



## Delivery System Transformation: Section 1115 Medicaid Waiver Demonstration Projects in California, Massachusetts, and Texas

For more than 40 years, the Centers for Medicare & Medicaid Services (CMS) has used Section 1115 of the Social Security Act to approve “experimental, pilot, or demonstration” projects that increase the flexibility and extend the reach of Medicaid and the Children’s Health Insurance Program (CHIP). These projects give states additional authority to design and improve their program in various ways, such as expanding eligibility; providing additional services; and incentivizing innovation that improves care, increases efficiency, and reduces costs.<sup>1</sup>

As states focus on transforming their delivery systems to prepare for Affordable Care Act (ACA) implementation, demonstration projects provide a platform for applying the Triple Aim—a framework developed by the Institute for Healthcare Improvement

for optimizing health system performance. The Triple Aim focuses on improving the quality of patient care, increasing efficiency and reducing costs, and addressing population health.<sup>2</sup> In recent years, a new trend in Section 1115 waivers has evolved in which states and providers are developing innovative approaches to incentivize fundamental delivery system reform in line with the Triple Aim. And safety net hospital systems in California, Massachusetts, and Texas are leading the way in achieving these goals under their current Section 1115 waivers.

The states have established targeted programs that provide incentive payments to safety net hospitals and health systems that have agreed to undertake intensive delivery system reform. The participating hospitals are required to develop detailed and highly specific plans for such reform and to identify progressive

milestones that must be met to receive funding. The mix of incentives and accountability measures is intended to spur change with lasting benefits for patients, providers, states, and the federal government.

It is important to note the incentive payments are not traditional Medicaid reimbursements for services provided, but instead incentives for delivery system change—which makes them a critical component of the waiver. For example, in California, payments from the delivery system reform incentive pool (DSRIP) are available only to develop activities that support California’s public hospitals in improving quality of care and the health of the patients and families they serve. The program “... shall be foundational, ambitious, sustainable, and directly sensitive to the needs and characteristics of an individual hospital’s population, and the hospital’s particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement.”<sup>3</sup>

DSRIP proposals must be consistent with the hospital’s mission and quality goals as well as CMS’ overarching approach to improving health care, which is consistent with the Triple Aim. In all three states, the incentive programs under the

**TABLE 1 | NAPH Member Hospitals Included in the California DSRIP**

Alameda Health System	San Joaquin General Hospital
Arrowhead Regional Medical Center	San Mateo Medical Center
Contra Costa Regional Medical Center and Health Centers	Santa Clara Valley Medical Center
Kern Medical Center	UC Davis Medical Center
Los Angeles County Department of Health Services*	UC Irvine Medical Center
Natividad Medical Center	UC Los Angeles Hospitals
Riverside County Regional Medical Center	UC San Diego Health System
San Francisco General Hospital	UC San Francisco Medical Center
	Ventura County Medical Center

\* Includes LAC+USC Healthcare Network, Harbor-UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center, and Olive View-UCLA Medical Center

waivers demonstrate the importance of coordinated, but tailored, solutions to build transformation.

This research brief describes the current Section 1115 Medicaid waiver agreements in California, Massachusetts, and Texas and offers some lessons learned about the setup and implementation of these demonstration projects.

## California

On Nov. 2, 2010, California’s Section 1115 Medicaid waiver, called the Bridge to Reform, was approved by the federal government. The waiver—in effect until Oct. 31, 2015—provides core funding for hospital system transformation and the delivery of health services to low-income populations.

### DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

The DSRIP, a central element of California’s waiver, supports both the state’s public hospital systems and some of the University of

California’s (UC’s) hospitals (Table 1) in furthering access, quality, and care coordination for the 2.5 million patients these hospitals serve.

To participate in the DSRIP, each hospital submitted a 5-year plan that was approved by the state and federal government.<sup>4</sup> In accordance with their plan, participating hospital systems are now engaged in systemwide strategies and process improvements relating to hundreds of project milestones in five categories (see Table 2). Plans must address all DSRIP categories and include a minimum number of projects within each category. On average, each hospital is involved in 15 concurrent projects, ranging from implementing and utilizing disease management registries to expanding medical homes and detecting and managing sepsis.<sup>5</sup> Hospitals must also report on their progress to receive DSRIP funding. At the conclusion of the DSRIP’s first year, the hospital systems achieved 100 percent of the milestones identified for that year and, as a result, all were eligible for

**TABLE 2** | California DSRIP Categories

**Category 1: Infrastructure Development**

This category lays the foundation for delivery system transformation through investments in people, places, processes, and technology. Projects include implementing disease management registries, expanding primary care capacity, and increasing primary care workforce training.

**Category 2: Innovation and Redesign**

This category includes piloting, testing, and replicating innovative care models. Many plans contain projects to expand medical homes, integrate physical and behavioral health care, expand chronic care management models, redesign primary care, and improve the patient experience.

**Category 3: Population-Focused Improvement**

By the end of the demonstration, hospitals will be required to report on 21 measures across five domains of health care and public health:

- patient experience
- effectiveness of care coordination (e.g., hospitalization rates for heart failure patients)
- patient safety (category 4 is deemed to meet this domain)
- prevention (e.g., mammogram and childhood obesity rates)
- health outcomes of at-risk populations (e.g., blood sugar and cholesterol levels in patients with diabetes)

**Category 4: Urgent Improvement of Care**

This category requires public hospital systems to significantly improve in targeted quality and patient safety measures that are particularly meaningful to safety net populations and have a strong evidence base. All hospitals are engaged in projects to improve severe sepsis detection and management and increase prevention of central line-associated bloodstream infections. In addition, hospitals must choose to be held accountable for two other measures selected from a list of five.

**Category 5: HIV Transition—Improvements in Infrastructure and Program Design\***

Each plan will include projects and milestones that are designed to improve care delivery to HIV patients, with an emphasis on ensuring efficient coordination of services among providers.

\* Category 5 was added in December 2012.

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100 percent of their first-year (2010–11) federal funding.<sup>6</sup>

**LOW INCOME HEALTH PROGRAM (LIHP)**

Another major component of the Bridge to Reform is the LIHP, a county-based transitional coverage expansion program available to adults ages 19 to 64 who are not eligible for Medi-Cal (California’s Medicaid health care program) and who meet county income and residency requirements. The program is effective from July 2011 through Dec. 31, 2013, at which time enrollees will become eligible for either Medi-Cal or California’s health benefit

exchange under health reform. The LIHP offers medical benefits including hospital and physician care and minimum health services. So far the LIHP has enrolled more than 500,000 low-income adults and assigned them a medical home.

**Massachusetts**

On Dec. 20, 2011, CMS approved Massachusetts’ request to extend its Section 1115 demonstration waiver for a 3-year period, until June 30, 2014. The Massachusetts waiver, titled MassHealth, was implemented in 1997 and has developed over time

**TABLE 3** Massachusetts DSTI Categories

**Category 1: Development of a Fully Integrated Delivery System**

This category includes investments in projects that are the foundation of delivery system change and encompass the concepts of the patient-centered medical home (PCMH) model to increase delivery system efficiency and capacity. Examples include communication systems to improve data exchange with medical home sites and integration of physical and behavioral health care.

**Category 2: Improved Health Outcomes and Quality**

This category includes development, implementation, and expansion of innovative care models that have the potential to make demonstrated improvements in patient experience, cost, and care management. Examples include enterprisewide care management or chronic care management initiatives such as disease management registries.

**Category 3: Ability to Respond to Statewide Transformation to Value-Based Purchasing and to Accept Alternatives to Fee-for-Service Payments**

This category focuses on alternative payment models and enhancing performance improvement and reporting capabilities.

**Category 4: Population-Focused Improvements**

This category evaluates the investments and system changes described in categories 1, 2, and 3 through population-focused objectives. Metrics gauge the impact of delivery system and access reforms on the quality of care delivered and the impact of payment redesign and infrastructure investments to improve cost efficiency, systems of care, and care coordination in community settings.

through amendments and renewals.<sup>7</sup> MassHealth supports Massachusetts' efforts to build integrated systems of care and develop alternative payment models, and it explicitly recognizes the key role safety net hospital systems play in sustaining the success of health reform in the state and in implementing the ACA.

Under the waiver, Massachusetts receives federal support in the form of a safety net care pool (SNCP), which provides matching funds to help cover uncompensated hospital costs. The SNCP also funds Commonwealth Care, a free or low-cost managed care health insurance program for uninsured low- and moderate-income Massachusetts residents.<sup>8</sup> MassHealth's current extension calls for restructuring the SNCP to support delivery system and payment model improvements, including funding

delivery system transformation initiatives (DSTIs).<sup>9</sup>

**DELIVERY SYSTEM TRANSFORMATION INITIATIVES (DSTIs)**

Similar to California's Bridge to Reform, MassHealth allows Massachusetts to provide incentive payments for specific initiatives that advance integrated delivery systems in line with the Triple Aim.<sup>10</sup> Seven safety net hospitals are participating in MassHealth's DSTI program. As described in Table 3, funding for DSTIs is available in four categories, each having an explicit connection to achieving the Triple Aim.

Massachusetts has developed and submitted a master DSTI plan to CMS, which outlines the goals and outcomes the state seeks to achieve through individual hospital projects. Participating hospitals must develop

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new, or significantly enhance existing, health care initiatives. Each hospital has its own specific DSTI plan, which must address all four DSTI categories and include a minimum number of projects within each category. The projects may include a mix of process-oriented and outcome metrics to measure progress in the development and implementation of infrastructure and the impact of the investment, respectively. Eligibility for DSTI payments is based on successfully meeting metrics associated with approved projects and reporting on progress.

MassHealth also requires hospitals to be part of a learning collaborative, whether they join an existing collaborative or form their own. Six of the seven hospitals participating in the DSTI program are working together in the Massachusetts DSTI Learning Collaborative, which is a partnership with NAPH's Transformation Center and is led by NAPH members Boston Medical Center, a 626-bed academic medical center and the largest safety net hospital in New England, and Cambridge Health Alliance, a major public health system. The collaborative provides a forum to share knowledge and best practices in the pursuit of high-quality, integrated, accountable care for all state residents, with a particular focus on minority and low-income populations. Learning sessions allow DSTI hospital leadership and teams to hear from outside experts on key topics related to the DSTI projects and to share their experiences with each other.

## Texas

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In December 2011, the Texas Health and Human Services Commission received approval from CMS for a 5-year Section 1115 waiver demonstration project termed the Transformation and Quality Improvement Program. The waiver aims to achieve the following:

- expand risk-based managed care statewide
- support the development and maintenance of a coordinated care delivery system
- improve outcomes while containing cost growth
- protect and leverage financing to improve and prepare the health care infrastructure to increase access to services
- transition to quality-based payment systems in managed care and in hospital payments
- provide a mechanism for investments in delivery system reform, including improved coordination in the current care system in advance of health care reform<sup>11</sup>

The waiver does not include coverage expansion, but does provide for a significant expansion of the number of Medicaid beneficiaries required to enroll in capitated Medicaid managed care organizations. It also establishes two funding pools—one that will assist providers with uncompensated care costs and another that will fund a DSRIP to promote system transformation.

MassHealth supports Massachusetts' efforts to build integrated systems of care and develop alternative payment models, and it explicitly recognizes the key role safety net hospital systems play in sustaining the success of health reform in the state and in implementing the ACA.

The goal of Texas' DSRIP is to improve care delivery systems and capacity, while emphasizing accountability and transparency.

TABLE 4	Texas DSRIP Categories
<p><b>Category 1: Infrastructure Development</b></p> <p>This category lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen providers' ability to serve populations and continuously improve services by expanding the following:</p> <ul style="list-style-type: none"> <li>■ primary care capacity</li> <li>■ behavioral health care capacity</li> <li>■ specialty care capacity</li> <li>■ clinical and administrative reporting systems that support quality improvement</li> <li>■ primary care workforce training</li> <li>■ reporting and health information technology systems and capabilities</li> </ul>	
<p><b>Category 2: Program Innovation and Redesign</b></p> <p>This category includes piloting, testing, and replicating innovative care models in the following ways:</p> <ul style="list-style-type: none"> <li>■ redesigning primary care</li> <li>■ redesigning behavioral health care</li> <li>■ increasing specialty care access/redesigning referral process</li> <li>■ adopting medical homes</li> <li>■ expanding chronic care management model</li> <li>■ implementing/expanding care transition programs</li> <li>■ implementing real-time hospital acquired infections system</li> </ul>	
<p><b>Category 3: Quality Improvements</b></p> <p>This category's overall objective is to assess the effectiveness of category 1 and 2 interventions using evidence-based and nationally endorsed outcomes measures.</p>	
<p><b>Category 4: Population-Focused Improvements</b></p> <p>This category, which pertains only to hospital participants, incentivizes reporting (as opposed to achieving performance targets) in the following required reporting domains:</p> <ul style="list-style-type: none"> <li>■ potentially preventable admissions</li> <li>■ 30-day readmissions</li> <li>■ potentially preventable complications</li> <li>■ patient-centered health care, including patient satisfaction and medication management</li> <li>■ emergency department</li> <li>■ CMS initial core set of measures for adults and children in Medicaid/CHIP (this is the one optional reporting domain)</li> </ul>	

**DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)**

The goal of Texas' DSRIP is to improve care delivery systems and capacity, while emphasizing accountability and transparency. DSRIP funding is based on new quality improvements in four categories (see Table 4). DSRIP work is conducted through 20 regional health care partnerships (RHPs), which are groups of providers—including hospitals, academic medical centers, mental health and mental retardation facilities, physician groups,

and public health departments—anchored by a public hospital or local governmental entity.<sup>12</sup> Each RHP is responsible for developing a 5-year plan that outlines projects and interventions that support delivery system reforms within the four categories but tailored to the needs of the communities and populations served by the providers in the RHP. The initiatives are chosen based on a community process of planning and needs assessments.<sup>13</sup>

The RHP develops regional assessments, identifies regional

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goals, and sets annual milestones for associated metrics and expected results. The RHP also measures and reports outcomes that serve as the basis for DSRIP payments (though first-year payments are based only on development and submission of the 5-year plan). The anchor facility organizes activities, collaborates with all health care providers and organizations, and ensures ongoing communication. The RHP structure allows for regional solutions to care coordination, leveraging the safety net hospital experience with vulnerable patients and an understanding of local markets.

### Similarities and Differences Among the Three Waivers

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#### SIMILAR DELIVERY SYSTEM IMPROVEMENTS

In each of the three states, the Section 1115 waiver promotes delivery system change and integrated care delivery through initiatives selected to support the Triple Aim. To meet these goals, all three waivers identify categories of improvement specific to each state, but all three also share the following key areas of focus:

- integrated health care delivery, including testing innovation and redesign by developing PCMHs, integrating behavioral and physical health, and building an integrated primary care network
- expanded primary care capacity to provide preventive as well as chronic disease care
- improvement in health care quality, though the selected

conditions or adverse events vary from state to state

- population-focused improvements, including an emphasis on preventive care, at-risk populations, and care coordination

#### PAYMENT VERSUS DELIVERY SYSTEM REFORM

The three waivers are distinct from each other in the features and requirements derived from circumstances unique to each state.

In Massachusetts, in addition to developing more integrated care, hospitals are required to focus on payment reform to prepare for a statewide transition to value-based purchasing. The Massachusetts waiver establishes requirements for the DSTI hospitals to develop risk stratification capabilities and alternative payment models that replace the fee-for-service payment model. In contrast, the California and Texas incentive programs emphasize delivery system reform but not payment reform.

#### PARTICIPATION AND COLLABORATION DIFFERENCES

The waivers differ with regard to the number and type of hospitals participating in the incentive program and how participation is organized at the state level. In California, the 21 participating hospitals are either county-owned or part of the UC system. In Texas, more than 300 private, nonprofit hospitals, some public health departments, and 38 local mental health authorities are participating in the 20 newly formed RHPs, each anchored by a public

TABLE 5	California	Massachusetts	Texas
Demonstration Term	Nov. 1, 2010–Oct. 31, 2015	Dec. 20, 2011–June 30, 2014	Dec. 12, 2011–Sept. 30, 2016
Demonstration Length	5 years	2 years, 6+ months	4 years, 9+ months
CMS Approval of Delivery System Reform Framework*	March 17, 2011	May 21, 2012	Sept. 6, 2012
CMS Action on Hospital/RHP Plans	March 18, 2011	~ June 30, 2012	Pending
Improvement Period	4 years, 7.5 months	2 years	TBD

\*The special terms and conditions for each demonstration required the state to submit and receive approval for an overarching framework for each state's delivery system reform program. In California, this framework is embodied in Attachments P (DSRIP Payment Mechanics) and Q (DSRIP Protocol) to the terms and conditions of the plans. In Massachusetts, the state was required to develop a master DSTI plan. The Texas terms and conditions require the development of an RHP planning protocol and a program funding and mechanics protocol.<sup>16</sup>

hospital or other public entity. In Massachusetts, the DSTI is focused on a core set of seven safety net hospitals (public and private) with a Medicaid and Commonwealth Care payer mix that is, on average, nearly 2.5 times the statewide average for acute care hospitals.<sup>14</sup>

Collaboration among the waiver hospitals is also structured differently in each state. The Massachusetts hospitals are required to join a learning collaborative, with all but one participating in a single collaborative. In Texas, providers participate in both a statewide and regional learning collaborative. In California, the 21 participating hospitals function in large part as a learning collaborative, working with the Safety Net Institute, an affiliate of the California Association of Public Hospitals and Health Systems.

### Lessons Learned

#### INVESTING TIME AND RESOURCES

- Developing the waivers and demonstration projects takes intensive work and negotiation between providers, state Medicaid

agencies, and CMS. Provider participation requires considerable up-front time, capital, and human resource investment.

- Following approval of a waiver, additional resources are needed to implement and fund various delivery system reform and quality improvement activities. For example, one Texas safety net hospital estimated an up-front investment of more than \$2 million just to lay a foundation for some of the transformation work.<sup>15</sup> Considerable resources are also required to manage the RHPs.
- Although not structured as payments for services, the incentive payments replace in whole or in part core funding most of the participating hospitals previously received to support the uncompensated care they provide. Thus, the payments received often do not represent new or additional resources for the hospitals to invest in their improvement work. Many safety net hospitals find it challenging to support their projects with existing funding levels when the return on

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investment may be many years in the future.

- The waivers emphasize data collection and the ability to report on achievement metrics and benchmarks, which often require training and additional resources.

#### **COLLABORATING AND DISSEMINATING**

- Much can be accomplished by collaboration between and coordination with experienced providers. The collaborative networks in each of the states have brought together safety net innovators to share best practices and discuss challenges.
- On a broader level, demonstration participants in California, Massachusetts, and Texas can provide a wealth of information on promising practices for achieving the Triple Aim. Dissemination of their work will be critical in helping safety net hospitals and health systems in other states achieve these goals.

#### **SUCCESSFULLY IMPROVING CARE**

- Safety net providers in California, Massachusetts, and Texas have identified integrating behavioral health and physical health as a successful method of improving care, though it is still being tested.
- The success of many of these projects rests on the hospital's ability to improve and expand primary care—a scarce resource in many communities. Participants note new approaches for delivering primary care or expanding the workforce will have to be

developed to meet project goals.

- These projects' lifespan is somewhat artificially dictated by the regulatory time periods governing demonstration projects, rather than by a realistic assessment of the time necessary to accomplish the reform goals. As a result, some of the programs, particularly in Massachusetts, whose demonstration project is in a renewal period, are subject to short time frames for accomplishing transformation that normally takes many more years to take hold.
- The reform projects undertaken by these hospitals is foundational to larger scale reform of the health care system envisioned in the ACA. Because these hospitals are treating the most vulnerable, challenging, and costly patients, their success will have widespread implications for the entire system. Though laborious and resource-intensive, their efforts are laying the building blocks that are critical to achieving the Triple Aim.

#### **Conclusion**

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Safety net hospital systems in California, Massachusetts, and Texas are engaged in extensive initiatives under Medicaid Section 1115 waivers to improve the quality of patient care, reduce costs, and improve the health of the populations they serve. In each state, these hospitals engaged in intensive negotiations to help set the terms and specifications of the waiver. Despite these challenges, safety net

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hospitals believe strongly in the goals they hope to achieve through the waivers and are uniquely capable of developing tailored solutions to improve care for vulnerable patients.

The waivers promote collaboration and recognize the value of shared learning by helping to establish learning networks and project lists so peer hospitals are likely to be working on similar projects and time lines. However, there is room for flexibility within this shared learning environment, as individual hospital plans are tailored to specific needs and circumstances—though still consistent with the direction set at the federal,

state, or regional level.

Safety net providers do not always have the funds to transform their delivery systems. Waivers offer an innovative mechanism for obtaining seed funding for hospitals willing to be held accountable for their transformation activities. However, transformation is a long and continuous process. The 3 to 5 years covered by the current waivers in California, Massachusetts, and Texas will assist hospitals on their way to system transformation, but continuing efforts will likely be needed to fully transform health care systems.

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## Notes

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1. "An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity," Kaiser Commission on Medicaid and the Uninsured, May 2012.
2. "The IHI Triple Aim," The Institute for Healthcare Improvement, retrieved from <http://www.ihi.org/offering/Initiatives/TripleAim/Pages/default.aspx>.
3. Letter to Toby Douglas, Chief Deputy Director of Health Care Programs in California, from Cindy Mann, JD, Director of the Center for Medicaid and CHIP Services and Deputy Administrator of the Centers for Medicare & Medicaid Services, Dec. 31, 2012.
4. "The Delivery System Reform Incentive Program: Transforming Care Across Public Hospital Systems," California Association of Public Hospitals, June 2011, retrieved from <http://www.caph.org/content/upload/AssetMgmt/PDFs/Incentive%20Brief%20Executive%20Summary%20June%202011.pdf>.
5. Ibid.
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7. "MassHealth Medicaid Section 1115 Demonstration," Centers for Medicare & Medicaid Services, Dec. 14, 2011, retrieved from <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-fs.pdf>.
8. "Commonwealth Care," Community Resources Information, Inc., retrieved from <http://massresources.org/commonwealth-care.html#whatis>.
9. Approval letter from Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, to Judy Ann Bigby, MD, Secretary, Massachusetts Executive Office of Health and Human Services, Dec. 20, 2011.
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11. "Overview of Transformation Waiver," Texas Health and Human Services Commission, retrieved from <http://www.hhsc.state.tx.us/Program-Brief-080411.pdf>.
12. The websites for each of the 20 RHPs are listed on the following website <http://www.hhsc.state.tx.us/1115-docs/Websites.pdf>.
13. Letter to Billy Millwee, State Medicaid Director, from Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, Dec. 12, 2011, retrieved from <http://www.medicare.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/Downloads/TexasHealthcareTransformationQualityImprovementProgramCurrentApprovalDocuments.pdf>.
14. "MassHealth Medicaid Section 1115 Demonstration," Centers for Medicare & Medicaid Services, Dec. 14, 2011, retrieved from <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-fs.pdf>.
15. Call with David Salsberry, Texas RHP 10, March 6, 2013.
16. The protocols of the California Incentive Program and the 5-year plans submitted by the public hospital systems are available on the California State Department of Health Care Services' website, <http://www.dhcs.ca.gov>. The detailed RHP plans are available on the Texas Health and Human Services website at <http://www.hhsc.state.tx.us/1115-Waiver-Overview.shtml>.