals. Expansion states experienced greater increases in Medicaid shortfalls than non-expansion states did (MACPAC 2019b).<sup>20</sup>

Hospitals serving higher shares of Medicaid and uninsured patients, by definition, have lower shares of Medicare and commercial patients, which limits their ability to cross-subsidize low Medicaid payment rates. According to the terms of Texas’ section 1115 waiver, uncompensated care pool funds cannot cover Medicaid base payment shortfalls. Combined with the scheduled cuts to Medicaid DSH funds, and as the end of the five-year section 1115 DSRIP demonstration draws near, one respondent described the situation in Texas as a looming “fiscal cliff” for many hospitals. The only option is to seek more county-based financing to cover the state share of cost for other types of supplemental payments that can be targeted to safety net hospitals in those counties. Washington state stakeholders also see a need for continuing supplemental payments (apart from DSRIP) to subsidize small and rural hospitals that are struggling to develop a viable strategy to stay afloat.

**Sustaining delivery reforms.** Although DSRIP was intended to provide seed capital and not to be a permanent funding stream, policymakers and providers said continued investments in infrastructure are needed to sustain and improve the reforms achieved through DSRIP. IT systems need continual improvement. Funding is needed to maintain population health platforms, community health worker teams, and services that address the social determinants of health. Said one provider: “These changes need to be around a while before they stick.” If DSRIP funds are no longer available, and managed care organizations do not pay for this infrastructure, the reforms are likely to fade over time.

## **Conclusion**

State policymakers use a mosaic of payment strategies to support safety net hospitals. Because Medicaid base rates in many states do not cover the actual costs of serving Medicaid beneficiaries, many of these safety net hospitals rely on Medicaid supplemental payments of many types to fill shortfalls associated with treating Medicaid beneficiaries, as well as uninsured individuals. All five study states have recently revised—or were in the process of revising—their hospital payment policies during the time they operated DSRIP demonstrations. Their goal has been to align the incentives across payment mechanisms to improve value through delivery reforms and population health management. States’ DSRIP demonstration experiences appear to have driven some of these changes, though it is difficult to say how much influence they have had.

This study did not find any evidence to suggest that the persistence of supplemental payments, by itself, diminishes the incentives for hospitals to make progress toward delivery system reform and VBP goals. However, we found that fragmented payment systems and inadequate base payment rates create challenges for safety net systems because they have tight financial margins, which limit their ability to take on financial risk under VBP models, and lead to financial uncertainty given their dependence on disparate funding streams.

Policymakers and providers interviewed for this study shared a commitment to advancing progress toward VBP while at the same time protecting access to essential care. Achieving both goals requires maintaining supplemental payments, which help to stabilize hospital finances and ensure access to care as they make the transition to performance and value-based payment. Ultimately, the total amount of Medicaid payment to cover these costs matters more than the specific amount received from any particular supplemental payment stream. In states where Medicaid base payment rates do not cover the costs borne by safety net providers of caring for Medicaid and uninsured patients, supplemental payments will continue to play an important role in supporting these providers’ ability to succeed under value-based payment arrangements.

## DATA SOURCES AND METHODS

To understand the relationship between state DSRIP demonstrations and Medicaid's policies on supplemental payments to providers, we drew on both qualitative and quantitative data sources.

Between mid-February and April 2019, we conducted 16 semi-structured telephone interviews with state Medicaid agency policymakers, representatives of state hospital associations, and leaders of provider entities participating in DSRIP demonstrations in five states: California, Massachusetts, New York, Texas, and Washington. We prioritized states with DSRIP demonstrations that emphasize value-based payment and are relatively large in terms of the total funding available. We also selected these states to achieve variation in (1) the proportion of Medicaid hospital payments that were supplemental, (2) Medicaid expansion status, and (3) the relationship of the DSRIP demonstration to historical supplemental payments (including states with demonstrations that were and were not connected to historical supplemental payment dynamics). We included hospital associations to ensure a broad perspective on their state's hospital payment policies, and selected provider entities on the basis of size (seeking entities with moderate to large DSRIP funding allocations) to ensure representation from safety net hospitals. Overall, we spoke with at least two provider representatives in each state.

Interview topics covered: (1) the history of each state's use of supplemental payments before DSRIP, (2) how DSRIP demonstration policies changed the use of those payments, and (3) Medicaid hospital payment changes made concurrently with DSRIP demonstrations, including those affecting base, upper payment limit, disproportionate share hospital, and managed care pass-through or state-directed payments. We also asked respondents about the relationship between supplemental payments and the shift to value-based payment, and the role of supplemental payments in supporting safety net hospitals during and after the DSRIP demonstration period. We recorded interviews with respondents' consent and analyzed themes from these interviews across states.

We also conducted cross-state comparisons and analyzed trends in the features of state DSRIP demonstration programs, Medicaid hospital payment policies, managed care state-directed payment programs, and state supplemental payment expenditures, drawing on several sources including section 1115 waiver demonstration special terms and conditions, state Medicaid websites, and MACPAC reports, including MACPAC's analysis of total Medicaid expenditures on inpatient hospital services, which used CMS 64 net expenditure data.

This study has the following limitations. First, we focused on DSRIP demonstration states. Because of DSRIP, these states' experiences may differ from the experiences of other states. For the provider interviews, we used purposive sampling and held interviews with several respondents in each state; thus, the provider interviews may not be representative of the full experience of DSRIP provider participants. Third, this study deliberately focused on safety net hospitals and their financing, and therefore gives insights into the hospital perspective only. DSRIP demonstrations in several states are designed to influence nonhospital providers in an effort to build a care continuum for Medicaid and uninsured patients. This brief does not give their perspective. Follow-on work may take a comprehensive view of the payment models that best support the types of multi-provider arrangements being promoted through alternative payment models.

## 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 will inform a final evaluation report in 2020.

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## Endnotes

<sup>1</sup> Alternative payment models (APMs) are specific payment arrangements used in VBP programs. All APMs link payments to providers with quality metrics—and sometimes costs—for defined, attributed patient populations. APMs vary in the size of their bonuses or penalties, and in the degree of financial risk assumed by providers.

<sup>2</sup> Emergency Medical Treatment & Labor Act (EMTALA) of 1986.

<sup>3</sup> The Institute of Medicine defines safety net providers as those who, by mandate or mission, offer access to care regardless of a patient’s ability to pay, and whose patient population includes a substantial share of Medicaid, uninsured, and other vulnerable patients (Lewin and Altman 2000).

<sup>4</sup> In fiscal year 2017, supplemental payments made up 24 percent of the total amount of all Medicaid payments to hospitals nationwide (MACPAC 2019a). This figure, which varies widely from one state to another, includes section 1115 DSRIP payments.

<sup>5</sup> According to MACPAC, “In 2016, Medicaid DSH payments accounted for about 4 percent of hospital operating costs for deemed DSH hospitals. Without DSH payments, these hospitals would have reported operating margins of negative 6 percent in the aggregate” (MACPAC March 2019b)).

<sup>6</sup> In addition to these forms of payment, states also make graduate medical education (GME) supplemental payments to teaching hospitals to help offset costs associated with medical training. This analysis does not explicitly address GME payments, because they represent only 1 percent of total Medicaid hospital payments.

<sup>7</sup> Federal statute requires that states provide actuarially sound capitated payments to managed care plans; this requirement presumes that capitation rates are sufficiently comprehensive and thus would not warrant supplemental payments, thereby restricting states from providing supplemental UPL funding for managed care beneficiaries (MACPAC 2011).

<sup>8</sup> In federal fiscal year 2017, total DSH spending by federal and state governments was \$18.1 billion. DSH spending as a share of total state Medicaid benefit spending varies by state, from less than 1 percent to 12.3 percent. For more information on the scheduled reductions in DSH payments, see Chapter 1 in the MACPAC March 2019 Report to Congress (MACPAC 2019b) at <https://www.macpac.gov/publication/improving-the-structure-of-disproportionate-share-hospital-allotment-reductions/>.

<sup>9</sup> 42 CFR §438.6(d) For more background on pass-through limitations, see [Federal Register, Final Rule, May 6, 2016, p. 27589](#).

<sup>10</sup> State quality strategies must cover these domains as outlined in 42 CFR §438, subpart D.

<sup>11</sup> In 2015, CMS outlined a set of principles it would consider for states seeking to renew their uncompensated care pools. Since then, CMS and states seeking to maintain this source of funding have narrowed the pools to focus on offsetting shortfalls associated with treating uninsured individuals or those with low incomes, eliminating any prior focus on Medicaid shortfalls.

<sup>12</sup> Federal regulations set national standards governing the use of Medicaid DSH and UPL payments, but states can seek section 1115 waiver authority to direct these types of payments to hospitals to support delivery system reform goals.

<sup>13</sup> Massachusetts' initial DSRIP demonstration, which ran from 2011 to 2017, was called the Delivery System Transformation Initiatives (DSTI). As part of the section 1115 waiver authorizing the demonstration, the state established a Safety Net Care Pool, funded in part through federal and state expenditures that historically funded Medicaid DSH payments and supplemental payments to two managed care plans (Moody and Rosenstein 2009).

<sup>14</sup> New York and Washington, in addition to four other states, financed DSRIP demonstrations partly with Designated State Health Programs (DSHP) funds, which allowed state monies that paid for health programs not covered by Medicaid to qualify for federal Medicaid funds. Using these funds for delivery system reform was assumed to yield savings that would ultimately accrue to the federal government. In December 2017, CMS announced that it would not grant new waivers, nor renew portions of existing waivers, that include DSHP funding (State Medicaid Director Letter #17-005, available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf>).

<sup>15</sup> In the first two performance years, 5 percent of each provider's Safety Net Provider Payments are at risk, ramping up to 10 percent in Year 3, 15 percent in Year 4, and 20 percent in Year 5.

<sup>16</sup> See Lipson et al. 2019, Figure II.1, State VBP target percentages by year, for details on specific states.

<sup>17</sup> All study states use Diagnostic Related Groups or a similar method to pay for hospital inpatient services. However, California uses a cost-based method to reimburse public health care systems. For outpatient services, Massachusetts, New York, and Washington pay hospitals on the basis of a bundle of services or episode of care; California uses a fee schedule, and Texas uses a cost-based method.

<sup>18</sup> U.S. Census Bureau. "Health Insurance in Rural America." Available at <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>. Accessed August 11, 2020.

<sup>19</sup> A description of the Pennsylvania pilot project, sponsored by the CMS Center for Medicare and Medicaid Innovation, can be found at <https://innovation.cms.gov/initiatives/pa-rural-health-model/>.

<sup>20</sup> In contrast, based on Medicare cost reports for hospitals of all types, hospital charity care and bad debt costs declined by \$5.7 billion between 2013 and 2014, exceeding Medicaid shortfalls which increased by \$0.9 billion during this same time period nationally (MACPAC 2019b). The differences between the trends in uncompensated care costs for all hospitals submitting Medicare cost reports and for DSH hospitals may be partly because the DSH analysis included the six months before and after the ACA was implemented.

**Appendix**

**Table A.1. Section 1115 DSRIP demonstrations: features and policy context**

	California		Massachusetts		Texas			New York 2014–2019	Washington 2017–2021
	DSRIP 2010–2015	PRIME 2015–2020	DSTI 2011–2017 <sup>a</sup>	DSRIP 2017–2022	DSRIP 1 2011–2017 <sup>b</sup>	DSRIP 2 2018–2022			
<b>DSRIP demonstration features</b>									
DSRIP funding available (in millions; total computable)	\$6,671	\$7,464	\$13,192	\$1,800	\$14,518	\$11,600	\$8,250	\$1,125	
Eligible providers	Designated public health care systems	Designated public health care systems and district municipal public hospitals	Acute care hospitals serving disproportionate share of Medicaid beneficiaries and uninsured individuals	Accountable care organizations, community partners, and community service agencies	Regional Healthcare Partnerships, anchored by public hospital or local governmental entity	Regional Healthcare Partnerships, anchored by public hospital or local governmental entity	Performing Provider Systems	Accountable Communities of Health	
Source of nonfederal financing for DSRIP	IGT	IGT	State revenue and IGT	State revenue and provider taxes	IGT	IGT	IGT and DSHP	IGT and DSHP	
<b>Policy context motivating DSRIP</b>									
Medicaid expansion for low-income adults concurrent with DSRIP	X	X	X	X	X <sup>c</sup>		X	X	
Managed care expansion concurrent with DSRIP demonstration	X				X		X <sup>e</sup>	X <sup>f</sup>	
Converted historic supplemental payments into DSRIP	X	X	X	X					
Converted historic supplemental payments into UCP	X	X	X	X	X	X	n.a.	n.a.	
State commitment to payment reform			X <sup>g</sup>	X <sup>h</sup>			X <sup>i</sup>	X <sup>i</sup>	

**Source:** Analysis of state section 1115 demonstration special terms and conditions; interviews with state policymakers conducted for this study.

DSHP = designated state health programs; DSRIP = delivery system reform incentive payment; DSTI = Delivery System Transformation Initiatives; IGT = intergovernmental transfers; UCP = uncompensated care pool; n.a. = not applicable.

<sup>a</sup> The state's initial DSTI demonstration ran from 2011–2014. It was extended but modified for the demonstration period of 2014–2017.

<sup>b</sup> Texas had an extension year between 2016 and 2017 while CMS and the state worked through the terms of its second DSRIP demonstration. During this extension period, the terms of the previous demonstration were carried forward.

<sup>c</sup> At the time it negotiated its initial section 1115 waiver with CMS, Texas expected that it would be required to expand Medicaid eligibility per the Affordable Care Act. Thus, its DSRIP performance expectations encouraged providers to expand their capacity to serve Medicaid beneficiaries.

<sup>d</sup> The four study states that expanded coverage to low-income adults under the ACA starting in 2014—California, Massachusetts, New York, and Washington—use managed care to serve this group.

<sup>e</sup> New York expanded managed care to cover additional population groups, services, new geographic areas, or mandatory enrollment of beneficiaries using long-term services and supports starting in 2014.

<sup>f</sup> Washington expanded managed care to cover medical care services for the aged, blind, and disabled population, and carved behavioral health services into managed care plan benefits.

<sup>g</sup> Massachusetts sought to contain cost growth while also preparing safety net hospitals for VBP. At the time of the initial DSTI waiver in 2011, the state was preparing to encourage movement to VBP.

<sup>h</sup> In 2012, the state passed legislation (Chapter 224 of the Acts of 2012) specifying targets for the percentage of MassHealth beneficiaries whose care should be financed through alternative payment methods: 25 percent (2013), 50 percent (2014), and 80 percent (2015).

<sup>i</sup> New York's DSRIP demonstration is part of a broader reform effort undertaken by the state to improve the health care delivery system for Medicaid beneficiaries and reduce annual growth in Medicaid costs so they remain within a global spending cap mandated by state law in 2012. For state fiscal year 2017, which began April 1, 2016, the growth cap was 3.4 percent, with 3.2 percent projected in 2018, 3.0 percent in 2019, and 2.8 percent in 2020 (Felland et al. 2018).

J Building on its State Innovation Model grant, Washington is using its DSRIP demonstration to further its commitment to shifting 90 percent of state-financed health care payments into VBP arrangements by 2021.

**Table A.2. Overview of study states' non-DSH Medicaid hospital supplemental payment streams as of 2019**

Supplemental payment stream	Policy mechanism or authority	Directed to safety net hospitals only?	Linked to quality?
<b>California</b>			
UPL—supplemental payment for private hospitals	Approved state plan	No	No
State-directed managed care payments—enhanced payment	42 CFR 438.6(c)	Yes	Yes
State-directed managed care payments—quality incentives	42 CFR 438.6(c)	Yes	Yes
Global Payment Program <sup>1</sup>	Section 1115 demonstration waiver authority	Yes	Yes
PRIME	Section 1115 demonstration waiver authority	Yes	Yes
<b>Massachusetts</b>			
UPL—payment for MassHealth essential hospitals	Approved state plan	Yes	No
UPL—payment for high public payer hospitals	Approved state plan	Yes	No
UPL—hospital pay for performance	Approved state plan	No	Yes
Safety Net Care Pool (includes DSRIP and Safety Net Provider Payments)	Section 1115 demonstration waiver authority	Yes	Yes (although not for all streams within broader pool)
State-directed managed care payments—disability access incentive	42 CFR 438.6(c)	No	Yes
State-directed managed care payments—hospital quality incentive	42 CFR 438.6(c)	Yes	Yes
State-directed managed care payments—integrated care incentive	42 CFR 438.6(c)	Yes	Yes
State-directed managed care payments—behavioral health quality incentive	42 CFR 438.6(c)	Yes	Yes
<b>New York</b>			
UPL—Voluntary Supplemental Inpatient Payments	Approved state plan	No	No
UPL—Voluntary Supplemental Outpatient Payments	Approved state plan	No	No
DSRIP	Section 1115 demonstration waiver authority	Yes	Yes
Value-Based Payment Quality Improvement Program (similar to state-directed managed care payments)	implemented before the 2016 managed care regulations	Yes	Yes

*(continued)*

Supplemental payment stream	Policy mechanism or authority	Directed to safety net hospitals only?	Linked to quality?
<b>Texas</b>			
DSRIP	Section 1115 demonstration waiver authority	No	Yes
UC Pool	Section 1115 demonstration waiver authority	Yes	No
Network Access Improvement Program	Implemented before the 2016 managed care regulations	No	Yes
State-directed managed care payments—uniform hospital rate increase	42 CFR 438.6(c)	No	Yes
<b>Washington</b>			
Hospital Safety Net Assessment Program (combination of DSH, UPL, managed care pass-through payments, and payments targeting specific hospitals)	Approved state plan	No	Not universally, but the UPL payment program includes a Quality Incentive Payment program that is linked to hospital quality reporting and performance
DSRIP	Section 1115 demonstration waiver authority	No	Yes

DSH = disproportionate share hospital; DSRIP = delivery system reform incentive payment; UC = uncompensated care; UPL= upper payment limit.

**Note:** Safety net hospitals are those that serve a disproportionate share of Medicaid beneficiaries or uninsured individuals.

In addition to the supplemental payments listed here, New York, Texas, and Washington all make Medicaid DSH payments to hospitals to offset uncompensated care costs associated with treating Medicaid beneficiaries and uninsured individuals. California and Massachusetts direct their Medicaid DSH allotments to their section 1115 demonstrations.

Under its section 1115 demonstration, Massachusetts diverts its Medicaid DSH allotments to the state's Safety Net Care Pool, which funds uncompensated care and supplemental payments. Massachusetts' UC Pool, referenced in this table, is a component of its broader Safety Net Care Pool.

#### Sources:

Section 1115 demonstration documentation

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