

MEDICAID MANAGED CARE AND DSRIP PROGRAMS: CURRENT APPROACHES, FUTURE CONSIDERATIONS

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KEY FINDINGS

- Delivery System Reform Incentive Payment (DSRIP) programs and Medicaid managed care are two policy approaches used in recent years to drive cost savings and efficiencies across state Medicaid programs. At this point, the two have largely not been coordinated.
- The Centers for Medicare & Medicaid Services (CMS) seeks to further align these important approaches to drive delivery system reform.
- Early efforts to integrate DSRIP programs with managed care focused on increasing the sustainability of reforms.
- Approved and pending DSRIP programs are beginning to require shifts of managed care patients into alternative payment models (APMs)—this includes waivers in California, New Hampshire, and New York.
- Managed care pathways might serve as a potential complement—or alternative—to waiver-based delivery system reform.

The Medicaid program continues to evolve in the years after the Affordable Care Act (ACA) was passed, moving in innovative directions to drive down costs while transforming the delivery of care. This brief explores two drivers of current and future innovation—the DSRIP waiver and managed care.

BACKGROUND ON DSRIP PROGRAMS

For more than 40 years, 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 demonstration projects give states additional authority to:

- design and improve their programs;
- demonstrate and evaluate policy approaches, including expanding eligibility; and
- provide additional services or use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Following the implementation of the ACA in 2010, California used the flexibility of Section 1115 to establish the first DSRIP program as a new part of its existing Medicaid

waiver program. Both Texas and Massachusetts followed with similar waiver-based programs shortly thereafter, creating a new trend in health care reform. After six years, 15 states now have active, approved, or proposed DSRIP program waivers, and California has unveiled the next generation of delivery system reform models in its 2015 Section 1115 waiver renewal.

DSRIP programs incentivize systematic changes in care delivery, particularly among essential hospitals, which are the predominant providers of care to Medicaid and uninsured populations. These programs are unique because they offer payments to providers for achieving predetermined milestones in delivery system reform and transformation, rather than using the traditional format of reimbursing providers for units of services provided to Medicaid beneficiaries. Through a DSRIP program, providers are not paid if they do not successfully achieve the transformational milestones.

All Medicaid waivers require a review process and approval from CMS prior to implementation and must be budget-neutral for federal spending. As part of the approval process, states must submit a comprehensive description of the goals and objectives of the waiver, as well as details on

the finance, oversight, and projected outcomes of the waiver.¹ The timeline for submission and approval of waivers varies on a case-by-case basis, ranging from several months to more than a year. Waivers have generally been approved by CMS for a five-year period, and more recently for three-year periods

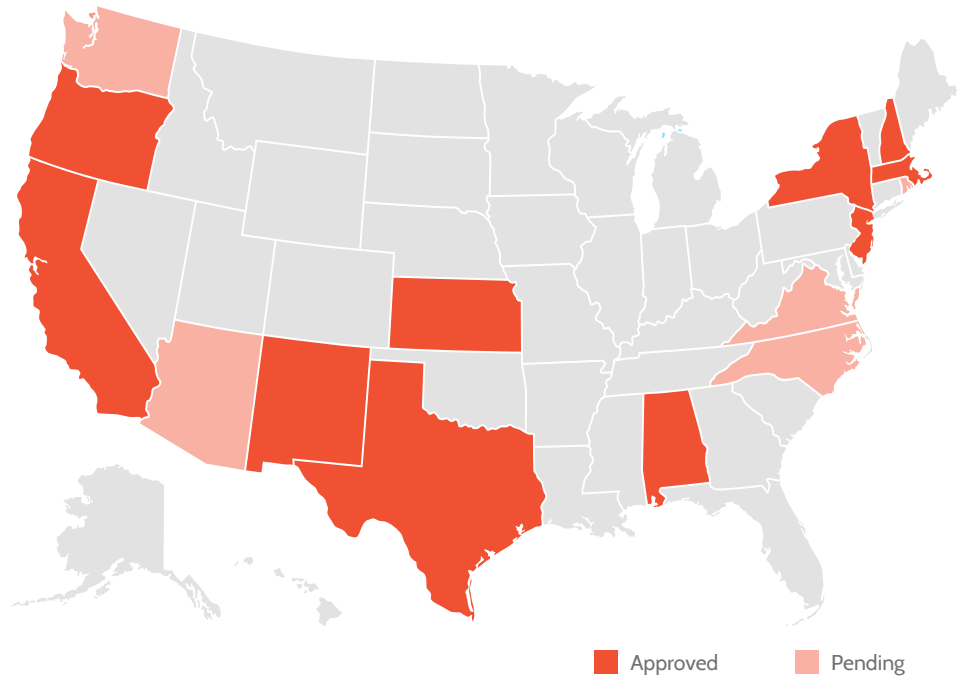
Reforms carried out through DSRIP programs reflect CMS' changing expectations and priorities for the Medicaid program. The system reforms they promote show an increased emphasis on care delivery and population-based health improvement, as well as methods to sustain changes once DSRIP programs expire.

BACKGROUND ON MEDICAID MANAGED CARE

Medicaid managed care is an alternative to the traditional fee-for-service (FFS) payment model. In the FFS delivery system, providers are paid a predetermined amount for each unit of service provided to a patient. Therefore, the total amount of reimbursement is determined by the quantity of services delivered. Medicaid reimbursement rates tend to be significantly lower than those of private insurers and Medicare. Because of this, states have provided supplemental payments to FFS providers in addition to Medicaid base payments. These payments are critical to the ability of essential hospitals to serve their multiple missions, including providing care for the most vulnerable populations.

Under Medicaid managed care programs, states contract with managed care organizations (MCOs) to take on the risk of providing Medicaid services to a defined population of beneficiaries through a provider network developed by the

STATES WITH APPROVED AND PENDING DSRIPS



Source: Internal analysis of Medicaid.gov Demonstrations & Waivers.

MCO. The move to managed care is intended to control costs of care, while increasing the predictability of costs and improving system efficiency. The most common Medicaid managed care model is comprehensive risk-based managed care, under which MCOs accept capitated—or fixed per-member per-month—rates to provide services for enrollees. MCOs then contract with providers to pay a negotiated rate for individual services.² Managed care has expanded rapidly, with nearly 80 percent of Medicaid beneficiaries covered under some form of managed care, including about 60 percent enrolled in comprehensive managed care.³

CMS recently finalized the first significant overhaul of the regulations governing Medicaid managed care programs in more

than a decade. Among its many provisions, CMS views the new rules as “promot[ing] the quality of care and strengthen[ing] efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries.”⁴ In particular, the rule creates the authority for states to mandate that plans participate in delivery system reform or performance improvement initiatives,⁵ and maintains existing authority for states to create programs through which MCOs can earn incentive payments.⁶

PARALLEL TRACKS: DELIVERY SYSTEM REFORM THROUGH DSRIP AND MEDICAID MANAGED CARE PROGRAMS

Many states were establishing DSRIP programs while simultaneously

shifting their Medicaid populations from a traditional FFS structure to managed care systems. These seismic changes often caused instability in provider reimbursement and the creation of two separate vehicles to support provider-based reform. At present, in most states, there is little formal overlap between DSRIP and Medicaid managed care-based reform efforts.

One important distinction between DSRIP reforms and those implemented through managed care is the way funds flow to providers to implement transformation. Under DSRIP programs, the state Medicaid agency distributes incentive payments directly to providers or organizations of providers who are implementing reforms. Under managed care, state Medicaid funds are filtered through MCOs before reaching providers.

DSRIP and managed care programs also differ in who controls the system changes. In DSRIP programs, providers have some flexibility in how they improve care delivery. Whereas managed care-based organizations maintain their role in the implementation, evaluation, and other areas of system reform efforts—even when the reform efforts are state-mandated.⁷

Increasingly, CMS is encouraging states to look at all potential tools to drive change in reimbursement and delivery and to align efforts across providers and payers. At this moment—as managed care continues its rapid expansion and more states opt for DSRIP programs as a way to innovate—it is particularly crucial to consider how these two policy approaches can be used to strengthen each other.

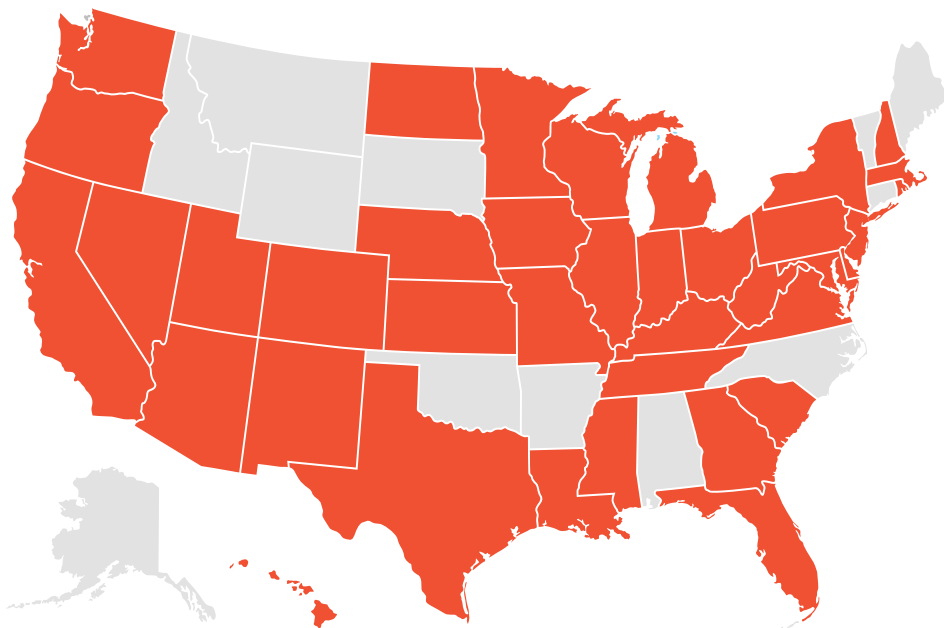
EMERGING INTERSECTION OF DSRIP PROGRAMS AND MEDICAID MANAGED CARE, AND POTENTIAL MODELS FOR FUTURE INTEGRATION

Despite a lack of formal overlap between the two, DSRIP programs and managed care-based efforts share similar goals of affecting care delivery within the Medicaid program.

DSRIP programs are likely to benefit managed care plans in which enrollees receive services from DSRIP-participating providers. Many DSRIP programs actively target the way care is accessed by updating processes and delivery system infrastructure. The reforms they implement are intended to slow the rate of spending growth and increase accountability within the health care delivery system. To the extent that these efforts increase efficiency and improve quality, MCOs might benefit from the lower costs of providing care and improved performance. Given this synergy, CMS and states are expressing an interest in incorporating MCOs into DSRIP program work.

CMS has emphasized that DSRIPs are intended to be time-limited programs that transition into sustainable long-term system reforms. As such, states are looking for alternative reimbursement policies—particularly in conjunction with managed care plans—as a potential way of achieving funding sustainability after the DSRIP term expires. For example, several states now require that a specific percentage of managed care payments be made through APMs by the end of their waiver period (see box on next page for more information).⁸ Other policy models could include mandating that managed care plans participate in DSRIP-eligible entities, making them eligible to receive portions of the incentive payments.

STATES WITH MCO CONTRACTS



Source: Kaiser Family Foundation

States also might consider paying DSRIP funds through managed care plans rather than directly to providers.

CONTINUED ADVANCEMENT OF MCOs

CMS' recent Medicaid managed care rule includes provisions to encourage states to use MCOs as a vehicle to achieve delivery system and payment reforms.

Under the rule, CMS prohibited states from directing plans to make certain payments to some providers in their managed care contracts, with some important new exceptions.⁹ States can require MCOs to make directed payments to providers to participate in delivery system reform and performance improvement initiatives—which might resemble DSRIPs—as well as to implement value-based purchasing models.¹⁰ It is important to note that these programs come with a number of conditions attached, including financial restrictions and no option for states to automatically renew. Additional guidance from CMS is expected on a number of outstanding questions in this area.

In addition, states can create incentive payment programs for MCOs that can be aligned with efforts by their network providers—either under waiver-based DSRIP programs, or as separate initiatives with the MCOs. This flexibility not only creates opportunities for alignment between DSRIP and managed care efforts, but also creates an alternative pathway for delivery system reform in states that might not be able or willing to develop a DSRIP waiver-based program.

Moving forward, it is clear that managed care and DSRIP programs will continue to be two important policy approaches for driving health system change within states. The

improvements achieved through DSRIP programs might benefit MCOs, while the simultaneous expansion of managed care provides opportunities to sustain and enhance these improvements. This relationship

is likely to continue as early DSRIP states begin their waiver renewal process and as new states decide that DSRIPs are a useful tool for improving their Medicaid programs.

Leveraging APMs for Sustainable Reforms

Several states have set goals as part of their DSRIP waivers to cover a percentage of Medicaid managed care enrollees through APMs. Many APMs facilitate care integration to improve patient care while controlling costs through the use of accountable care organizations and health homes.¹¹ CMS continues to encourage the transition to APMs as a way of moving the health care system “from volume to value.”¹²

California

As part of California's Public Hospital Redesign and Incentives in Medi-Cal (PRIME) waiver, Medicaid beneficiaries must gradually be shifted to APMs by the end of the waiver term.¹³ When the term ends in January 2020, 60 percent of beneficiaries must be covered by APMs.¹⁴ California stakeholders are in the process of determining the most effective types of APMs for enrollees of its Medi-Cal managed care program.¹⁵

New Hampshire

New Hampshire's DSRIP waiver requires the state to submit a roadmap to sustainability to CMS by July 1, 2017. As part of the plan, the state must specify strategies to meet its goal of covering 50 percent of managed care beneficiaries under APMs.¹⁶

New York

One of the primary goals of New York's waiver is to ensure the sustainability of its delivery system reforms. Ultimately, 90 percent of managed care payments made in the state must go to providers using value-based methodologies. New York is also the first state that is at risk of losing funding if it does not meet its goals, including further integrating its DSRIP program into managed care.¹⁷

Notes

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4. CMS, Medicaid Managed Care Final Rule, 81 Fed. Reg. 27498 (May 6, 2016).
5. 42 CFR 438.6(c)(ii).
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