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MEDICAID 1115 DEMONSTRATIONS

Achieving Coordination of Care to Improve Population Health: Provider Collaboration in Delivery System Reform Incentive Payment Programs

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Introduction

Delivery System Reform Incentive Payment (DSRIP) programs, authorized as Medicaid section 1115 demonstrations, provide incentive payments to safety net hospitals and other providers, such as physicians and community clinics. Participating providers conduct improvement projects to earn incentive payments, which are tied to their achievement of specified milestones and metrics. The projects are broadly designed to build capacity among safety net providers, transform the way services are delivered, and improve the health of Medicaid beneficiaries and the uninsured. This brief focuses on the largest DSRIP demonstrations as of July 2015, which were in California, Massachusetts, New Jersey, New York, and Texas.[1]

Since 2010, when CMS approved the first DSRIP demonstration in California, CMS and the states have defined demonstration goals that vary with each state. In general, DSRIP demonstration goals emphasize improved quality and enhanced access to care for vulnerable populations, but the demonstrations are also structured to address the local delivery system and population health priorities of the state. Early DSRIP demonstrations in California and Massachusetts aimed to support safety net health systems serving high volumes of Medicaid beneficiaries and uninsured people. In these states, the DSRIP demonstrations emphasized delivery system integration and redesign within health systems. Larger demonstrations in Texas and New York place more emphasis on transforming the delivery system across care settings and provider organizations to improve population health more broadly.

Achieving the goals of DSRIP requires collaboration and coordination across providers and settings. The term **collaboration** is used in this brief to describe the ways in which health care providers work together, formally or informally, as part of DSRIP programs. In all DSRIP states, providers collaborate through the creation of formal or informal **alliances** to achieve the goals of DSRIP projects. For example, early DSRIP programs targeted health systems, and participating health systems formed alliances with other providers inside and outside of their health systems to carry out improvement projects. These alliances formed out of project need. Alternatively, DSRIP programs in Texas and New York require participating providers to form **regional networks** of providers and other organizations. These networks provide a formal organizational structure through which providers can coordinate with each other to achieve the goals of DSRIP.

This brief describes the variation in eligibility requirements for provider participation, as defined by CMS and the states; how providers collaborate to meet the goals of DSRIP; the factors that influence collaboration; and implications for the national evaluation of DSRIP. The brief also includes three case studies that illustrate the types of collaborations that occur in DSRIP 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 program 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 intend to reward improved outcomes over volume.

STATE WITH REGIONAL NETWORKS: KEY TERMS

Regional healthcare partnerships (RHPs) in Texas: RHPS are geographically distinct, regional consortia that are anchored by a lead health care provider or government entity to coordinate the activities of performing providers who carry out improvement projects locally. Public entities provide the nonfederal share of DSRIP funding.

Performing provider systems (PPSs) in New York: PPSs are coalitions of providers that serve a high number of Medicaid beneficiaries and uninsured individuals and collaborate to carry out improvement projects. There may be one PPS or multiple PPSs in a given region.

How do requirements for provider participation vary across states?

Table 1 shows the two DSRIP models for provider participation by state, based on state eligibility requirements for DSRIP participation. Given their focus on building capacity among hospital systems, Massachusetts, New Jersey, and California limit program and funding eligibility to hospitals and health systems. Texas and New York have broader system transformation goals and require providers to form regional networks.[2] These networks expand eligibility for DSRIP participation and incentive payments to a wider range of providers. These networks are called regional healthcare partnerships (RHPs) in Texas and performing provider systems (PPSs) in New York.

Table 1. DSRIP collaboration models and eligible providers, by state

DSRIP collaboration model	New York	Massachusetts	New Jersey	Texas	California
Hospitals or health systems (Number participating)		Public and private acute care hospitals and health systems (7)	Acute care hospitals (49)[a]		Public health systems (21)
Regional networks[b] (Number participating)	Many types of safety net providers, participating through Performing Provider Systems (PPSs) (25 PPSs)			Public entities or private entities with public sponsorship,[c] participating through Regional Healthcare Partnerships (RHPs) (20 RHPs)	

Source: Mathematica's analysis of state special terms and conditions (STCs) and key informant interviews

Note: States are listed from newest to oldest by program start date, including renewals, as of July 2015. New York began in 2014 and California began in 2010.

[a] Based on key informant interviews with New Jersey representatives.

[b] STCs explicitly require eligible entities to be regional networks, and only these networks are allowed to participate and receive DSRIP funding.

[c] Texas requires the inclusion of a public entity that can contribute intergovernmental transfers (IGTs) to generate the nonfederal share of the DSRIP funding. Because only public entities can contribute IGTs, private providers must find a public sponsor.

Because the early programs in California and Massachusetts intended to build capacity among safety net systems, they limited eligibility for DSRIP participation and incentive funding to hospitals or hospital-based systems. In Massachusetts, the main goal of its Delivery System Transformation Initiatives (DSTI) demonstration (implemented between July 1, 2012 and June 30, 2017) was to invest in the development of integrated delivery systems among safety net hospitals to support the shift toward value-based payment models. A secondary goal of the demonstration was to replace Medicaid supplemental payments[3] to hospitals with DSRIP funding. Likewise, in California, a key goal of its DSRIP demonstration was to build the capacity of public health care systems and "support and maintain a vibrant safety net system" in preparation for people who would become newly insured by Medicaid under the Affordable Care Act expansion.

New Jersey's DSRIP demonstration was designed to strengthen acute care hospitals and their partners, and improve the health of patients with chronic conditions, which requires coordination across the care continuum. Although only acute care hospitals are eligible to receive funding in New Jersey, they are held to a set of outpatient metrics that depend on collaboration with community providers, either within or outside the hospital system. In 2015, the state began to give explicit incentives to hospitals to form partnerships with community-based providers to improve population health.[4]

Unlike the programs in California and Massachusetts, the programs in New York and Texas are oriented toward broader system transformation. As such, participating providers carry out improvement projects under the aegis of formal regional networks; such networks, composed of hospitals and many community providers, aim to re-design how care is delivered. According to a state representative in New York, "the goal [of

the PPS requirements] was to focus on access to health care within a community and to ensure that the providers could support each other. The overall goal [for the state's program] is to reduce avoidable hospital use by 25 percent in five years." In the state's view, achieving such a goal requires regional networks composed of multiple providers to redesign how care is delivered. To achieve this goal, CMS and the state specified a broad range of provider and organization types that must be included in the network to be eligible to participate as PPSs. Providers participating in PPSs can receive DSRIP funds if they achieve project milestones, but PPSs determine the method for distributing these funds. In Texas, the goals related to transforming the delivery system require the participation of multiple provider types beyond public hospitals. Like New York, the goals of the demonstration in Texas require multiple provider types; however, in Texas, the participation of private providers requires sponsorship from public entities who provide the nonfederal share of DSRIP funding through intergovernmental transfers (IGTs).

How do DSRIP providers collaborate?

Collaboration among providers is universally relevant but highly variable within and across DSRIP demonstrations. Formal and informal alliances take place to carry out improvement projects, and given the nature of these alliances, it is challenging to comprehensively characterize all participating providers.

Some provider alliances have grown out of earlier collaborative efforts that evolved to fit DSRIP demonstration goals. In California and Texas, previous experiences with multidisciplinary coalitions, such as Ryan White[5] and other HIV programs, laid the groundwork for DSRIP alliances. In these states' demonstrations, coalitions formed to provide comprehensive, coordinated HIV care that successfully brought together numerous and varied stakeholders. Similarly, in Massachusetts, one state representative noted that partnerships were more effective when the hospital used the demonstration to expand existing relationships. In New Jersey, interviewees noted the state's history of integration between hospitals and outpatient community providers as a factor in the formation of collaborations for DSRIP.

In addition to building on existing partnerships, new collaborations among providers have grown out of project need. For example, in California, one interviewee described alliances between public health systems and behavioral health departments to carry out projects focused on integration and colocation of medical and behavioral health services.

In states requiring regional networks, there is a far more prescribed approach to collaboration formation, focusing on representation of multiple provider types. This approach can create a dynamic where previously competitive organizations formally come together to create regional networks. However, state administrators may have to play a critical role in this network building. For example, New York specified that all PPSs must include a safety net provider lead and a wide network of providers, and the state encouraged the formation of one PPS in each region. This requirement for diverse provider representation helps to ensure the right players are there to carry out improvement projects, as one provider representative noted. However, in some cases, it has led to unexpected collaborations. One hospital representative mentioned that "the state really did push for providers to come together…as a single PPS in the region, and that often created very interesting sets of odd bedfellows, who were…historically strong competitors in certain marketplaces [but] came together for purposes of [DSRIP]. So that's more of a forced regional network-building because of the structure of the way DSRIP was set up here." A similar process played out in Texas, where the state encouraged numerous stakeholders to work together at the local level, often overcoming historical tensions. One RHP representative noted that, despite early challenges, as the benefits of participation accrued across multiple providers, provider engagement increased, and participation in DSRIP expanded. Thus, requirements for regional networks may bring together new collaborations at the local level that may need time to solidify.

CASE STUDY: MONMOUTH MEDICAL CENTER, NEW JERSEY

Monmouth Medical Center is implementing the "Integrated Health Home for the Seriously Mentally Ill (SMI)" project. Recognizing the high prevalence of untreated physical conditions in adults with SMI, Monmouth seeks to integrate physical and behavioral health services by co-locating primary and mental health services at the hospital's outpatient mental health program. The project operates through a variety of internal and external alliances. Internally, the outpatient mental health program coordinates care among the hospital's diabetes, respiratory, and nutrition subspecialties for its patients who need these types of services. Externally, following years of collaboration, Monmouth established a formal partnership with a local federally qualified health center (FQHC) to act as a data reporting partner. The FQHC reports DSRIP outpatient metrics to the state for Monmouth patients seen at the FQHC. The FQHC also provides medical support to Monmouth patients with SMI, including a dental program and various women's and adult services unavailable through Monmouth. Monmouth representatives believe that the historical collaboration between the hospital and FQHC has been critical to the project's implementation and is key to serving the needs of adults with SMI.

CASE STUDY: GOVERNANCE MODEL OF FINGER LAKES PPS, NEW YORK

To meet New York's requirement that each PPS establish a governance structure, the Finger Lakes PPS (FLPPS) created an organizational infrastructure that enabled stakeholder representation throughout its network. Its model centralizes decision making based on state-defined PPS standards but delegates project implementation to regional providers. The structure consists of two prioritized functions: core and geographic. The core function ensures "central services, consistent processes, and a singular vision," while the geographic function ensures localized problem-solving and leadership (Finger Lakes PPS 2014).

The core function consists of the board of directors, committees, and workgroups that develop FLPPS's systemwide strategies and operations. These systemwide standards govern the PPS's approach to issues such as information technology, finance, workforce development, and clinical quality.

FLPPS's geographic function consists of five naturally occurring care networks (NOCNs)—regions defined by usage patterns based on Medicaid claims data. The NOCNs seek to engage providers and execute projects locally—goals that are assisted by geographic delegation. Because NOCNs are defined by usage patterns, there are existing relationships between providers and patients. The geographic function is also designed to increase the participation of local providers by diffusing decision making and preserving autonomy. These benefits promote the buy-in of community providers and draw on the local expertise needed for effective project implementation.

Despite some similarities between Texas and New York's demonstrations and their implementation processes to date, there are key differences, as well. For example, only New York requires PPSs to specify a formal governance structure, although the state allows for selection among models (see the Finger Lakes PPS case study for an example of a hybrid governance model) and to specify how funds will flow among participating providers. By design, the PPSs include representatives from many settings, such as hospitals, primary care practices, specialty care, long-term services and supports, pharmacies, research organizations, and social service organizations. In Texas, requirements around IGT sponsorship have affected the nature of collaboration and how incentive funding is dispersed within RHPs.

Regardless of the collaboration model (hospital-focused or regional networks), several interviewees noted challenges with engaging community-based providers, such as primary care practices, federally qualified health centers, and other community health centers and clinics. For example, two interviewees in New York noted that meaningful engagement between PPSs and community providers had been lacking and that there was fear among community providers that the large health systems were driving the agenda. In New Jersey, interviewees noted that the limitations of DSRIP funding eligibility to hospitals created challenges in engaging community partners. In Texas, private organizations without public sponsorship in Texas are ineligible for DSRIP funding, although they can take part in learning collaboratives[6] through the regional networks and form alliances with participating providers to conduct projects. Despite the goals of regional network requirements related to broad inclusion of providers and organizations, interviewees noted that in these states, certain groups are still underrepresented or missing. Substance use providers, managed care organizations, and organizations serving people with developmental disabilities were cited as missing in some regional networks. Others noted the challenges in ensuring inclusion of community-based organizations outside the health care system such as social service providers and faith-based organizations in regional networks.

What factors are associated with successful collaborations?

Across DSRIP states and models, interviewees mentioned a variety of factors that they thought affected the success of a collaboration. Table 2 presents these factors, which are either (1) internal, or specific to the collaborating organizations, or (2) external, or specific to the local or state environmental and policy context.

Internal factors. HIT was the most commonly cited internal factor affecting coordination among providers. Coordination across settings, either within systems or with outside organizations, requires the exchange of patient-level data. Interviewees noted challenges in data exchange, particularly with community-based providers that were not as far along with HIT adoption. Even where HIT is in place, use of different electronic health records may preclude interoperability, which can impede care coordination. Others cited concerns about patient privacy and secure uses of the data and difficulties establishing data use agreements as challenges to collaboration. HIT is also important for performance measurement, specifically for the demonstration of milestone achievement and incentive disbursement. Thus, data sharing and reporting capabilities across collaborating organizations are critical factors in shaping collaborations in DSRIP states.

Another commonly cited factor was stakeholder buy-in and commitment to the goals of DSRIP. States, hospitals and health systems, and regional network leaders play an important role in engaging stakeholders and ensuring representation. An RHP representative in Texas described a history of silos and competition in the region; in response, the RHP leadership engaged over

Table 2. Internal and external factors that affect collaborations (at the project level or regional network level)

Internal factors	External factors
• Governance and leadership structures • Organizational commitment to the goals of DSRIP • Aligned goals among collaborating organizations • Stakeholder engagement, representation, and buy-in • Availability of financial resources for participation, particularly for community-based providers • Distribution of incentive payments across collaborating providers and perceptions of fairness • Age, longevity of alliances • Health information technology (HIT) and information exchange capabilities • Data security and privacy concerns associated with health information exchange	• Managed care penetration within the Medicaid population • Extent to which safety net providers are participating in delivery system transformation and payment reform • Other related state initiatives and major policies affecting the safety net providers and/or Medicaid populations (e.g., Medicaid expansion) • CMS and state requirements for DSRIP program participation, milestone achievement, and incentive disbursement

Source: Mathematica's analysis of key informant interviews.
Note: All of the factors were identified by interviewees in at least two states.

300 stakeholders, convened 30 workgroups, and visited counties throughout the region to build support. As a result, the health systems, FQHCs, and other providers across the care continuum came together "to make the community a better place." Similarly, a health system representative in California described the need for clear, common goals for DSRIP participants across the system and across external collaborating organizations.

External factors. The most commonly cited external factor was the extent to which the local and state delivery system and policy context have started to move toward increased integration, redesign, and value-based payment mechanisms—which can facilitate or inhibit collaboration depending on how far along these reforms are locally. This factor also reflects how prepared the local delivery system is for the reforms of DSRIP.

Managed care expansions in Medicaid are one mechanism by which states are moving toward more integrated services, payment reform, and care improvements. All DSRIP states participate in these managed care expansions, but there is considerable variation in the degree of penetration within and across states. Several participants cited the presence of managed care as a facilitator of collaboration in their local environment. For example, one participant in California said, "California is distinguished in its delivery system in having 80 percent managed care penetration [among Medicaid beneficiaries] already…. As a result, you have inherent in our structure [an incentive for] safety net provider networks [to work with] Medi-Cal managed care plans to improve care coordination…. The two [DSRIP and managed care] work in conjunction and in ways that are mutually beneficial and mutually strengthening, again with the patient at the center." In general, the networks in place can be built upon to carry out DSRIP improvement projects.

Alternatively, in regions where managed care has not been established, DSRIP initiatives are a major force for value-based purchasing and population health management and thus face challenges related to reforming traditional fee-for-service models. One provider representative in New York stated that their region has had little experience with value-based models in the past, as fee-for-service payment models have dominated the local market. As such, the care delivery models incentivized through New York's DSRIP are a new concept for most organizations in the region, and implementing these models is expected to be challenging. However, the PPS intends to align DSRIP activities with emerging accountable care organizations in the region to overcome this challenge.

CMS and state requirements and policies also affect the form and effectiveness of DSRIP collaborations. For example, the eligibility requirements for participation and funding influence the nature of collaborations taking place. In California and Massachusetts, initial DSRIP demonstrations were oriented toward hospital-focused improvement projects. In states without regional network requirements, interviewees noted that policies precluding the transfer of DSRIP funds between providers were barriers to partnering with community-based providers. Without funding, collaboration is then only based on shared goals or shared benefits associated with participation, as one health system representative from California said.

In New Jersey, the state's evolving requirements around partnership have been a critical factor in implementation to date. Interviewees described how the original demonstration design was oriented toward hospitals. As the program evolved to emphasize hospital-community provider partnerships, hospitals had to adjust their plans and identify partners. CMS and state requirements for a standard set of outpatient metrics also influenced which community partners hospitals engaged, because partners need to be able to report the relevant outpatient data. Finally, interviewees discussed the challenges created by the requirement that community partners only have one "parent" hospital, which complicates referral patterns and access and has been an issue hospitals have had to work around.

CASE STUDY: CONTRA COSTA REGIONAL MEDICAL CENTER, CALIFORNIA

Contra Costa Medical Center (CCMC) is one of 21 public health care systems participating in DSRIP in California. CCMC is committed to integrated, patient-centered care. CCMC leaders have historically promoted a patient-centered philosophy across the medical center and extended this culture to the DSRIP program. During the DSRIP planning and implementation phase, CCMC leaders placed patients and their families in key decision-making roles and continue to include patients in high-level policy meetings. As a result, DSRIP project selection represented a commitment to patient-centered care.

Projects ranged from enhancing culturally competent care to improving patient experience to integrating physical and behavioral health care. While planning the integration of physical and behavioral health care project, CCMC recognized that it lacked the appropriate workforce and established a formal partnership with the Wright Institute, a psychology graduate school. Through this partnership, the Wright Institute located providers, including behavioral health specialists at CCMC to help improve access to care for patients with complex behavioral conditions.

In Texas and New York, regional network requirements have brought together many different types of providers. However, the way funding is distributed within the networks is a critical issue. In Texas, the need to identify sources of IGT funding within RHPs has created "silos that collaborations were trying to get away from," according to one RHP representative. The need for sponsorship for participation from a public entity has been consequential in Texas, affecting who can participate and the flow of DSRIP incentive funding. In New York, the requirements have motivated many different provider types to work together, and the state required PPSs proactively address the issue of fund flow in their applications. However, interviewees noted the uncertain role of community-based organizations in PPSs and whether they were eligible for incentive funding. Thus, state requirements around eligibility for participation and funding influence collaborations that form.

Like eligibility requirements, other state requirements affect collaboration. Other core program features of DSRIP, such as attribution and project valuation (which ultimately affect the allocation of DSRIP funds), directly influence participation in regional networks within and across DSRIP states. For example, one hospital representative in New York described the influence of the state's attribution and valuation methods, which assign more value to higher numbers of attributed Medicaid and uninsured people, on PPS formation. As a result, lead entities in the PPSs had an incentive to partner with organizations that serve the most Medicaid beneficiaries in the region to maximize attribution and secure the funding needed to achieve demonstration goals. However, the influence of this requirement was only one factor in collaboration.

DSRIP PROGRAM FEATURES: KEY TERMS

Attribution: the method of assigning patients to providers for the purposes of establishing providers' total eligible incentive amount and to measure performance on project milestones.

Valuation: the state-defined method for assigning value to projects based on a set of established criteria. These criteria may take into account the types of projects, the number of Medicaid beneficiaries, the number of performing providers, and the number of milestones associated with the project, among other criteria.

Attribution and valuation will be topics of future DSRIP issue briefs.

What are the implications for the national evaluation of DSRIP?

Collaboration plays a large role in the implementation of DSRIP demonstrations, and the eligibility requirements and incentives the states create to join the program can help or hinder these collaborations. However, the role of collaboration varies within and across DSRIP states and its contribution to the overall effectiveness of DSRIP demonstrations remains unclear.

To measure the effectiveness of DSRIP demonstrations, the national evaluation needs to consider variation in demonstration features across states. State requirements for regional networks are one formalized demonstration feature that can be leveraged when measuring differences in outcomes across DSRIP states. For example, this difference in design could help to shed light on potential differences in outcomes across DSRIP states—both in terms of outcomes achievement as well as in the types of outcomes that appear to be more influenced by regional network requirements. While collaborations are relevant in all states, the regional network requirement explicitly brings together multiple providers to achieve the goals of DSRIP. However, because certain providers or organizations still are underrepresented in these networks, there may be limitations in the evaluation's ability to fully characterize collaborations that are occurring. Thus, the national evaluation will explore the inclusion of this and other demonstration features as key differences in the design and implementation of the various DSRIP demonstrations.

Conclusion

Collaboration among providers plays a critical role in the implementation of DSRIP demonstrations. It is a key characteristic of how these demonstrations function at the state and local levels. As eligibility for DSRIP incentives has extended beyond hospitals to other relevant providers to achieve the goals of system transformation, CMS and states have brought in formal requirements for regional networks. DSRIP eligibility requirements that specify inclusion of a broad range of provider types bring greater complexity and have a dynamic interplay with other demonstration features, such as performance measurement, attribution of beneficiaries, and the flow of incentive funding across participating providers. Thus, understanding the role of collaboration in DSRIP is a fundamental first step in understanding the implementation of DSRIP demonstrations and evaluating their effectiveness.

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 Policy Research, Truven Health Analytics, 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) programs, (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 will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

METHODS AND DATA SOURCES

Between June and July 2015, Mathematica staff conducted semistructured key informant interviews with stakeholders in the five states with the largest DSRIP demonstrations. To understand the role of collaboration in these demonstrations, the team identified stakeholders in the following categories: state administration officials, external evaluators or state contractors, DSRIP providers, and provider associations. Contacts for these interviews were identified through state documentation and public source documents.

The team developed semistructured interview protocols that included questions related to development of collaboration in general, provider eligibility requirements for DSRIP and factors affecting implementation. When developing the protocols, the research team took into account the type of participants to be interviewed, state demonstration special terms and conditions (STCs), and state monitoring reports.

The research team conducted 18 phone interviews with 36 participants across the five states. One team member led each interview, while another recorded the discussion with the participants' permission. Throughout the interview process, the team held debriefing meetings. After each interview, a team member compiled notes. Writers supplemented information from these interviews with state or provider documentation.

References

Centers for Medicare & Medicaid Services and California Health and Human Services Agency. "Special Terms and Conditions, No. 11-W-00193/9, California Bridge to Reform Demonstration." Approval period: November 1, 2010 through October 31, 2015, as amended February 27, 2015.

Centers for Medicare & Medicaid Services and Massachusetts Executive Office of Health and Human Services. "Special Terms and Conditions, No. 11-W-00030/1, MassHealth Medicaid Section 1115 Demonstration." Approval period: December 20, 2011, through June 30, 2014, as amended October 1, 2013.

Centers for Medicare & Medicaid Services and New Jersey Department of Human Services Division of Medical Assistance and Health Services. "Special Terms and Conditions, No. 11-W-00279/2 (Title XIX), New Jersey Comprehensive Waiver Demonstration." Approval period: October 1, 2012, through June 30, 2017; technical corrections approved August 14, 2014.

Centers for Medicare & Medicaid Services and New York State Department of Health. "Special Terms and Conditions, No. 11-W-00114/2, New York Partnership Plan Section 1115 Medicaid Demonstration." Approval period: August 1, 2011, through December 31, 2014, as amended April 14, 2014.

Centers for Medicare & Medicaid Services and Oregon Health Authority. "Special Terms and Conditions, No. 21-W-00013/10 and 11-W-00160/10, Oregon Health Plan." Approval period: July 5, 2012, through June 30, 2017, as amended July 5, 2012.

Centers for Medicare & Medicaid Services and Texas Health and Human Services Commission. "Special Terms and Conditions, No. 11-W-00278/6, Texas Healthcare Transformation and Quality Improvement Program." Approval period: December 12, 2011, through September 30, 2016, as amended February 26, 2015.

Finger Lakes Performing Provider System. "DSRIP PPS Organizational Application." Rochester, NY: Finger Lakes Performing Provider System, December 22, 2014.

Gusmano, M.K. and F.J. Thompson. "An Examination of Medicaid Delivery System Reform Incentive Payment Initiatives Under Way in Six States." *Health Affairs*, vol. 34, no. 7, July 2015, pp. 1162-1169.

New Jersey Department of Health. "NJ DSRIP Learning Collaborative." New Jersey: Myers and Stauffer, May 2015. Available at [https://dsrip.nj.gov/Documents/LC%20Monthly%20Call%20Presentation_LC3_4_May%202015.pdf]. Accessed July 2015.

New Jersey Department of Health. "Webinar 6: Project Partners and Attribution." New Jersey: Myers and Stauffer, September 2014. Available at [http://dsrip.nj.gov/documents/Webinar_6_09-03-2014_Attribution.pdf]. Accessed July 2015.

U.S. Department of Health and Human Services. "About the Ryan White Program." Available at [http://hab.hrsa.gov/abouthab/aboutprogram.html]. Accessed November 2015.

Wachino, Vikki. "CMS Temporary Extension Approval." Letter to Texas Health and Human Services Commission, May 2, 2016. Available at [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-temp-ext-app-05022016.pdf]. Accessed May 31, 2017.

Endnotes

[1] This brief focuses on California's first DSRIP demonstration (implemented between November 2011 and December 2015) and Massachusetts' Delivery System Transformation Initiatives (DSTI) demonstration (implemented between July 2012 and June 2017). In May 2016, CMS approved Texas' request for a temporary extension of its DSRIP demonstration through December 31, 2017.

[2] In an article about DSRIP initiatives in six states, Gusmano and Thompson (2015) described Texas and New York as "regional network" states and drew the same distinction between hospital-focused and regional network states.

[3] Medicaid supplemental payments are payments to providers, usually in a lump sum, that are in addition to regular reimbursement, but are not reimbursement for health care services. There are several types of supplemental payments in use in the states with DSRIP programs. Analysis and characterization of these various approaches to providing supplemental payments to providers were outside of the focus of this brief but may be included in future issue briefs.

[4] By July 1, 2015, New Jersey wanted hospitals to have identified and secured data-sharing agreements with community providers. Although these partnerships are not required for continued participation in the DSRIP program, they are a "desired enhancement" (New Jersey Department of Health 2015). To encourage hospitals to form these partnerships, New Jersey lowered the performance target required to receive DSRIP funds from a standard 10 percentage point gap reduction to 8 percentage point gap reduction, for hospitals successfully securing a community-based or enhanced reporting partner. Reporting partners are included in the model that attributes patients to hospitals for the purposes of performance measurement and are required to collect and report outpatient data. These partnerships must meet the following criteria: (1) the community partner cannot be a hospital-based clinic that bills under the hospital's provider identifier; (2) the partner must be a Medicaid-enrolled clinic, facility, or physician practice that can report outpatient data; (3) the hospital and partner must have a data use agreement by July 2015; and (4) the partner must have at least 1,000 low-income patients. Hospitals are eligible for the same reduction in their performance target if they have an enhanced reporting partner that meets criteria 1 through 3 and does not have an existing relationship with the hospital (New Jersey Department of Health 2014).

[5] Sponsored by the Health Resources and Services Administration, the Ryan White HIV/AIDS Program works with local community-based organizations to provide services to individuals who do not have adequate health care coverage or financial resources to cope with HIV. The majority of program funding goes to primary medical services and social support services, while a smaller portion funds technical assistance, clinical training, and the development of innovative models of care to improve the services provided to this population (U.S. Department of Health and Human Services).

[6] States require provider participation in learning collaboratives, which are intended to be forums for cross-regional collaboration and information exchange, for example about best practices or challenges to implementing improvement projects.