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MEDICAID 1115 DEMONSTRATIONS

Designing Medicaid Delivery System Reform Incentive Payment Demonstrations to Reward Better Performance

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Executive Summary

In the quest to improve care outcomes and manage cost growth, state Medicaid programs are pursuing Delivery System Reform Incentive Payment (DSRIP) demonstrations, operating under federal Medicaid section 1115 waiver authority. States differ in how they structure their DSRIP incentive designs with regard to: which types of providers or accountable entities are eligible; the size of the incentive payments; the way in which total funds are distributed among eligible providers; how different reform activities are valued; and the mix of performance requirements and measures over the course of the demonstration (that is, pay-for-activities, pay-for-reporting, or pay-for-performance).

This brief describes differences in incentive design features of six DSRIP demonstrations and assesses their strengths and limitations in promoting provider participation in delivery system reform and value-based payment (VBP) arrangements. While the effects of DSRIP incentive designs on outcomes are not yet known, this study finds that differences in key design features influence the strength of the incentives for providers to participate in delivery reform projects and their motivation to prepare for or engage in VBP arrangements.

Early DSRIP demonstrations, which tied the majority of funding to infrastructure development and pay-for-reporting, focused on building capacity among safety net providers while introducing them to pay-for-performance. Current DSRIP demonstrations have ramped up performance expectations – particularly for later years of the demonstration periods – and place a portion of state DSRIP funding at risk based on aggregate performance. Several lessons and insights can be drawn from state experiences to date:

- The more complex the financial incentive design, the harder it is for providers to understand the link between their performance and expected earnings, which can dampen the overall strength of the incentives.
- Performance measure targets need to strike a careful balance between being ambitious and achievable, so they do not penalize financially vulnerable safety net providers which face greater challenges than other providers in meeting high performance targets.
- Alignment of financial incentives and performance metrics for DSRIP eligible entities and Medicaid managed care organizations strengthens the impetus for these entities to prepare for and engage in value-based payment and alternative payment models.

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.

- Progress towards reducing the use of high-cost, hospital-based care – a key aim of delivery system reform – may be hindered if most DSRIP funding is allocated to large health systems and hospitals, rather than community-based primary care providers and organizations.

Introduction

Through Medicaid Section 1115 Delivery System Reform Incentive Payment (DSRIP) demonstrations, the Centers for Medicare & Medicaid Services (CMS) and states seek to create incentives to motivate health care providers to engage in delivery system transformation and reward them for improving quality, efficiency, and health outcomes. Early DSRIP demonstrations, which began in 2010, sought to convert the use of Medicaid supplemental funds from direct hospital payments to cover uncompensated care costs to performance-based incentive models that make payments contingent on demonstrating better outcomes for Medicaid beneficiaries, and to some extent, uninsured individuals. More recent DSRIP demonstrations, starting in 2014, focus on promoting delivery system transformation along the care continuum by linking a portion of DSRIP incentive funding to support, and motivate participation in, value-based payment (VBP) and alternative payment models (APMs), which tie payment to quality or other performance metrics. Each state's DSRIP demonstration is designed to address the specific needs of state and local delivery systems and pressing population health issues. However, all DSRIP demonstrations tie DSRIP funding to infrastructure development and capacity building and ultimately to performance on clinical quality, cost, and population health outcomes.

This issue brief is the fourth in a series that focuses on DSRIP implementation topics.[1] The aims of this study are to understand the factors influencing the design of the incentive program in different states, how financial and nonfinancial incentives motivate providers to participate in delivery system transformation and VBP arrangements, implementation successes and challenges, and potential improvements to the design of incentives that can maximize the attainment of program goals. We examine DSRIP demonstrations in six states, spanning 2011 through 2017—California, Massachusetts, New Hampshire, New York, Texas, and Washington. For California and Massachusetts, we examine the previous and current DSRIP demonstrations. DSRIP demonstrations now in progress in Massachusetts, New Hampshire, and Washington are in their first or second years of implementation; thus, the data presented for these states reflect demonstration designs and early implementation experiences. Findings are based on information from three sources: key informant interviews, state demonstration special terms and conditions (STCs) and related attachments, and program documents available on state Medicaid websites (see Methods box).

This brief presents a conceptual framework for DSRIP incentive design, drawing on relevant literature, and describes the similarities and differences across states' DSRIP designs. It then discusses the factors that influence incentive design within and across states and summarizes stakeholder views on the strengths and limitations of DSRIP incentive design features in promoting provider participation and improving outcomes. This brief concludes with lessons from states' experiences to date in implementing incentive designs, synthesizing feedback from key informant interviews, which may be useful to other states planning similar programs.

DSRIP incentive designs in theory and in practice

State DSRIP demonstrations include multiple components that together influence the incentives for providers and managed care organizations (MCOs) to engage in delivery system transformation and payment reform. For the purposes of this brief, we examined:

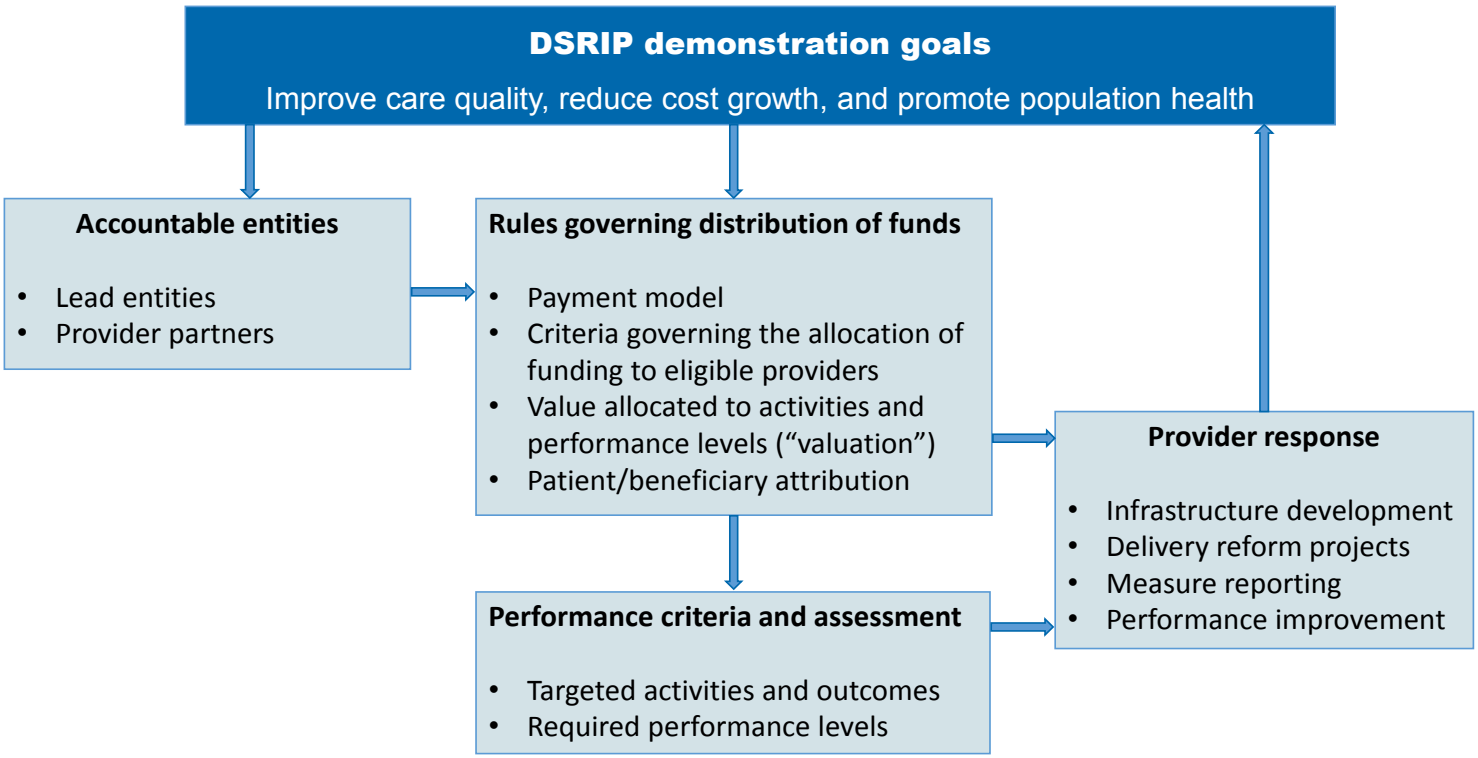
- Eligibility for DSRIP participation and incentive funding
- Financial incentives, including incentive amounts, payment models, the degree of provider risk-sharing, criteria for allocating funding across providers, and valuation of projects and methods
- Performance criteria and assessment, including targeted activities and outcomes and required performance levels
- Intersection between DSRIP and Medicaid managed care payment policy in advancing VBP arrangements

Most DSRIP demonstrations tie incentive funding to infrastructure development, project implementation,[2] measure reporting, and performance outcomes. The Health Care Payment Learning and Action Network (HCP LAN), a multistakeholder collaborative that tracks national progress toward the implementation of APMs, defines four categories of progressively sophisticated payment models, with the first being fee-for-service (FFS). Category 2 models use FFS reimbursement, but have a link to quality and value. More advanced APMs (Categories 3 and 4) tie a portion of provider reimbursement for health care services to performance quality metrics as well as costs, so that providers can share any savings, and in some models, assume financial risk for incurred costs that exceed expected spending.[3] Most DSRIP demonstrations generally fall into Category 2 models in that they tie bonus payments to infrastructure development, implementation of delivery system projects, reporting of outcome measures, and ultimately performance on outcome measures.

Indeed, DSRIP demonstrations share features of other pay-for-performance (P4P) programs, such as the Medicare Value-Based Purchasing Program, and Medicaid accountable care organizations (ACOs).[4] Like these models, all DSRIP demonstrations tie a percentage of DSRIP incentive funding to performance on outcome measures. Further, like ACOs, some DSRIP demonstrations require multiple providers to work together as one entity and hold them jointly accountable for their performance. However, DSRIP demonstrations have several unique features. First, states often ascribe different values or "points" to various projects, implementation milestones, and outcomes, rather than valuing all activities, milestones, or metrics equally. Second, in addition to required projects and metrics, states allow providers to select optional projects and metrics from a menu, giving providers some discretion over which types of reforms to pursue. Third, most states allocate substantial proportions of DSRIP incentive funds to infrastructure and capacity building and project implementation in the initial years of the demonstration periods, rather than directly incentivizing performance outcomes at the outset. Thus, it is important to assess how the incentives unique to DSRIP motivate participation by different types of providers, and provider entities, in delivery system reform and VBP arrangements.

Figure 1 presents a conceptual framework to illustrate the interaction between DSRIP incentive design features, provider responses, and their impact on demonstration goals. The demonstration goals inform whom to target, that is, which entities are **accountable** for using DSRIP incentive funding to support delivery reform activities, and which types of provider partners may (or must) be involved; accountable entities may also be responsible for sharing funds with other partners. States also establish **rules for distributing funds**, which include the payment model, valuation of projects and metrics, beneficiary attribution,[5] and criteria that determine the percentage of total funds that can be allocated to certain providers or provider types. States also determine **criteria for earning funds and assessing performance** against specified milestones and performance levels or targets. These features influence provider responses, including the development of infrastructure needed to support reform, how many and which types of delivery reform projects are implemented, which measures are reported, and the extent and pace of improvement – all of which affect progress in achieving the demonstration goals. As we describe state DSRIP program similarities and differences in these key incentive design features below, we highlight key findings from relevant literature on Medicare and Medicaid P4P programs and Medicaid APMs.[6]

Figure 1. Conceptual framework for DSRIP incentive design



Eligibility for DSRIP participation and incentive funding

Eligible entity. A critical issue in designing effective P4P programs is determining whom to target and establishing accountability for outcomes. For example, certain measures, such as avoidable hospital readmissions, may require shared accountability among multiple providers along the care continuum, while other metrics may be more directly under the control of individual clinicians (Greenwald 2011). Thus, programs need to determine which entities are accountable for achieving program goals and measures and design their programs accordingly (Miller and Marks 2015).

States vary in how they define eligibility requirements for DSRIP participation and receipt of incentive funds. Certain states limit eligibility to **hospitals or health systems**, while others require **regional collaborations** that include multiple providers and organizations within a region that participate in DSRIP under the aegis of a lead organization.[7] For example, New Hampshire and Washington require regional collaborations with representation from specific provider types, such as federally qualified health centers (FQHCs) and primary care physicians, in addition to hospitals and health systems. The goals of the regional collaboration approach are to create shared accountability and promote partnerships across relevant stakeholders. Alternatively, California targets public health systems and district municipal hospitals through its current DSRIP demonstration (called Public Hospital Redesign and Incentives in Medi-Cal, or PRIME), and Massachusetts' first DSRIP demonstration, the Delivery System Transformation Initiatives (DSTI) which ended in June 2017, targeted acute care hospitals.

Regional collaborations take on different organizational forms. Texas' Regional Healthcare Partnerships (RHPs) are regional consortia "anchored" by a lead organization that coordinates activities for performing providers in their regions. However, performing providers are evaluated as individual providers and earn DSRIP financial incentives directly. In other states, the regional collaborations are evaluated as a whole, serve as the accountable entities, and assume some level of fiduciary responsibility for the distribution of incentive funds to partnering providers. For example, New York's Performing Provider Systems' (PPSs') performance is calculated across all participating providers, and PPSs earn incentive funding that is then disbursed among participating providers. Similarly, Integrated Delivery Networks (IDNs) in New Hampshire, Accountable Communities of Health (ACHs) in Washington, and ACOs in Massachusetts are assessed as single entities.

STATES' DSRIP DEMONSTRATIONS GOALS

California's DSRIP, Massachusetts' Delivery System Transformation Initiatives, and Texas' DSRIP demonstration sought to improve quality of care, enhance access, and build capacity among safety net hospitals and, in the case of Texas, other providers. Alternatively, more recent demonstrations emphasize delivery system transformation in the ambulatory setting and along the care continuum. In addition, all states seek to promote provider payment through VBP/APMs through DSRIP or other initiatives.

Eligibility requirements for lead entities within regional collaborations can also vary. Usually one organization (sometimes a hospital) acts as the lead, provides administrative and educational support, and functions as a convener of stakeholders. However, the scope of the lead's role varies across, and sometimes within, states. In Texas, RHPs must be anchored by a public hospital or local governmental entity. In Washington and New York, regional collaboration requirements have resulted in the creation or strengthening of new entities that operate as independent nonprofit entities such as ACHs and PPSs.

Partnering providers. Underlying these regional collaborations are partnerships with providers and organizations that participate in DSRIP. New Hampshire, New York, and Washington include a variety of provider types, including primary care providers, behavioral health providers, and social service agencies. New Hampshire and Washington explicitly require representation from a broad range of providers and organizations. Unique among DSRIP states, Washington also includes tribes, Indian Health Service (IHS) providers, and Urban Indian Health Program (UIHP) providers in their ACHs.[8]

Other eligible entities. Other entities – outside of regional collaborations – may be eligible to participate and earn DSRIP incentive funding. Washington directly makes DSRIP incentive funding available to MCOs to encourage VBP/APM advancement. Washington also allows for tribes, IHS, and UIHP providers to receive funding directly from the state for eligible tribal-specific projects. Massachusetts is making incentive funding available to community partners (CPs) in behavioral health (BH) and long-term services and supports (LTSS) and community service agencies (CSAs) to strengthen their ability to participate in ACOs. Table 1 presents an overview of the entities that are eligible for DSRIP participation and are held accountable for performance.

Table 1. DSRIP participation and performance accountability

States	Demonstrations	Accountable entities	Entities eligible for DSRIP participation and incentive funding
California	DSRIP	• DPHs	• DPHs
	PRIME	• DPHs and DMPHs	• DPHs and DMPHs
Massachusetts	DSTI	• DSTI hospitals	• DSTI hospitals
	DSRIP	• ACOs (including DSTI hospitals) • CPs/CSAs	• ACOs and partnering providers (including DSTI hospitals) • CPs/CSAs
New Hampshire	DSRIP	• IDNs	• IDNs and partnering providers
New York	DSRIP	• PPSs	• PPSs and performing providers
Texas	DSRIP	• RHP anchoring entities • Performing providers	• RHP anchoring entities • Performing providers
Washington	DSRIP	• ACHs • MCOs (if participating separately) • Tribes, IHS, UIHP (if implementing separate projects)	• ACHs and partnering providers • MCOs (if participating separately) • Tribes, IHS, UIHP (if implementing separate projects)

Sources: Mathematica's analysis of states' demonstration special terms and conditions and related attachments

Notes: Accountable entities represent the level at which performance is assessed under DSRIP. In certain states, accountable entities also have a fiduciary role, as they are primarily responsible for determining how much funding should flow to partnering providers.

California's first DSRIP demonstration expired in December 2015, and its new DSRIP demonstration started January 1, 2016.

Massachusetts' DSTI demonstration expired June 30, 2017, and its new DSRIP demonstration started on July 1, 2017.

ACH = accountable community of health
ACO = accountable care organization
CP = community partner
CSA = community service agency
DMPH = district municipal public hospitals
DPH = designated public hospital systems
DSTI = Delivery System Transformation Initiatives
IDN = Integrated Delivery Network
IHS = Indian Health Service
MCO = managed care organization
PRIME = Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
PPS = Performing Provider Systems
RHP = Regional Healthcare Partnerships
UIHP = Urban Indian Health Programs

Funding distribution

A key element of DSRIP incentive design concerns the amount and methods by which funds are distributed to eligible providers. This design element includes several components: (1) the payment model and degree of provider risk sharing; (2) the total amount of incentive funding available; (3) requirements governing the allocation of funding among providers, and (4) the methods for assigning value to DSRIP projects, milestones, and metrics (the targeted activities and achievements).

Payment model and provider risk sharing. DSRIP demonstrations include a specific payment model and potentially some element of provider risk sharing. All DSRIP demonstrations, except Massachusetts' current DSRIP demonstration, make the receipt of funds contingent on carrying out specific activities, pay-for-reporting (P4R), and P4P.

Massachusetts' DSRIP demonstration is using DSRIP funding to support the state's ACO models. The state disburses DSRIP incentive funding for participating ACOs through separate funding streams related to (1) startup and ongoing infrastructure and capacity investments, and (2) the provision of flexible services to address health-related social needs. The state does not tie funding for startup/ongoing primary care investments and health-related social services to performance on cost and quality outcomes. However, a portion of an ACO's funding for state-approved discretionary investments is at-risk based on cost and quality performance.[9]

As providers move along the continuum of APMs, they are expected to assume greater financial risk for the clinical care outcomes of attributed patients (Health Care Payment Learning and Action Network 2017).[10] Under advanced APMs, such as shared savings models with downside risk, providers assume some risks for financial losses for costs in excess of expected costs. However, even under APMs with no downside risk, participation in a P4P program may result in loss of revenue that providers would have otherwise received because funding is tied to performance achievement (Pope 2011). Thus, the incentive payment amount may need to offset not only the

costs of participation but also potential revenue losses (Pope 2011; Christianson et al. 2008). Further, providers may take on "business risk" if they need to make upfront infrastructure investments to participate in the P4P program (Pope 2011). Indeed, a key barrier to participation in APMs among safety net providers is the financial reserves and resources needed to invest in data systems necessary to coordinate care and manage population health (Government Accountability Office 2016; Burns and Bailit 2015; Bailit and Waldman 2016). In general, the uncertainty of whether these investments will be rewarded in terms of the incentive payment creates a perception of risk; the greater the perceived risk, the less likely providers may be to participate (Pope 2011).

All current DSRIP demonstrations included in this study tie some portion of funding to performance, and all six states—except Texas—include performance measures that are assessed on a statewide basis. As required by the demonstrations' special terms and conditions, failure to meet these statewide performance targets, typically starting midway through the five-year demonstration period, leads to reductions in aggregate DSRIP funding, which then affects the total amount available to DSRIP entities. These statewide performance goals aim to create shared accountability for DSRIP performance goals and risk among providers for potential loss of total DSRIP funds. Table 2 presents the percentage of state funding at risk for aggregate performance on select measures. States vary in terms of the percentage of funding that is at risk based on statewide performance – for example, Massachusetts, New York, and Washington all have 20 percent of total DSRIP incentive funds at risk by the fifth demonstration year, while California only has five percent of funding at risk by the end of its demonstration period.

Table 2. Percentage of state funding at risk for aggregate performance on select measures

States	Demonstrations	Percentage of funding at risk based on state performance	Measures included in statewide accountability assessments
California	DSRIP	NA	NA
	PRIME	• DY14: 5% • DY15: 5%	• Percentage of Medicaid beneficiaries for whom providers received payment under a contracted APM
Massachusetts	DSTI	• DY20: 5%	• Aggregate hospital performance on delivery system at-risk Category 4 measures • Demonstration of successful project implementation in Categories 1-3
	DSRIP	• DY22: 5% • DY23: 10% • DY24: 15% • DY25: 20%	• ACO/APM adoption rate • Reduction in state spending growth • ACO quality and utilization
New Hampshire	DSRIP	• DY3: 5% • DY4: 10% • DY5: 15%	• Performance on universal set of 4 quality measures
New York	DSRIP	• DY3: 5% • DY4: 10% • DY5: 15%	• Performance on universal set of delivery system improvement metrics • Composites of project-specific and population-wide quality metrics • Medicaid cost growth containment • Progress toward state VBP/APM goals
Texas	DSRIP	NA	NA
Washington	DSRIP	• DY3: 5% • DY4: 10% • DY5: 15%	• Performance on universal set of project-specific quality metrics • Progress toward state VBP/APM goals

Source: Mathematica's analysis of states' demonstration special terms and conditions and related attachments

Note: States tend to group projects, milestones, and metrics into "categories" or "domains" that designate a set of projects that are focused on similar goals, such as infrastructure development or clinical quality improvement.

No funding is at risk in the demonstration years that are not listed.

California's first DSRIP demonstration expired in December 2015, and its new DSRIP demonstration started January 1, 2016.

ACO = accountable care organization

APM = alternative payment models

DSTI = Delivery System Transformation Initiatives

DY = demonstration year

PRIME = Public Hospital Redesign and Incentives in Medi-Cal

VBP = value-based payment

Total incentive funding available. A foundational component of DSRIP incentive design is the amount of incentive funding available. The total amount of funding available in DSRIP demonstrations reflects several factors, including state negotiations with CMS, historical funding streams that were repurposed for DSRIP, how the nonfederal share of Medicaid funding is financed, the amount of funding needed to stabilize safety net providers, and the amount of funding needed to cover the costs of changing provider practice to participate in DSRIP. The strength of the financial incentives in promoting changes in provider practice in part depends on its relative size vis-à-vis providers' current revenues and is therefore variable at the provider level (Christianson et al. 2008; Eijkenaar 2013). Further, the financial incentives should be sufficiently large to cover the costs of making the necessary changes to participate (Christianson et al. 2008; Pope 2011). In designing their DSRIP demonstrations, some states took such costs into account when calculating the total DSRIP funding amount.

Methods for funding disbursement

States specify various criteria that (a) govern the allocation of incentive funding among accountable entities and performing providers and (b) determine the financial value of DSRIP activities and performance criteria. These criteria are described below. Appendix Table A.1 provides more detail regarding the rules governing the allocation of funding and valuation methods.

Rules governing the allocation of funding among providers. All states attempt to target more funding to entities with higher Medicaid (and sometimes uninsured) patient volumes and/or costs by incorporating this factor in the incentive funding allocation formulas that determine the percentage of total DSRIP funding available to participating providers. For example, California and Massachusetts' DSTI demonstrations specified provider-specific "proportional allotment factors,"[11] which are based on hospitals' Medicaid patient volume, and in the case of California, uninsured patient volume as well. In New Hampshire, New York and Washington, accountable entities with the largest number of attributed Medicaid beneficiaries are eligible for a greater share of total DSRIP funding.[12]

State rules differ, however, regarding the allocation of DSRIP incentive funding to specific types of providers. States in which the accountable entity is a regional collaboration leave the fund flow methodology for distributing funding to participating providers to the discretion of the lead organization, subject to certain limitations. For example, the New York demonstration special terms and conditions set a cap of 5 percent of total PPS funds that can be allocated to providers that do not qualify as safety net providers. Among the states with regional collaborations, Texas requires that 75 percent of each RHP's annual DSRIP funding is allocated to hospitals, while the balance is allocated to nonhospital provider types, which ensures that hospitals receive a minimum share of repurposed supplemental funding.

STATES' APPROACHES TO FINANCING DSRIP DEMONSTRATIONS

Some states finance DSRIP incentive payments using repurposed Medicaid supplemental streams, while others use new funding. California, Massachusetts' DSTI, and Texas redirected prior supplemental funding to fund DSRIP incentive payments. Massachusetts' DSRIP uses a combination of repurposed supplemental and new funding. Alternatively, New Hampshire, New York, and Washington use new sources of funding to finance DSRIP incentive payments, such as Designated State Health Program funding.

Project and milestone/metric valuation. States calculate the value of DSRIP activities and achievements using similar methods. First, they specify the percentage of funding that can be allocated to each DSRIP activity or performance domain in each demonstration year (DY). Second, states assign weights, index scores, or base dollar values to activities, projects, and metrics based on various factors to signal the relative importance of these projects. In assigning these values, states often consider the anticipated benefits of projects to delivery system transformation, the number of beneficiaries of affected, and the intensity of effort required to achieve project milestones or metrics, among other factors. These scores and values are combined with each entity's number or percentage of attributed Medicaid beneficiaries to determine the final maximum valuation or total DSRIP incentive funding that each DSRIP entity is eligible to earn.

Performance assessment

In all DSRIP demonstrations, the receipt of DSRIP funds is contingent on accountable entities' performance relative to specified milestones and metrics, which correspond to delivery system reform goals and objectives. **Milestones** are the activities that providers must complete within a specified timeframe to receive the incentive payment. **Metrics** are quantitative measures with defined numerators and denominators that providers must either report (P4R) or achieve or improve relative to a specified target (P4P) to receive incentive funding. Defining and measuring these types of activities and the mix of these measures that qualify for DSRIP funds determines which delivery system reforms are incentivized, as well as the level and pace of those reforms.

Activity milestones. In the initial year of the DSRIP demonstrations, most states allowed their funds to be used for planning and organizational activities. In California, New Hampshire, New York and Texas, nearly all DSRIP funds could be spent in the initial year on planning and organizational setup, as long as certain milestones, such as submitting community

needs assessments and board member composition, were met. Washington's demonstration sets a cap of 25 percent of DSRIP funds for ACH design activities. Across states, in the first several years of the demonstrations, the majority of funding is also contingent on implementing delivery reform projects and meeting milestones associated with those projects. Projects generally fall into one of three types: (1) infrastructure and workforce development, such as setting up new primary care clinics and hiring community outreach workers; (2) service innovation and redesign, such as integrating primary care and behavioral health services, and (3) population health, such as promoting early prenatal care.

Share of funds tied to performance. In all DSRIP demonstrations, as the demonstrations progress, the share of funding eligible for payout shifts from organizational and project milestones, to P4R, and eventually to P4P (Table II.4). States vary in the amount and pace of DSRIP funding tied to performance on quality and other metrics. For example, by the end of the five-year demonstration period, the share of DSRIP funding tied to performance on metrics rises to 75 percent (Washington), 85 percent (New York), and 98 percent (California). Under DSTI, Massachusetts tied 20 percent of funding to quality performance after three years (not presented). In its new DSRIP demonstration, Massachusetts will withhold up to 50 percent of ACO per member, per month (PMPM) payments for startup and ongoing investments made in approved discretionary areas based on an "accountability score" that assesses cost and quality performance by the fifth year.

Table 3. Percentage of DSRIP incentive funding tied to performance by state and by entity

DY	CA - PRIME	MA - DSRIP (ACO)	MA – DSRIP (CP/CSA)	New Hampshire	New York	Texas	Washington
Total DSRIP incentive funding amount (total computable; in millions)							
1	$1,600	$329	$57	$30	$1,049	$500	$242
2	$1,600	$290	$96	$30	$1,249	$2,300	$241
3	$1,600	$229	$132	$30	$1,698	$2,666	$236
4	$1,440	$152	$134	$30	$1,411	$2,852	$217
5	$1,224	$65	$128	$30	$909	$3,100	$190
Percentage of funding tied to performance by DY							
1	0%	5%[a]	0%[a]	0%	0%	0%	0%
2	60%	15%	5%	0%	15%	0%	0%
3	79%	30%	10%	Up to 25%[b]	45%	0%	25%
4	98%	40%	15%	Up to 100%[b]	65%	50% of allocation to each Category 3 outcome measure[c]	50%
5	98%	50%	20%	Up to 100%[b]	85%	100% of allocation to each Category 3 outcome measure[c]	75%

Source: Mathematica's analysis of state demonstrations' special terms and conditions and related attachments

Notes: Annual DSRIP funding amounts are approximate.

Under DSRIP in California, 20-30 percent of total aggregate DSRIP funding for the 5-year demonstration period within each DPH's plan was allocated to P4P measures in Category 4 (Urgent Improvement in Care).

[a] The state calculates accountability scores to determine the percentage of funds at risk for funding streams subject to withholds based on performance. Note: For ACOs, only discretionary funding is subject to a payment withhold based on performance.

[b] The state classifies Stage 4 APM metrics as performance outcomes; however, they are evaluated on the basis of reporting only. The percentage of funding at risk for performance metrics in Stages 2-4 is 25 percent in DY3 and 100 percent in DYs 4 and 5. The state's STCs do not explicitly indicate the percentage of funding allocated specifically to Stage 4 measures (versus Stages 2 and 3 measures). Thus, the percentage of funding at risk is overstated as it includes Stage 4 APM P4R measures.

[c] In Texas, only metrics in Category 3 (of four categories of projects and/or metrics) are P4P. The percentage at risk of Category 3 payment at risk varies based on performing providers' selections.

ACO = accountable care organization

CY = calendar year

DPH = designated public hospital systems

DY = demonstration year

Type and mix of metrics. Several factors influence which measures are used in P4P programs. To motivate providers to participate, P4P programs should include measures in which current performance scores indicate room for improvement by most providers (Damberg et al. 2014b; Ryan and Damberg 2013). Further, outcome measures should have a clear evidence base and be viewed by providers as being clinically important (Kondo et al. 2016). Process measures should be clearly linked to targeted outcome measures – serving as guideposts to help providers improve on the targeted outcomes – and should measure processes that are within the accountable entities' control (Pope 2011' Kondo et al. 2016). P4P programs should also incentivize a balanced mix of structure, process, and outcome measures (Damberg et al. 2014b). Further, it is important to include a broad set of measures to avoid narrowing providers' focus to a few measures that may affect large numbers of people, while ignoring those that affect fewer people but are large cost drivers (Damberg et al. 2014b). However, a large measure set can diffuse providers' attention across too many areas and create a large reporting burden. Thus, programs need to select a set of measures that allows providers to focus on targeted behaviors and outcomes (Damberg et al. 2014b; Eijkenaar 2013).

For reporting and performance metrics, states typically include some measures from the CMS Core Sets of Adult and Child Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP).[13] Most of the measures in these sets are nationally standardized measures, such as those endorsed by the National Quality Forum, National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set© (HEDIS) measures for assessing health plan performance,[14] and Consumer Assessment of Healthcare Providers and Systems® (CAHPS) experience of care measures, developed by Agency for Healthcare Research and Quality (AHRQ). For example, HEDIS measures include cancer screening rates, control of high blood pressure, and follow-up care after a hospitalization. Utilization rates for hospital admissions, readmissions, and emergency room visits are often included in P4R and P4P measure sets, since one of the major goals of DSRIP demonstrations is to substitute costly hospital-based care with primary and ambulatory care. Potentially avoidable hospitalizations, measured by AHRQ Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI), which may or may not be risk-adjusted, are also frequently included in state DSRIP program measure sets.

The prevalence of mental health and substance use disorders in the Medicaid and uninsured populations has led to a focus in some states, including New Hampshire, on standardized measures that focus on behavioral health (BH). These include such measures as (1) all-cause hospital readmissions for the BH population; (2) standardized assessment to screen for substance use and depression; (3) potentially preventable emergency department visits for the BH population and total population; and (4) initiation of alcohol and other drug dependence treatment within 14 days.

Because most nationally standardized measures are clinically oriented, or not specified for use among Medicaid populations, many states add state-specific "home-grown" metrics, particularly for population health and innovative projects. For example, in California, if standardized metrics are not available, or ad¬equately assess success, a set of "innovative metrics" is used, comprising about 20 percent of PRIME metrics. Examples include evidence of technology-based visits, targeted care coordination for high risk patients, and specialty care consultation.[15] In Washington, population health metrics include the percentage of patients who are homeless or arrested.

When DSRIP-eligible providers, rather than MCOs, are responsible for meeting VBP goals, VBP metrics that measure progress toward VBP/APM adoption may also count towards DSRIP funding requirements. For example, in Massachusetts, eligible hospitals that participated in DSTI were expected to build capacity to participate in APMs by developing data and risk stratification systems. In Massachusetts's new DSRIP demonstration, participating entities earn incentive funds for infrastructure and capacity investments, as well as the provision of health-related social services, to develop ACOs which are paid via APMs.[16] In Washington, ACHs are expected to share financial risk for VBP progress with Medicaid MCOs. In California, by January 2018, all designated public hospital systems (DPHs) must contract with at least one Medicaid managed care plan in their service area through an APM. In addition, 50 percent of the state's Medicaid managed care enrollees assigned (or attributed) to one of the DPHs must receive all or a portion of their care under a contracted APM, which increases to 55 percent by January 2019 and 60 percent by the end of the waiver period in 2020. In 2019 and 2020, 5 percent of the annual statewide allocation PRIME pool amount for all public health care systems will depend on meeting these goals.

Performance targets. Performance targets in incentive programs should be set in relation to program goals and baseline performance, and ideally should encourage providers to improve regardless of where they stand along the performance continuum. Because providers are more responsive to targets that are within reach, programs need to set targets that are viewed as ambitious but still feasible to attain (Ryan et al. 2012; Ryan and Damberg 2013; Eijkenaar 2013; Eijkenaar et al. 2013). One method is rewarding both performance attainment (that is, achievement of a high-performance benchmark) and improvement (that is, performance gains over past performance) (Ryan and Damberg 2013; Damberg et al. 2014a).

In setting the threshold that qualifies for achieving P4P measures, state DSRIP demonstrations generally adopt one of three following benchmarks, to which provider performance levels are

compared. Benchmarks vary depending on whether the measure is established, and therefore has the necessary historical data to calculate a national or state benchmark, or newly created. Table A.2 in the appendix provides more details on the states' performance targets for P4P measures.

1. **A national or statewide mean, or a specified percentile.** California, for example, assesses DPH performance against the 25th and 90th percentiles of the state performance distribution for each measure. In DYs 2-5, DPHs must meet a minimum performance threshold (25th percentile of the established benchmark) to receive funding.

2. **Degree of improvement in the provider's previous performance.** When there are no national or state benchmarks, states often allow eligible providers to receive funds if they meet minimum levels of improvement over a prior year. Texas, for example, requires improvement by 5 percent in DY4 and 10 percent in DY5 for measures for which no national or state benchmarks were available.

3. **Degree of improvement or progress towards a specified performance level.** This benchmarking approach is a hybrid of the first two, commonly known as closing the "gap-to-goal," and requires eligible providers to close, or narrow, the gap from their baseline or annual performance by a certain percentage relative to a specified performance target (for example, a state benchmark) to reach an "achievement value." In California, for example, in addition to performing above the minimum threshold, providers must close the gap between their current performance and the top performance threshold (90th percentile) by at least 10 percent each year to receive funds. Systems that are already at the 90th percentile or above on a metric must maintain that level of performance to receive funding. New York set a minimum 10 percent gap-to-goal closure for each measure to earn funds. Washington set a higher bar—25 percent gap-to-goal closure—but allows providers to earn a portion of the achievement value for making partial progress.

Tying DSRIP incentives to VBP progress

Like DSRIP demonstrations, VBP initiatives and APMs are designed to hold providers accountable for cost and quality outcomes, as well as population health management. As part of Medicaid DSRIP demonstrations, states often set specific goals and requirements for DSRIP providers and/or Medicaid MCOs to participate in VBP and APM arrangements. State policymakers view VBP/APM demonstration goals as the major strategy for sustaining delivery reforms after the demonstrations end. By shifting the source of the payment from the state to Medicaid MCOs, they believe that DSRIP-eligible safety net providers will face continued incentives to transform care delivery in ways that produces better outcomes at lower cost, or reduced rates of cost growth.

All six of the states examined in this study have set VBP or APM goals, although they differ in several respects, including (1) the accountable entity, (2) the VBP targets and APM categories (financial risk levels) that must be achieved by end of demonstration, (3) penalties and enforcement mechanisms, and (4) the services, populations, or types of MCOs that are included or excluded from the VBP/APM goals. In addition, Massachusetts, New York and Washington allocate a portion of DSRIP funds to help providers and/or MCOs prepare for and meet VBP goals and have sought to align concurrent incentives to achieve their VBP goals. For example, New York established the Quality Incentive Program, which administers funding through MCOs to support financially distressed hospitals and reward them for rapid contracting via VBP, to support its DSRIP demonstration.[17]

Accountable entities for VBP/APM progress. Four of the six states – New Hampshire, New York, Texas, and Washington – place primary responsibility with Medicaid MCOs for achieving VBP/APM goals and sometimes specify managed care requirements related to VBP/APM advancement outside of their DSRIP demonstrations. In these states, the requirement is expressed as a percentage of Medicaid payments made by each plan to all contracted providers through VBP/APM arrangements, including safety net providers that receive DSRIP funds. Under California's PRIME demonstration, DPHs are responsible for meeting VBP/APM goals, expressed as the percentage of their attributed patients whose care (in whole or in part) is paid through APMs. Under Massachusetts' DSRIP demonstration, the state is responsible for meeting a statewide ACO/APM adoption rate, defined as the percentage of ACO-eligible members enrolled in or attributed to ACOs or who receive services from providers paid under APM. Although not explicitly part of its DSRIP demonstration, Texas is requiring its MCOs to disburse 25 percent of provider payments through any type of VBP in calendar year 2018, increasing to 50 percent by 2021.[18] Washington will set aside up to 15 percent of DSRIP incentive payments to reward VBP progress among both ACHs and MCOs.

VBP/APM goals and targets. As with the share of DSRIP funds tied to achieving performance targets, states gradually increase the share of Medicaid managed care payments to providers that must made through an APM arrangement, or the services provided to beneficiaries attributed to an ACO or APM. By the fifth year of the demonstration, the target ranges from 50 percent of payments in VBP of any type in New Hampshire to 90 percent in Washington. The share of VBP/APM payments that must be risk-based, that is, those that fall into Categories 3 or 4 of the HCP-LAN framework,[19] are generally lower—by half or more—than the overall VBP/APM target level. For example, the fifth-year goal in New York is that MCO payments to providers through APMs will be 35 percent for Level 2 or higher (corresponding to HCP-LAN category 3B and 4) compared to its overall goal of 80 to 90 percent of all MCO payments. Washington

makes further allowances by counting payments in HCP-LAN Category 3A (shared savings with upside risk only) as risk-based, and specifying the fifth year target as 50 percent of Medicaid payments made at that level or higher.

Key findings regarding DSRIP incentive design in practice

Based on the perspectives and experiences of key informants involved in each state's DSRIP demonstration, and our analysis of program documents, we identified several themes regarding factors that influenced incentive design, whether they facilitate or impede provider participation, and how stakeholders view their potential impact on progress towards delivery reform goals.

Eligibility for DSRIP participation and incentive funding

Some states allow regional accountable entities to decide how to allocate DSRIP funds to community-based providers, while others make such payments directly to community-based providers. However, it is not yet clear whether one model will be more effective in reducing avoidable hospital care and increasing care quality and efficiency. In Massachusetts, one policymaker noted that allocating incentive funding to CPs directly is important "because we believe medical care alone does not lead to better health status, so we are using DSRIP funding to support community-based organizations that are providing care coordination supports to people with behavioral health and long-term services and supports [needs]." Noting that CPs delivering such services must contract with an ACO to receive DSRIP incentive funding, the state representative added, "By using this significant carrot, we created an incentive structure to try to get the ball moving in the direction of further integration."

At the same time, some regional collaborations are using DSRIP funds to forge strong partnerships with community-based providers. As one lead in Washington noted, "because of the DSRIP dollars, all of our FQHCs are now actively involved. I think our engagement with tribal and Native American health partners is significantly more robust than [it was before]...."

Facilitators of provider participation. Even if they are eligible to receive funds, other factors affect providers' decisions to participate in DSRIP, including (1) alignment between DSRIP goals and organizational goals; (2) interest in being at the table to shape the direction of the DSRIP demonstration given its scale; and (3) preexisting relationships. For example, in New Hampshire, a lead provider noted that their organization wanted to participate because it aligned with, and supported, their transformation goals, explaining: "We've been pushing integration since I've been here. … DSRIP began to expand these efforts throughout our community...." Other lead organizations noted that they wanted to participate to "shape the direction" of the DSRIP demonstration. Stakeholder observed that the representation of community-based organizations on governing boards helped to ensure equitable fund flow decisions. In addition, providers who built their regional collaborations on preexisting relationships found that it gave them a head start. For example, some ACHs in Washington and PPSs in New York were able to build accountable entities on historic relationships. As one state policymaker in Washington described, "I feel like we benefited greatly by having a 5-year innovation plan [through the State Innovation Model Award], strong buy-in across sectors and startup activity related to value-based purchasing efforts… which all pre-dates our Medicaid demonstration."

Challenges related to eligibility requirements. While state policymakers and lead entities espoused the benefits of regional collaborations, certain state rules sometimes created challenges. In states that allowed overlapping regions, such as New York, large health systems were motivated to participate in multiple collaborations, increasing resource demands. In addition, the boundaries of the PPSs in New York and RHPs in Texas did not always align with patient care delivery patterns, which made it hard to predict how delivery reform projects would translate into performance metrics and ultimately receipt of incentive funds.

Funding distribution

Size of financial incentives in DSRIP. Overall, providers participating in DSRIP demonstrations view the amount of funds available through DSRIP to be substantial and sufficient to motivate their involvement. In mature demonstrations, providers believed the incentive funding helped safety net providers make critical investments. As one provider in Massachusetts noted, "We used some DSTI funding for ACO development . . . community-based care coordination, and solidified our relationship with community health centers….. [DSTI dollars also] have been helpful in supporting our evolution [to prepare for VBP]." For newer demonstrations, the amount of incentive funding appeared to motivate provider engagement in working towards the goals of DSRIP, but the effects are not yet clear. As one policymaker noted, "The structure of [the demonstration] does create a motivation for these [providers] to meet challenging performance milestones and [gives them] the opportunity to earn in the aggregate more than $3 billion over five years." However, some providers caution that the available incentive funding may be too small relative to the needed changes.

Performance-based payment and the perceptions of risk. Even though most DSRIP demonstrations do not formally involve provider risk sharing, providers say that achieving the targeted outcomes requires considerable changes and effort. Therefore, providers tend to perceive DSRIP payment as being at risk, even though they are not liable for actual losses as they

would be in advanced APMs.[20] As one Texas provider noted, "At the outset of DSRIP, the perceived risks were really about pay for performance and the idea that an organization had to invest in a new program without any insurance that they would achieve metrics and get paid." They perceive a tension between wanting to make the upfront investments to participate in DSRIP and achieve the targeted outcomes, while at the same time relying on the funds to cover the cost of healthcare services to low-income populations. Nonetheless, some providers have accepted the reality of P4P. As one provider in California noted, "…the bottom line is that we need the [DSRIP] money to be able to make improvements in infrastructure, staff, training, and in systems, but we should have the money at risk. Even with earn-backs and over-performance opportunities, we're going to make 90 to 95 percent, maybe, of the metrics. Some are just hard, the bar is set high, and the money is truly at risk, and I think that's fair."

Rules governing the allocation of funding among providers. Stakeholders in California believe that proportional allotment factors were necessary to fairly allocate funding to safety net providers based on the relative size of their Medicaid and uninsured populations. One policymaker noted that it might have been preferable to set up a simpler process, but: "we're talking about significant dollars for these systems and [we did] not want to destabilize [them] by giving them less money [than they received before]." In Texas, stakeholders viewed the higher percentage allocations to hospitals as being fair given that DSRIP repurposed historic hospital supplemental funding streams.

Project and metrics valuation. Overall, valuation methods designed by the states reflect specific goals of the demonstrations. For example, New York deliberately incentivized speed and scale of delivery system transformation activities in its valuation method. However, understanding the merits or drawbacks of states' valuation methods is challenging for stakeholders given the breadth of projects and metrics that are included in DSRIP. In Texas, a key consequence of the state's approach to valuation was that some providers did not place enough value on their work when they valued project milestones and metrics at the start of the demonstration. Small and rural providers were particularly affected by this issue.

Balance of state and regional control over fund flow mechanics. In states that designate regional collaborations as accountable entities, lead organizations set the fund flow methods. Washington and New Hampshire state policymakers viewed their role as establishing network composition requirements and a framework for governance and fund flow. State policymakers recognized the challenge of these discussions and believe that deferring decisions regarding fund flow to the lead organizations and their partnering providers "…forced the networks to have these difficult conversations with one another…" to build the foundation for their collaborative work.

> "That's the nature of this work, trying to balance state ownership and responsibility for the Medicaid program with local direction and needs determined locally. It would be an error to try to infuse ourselves into every one of these programmatic decisions, which need to be owned locally."
>
> –State policymaker

Lead entities indicated that they structure their fund flow methods with particular goals in mind. For example, a lead provider in New Hampshire offered a bonus incentive payment to incentivize primary care providers to participate in its network. In Washington, a lead entity indicated that its ACH planned to focus on equitable payment for equal achievement across small and big providers. In Texas, an RHP anchor indicated that they sought to ensure consistency in valuation among performing providers based on the number of projects they implemented.

However, some providers in states with regional collaborations felt that hospitals often dominate the governing boards and receive a majority of DSRIP funds flowing through them. In addition, one provider representative in New York noted a lack of meaningful engagement of community health centers within some PPSs.

Facilitators of DSRIP incentives. Several factors strengthened DSRIP financial incentives and potentially increase the ability of states to achieve overall DSRIP goals. First, many stakeholders noted the powerful nonfinancial incentives that augmented the financial incentives of DSRIP. In New Hampshire and Washington, stakeholders noted the widespread recognition of impending delivery and payment reforms by payers other than Medicaid as motivating participation. Second, the need to contain Medicaid cost growth is an important motivator. As one Massachusetts provider representative acknowledged, "[If we do not reduce cost growth], Medicaid will have to reduce eligibility, benefits, or payments to us, all of which compromise our ability to take care of people. We saw the writing on the wall, so were concerned about sustainability of Medicaid, and we knew we needed to move away from fee for service." Third, some providers noted the value of the opportunities in their DSRIP demonstrations to earn incentive funding for high performance, which might improve their bottom lines.

Challenges affecting the strength of the financial incentives. A number of factors weaken the perceived strength of DSRIP financial incentives to promote delivery system reform. First, in states that used repurposed supplemental funding streams, safety net hospitals continue to depend on DSRIP funds to support operating costs. As one provider noted, "[DSRIP] dollars really were needed to make up for Medicaid payment deficiencies and uncompensated care, so they went into the hospital operating budget." Second, relying on hospitals

to finance part of the nonfederal share of DSRIP funds effectively reduces the amount of incentive funding they earn for DSRIP achievements. As one provider representative said about the adequacy of incentive funds to support delivery reforms, "The whole concept of 'adequate' is a tough one for us, for lots of reasons, one of which being that we self-finance the program, the nonfederal share comes from [us], so putting up a dollar and getting 50 cents back, you're out 50 cents."

Performance assessment

Mix of activities incentivized through DSRIP. Providers generally view DSRIP milestones as targeting meaningful delivery reform activities. As one IDN lead in New Hampshire noted, "When it comes to clients, we're improving our transitions of care, which is what DSRIP is about. … as we've built these systems, we've seen the benefits." Others believed the projects and outcomes are motivating system-wide change. One California stakeholder thought that the structure of the new PRIME demonstration requires providers to "look across systems to think about how they are integrating their interventions, data analytics capacities, clinical improvement." One ACH lead in Washington echoed this view: "we're trying to move away from thinking of these as [individual] projects." Instead, providers view the activities as building a coordinated system of care.

Length of time to transition to P4P. State officials and provider organizations agree that most hospitals needed a period of time to transition from supplemental payments to a P4P model. This model requires providers to assess their current performance against a set of metrics, develop and implement strategies to improve performance relative to goals and targets, and develop systems to collect data and report measures. In some cases, several years were needed to specify and test new measures and determine the appropriate benchmarks based on statewide averages.

For example, according to a New York policymaker, "We agreed you couldn't just stand up a [new entity] and expect it to be able to perform overnight. So we developed a 6-year timeframe. The first year gave [the entities] time to coalesce, figure out how to govern themselves, conduct a community needs assessment, and bring together an advisory group made up of providers and Medicaid members. Then, they needed to build the capacity to report process-type measures, and eventually move to outcome measures." Many interviewees saw other benefits to requiring providers to report project milestones and process metrics first. While some providers viewed the initial milestones as "check the box" measures and believed that there were too many process measures, it forced them to track their performance and comply with reporting requirements. Others said the milestones and process metrics were necessary prerequisites to P4P measures in later years. For instance, progress in development of a multidisciplinary palliative care team builds the foundation for subsequent metrics that gauge the provision of palliative care for patients with certain diagnoses.

How soon the transition to P4P should occur remains a matter of debate. Several provider representatives pointed to the importance of DSRIP funds to build the infrastructure to support delivery reform, noting that "…some changes take 3 to 5 years to mature" and moving from project activities to system wide metrics tied to P4P takes time – "…more than the state allowed."

Mix of national and state-specific measures. All stakeholders agreed that the selection of nationally standardized or endorsed measures was important to obtain buy-in from providers and to create improvement targets pegged to national or state performance benchmarks. However, the lack of standardized measures for several areas critical to Medicaid, such as complex care management, opioid use, and social determinants of health required states to develop new measures. Such "innovative measures" need to be tested, and in some cases entail a significant reporting burden. As one provider representative noted, "We're always in support of using nationally standardized measures, for example, HEDIS measures, but the state came up with some customized measures, which are more difficult to report." When standardized measures did not exist for certain areas, some states omitted them entirely, making it difficult for providers to demonstrate progress towards delivery system reform goals.

Performance targets. Many interviewees agreed that basing DSRIP fund awards on providers' ability to close the gap from current performance to a goal offers a strong incentive to improve, no matter where they start. Several also believe it is important to reward partial credit for narrowing the gap, especially for measures that are harder to improve, and for providers with fewer resources to make significant progress. As a Washington policymaker noted, the state established the DSRIP performance target at the 90 percentile for most metrics, with the gap to goal fitting underneath it. Partial achievement in the gap-to-goal target incentivizes continuous improvement by all providers, even if they do not hit the 90th percentile, according to the policymaker. Another state policymaker shared the concern that only awarding full achievement of the gap-to-goal target may inadvertently narrow providers' attention to those measures for which full achievement is possible. A provider representative cautioned that "Each hospital has the same goal – reducing readmissions – but they vary in their ability to control what happens in post discharge settings, and in the resources they have to address the full continuum of care. Those are real factors affecting in how much you can actually improve." Another provider noted that some measure targets did not take into account differences in hospital characteristics and patient populations that affect performance.

Facilitators of achieving performance targets. Several factors other than DSRIP incentives have created "tailwinds" increasing the speed with which hospitals or provider entities are able to achieve certain performance targets. For example, even before the start of some states' DSRIP demonstrations, the rate of hospital readmissions was declining due to penalties imposed by the Medicare Hospital Readmissions Reduction Program (Carey and Lin 2016; Zuckerman et al. 2016), increased use of outpatient surgery, and other trends, which helped most providers meet measure targets. In addition, most performance targets were easier to achieve than some had predicted. According to one interviewee in New York: "There was concern that some hospitals would participate for the first 2–3 years, and drop out after that because they couldn't achieve the pay-for-performance targets in later years. However, Year 2 goals were lower on all the measures, so closing the 10 percent gap-to-goal [target] was pretty easy on almost every measure."

If some of the performance targets are relatively easy to achieve, it may be because the bar was intentionally set at what most stakeholders viewed as achievable. For example, New York's demonstration terms and conditions require the state to improve on the majority of delivery system metrics—not all of them. In California, where the measures and targets were set through an iterative process involving the state, CMS and hospitals, the performance measures selected were based on attempting to strike a balance between what was achievable and ambitious performance goals to enhance outpatient care among participating health systems and hospitals. Not every provider is expected to achieve all targets, especially in later years when performance expectations ramp up and closing the gap to goal gets harder.

Challenges to achieving performance targets. Certain measure targets have been difficult to achieve, albeit for different reasons. First, some measures were selected before knowing how providers performed at baseline; when actual performance scores were examined, it became clear that they did not fit well with a "gap-to-goal" achievement standard. For example, the distribution of CAHPS experience of care measures across providers is typically quite small and performance scores are relatively high. When a providers' score is 96 percent and the goal is 98 percent, the difference is negligible. According to one provider representative: "If you're really doing relatively well in a measure, you don't have much more room to improve. We didn't know that five years ago." Another provider noted the regression to the mean problem: "It is not easy to maintain high levels of performance. If you have to close the gap each year, you can't rest on your laurels. Next year you have to do it all over again when there is no "low-hanging fruit."[21]

Second, some states allowed providers to select among dozens or even hundreds of projects, each with their own metrics. Doing so created a large reporting burden, took time away from project activities, and detracted from providers' ability to perform well in a limited number of areas. In some instances, state policymakers were surprised that hospitals selected numerous projects, when they were only required to select a few. However, some providers thought they needed to undertake more projects than required to increase the likelihood of meeting targets that would earn DSRIP funds.

> "[The gap-to-goal performance assessment is] a relatively rigorous methodology for someone like me who is each and every year trying to come up with ways to maintain our current performance and then adding to that. It feels very rigorous."
>
> –California PRIME participant

The third, and most significant challenge to achieving performance measures, is the lack of timely data. Most providers and states do not have data to monitor their progress toward the performance goals—they face challenges in building data systems that give them needed information to manage attributed patients' use of services that affect performance. According to one provider: "We don't have baseline data on the metrics we're going to be measured against to know how far we have to go." Several providers expressed frustration that they did not have information about their patients' use of services other than at their own hospital or clinic. For example, in many states, hospitals must report on readmissions, but rely on the state to provide data on readmissions to all hospitals, regardless of the hospital from which patients were initially discharged. A hospital manager complained, "We didn't receive the first report (with that data) until the beginning of the measurement period, so we couldn't establish a valid baseline and design strategies to address it. If the state or federal government establishes a target, they should do so based on information they already have." In addition, projects that are trying to improve the capacity of primary care practices depend on data from the National Committee for Quality Assurance (NCQA) regarding certification for each level. Small providers are especially disadvantaged if they do not have electronic medical records (EMRs) that capture what they need for DSRIP reporting, and need to collect it manually.

Tying DSRIP incentives to VBP progress

When they initially established five-year goals and targets in VBP "roadmaps" and other planning documents, no state knew the share of total spending, or Medicaid patients, that was paid through VBP or APM models; nor did they know which categories of APM were in use. This finding suggests that states set ambitious goals to drive the pace of reform as quickly as possible, rather than basing them on current or expected trends. For example, New York established its goal of having 80 to 90 percent of managed care payments to providers being through VBP arrangements by March 2020 without having baseline

data. By the time it conducted a baseline survey of MCOs for CY 2015, covering nine months of the first demonstration year, roughly 34 percent of their payments were made through APM models in Levels 1-3,[22] indicating a sizable gap between baseline and the targeted performance level of 80 to 90 percent.

In addition, in many states, DSRIP program staff did not consult with Medicaid managed care program staff, or with Medicaid MCOs when setting VBP targets, deciding which services are covered or excluded, and whether or how much money to distribute to MCOs to support safety net providers. One state Medicaid managed care official said: "The DSRIP staff met with a couple of plans to discuss contract language, clarify outcomes, and clarify how success will be measured, but did not coordinate with us (state managed care staff), and didn't appear to understand implications for actuarial rate setting." In another state, several respondents said it would have been helpful to involve Medicaid MCOs at the beginning of DSRIP to think through partnerships and fund flow methodologies.

At the time of this study, little was known about the effectiveness of setting ambitious VBP targets, progress towards such goals, and whether the goals are likely to be achieved in the specified timeframes. In New York, which was the first state to include VBP goals as part of its DSRIP demonstration, the initial VBP target—10 percent of MCO spending in VBP Level 1 or above by March 2018—is relatively modest. Consequently, the MCO representatives we spoke to believe that next year's target can be easily met. However, the targets increase significantly in 2019 and 2020, and most say these targets will be much more difficult to achieve. If progress does not keep pace with annual targets, penalties will be applied, or the goals may change in response to objections by MCOs and providers.

Facilitators to implementing VBP. Several factors are helping DSRIP providers and MCOs make progress towards VBP contracting goals. First, Medicaid MCOs have already begun to contract with providers of all types, including safety net providers, using VBP/APM arrangements, giving them experience and lessons on how best to do so. Second, the financial benefits of VBP to MCOs are significant because they shift risk off their "balance sheet" onto those of providers. Finally, DSRIP funds are helping to build capacity among financially vulnerable safety net providers to prepare for APM and partner with MCOs.

Challenges to meeting VBP targets. Despite the optimism about pursuing VBP, several stumbling blocks remain to achieving the VBP targets, either statewide or among certain types of providers and services. These include: (1) inability or insufficient experience among many providers to accept and manage the financial risk inherent in higher-level APM categories, particularly small providers, those in rural areas, financially distressed hospitals, and community-based providers of behavioral health services and LTSS; (2) concerns about how cost savings will be shared among the state, MCOs, and providers and how the cost savings will be factored into managed care capitation rates; and (3) mismatches between the VBP goals and the services that are the focus of DSRIP delivery reforms.

Lessons learned from implementing DSRIP incentive designs

DSRIP demonstrations are fostering greater collaboration among providers, and DSRIP financial incentives and performance criteria appear to be driving hospitals and health systems to reform the way they deliver care by expanding access to outpatient services, partnering with community-based providers, and preparing to contract using VBP models. While the extent to which these changes are affecting outcomes remains unknown, it is clear that the pace and types of delivery reforms, and the effects on different types of providers, varies based on how DSRIP incentives are structured. Early DSRIP demonstrations tied the majority of funding to process milestones, including infrastructure development and capacity building, and P4R and did not significantly alter existing financial incentives. However, these demonstrations introduced safety net hospitals to P4P and encouraged collaboration with other providers. Current DSRIP demonstrations have ramped up performance expectations – particularly for later years of the demonstration periods – and place state DSRIP funding at risk based on aggregate performance. Thus, DSRIP policy continues to evolve and the role of DSRIP funding in changing performance expectations has grown. Several lessons and insights can be drawn from states' experiences to date in implementing incentive designs, which may be useful to other states planning similar programs.

Progress towards delivery system goals may be hindered if DSRIP incentives give too much funding and power to large health systems and hospitals. In regional collaboration models, where the majority of DSRIP funding goes to a particular provider type, such as hospitals, other types of providers such as primary care providers and community-based organizations that deliver behavioral health and social services face greater challenges, and weaker incentives, to achieve delivery system goals. While providers need some flexibility to structure their alliances, governance, and fund flow decisions, state policymakers believe it is important to hold the entities jointly accountable for achieving delivery reform performance goals and metrics. Consequently, if DSRIP demonstrations seek to strengthen the role of community-based providers in improving quality, lowering costs and promoting population health, the incentives need to be structured so that hospitals clearly understand the value of partnering with community providers, and for community-based providers to receive adequate funding to participate in meaningful ways. Thus, CMS and the states may consider ways to create more accountability for fund flow to downstream providers.

Incentive program goals and measures need to strike a careful balance between being ambitious and achievable, due in part to the financial vulnerability of safety net providers. In more recent DSRIP demonstrations, state policymakers and CMS have set relatively ambitious performance goals for improving the value of health care delivery under DSRIP. For their part, most providers recognize the imperative to improve their performance on key outcomes and move toward performance-based payment. However, some of the goals and expectations for improvement may be too ambitious, or not achievable in the specified timeframe, if safety net providers remain financially dependent on the Medicaid supplemental funding streams that preceded (and were repurposed for) DSRIP in some states. Stakeholders raised concerns about the financial viability of large health system safety net providers as well as small, community-based providers. Providers with high uninsured patient populations raised doubts about their ability to sustain DSRIP-funded programs after the demonstration ends, due to a lack of funding. In addition, the complex needs of many Medicaid and uninsured people also create challenges in achieving ambitious population health improvement goals as quickly as they would like. Consequently, states could create dedicated funding pools targeted to financially vulnerable providers with specified criteria for eligibility and parameters for how funds could be used.

The more complex the incentive design, the harder it is for providers to understand the link between their performance and expected earnings. Several stakeholders cited the large number of projects and metrics, complex methods of valuation, and complicated mechanics of fund flow, as challenges that make it hard for providers to discern which reforms are most important, and how they will be rewarded for their efforts. It would be helpful to providers if the incentive designs were simpler and easier to understand, by making a direct link between the DSRIP projects eligible for funding and the performance metrics on which providers are judged and to which incentive funding is tied. States should also develop a project menu that is limited to activities with strong evidence regarding their effectiveness in closing the gap between the current and desired performance goals. If states need to reconcile competing priorities and stakeholder interests, they should be transparent about the trade-offs and help providers understand why earnings may not be based entirely on performance.

Alignment of financial incentives and performance metrics for DSRIP eligible entities and Medicaid MCOs strengthens the impetus for providers to reform. State policymakers are intentionally seeking to align DSRIP with Medicaid managed care payment policy, either as part of the DSRIP demonstration or as a complement to it. Among the stakeholders we interviewed, there is widespread agreement that the performance metrics for holding both sets of organizations should be aligned. In Massachusetts' new DSRIP demonstration, the provider entities eligible for DSRIP funds are ACOs, which may be either MCO-administered or vertically integrated with managed care plans, so the providers that become part of the ACOs will, by definition, already be subject to VBP model.

However, in other states, MCOs are concerned that they will be financially penalized for failure to meet VBP/APM contracting goals, while providers do not face the same incentives to meet these goals. Furthermore, although regional DSRIP collaborations in New York and Washington are expected to facilitate VBP/APM participation among partnering providers, they are not accountable for achieving their state accountability goals, which may reduce the priority they give to this area. Consequently, states should consider how the VBP incentives created for each set of actors will interact during the design of such incentives.

Conclusion. Understanding how the design of DSRIP incentive programs varies by state provides important context for the evaluation of the effects on care quality, cost growth, and health outcomes for Medicaid beneficiaries. For example, if outcomes vary across states, it will be useful to know whether certain design features distinguish states with strong outcomes from those with weaker ones. Until the results of a final impact evaluation are available, the findings from this study indicate that differences in how states design DSRIP financial incentives can affect the following: (1) which providers, and how many, participate in delivery reform initiatives; (2) how much money is earned to reward providers for improving performance; (3) which activities and performance metrics qualify for incentive payments, and in turn influence the focus of provider practice changes; and (4) the degree to which DSRIP-eligible providers, and Medicaid managed care plans, are required or motivated to adopt VBP/APM arrangements.

The findings of this study also underscore the significant challenges in designing effective incentive programs for providers treating Medicaid and uninsured patient populations. Historical Medicaid financing strategies continue to affect the perceived value of DSRIP financial incentives and how funds are allocated. Ensuring that the delivery reforms continue and are sustained beyond the demonstration period is also challenging. CMS and the states are trying to create synergies between DSRIP and Medicaid managed care to promote VBP and APMs to sustain such changes. Their success in doing so will be examined in a future study that will take an in-depth look at the intersection between Medicaid managed care and DSRIP demonstrations.

METHODS AND DATA SOURCES

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

Between June and August 2017, Mathematica Policy Research conducted 26 semi-structured telephone interviews with state policymakers, lead provider entities, state provider and health plan associations, and managed care plan representatives in six states: California, Massachusetts, New Hampshire, New York, Texas, and Washington. In California and Massachusetts, which have implemented two rounds of DSRIP demonstrations, we asked questions about both demonstration periods. Interview questions focused on different aspects of incentive design, including eligible entities, incentive amounts and payment models, performance criteria, and the intersection between DSRIP and Medicaid managed care plan payment policy. The team recorded interviews with the respondents' consent, and analyzed themes across states based on a standardized set of topics.

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Endnotes

[1] Previous DSRIP-focused issue briefs addressed (1) coordination and collaboration across providers and care settings; (2) performance measures and the way in which they influence the focus of delivery reforms; and (3) attribution methods used to assign patients to providers and networks accountable for their care.

[2] Most DSRIP demonstrations include projects that include specific activities, and sometimes associated milestones and metrics, addressing clinical care and population health goals.

[3] The HCP-LAN identifies the following categories of provider payment: Category 1 (Fee-for-service [FFS] with no link to quality or payment), Category 2 (Fee-for-service linked to quality and value), Category 3 (APMs built on FFS infrastructure), and Category 4 (Population-Based Payment).

[4] Accountable care organizations (ACOs) are a type of delivery system model that is made up of local groups of providers who are contractually accountable to a payer for the quality and cost of care for defined patient populations.

[5] This brief does not address Medicaid beneficiary attribution, because a prior DSRIP issue brief examined the topic in-depth. See Au et al. 2017.

[6] Drawn largely from a previous literature review: Heeringa et al. "Alternative Payment Models in Medicaid: Findings from a Literature Review and Policy Considerations. Report submitted to the Centers for Medicare & Medicaid Services. Cambridge, MA: Mathematica Policy Research, March 9, 2017.

[7] In the issue brief on coordination and collaboration in DSRIP (see Heeringa et al. 2017), we referred to these models as regional networks, borrowing a term first put forth by Gusmano and Thompson (2015). However, state officials in Washington do not view Accountable Communities of Health as "networks" because the term connotes an attribution scheme for assigning providers (as with managed care plans and ACOs) whereas collaborations are defined exclusively by region. Thus, we use a broader term for the purposes of this brief.

[8] Washington requires ACHs to include representatives from tribes, Indian Health Service providers, or Urban Indian Health Program providers on their boards and either adopt the state's Tribal Collaboration and Communication Policy or develop their own policy, which is agreed to by every tribe and Indian Healthcare Provider in the ACHs' regions.

[9] Examples of discretionary investments include health information technology investments, care coordination/ management investments, and workforce capacity development. ACOs must submit a plan and budget for these investments, and upon state approval of the plan, are subject to a withhold of at-risk payments on the basis of cost and quality performance. In addition to making funding available for ACOs, Massachusetts' DSRIP demonstration makes incentive funding available to Community Partners (CPs) and Community Service Agencies (CSAs) for capacity building, the provision of care coordination services, and the achievement of high levels of performance on certain quality and utilization measures.

[10] Value-based payment (VBP) arrangements tie payment to certain quality, efficiency, and other performance requirements and are intended to promote high-value (rather than high-volume) care. These arrangements can be used with, or a replacement to, fee-for-service (FFS) reimbursement. Alternative payment models (APMs) are payment models are intended to replace FFS reimbursement and tie reimbursement to providers' cost and quality performance, shifting increased risk for population health management to providers (Health Care Payment Learning and Action Network 2017). Thus, APMs are a type of VBP arrangement.

[11] Proportional allotment factors essentially designate the share of DSRIP incentive funding that can be apportioned to each provider based on criteria such as Medicaid patient volume.

[12] These approaches require formal attribution of Medicaid beneficiaries to accountable entities using the states' attribution methodologies. See Au et al. 2017.

[13] A list of measures in these two sets can be found at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html and https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

[14] Although specified for use by health plans, HEDIS measures are often used for other entities such as ACOs or regional provider groups in New York and Texas, using patients attributed to such entities as the measure denominator rather than health plan members.

[15] For example, specialty care consultation measures include specialty care touches, defined as specialty expertise requests managed via non-face-to-face encounters and the referral reply turnaround rate, defined as the percentage of requests for specialty care expertise replied to within four calendar days.

[16] Outside of its DSRIP demonstration, Massachusetts' contracts with all ACOs have both upside and downside risk starting in the first year; the state offers three different models and risk tracks for a total of six options of varying levels of insurance risk and performance risk.

[17] For more information on New York's VBP Quality Incentive Program, see https://www.health.ny.gov/health_care/Medicaid/redesign/dsrip/vbp_initiatives/index.htm.

[18] In Texas, the requirement to increase the share of Medicaid MCO payments made through APMs is not part of the DSRIP demonstration. Instead, starting with FY 2015 contracts, MCOs were required to develop plans to expand VBP contracting with providers, and show a measurable increase in the percent of business (providers, dollars, or other) being incentivized from the previous year (§8.1.7.8.2 of the Uniform Managed Care Contract Terms and Conditions, version 2.22, March 2017). Starting in FY 2018, the contract will formally establish MCO VBP targets. In addition, at least one MCO performance improvement project (PIP) must be conducted in collaboration with other MCOs, dental contractors, or participants in DSRIP projects.

[19] According to the latest HCP-LAN APM Framework: Category 3 includes APMs built on FFS architecture and covers HCP-LAN 3A (APMs with shared savings and upside risk only) and 3B (APMs with shared savings and downside risk). Category 4 includes population-based payment and covers 4A (condition-specific PMPM payments), 4B (comprehensive PMPM payments or global budgets covering all or most services), and 4C (integrated finance and delivery systems operating on global budgets). See also http://hcp-lan.org/workproducts/apm-framework-onepager.pdf.

[20] Although some funding is performance-based, DSRIP provides bonuses or additional payments, outside of Medicaid reimbursement for health care services, and does not hold providers at risk for incurred costs in excess of budgeted costs like advanced APMs do.

[21] "Regression to the mean" is a statistical phenomenon in which a variable that is extreme when first measured tends to be closer to the average by its second measurement.

[22] Level 1: FFS with upside risk only (shared savings); Level 2: FFS with upside and downside risk (shared savings with risk of financial losses due to low quality performance); Level 3: fully capitated payments or prospectively paid bundles.

Table A.1. State criteria for distributing incentive funding

	California	Massachusetts	New Hampshire	New York	Texas	Washington
Rules governing allocation of funding among providers						
Specifies proportional allotments of total funding for participating providers	• State sets proportional allotment factors (DSRIP and PRIME)	• State sets proportional allotment factors (DSTI)[a] • Criteria for allocating funding to DSTI hospitals via the DSTI Glide Path consider hospital-specific circumstances[b] (DSRIP)	• No	• No	• No	• No
Caps percentage of funding that can be allocated to certain types of providers	• No (DSRIP and PRIME)	• State specifies the percentage of funding that ACOs and CPs can receive (59% and 30%, respectively) (DSRIP)[c]	• No	• Funding to nonsafety net providers is capped at 5% of total PPS valuation	• State specifies the following initial but not capped percentages:[d] • 75% of an RHP's annual DSRIP funding to hospitals • 10% to community health centers • 10% to physician practices affiliated with academic centers • 5% to local health departments	• No

(continued)

	California	Massachusetts	New Hampshire	New York	Texas	Washington
Rules governing allocation of funding among providers						
Fund flow methodology	• No (DSRIP and PRIME)	• NA (DSTI) • State specifies uses for each funding sub-stream; ACOs determine funds flow among ACO participants (DSRIP)	• IDNs determine funds flow among partnering providers	• State specifies a 5% cap on funds to nonsafety net providers; otherwise, PPSs determine funds flow among partnering providers	• RHPs oversee initial valuation of projects, milestones, and metrics within their regions based on state allocations and guidelines	• ACHs determine funds flow among (a sole financial executor disburses funding)
Valuation of projects, milestones, and metrics						
Uses provider-specific criteria in valuation	• Not beyond proportional allotment factors (DSRIP and PRIME)	• Not beyond proportional allotment factors (DSTI)[f] • State establishes separate funding streams given provider type (DSRIP)	• State adjusts valuation based on each IDN's share of attributed Medicaid beneficiaries	• State adjusts valuation based on: • Number of Medicaid and uninsured individuals attributed to the PPS • Duration of PPS projects (in months) • Implementation of the "11th project"[e]	• State adjusts each hospital's initial funding amount to account for their role in serving Medicaid and uninsured individuals[f]	• State considers number of attributed Medicaid beneficiaries in determining maximum valuation for each ACH
Allows accountable entities to assign dollar values to projects, milestones, or metrics	• State allowed DPHs to specify value for each project and metric within overall percentage allocations for each category (DSRIP) • No (PRIME)	• No (DSTI) • No (PRIME)	• Not for initial valuation, but state allows adjustments within the fund flow to participating providers	• Not for initial valuation, but state allows adjustments within fund flow to participating providers	• RHPs and performing providers specify project valuation for DYs 2-5 within requirements specified by the state for each DY and category	• Not for initial valuation, but state allows adjustments within fund flow to participating providers

(continued)

	California	Massachusetts	New Hampshire	New York	Texas	Washington
Rules governing allocation of funding among providers						
Assigns values or weights to projects, milestones, or metrics	• No (DSRIP) • State established percentage of PRIME funding that will be allocated to each of three domains in each DY and established a base value for every PRIME metric (PRIME)	• State established uniform base values for projects and metrics (DSTI) • State specified weights for each quality domain for quality measures included in ACO and CP/CSA accountability scores (DSRIP) • State set the relative weight of quality and TCOC components of ACO accountability scores (DSRIP)	• State assigned relative weighting percentages to the state's three project groups; projects within these groups are valued equally	• State assigned project index score and created a project PMPM by multiplying the index score by the state's valuation benchmark[g] • State assigned each PPS application a score based on a total of 100 points • State specified milestone/ metric valuation percentages for each domain and DY	• RHPs specify project valuation within state requirements for each DY and category • State specified that milestones for a project within a given DY will be valued equally for Categories 1, 2, and 4	• State assigned relative weighting percentages to the state's projects

Source: Mathematica's analysis of state demonstrations' special terms and conditions and related attachments

Notes: States tend to use different allocation methods for the first DY than subsequent DYs to allow for planning. This table reflects the methods used in the preponderance of DYs.

[a] Under DSTI, hospitals could elect to have an additional adjustment factor applied to their metric values that accounted for various hospital circumstances, such as differences in patient populations; however, this adjustment factor was budget neutral, meaning it did not increase the total value allocated to hospitals.

[b] The DSTI Glide Path is intended for hospitals that participated in DSTI.

[c] The state is allowed to vary from these initial allocations by no more than 15 percent.

[d] Individual hospitals' initial allocations were determined by weighting three variables assessing the role of the hospital in serving low-income populations: the individual hospital's percent share of Medicaid acute care payments (weighted by 25 percent), percent share of Medicaid supplemental payments (weighted by 25 percent), and percent share of uncompensated care (weighted by 50 percent).

[d] Texas created a three-step allocation process: Pass1 was intended to encourage broad participation among eligible providers within each RHP region; Pass 2 enabled RHPs to access unused funding for new projects. The state specified that 75 percent of Pass 2 funding is allocated to performing providers who participated in Pass 1 and that 25 percent is allocated to potentially eligible performing providers who did not participate in Pass 1 (with the majority of funding being allocated to hospitals). Physician practices that were not affiliated with academic centers can participate in Pass 2. Pass 3 and the three-year projects process enabled RHPs to access further unused funding for new projects. RHPs determined the process within state guidelines.

[e] The state attributed uninsured beneficiaries in defined PPS regions when PPSs elect to implement the 11th project; this attribution increased initial project valuation.

[f] Individual hospitals' allocations were determined by weighting three variables assessing the role of the hospital in serving low-income populations: the individual hospital's percentage of Medicaid acute care payments (weighted by 25 percent), percentage of Medicaid supplemental payments (weighted by 25 percent), and percentage of uncompensated care (weighted by 50 percent).

[g] State specified a statewide valuation benchmark for each project based on its assessment of costs of delivery system reforms.

ACH = Accountable Communities of Health

ACO = accountable care organization

CP = Community Partner

CSA = Community Service Agency

DSTI = Delivery System Transformation Initiatives

DY = demonstration year

IDN = Integrated Delivery Network

PPS = Performing Provider System

PRIME = Public Hospital Redesign and Incentives in Medi-Cal

RHP = Regional Healthcare Partnership

TCOC = total cost of care

Table A.2. Overview of state performance targets

State	Demonstration	Performance targets
California	DSRIP	• DPHs set improvement targets for most Category 4 measures; the state established a HPL and MPL for certain measures and required that improvement targets for DYs 9 and 10 meet or exceed the minimum performance level. For DPHs that elected to participate in Category 5, the state instructed DPHs to tie their performance improvement target for at least four performance measures to national goals or benchmarks as available.
	PRIME	• Established measures: Gap-to-goal reduction of 10% • Newly created measures: state establishes annual improvement targets
Massachusetts	DSTI	• Categories 1-3, targets are set by acute care hospitals • Established measures: Gap-to-goal reductions of 5 to 10% • Newly created measures: Improvement targets of 1 to 2%
	DSRIP	• ACO and CP/CSA quality measures: performance assessed against both attainment targets (which specify a minimum level of performance) and excellence benchmarks (which specify a high performance standard); ACOs and CPs/CSAs are also eligible for points for improvement
New Hampshire		• Established measures: Gap-to-goal reduction of 15% for Stage 2 and 3 performance measures[a] • For newly created measures: TBD
New York		• Gap-to-goal reduction target of 10%

Texas		• Measures with state or national benchmark:
		  • For providers with baseline performance below MPL, meet MPL in DY4 and reduce gap between current-year performance and HPL by 10% in DY5
		  • For providers with baseline performance above MPL[b] close gap between baseline and HPL by 10% in DY4 and 20% in DY5 (where the HPL is the 90th percentile of performance and MPL is the 25th percentile)
		• Measures without a state or national benchmark:
		  • Providers must make 5% and 10% improvement over baseline performance in DY4 and DY5, respectively

Washington		• Established measures: Gap-to-goal reduction by 10% • Newly created measures: Improvement percent targets TBD on a metric-by-metric basis

Source: Mathematica's analysis of state demonstrations' special terms and conditions and related attachments

Notes: For states using gap-to-goal reduction targets, the high performance benchmark is based on the 90th percentile of the performance distribution within the state or nationally, unless otherwise stated.

[a] High performance benchmark is based on the 85th percentile of the performance distribution. Where providers meet or exceed high performance target, they must show 5 percent improvement annually.

[b] The MPL is set at the 25th percentile of the performance distribution.

ACO=accountable care organization

CY=calendar year

DPH=designated public hospital systems

DSTI = Delivery System Transformation Initiatives