The Politics and Policy of Health Reform

Supporting Transformation through Delivery System Reform Incentive Payment Programs: Lessons from New York State

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Abstract The New York Delivery System Reform Incentive Payment (DSRIP) waiver was viewed as a prototype for Medicaid and safety net redesign waivers in the Affordable Care Act (ACA) era. After the insurance expansions of the ACA were implemented, it was apparent that accountability, value, and quality improvement would be priorities in future waivers in many states. Despite New York's distinct provider relationships, previous coverage expansions, and local and state politics, it is important to understand the key characteristics of the waiver so that other states can learn how to better incorporate value-based arrangements into future waivers or attempts to limit spending under proposed Medicaid per-capita caps or block grants. In this article, we examine the New York DSRIP waiver by drawing on its design, early experiences, and evolution to inform recommendations for the future renewal, implementation, and expansion of redesigned or transformational Medicaid waivers.

Keywords Delivery System Reform Incentive Payment, DSRIP, New York, Affordable Care Act, ACA

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Few initiatives have been implemented that aim to reform state Medicaid programs consistent with the cornerstone provisions of the Affordable Care Act (ACA) that emphasize improving access through insurance expansion, reducing spending growth, and improving quality in the Medicare program. The Center for Medicare and Medicaid Innovation has focused much of its work on aligning incentives for value through Medicare payment or delivery reform, with a few notable exceptions focused on Medicaid or multiple payers. The State Innovation Models (SIM) initiative offered by the Center for Medicare and Medicaid Innovation is an example of such an effort. However, initiatives such as SIM may not be sustainable for states given that funding is time limited, the approach varies substantially across states, and the programs are not specifically targeted to the Medicaid population. Moreover, despite the adoption of the Triple Aim by the Centers for Medicare and Medicaid Services (CMS), state Medicaid programs are often hindered by substantial barriers to improving population health, reducing the per-capita cost of care, and improving the experience of care (Berwick, Nolan, and Whittington, 2008). Such barriers include state budget constraints, low provider reimbursement, limits on federal matching funds, and the widespread use of private Medicaid managed care plans to deliver services absent the right financial incentives for providers. These barriers and constraints, coupled with state politics, policy, and flexibility, often lead to significant variations in program operations, financing, and benefits at the state level (Thompson, Cantor, and Farnham 2016).

These barriers are compounded by the lack of coverage for services that enable providers and patients to develop robust treatment plans in the face of socioeconomic disparities and social determinants of health. There are well over 70 million (22 percent) US residents with some level of Medicaid coverage, and as Medicaid expansion reaches more low-income people, it will become a dominant source of reimbursement for hospitals, physicians, and other providers (Paradise 2015). Thus, if CMS wants to align Medicaid programs with the Triple Aim, it will be important to expand the role of existing Medicaid innovation programs beyond the SIM initiative to those that have proven successful in facilitating improvements in the health care safety net, enabling services that support the navigation of behavioral, social, and economic barriers and aligning payment mechanisms and cost pressures due to possible entitlement reform with improved health outcomes.

One mechanism for aligning incentives in state Medicaid programs with the CMS Triple Aim is the Section 1115 Medicaid demonstration waiver. Recently, these waivers have been used to improve care delivery and align

quality and cost in Medicaid programs. Existing Delivery System Reform Incentive Payment (DSRIP) waivers provide an important example and blueprint for customized attempts at improvement and innovation in Medicaid that can be used as components of Section 1115 waivers. Prior research supports this idea and has shown that current DSRIP waivers vary substantially across states but have the common goal of linking performance to Medicaid payment and supplemental federal funding (Gusmano and Thompson 2015). In this article, we examine the New York DSRIP waiver, the first—and one of the most expensive—waivers designed after the main components of the ACA were implemented. We draw on the design, early experiences, and evolution of the DSRIP model in New York to inform recommendations for the future renewal, implementation, and expansion of DSRIP waivers or use of transformational models to control costs in other states.

Growing Nationwide Interest in DSRIP Waivers

DSRIP programs emerged over the last decade as a mechanism to provide supplemental funding for safety net providers (mainly acute care hospitals) caring for low-income, vulnerable populations (CMS 2015). Since the earliest program was approved and implemented in California in 2010, DSRIP programs have evolved in scope and scale. Subsequent waivers were approved and implemented in Texas and Massachusetts in 2011 and focused less on acute hospital care and more on the delivery of integrated health care services across multiple settings, albeit maintaining a particular focus on safety net providers. In the years that followed, several other states (e.g., New York) approved and implemented DSRIP waivers. However, these states shifted the emphasis of their waivers toward more comprehensive payment and delivery system reforms (Gates, Rudowitz, and Guyer 2014). Moreover, the newest waivers have transformational aspects and contain design components that go well beyond solely maximizing coverage expansion. Today, eight states operate DSRIP programs: California, Texas, Massachusetts, New Hampshire, New Jersey, New Mexico, Kansas, and New York.[1] Slightly over $33 billion is available in total DSRIP funding across the various waivers and waiver periods in all eight states. In September 2016, Washington received CMS approval for its DSRIP program, while Virginia is currently pursuing a DSRIP program of its own. Although President Trump promised Medicaid block grants

1. California is now operating a successor to their original program, the PRIME (Public Hospital Redesign and Incentives in Medi-Cal) program.

during his campaign, it is likely that use of demonstration waivers by states will continue, even if Medicaid funding formulas are changed to a block grant or per-capita spending cap approach, as previously proposed by Republican congressional leadership. However, it is possible that demonstration waiver funds or supplemental payments for Medicaid would not be included in the base spending projection to calculate block grant or per-capita allotment amounts (US House of Representatives GOP Task Force 2016; American Health Care Act, H.R. 1628 [2017]) in future reform efforts. Despite uncertainty in the approach, Republicans continued to suggest that reducing federal liability for the Medicaid program by shifting budget risk to states, while granting more flexibility to states in operating their Medicaid programs, is a key goal in their health care reform effort. President Trump's inauguration day "Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal" signals the intention for desired flexibility to the Department of Health and Human Services and CMS in granting waivers and making exceptions for state Medicaid agencies (CNN 2017). This stated flexibility encouraged Indiana, Arizona, Kentucky, and Pennsylvania to apply for federal waivers to add work requirements to their Medicaid programs (Ku and Brantley 2017). Recent reports suggest that the Trump administration will seek ways to expedite waiver renewal decisions and to establish time limits for new waiver application review and approval (*Inside Health Policy* 2017).

State interest in DSRIP waivers continues for three primary reasons:

- To replace outdated supplemental payment models with performance-based incentives for hospitals, providers, and health plans to improve care for Medicaid and uninsured beneficiaries
- To begin to narrow, and further integrate, the network of providers caring for Medicaid beneficiaries to those with the demonstrated skill, ability, and volume to maximize patient and financial outcomes
- To incentivize the formation of large, technologically integrated provider networks (through the use of such innovations as health information exchanges, which identify and account for patient use patterns and incentivize cooperation among medical, specialty, behavioral health, and other service providers)

The Case of New York

The New York DSRIP program is the core component of a significant Medicaid redesign initiative that started in January 2011 and ended in April

2014 when the final redesign plan and Section 1115 waiver were enacted (NYSDOH 2014a). Its formation began when Governor Cuomo assembled a group of stakeholders representing organized labor, advocacy groups, the Greater New York Hospital Association, hospital leadership, the legislature, and state agencies to obtain input and provide guidance in renewing their existing Section 1115 demonstration waiver (NYSDOH 2011). The Medicaid Redesign Team (MRT) held public meetings and solicited ideas via web surveys so citizens could provide ideas and suggestions for stakeholder representatives to consider for the final MRT report and waiver. The MRT plan was rolled out in two phases. The first phase instituted a Medicaid global spending cap (allowing for a 4 percent increase each year) in the state and developed recommendations for redesigning and restructuring Medicaid (NYSDOH 2012). The second phase involved monitoring and implementing the recommendations enacted in the first phase, as well as addressing more complex issues that were left unanswered. In this phase, eleven work groups with a diverse collection of 175 total members were created to develop the final recommendations that are introduced in the final report and action plan (NYSDOH 2015a). In 2012, a waiver amendment was necessary to fully implement the intended action plan. The overall DSRIP concept was not unique to the New York MRT plan; other states (including Texas, Pennsylvania, and New Jersey) have similar programs with the same Triple Aim of better care for individuals, better population health, and lower cost through improvement and innovation. However, it is noteworthy that the multiyear MRT process, extensive stakeholder involvement on the MRT, and numerous work groups appear unique to New York. This design process likely contributed to the integrated components of the waiver that we see in its current implementation, including the required coordination with managed care plans through enrollee attribution and the content of the DSRIP projects undertaken by each performing provider system (PPS) aligning with the stakeholder and public feedback.

Table 1 summarizes the key characteristics of the New York DSRIP program. The five-year demonstration program began on April 1, 2015, and ends on March 31, 2020. In total, more than sixty-four thousand community partners are involved. To manage this extraordinarily large, diverse group of partners, New York has segmented the state into twenty-five regions called performing provider systems (PPSs). Each PPS is led by at least one organization from within the region that has administrative and authoritative responsibility. Each PPS varies in attribution size and has different potential maximum total award dollars. For example, the

Table 1 Characteristics of the New York Delivery System Reform Incentive Payment Program

Characteristic	Description
Participants	64,099 providers comprising hospitals, physicians, medical groups, clinics, mental health and public health agencies, health/home care management agencies, community based organizations, behavioral health and substance abuse organizations, skilled nursing facilities/nursing homes, hospice, pharmacies, and other organizations not fitting into these categories
Organizational/ administrative structure	25 performing provider systems (PPS) led by (an) organization(s) with administration and authoritative responsibility
Focus areas[a]	■ Overall project progress (domain 1) ■ System transformation (domain 2) ■ Clinical improvement processes (domain 3) ■ Population-wide improvements based on New York's prevention agenda (domain 4)
DSRIP funds available	$8.25 billion
Managed care integration	Yes, continues use of managed care in Medicaid program and attributed members to DSRIP programs
Time period/ demonstration years[b]	DSRIP year 0: 4/14/14–3/31/15 DSRIP year 1: 4/1/15–3/31/16 DSRIP year 2: 4/1/16–3/31/17 DSRIP year 3: 4/1/17–3/31/18 DSRIP year 4: 4/1/18–3/31/19 DSRIP year 5: 4/1/19–3/31/20
Required assessment of community needs	Yes, done prior to PPS proposals and designed to incorporate needs into planning and PPS creation
Required participation in learning collaboratives	Yes, facilitated by New York State Department of Health to encourage learning across PPSs
Partners and sources of technical assistance	KPMG, Greater New York Hospital Association, New York Department of Health
Supplemental payment sources	Designated state hospital program

Sources: Schoenberg, Miller, and Chau 2013; Gates, Rudowitz, and Guyer 2014; Schoenberg et al. 2015; Bachrach et al. 2016

Notes: New York's total for federal and state funds has been updated based on changes in DSRIP valuation reported after the publication of the report by the National Academy for State Health Policy report prepared for the Medicaid and CHIP Payment Access Commission (Schoenberg et al. 2015), which had the most current information available on DSRIP funding from state and federal sources as of March 2015.

[a]The various areas for improvement in different state DSRIP programs are structured as categories or domains, depending on the state. In some cases, categories/domains represent a specific set of activities chosen by the DSRIP programs as "projects" or a broader condition of participation required by the CMS. For example, domain 1 in the New York DSRIP relates to overall aggregate project progress by each participating network (i.e., PPS), while category 1 in California focuses on projects under the goal of developing infrastructure at each hospital site.

[b]DSRIP year 0 was for PPS planning, assessment, and project development.

New York City Health and Hospitals Corporation PPS has the largest attribution for valuation of 2,760,602 people and the largest valuation of more than $1.2 billion. By contrast, the New York-Presbyterian/Queens PPS has the smallest attribution for valuation of 12,962 people and smallest valuation of $31 million (NYSDOH 2016). The New York DSRIP program is also one of the largest Medicaid innovation programs in history, with over $8 billion of state and federal funding allocated to its components (Bachrach et al. 2016). Other vital structural components of the program are the requirements for each PPS to perform a Community Needs Assessment and participate in a statewide learning collaborative.

Each PPS went through a rigorous, time-sensitive application and vetting period during the years leading up to the start of the DSRIP program on April 1, 2015. Once the lead organization(s) in each PPS was finalized by the state, these organizations were required to submit an application that included their DSRIP project selections (which were the primary drivers of valuation when coupled with the PPS attribution numbers) and their approaches to meeting the state-mandated requirements of participation. Application components required that PPSs select certain projects from a menu that included four domains: project progress milestones, system transformation, clinical improvement processes, and population-wide projects. Each domain had several specific areas for which each PPS formulated a plan for optional and/or required projects. For example, domain 3, clinical improvement processes, included eight possible disease focus areas: behavioral health, cardiovascular health, diabetes care, asthma, HIV/AIDS, perinatal care, palliative care, and renal care; each PPS was required to select a minimum of four projects from these areas, with at least one in behavioral health. Each domain included specific outcome metrics that aligned with each project. For example, all PPSs implementing cardiovascular disease projects from domain 3 are evaluated on the same eight metrics. Overall, there are more than 120 metrics corresponding to 44 project options across domains 2, 3, and 4 (NYSDOH 2014b).

The early demonstration years have been further characterized by project implementation and community partner involvement. In beginning to execute project implementation plans, each PPS engaged its region's community partners in the development of new project-based care pathways. Multistakeholder teams were formed at the PPS level and met regularly (e.g., weekly) to begin planning. For example, the Finger Lakes PPS created process flow maps redesigning care processes for every project in their implementation plan. The creation of new processes involved community partners that provided thought leadership on the critical

components and steps involved in each new project pathway. Then, once the new pathways were complete, the project workgroup leader from the PPS performed numerous presentations at regional meetings that included other community partner organizations. Meanwhile, finance teams for each PPS had similarly created multistakeholder teams to determine the funds flow methodology (how to disperse the state funds and to whom) and begin organizing the contracting process that would need to occur between the PPS and community partners. One of the key ideals involved in this process for the finance teams was to ensure alignment of the funds flow methodology and contracting process with the goals of the New York State Value-Based Roadmap, which focuses on shifting 80–90 percent of managed care payments into a value-based payment methodology by the end of demonstration year 5 (NYSDOH 2015b). Linking progress on value-based payment transformation to the DSRIP funding is a core component of this effort.

However, the development of such care pathways, funds flow methodologies, and contracts did not occur without overcoming initial team challenges. Indeed, a number of PPSs found that community partners initially came to the table with their individual/employers' interests as the priority (e.g., ensuring maximum financial gain for their employer in the funds flow methodology) and not New York's vision for reducing waste in the health care delivery system. Through regular meetings and discussions with PPS leadership, these individual/employer-focused interests shifted toward the achievement of broader PPS goals, and consensus was ultimately achieved. Prior research supports the team dynamics found in New York in that consensus building may be difficult to achieve if common team goals are not established early and individual/employer-focused interests are removed (Hearld et al. 2013). Moreover, New York is unique in its DSRIP waiver design in that it essentially forces shared savings and collaboration among community partners, while other waivers such as those of California and Texas did not require this level of multistakeholder participation during the planning phases. If waivers similar to New York's are designed and negotiated with CMS in the future, it is likely that multistakeholder teams will play an increasingly significant role in the decision-making processes embedded in the planning and implementation phases.

Learning from the New York DSRIP Waiver

New York's is the first DSRIP waiver to be negotiated and implemented completely after the Medicaid and Health Insurance Exchange coverage

expansions, both of which the state aggressively adopted. In fact, New York's work on Medicaid expansion was limited compared to that of other states with DSRIP programs (e.g., California, Texas) because of the state's effort to expand coverage in 2000 when it increased eligibility for Medicaid and the Children's Health Insurance Program to childless adults up to 150 percent FPL and to children up to 405 percent FPL. The preexisting coverage expansion via Medicaid meant that concerns about pent-up demand and handling the needs of the previously uninsured moving into Medicaid were already dealt with to some extent, resulting in a primary focus on bolstering the safety net and obtaining federal funds for delivery system reform and transformation.

As the DSRIP model has evolved, it has become clearer that CMS hopes to drive improvement in the safety net by incentivizing change while also linking improvement to financial accountability. As reported by the National Academy for State Health Policy (Schoenberg et al. 2015), while CMS views DSRIP programs as a way to introduce accountability and value into Medicaid programs, some states still view the waivers as a way to issue supplemental payments in a way that replaces Disproportionate Share Hospital funding and may be resistant to taking on risk or engaging in true innovation or value-based models of care. CMS under President Obama was unlikely to view these proposals favorably, but the recent approval of Florida's $1.5 billion low-income pool and Texas's $3.1 billion uncompensated care pool by the Trump administration sends a different signal about linking spending to accountability or value (Rohrer 2017; Dickson 2017). In New York, linkage between the DSRIP and transition to value-based payment models is clear.

However, suggesting that the New York waiver should be considered a one-size-fits-all prototype based on its attempt to achieve the Triple Aim in the ACA era will likely lead to implementation challenges in other states. While new waivers should look to New York's waiver for guidance, not every component of the waiver can be used by other states in its current form. Policy makers and Medicaid directors seeking to design and implement a waiver (new or renewals) must carefully examine their state's current political climate, health care provider and insurer landscape, and community partner infrastructure prior to determining the ideal structure for its waiver. Moreover, the influence and involvement of different stakeholders within the health care safety net and state health policy circles mean that there is limited ability to create uniform DSRIP programs despite the underlying assumption that states must coordinate with these groups regardless of the specific state. For example, when considering state interest

groups, safety net care financing waivers must include hospital associations and their affiliates. In California, there are two primary groups: the California Association of Public Hospitals and the California Hospital Association. The California Association of Public Hospitals represents public and university hospitals that care for the vast majority of the poor, underserved, and uninsured in the state and is the primary partner to California's Medicaid program in safety net financing waivers. In New York, there are fewer public hospitals, and they are all members of a larger hospital association, the Greater New York Hospital Association, that represents a more diverse set of hospitals. The final DSRIP program designs in California and New York differed substantially in part because of the priorities of these influential groups and other key players who comprise the safety net in these states. Moreover, performance metrics, funding sources, and milestones will vary by state due to policy priorities, participants, political power of specific types of safety net providers, labor unions, provider associations, and community needs. To the extent possible, other states should consider the metrics and milestones currently being used in New York simply as a starting point for their negotiations with CMS.

Implementing innovation takes significant effort from providers, health plans, and state government officials. When trying to innovate in the safety net, resource concerns often hamper the ability of administrators and clinicians to develop new programs, train staff, develop new data collection and monitoring strategies, and sustain the projects. In New York, state support of planning grants and administrative costs as part of the DSRIP was helpful in establishing the resources to help in planning processes and implementation. Twenty million dollars was allocated for planning grants to help the PPS design and planning process, while $300 million for administration of the program was set aside to fund technical assistance, data support, and other activities that facilitated the planning and creation of the various applications and community needs assessments. In addition, New York is setting aside an additional share of the DSRIP funding to maintain a performance pool for those PPSs that exceed their quality improvement goals, to award additional bonuses for those high performers (Gates, Rudowitz, and Guyer 2014).

New York provides an interesting example of a forward-looking approach to DSRIP design, funding, improvement strategies and partnerships. Drawing on the lessons learned in our analysis of the New York waiver, we offer several potential recommendations for states considering future DSRIP waivers and renewals:

Attribution: Attributing managed-care and uncompensated-care patients to DSRIP networks and providers could be a key component of the waivers going forward, as CMS attempts to align incentives around value for hospitals and Medicaid managed care plans.

Funding: Allocate state general fund dollars to planning and supporting new and existing DSRIP participants, allowing for additional federal matching funds and increased state assistance to participants and partnerships. Underresourced planning and preparation could result in implementation challenges, missed performance targets, and a loss of federal funds.

Robust data monitoring and evaluation: Some of the core concerns from CMS with the existing DSRIP implementations have related to the lack of data for evaluation, performance monitoring, and real-time quality improvement. It is clear that the varying baselines for each participant and the lack of uniformity in goal setting and innovation have led to wide variation in the implementation of projects and disparate targets. The level of quality reporting and data-driven evaluation required in New York will be helpful in developing the future DSRIP successor programs and ensuring they demonstrate change. However, minimizing the administrative burden that can accompany reporting and evaluation wherever possible remains critical.

Program evaluation: Evaluating the waiver in total using aggregate data on improvement, savings, and achievement of total milestones and metrics may be helpful in understanding the program's overall impact. However, the real utility of the DSRIP is in its ability to test and develop smaller-scale changes within the context of the larger program. It is important to focus on specific data sources and measures that will enable comparative analysis of different programs and components of programs within the DSRIP initiatives in each facility, regional health partnership, or network. New York's PPS structure is ideal to test similar projects in different contexts.

Community partners: Additional partners are needed, from physicians, hospitals, social services, public agencies, and local communities to increase collaboration, support innovation, coordinate nonmedical services, and engage in whole-person care. In some cases, those partners can generate nonfederal dollars to contribute to the waiver. In others, their involvement may require payments or resources that they cannot generate on their own (Guyer et al. 2015). This could be solved

through provider taxes or other methods to generate the nonfederal share, if the participation of the entity could improve the DSRIP overall.

Shared metrics and milestones: The use of shared metrics and milestones across all projects and participants, as well as the coordination of DSRIP metrics with managed care quality and utilization metrics, will be a key element of overseeing and evaluating the impact of the DSRIP in the long term. Given CMS's interests in value-based incentives and change over time, documenting that type of progress will be important to guarantee continued investment and federal support.

The Future of DSRIP Waivers across the United States

It will be important for states looking to design, implement, and renew DSRIP waivers or other transformational models (e.g., Maryland's all-payer global budget waiver) to account for the cornerstone provisions of the New York waiver and ACA-related policy changes, especially the optional expansion of Medicaid and the focus on accountability and value in delivering and financing care. CMS has also used its experience developing the New York DSRIP waiver with its renewal negotiations in a number of states. As such, the CMS in the Obama administration appeared to be less likely to renew or sustain existing uncompensated-care financing pools in states that did not expand Medicaid (Harmatz and Cassel 2016). It did, however, appear supportive of continued DSRIP-type funding in those nonexpansion states via demonstration waivers. This is especially true when states attempt to draw down federal money for uninsured individuals who are now eligible for Medicaid under the mostly (90 percent) federally funded voluntary expansion (Schubel and Solomon 2015). If the Trump administration and Republican lawmakers are successful in turning Medicaid into a per-capita spending allotment or block-grant-style program, the incentives for states to pursue transformational change in the delivery and financing of care will still be relevant. However, the exact details of any change to Medicaid funding formulas are unknown. In previous Republican proposals to reform Medicaid, the Medicaid expansion population was included in calculating the per-capita spending allotment available to states, and waiver authority was preserved (US House of Representatives GOP Task Force 2016; American Health Care Act, H.R. 1628 [2017]). However, if the

CMS affords greater flexibility to redesign or reform Medicaid under block grants or per-capita allotment models, states may be able to pursue transformation with less oversight or guidance from CMS. The recent news that the Trump administration would like to expedite waiver approvals could mean shorter approval timelines, limited negotiation, and less CMS involvement in implementation, monitoring requirements, and readiness review. In addition, as seen in Florida's low-income pool, if the Trump administration is interested in allowing nonexpansion states flexibility in how they spend federal dollars directed toward indigent care and local programs, DSRIP-type waivers that link federal supplemental payments to improved value in Medicaid or the safety net will be less relevant.

California's waiver renewal proposal originally requested $17 billion in total state and federal funding and included a DSRIP-like successor program called Public Hospital Redesign and Incentives in Medi-Cal (PRIME) that provided both public and district facilities with approximately $4 billion in federal matching funds to engage in innovation and redesign (California Department of Health Care Services 2015). The CMS and the California Department of Health Care Services ultimately agreed on the terms of waiver renewal on December 30, 2015, but the CMS then recommended revisions to the sources of state funding and size and scope of the waiver that reduced the federal funding available for waiver programs to a total of $6.2 billion. Moreover, during negotiations, the hospital requirements were made more rigorous and focused on value-based payment despite the reduction in overall funding. Texas pursued its own long-term DSRIP waiver renewal, which resulted in achieving a fifteen-month extension waiver that aims to cover unpaid bills until Texas can submit, and have CMS review, an independent report assessing the continued need for the existing DSRIP and uncompensated care pools (CMS 2016). After requesting twenty-one months of level funding to continue the waiver, a renewal was recently approved in December of 2017 that phases out the Texas DSRIP over the next four years (Texas Health and Human Services Commission 2017; Dickson 2017). The newly approved waiver in Washington State focuses on delivery system transformation through Accountable Communities of Health, long-term services and supports, and supportive housing and supported employment (Washington State Health Care Authority 2016). Virginia is in the process of gaining final approval of its initial five-year Section 1115 Medicaid demonstration waiver that is designed to integrate the community delivery structure and move payment reforms

toward value-based purchasing (Virginia Department of Medical Assistance Services 2016). Last, in June 2016, New Jersey submitted its waiver renewal application to the CMS (New Jersey Department of Human Services 2016). Within the context of these renewal and new waiver requests, New York continues to be used by the CMS as the baseline in the negotiations for specific performance metrics, funding sources, and milestones.

It will be critical for states to determine their sustainability plan for the changes in programs and waiver policies to promote the ability of providers to maintain relationships and enable outcome improvements and integrated services. Promoting exchange products that enable early access to primary care and prevention, and developing managed care value-based payment roadmaps that guide managed care organizations and providers as they adapt to value-based payments will be crucial. New York has been exemplary in this respect. New York's roadmap was part of the budget process, which demonstrated the commitment to sustainable change with DSRIP funds to force alignment and support gradual conversion to value-based systems from fee-for-service and volume.

Setting up a DSRIP program similar to New York's certainly appears to be the basis of influence for future waivers, especially as it relates to managed care and the link to the newly insured. Given the focus of the Obama administration, states and Medicaid providers were encouraged and incentivized to engage in value-based purchasing within their existing Medicaid managed care contracts. Under the Trump administration, we think these same incentives still exist due to an interest in reducing federal Medicaid spending, whether through administrative steps or via future legislative proposals to move to a block grant or per-capita allotment model. However, the CMS may relax oversight and establish more aggressive timelines in an attempt to provide flexibility to states due to the reduced budget that will be available for these types of models. These models may continue to include some funds for delivery system redesign but shift the burden of paying providers and monitoring and tracking outcome metrics onto the Medicaid managed care programs. However, it does not appear that such models will be deployed via waivers in all fifty states. Rather, the CMS will begin to deploy the lessons learned from New York and existing DSRIP states in other settings through broader policy changes and specific initiatives or by relaxing waiver requirements to spur innovation and efficiency, if federal funding of Medicaid programs is reduced in the long term, or to reward states for pursuing reforms that align with the administration's political interests.

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