



Examining New York's Delivery System Reform Incentive Payment Demonstration: Achievements at the Demonstration's Midpoint and Lessons for Other States

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Summary

New York's Delivery System Reform Incentive Payment (DSRIP) demonstration, authorized by a Medicaid section 1115 waiver, is an ambitious and complex effort to transform the health care delivery system, reduce cost growth, and improve care outcomes for Medicaid beneficiaries and uninsured individuals. The demonstration involves thousands of health care providers and social service organizations and explicitly ties payment to outcomes. After the third year in its six-year demonstration period, the state has made significant progress toward its goals, while facing ongoing challenges in shifting the locus of health care delivery from expensive inpatient settings to primary and preventive care in the community. New York has found that safety net providers are at varying levels of readiness for value-based payment and delivery system change, suggesting that helping these providers prepare for the transition requires an agile, staged approach to ramping up performance expectations. Other states pursuing delivery system reforms can learn from New York's experience.

Introduction

Delivery System Reform Incentive Payment (DSRIP) demonstrations, authorized by Medicaid section 1115 waivers, aim to transform the delivery system for Medicaid beneficiaries

and uninsured individuals. Incentive funds awarded to safety net and other Medicaid providers are intended to support investments in infrastructure and workforce capacity that enable Medicaid providers to implement initiatives to improve clinical quality, reduce the growth of health care costs, and advance population health.

Since the Centers for Medicare & Medicaid Services (CMS) approved the first DSRIP demonstration in California in 2010, DSRIP demonstrations have evolved in terms of their key design features and goals. New York's DSRIP demonstration, approved in 2014, shares features and goals with preceding demonstrations in California, Massachusetts, New Jersey, and Texas but also includes new elements that were unique to the state at the time. For example, unlike its predecessor programs, New York:

- Aimed to create integrated networks of providers—called Performing Provider Systems (PPSs)—to be jointly held accountable for performance under DSRIP
- Placed a percentage of the state's federal funding at risk, based on the state's performance on four statewide milestones starting in the third demonstration year (DY)¹
- Emphasized the importance of sustaining delivery system reforms by pledging to expand the use of value-based payment (VBP) and alternative payment models (APMs)² between providers and managed care organizations (MCOs)

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.

Because New York's DSRIP demonstration influenced subsequent demonstrations, such as those in New Hampshire and Washington, insights and lessons learned from its implementation may be valuable to other states pursuing delivery system reforms. This brief presents major findings from a case study of New York's DSRIP demonstration at its midpoint, during spring and summer 2017. It sought to answer the following questions:

- Is New York's DSRIP demonstration meeting—or on track to meet—state goals for implementation and transformation?
- How have key aspects of the demonstration design, such as the structure of provider networks and the types of delivery reform projects selected for the demonstration, affected implementation and progress toward the demonstration's goals?
- What are the initial successes achieved by the state and regional provider networks? What contributed to these successes?
- What are the key challenges faced by the state and the PPSs in implementing the demonstration? What strategies were effective in addressing these challenges?

We reviewed numerous program documents and conducted interviews with key informants involved in implementing the state's DSRIP demonstration (see Methods box for more detail). This brief provides a snapshot of the state's qualitative progress toward its demonstration goals at a point in time, but it does not evaluate the impact of the demonstration on costs, quality, or other system performance metrics.

In the sections that follow, we describe key features of the demonstration, highlight major findings on progress to date, and outline lessons for other states pursuing delivery system reforms.

Background on New York's DSRIP Demonstration

New York operates the second largest Medicaid program in the United States, after California, in terms of both the number of people covered (about 6.5 million) and spending (nearly \$63 billion in FY 2016) (Medicaid and CHIP Payment and Access Commission 2017). Its DSRIP demonstration is part of a broader reform effort undertaken by the state to improve the health care delivery system for Medicaid beneficiaries and reduce annual growth in Medicaid costs in order to remain within a global spending cap mandated by state law in 2012.³ In addition to DSRIP, New York is concurrently implementing Medicaid patient-centered medical homes (PCMHs), Health Homes, and Accountable Care Organizations (ACOs) (Kaiser Family

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to inform CMS's decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. These briefs informed an interim outcomes evaluation report, released in 2018, and will inform a final evaluation report in 2019.

Foundation 2017). Further, New York is among the growing number of states that are requiring MCOs to pay providers through APMs (Gifford et al. 2017). Even though all of these initiatives share the common goal of improving the overall value of care provided to Medicaid beneficiaries, their concurrent implementation increases the scale and complexity of changes required among the state, Medicaid MCOs, and providers.

New York's DSRIP demonstration has garnered national attention in part because it constitutes a significant federal and state financial investment. The total federal funding (\$6.42 billion) allocated to the state's DSRIP demonstration is higher than that allocated to all other DSRIP demonstration, with the exception of Texas. Despite the large amount, total federal and state funding on New York's DSRIP demonstration—\$8.25 billion—represents roughly 2 percent of total federal and state Medicaid spending in New York projected over the six-year demonstration period.⁴ Still, policymakers see the demonstration as playing a critical role in advancing the state's reform agenda and therefore articulated broad, ambitious goals for the demonstration.

Goals. New York outlined three overall goals for the DSRIP demonstration:

- To transform the state's health care safety net system for Medicaid beneficiaries and low-income uninsured individuals
- To reduce avoidable hospital use and improve performance on clinical quality and population health measures at both the provider and state levels

- To sustain the delivery system transformation achieved under DSRIP through the advancement of VBP in Medicaid managed care

In addition, the state defined two measurable goals by the end of the demonstration in 2020:

- To reduce avoidable hospital use, including admissions and emergency department (ED) visits, by 25 percent
- To motivate providers and MCOs to establish VBP for provider payment so that 90 percent of all Medicaid managed care payments to providers rely on VBP methods

Performing Provider Systems (PPSs). To achieve these goals, the state specified that coalitions of safety net providers must form PPSs for the purpose of participation in DSRIP. The state expected PPSs to form networks of health care and social service providers to deliver integrated care to Medicaid beneficiaries and uninsured individuals.

The New York State Department of Health solicited applications from providers throughout the state to serve as “lead entities” to spearhead the PPSs.⁵ In total, the state selected 25 entities to lead PPSs; 22 are large hospital or health systems, one is a federally qualified health center (FQHC), one is a regional health consortium of community providers and hospitals, and one is a physician-hospital partnership. These lead entities have partnered with hospitals, community-based primary care and specialist physicians, community health centers, behavioral health care providers, long-term services and supports (LTSS) providers, and social services providers, among others.

The state required each PPS to form a governing body to oversee planning and implementation of DSRIP projects, determine how to distribute DSRIP funds, support the use of health information technology (IT), develop patient and provider engagement strategies, and be accountable to the state. The state also expects the governing bodies to develop strategies for supporting financially struggling partners. Each PPS selected a governance model, which determines the nature of the relationship among partnering entities and the breadth of authority delegated by partners to the PPS (KPMG 2014a).

MOST COMMONLY IMPLEMENTED DSRIP PROJECTS

- Primary and behavioral health integration: 25 PPSs
- Integrated delivery systems: 22 PPSs
- Care transitions for chronic disease: 17 PPSs
- Evidence-based strategies for disease management in high-risk populations: 15 PPSs

Delivery system transformation projects and activities.

DSRIP projects are a primary method by which New York aims to achieve health system transformation, reduce avoidable hospital admissions and emergency department use, and improve population health. In consultation with CMS, the state required PPSs to select between 5 and 10 delivery reform projects from a menu of 44 projects in three domains: (1) system transformation, which includes the creation of PCMHs or Advance Primary Care models and the improvement of care transitions from hospitals to home or other settings; (2) clinical improvement, which includes the integration of primary care and behavioral health services; and (3) population-wide health promotion, which is designed to improve health outcomes for people with mental health or substance use disorders, people with HIV/AIDS, and pregnant women. PPSs that selected 10 projects had an opportunity to select an 11th project. The additional project involves engaging the uninsured and low-utilizing Medicaid populations and linking them to primary and preventive services or other community-based care.⁶ In total, the 25 PPSs selected 258 projects, with 14 PPSs selecting the 11th project.

Funding awards and allocations. The PPSs earn DSRIP incentive funding in several ways. The total amount of funding that each PPS is able to receive (referred to as valuation) is based in part on the total number of attributed Medicaid and uninsured lives; the larger the number of attributed lives, the more funding a PPS could receive (Au et al. 2017; Bachrach et al. 2016). Total funding is also tied to the number of projects each PPS planned to implement.

The amount of the total valuation that a PPS actually earns is based on milestone achievement as well as on reporting and performance on specific process and outcome measures. Implementation milestones relate to core PPS organizational functions, including establishment of governance structures; developing workforce, cultural competency, and health literacy plans; creating plans to engage providers and patients; and developing financial sustainability strategies. Process and outcome measures include quality measures (for example, drawn from the Healthcare Effectiveness Data and Information Set [HEDIS] and the Consumer Assessment of Healthcare Providers and Systems [CAHPS]), utilization measures, and delivery system characteristics (for example, percentage of primary care providers [PCPs] meeting PCMH [National Committee on Quality Assurance] or state-developed Advance Primary Care standards). Performance metrics are heavily weighted toward population health improvement and service innovation and redesign, while a few metrics are tied to infrastructure and workforce development. In line with New York’s emphasis on primary care and community settings, 54 percent of measures focus on ambulatory settings and 46 percent on population health or community settings (Baller et al. 2017).

Over the course of the demonstration, New York increases the percentage of funding tied to performance. In DY1, incentive funding was based primarily on achievement of PPS implementation milestones. However, starting in DY2, the basis for earning incentive funding shifted to pay-for-reporting or pay-for-performance. By DY3, 45 percent of PPS incentive funding is tied to pay-for-performance metrics, increasing to 65 percent in DY4 and 85 percent in DY5. Incentive funds are awarded to PPSs on a pass/fail basis. If a PPS does not meet a milestone or metric in its entirety, it cannot receive any funds for that metric.

In addition, the state offers PPSs the opportunity to earn additional funding through several supplemental funding pools and programs as follows:

- **DSRIP High Performance Fund.** For DYs 2 through 5, the state sets aside 10 percent of DSRIP funding for a High Performance Fund to reward high performance on a set of 12 system transformation and clinical outcome measures (New York State Department of Health, Medicaid Redesign Team 2015a).⁷
- **Two Equity Programs.** The state created two supplemental programs to redress “inequities” created through the DSRIP valuation process: (1) the Equity Infrastructure Program, which provides funds to PPSs implementing certain infrastructure development activities, and (2) the Equity Performance Program, which provides funds to PPSs that achieve benchmarks directly related to the state’s demonstration goals. These equity programs are funded through separate state appropriations, rather than through demonstration funding, and are administered by MCOs (New York State Department of Health, Medicaid Redesign Team 2015b).
- **Additional High Performance Program (AHPP).** The state set aside an additional \$50 million annually to further incentivize the achievement of performance targets for 9 of the 12 measures eligible for reward under the High Performance Fund. A PPS may earn AHPP funds if it achieves at least half of its eligible AHPP metrics in a given year. MCOs administer the AHPP funds via contracts with PPSs; the state includes AHPP add-ons to per member, per month (PMPM) capitation rates for participating MCOs.⁸

Performance measurement and accountability.

PPS performance determines whether the state can receive the full amount of federal DSRIP funding. Starting in DY3, a share of the state’s total federal demonstration funding is at risk based on aggregate statewide performance on the following four milestones, assessed on a pass/fail basis:

- **Milestone 1: Delivery system improvement.** Statewide performance is assessed on a set of universal

delivery system improvement metrics against which the PPSs are also measured. To achieve this milestone, more metrics must be improving than worsening as compared to the prior year and baseline performance.

- **Milestone 2: Project-specific and population-wide performance.** This milestone is based on improvements made on project-specific and population-wide quality metrics. To achieve this milestone, all the PPSs in the state must collectively achieve their annual improvement targets on over 50 percent of included pay-for-performance metrics.
- **Milestone 3: Medicaid spending cost growth containment.** This milestone is based on growth in (1) statewide combined inpatient and ED Medicaid spending and (2) total Medicaid spending. This milestone is met when both measures are at or below the target trend on a PMPM basis.
- **Milestone 4: Conversion of Medicaid managed care payments to VBP models.** This milestone is based on targets set by CMS and the state regarding the percentage of total managed care payments to providers through VBP arrangements for each DY.

PERFORMANCE ASSESSMENT METHODS

Performance measures qualify for funding in two ways:

- **Improvement.** Achievement values (AVs) are awarded when a PPS closes the gap between its own performance and the statewide performance goal (gap-to-goal) by at least 10 percent in each measurement year, based on its prior-year baseline. High Performance Fund incentives are awarded when the PPS closes its gap-to-goal by 20 percent. If a PPS has already met or exceeded the goal, the improvement and high performance targets will be the PPS’s most recent performance results.
- **Attainment.** PPSs that meet or exceed a performance target set at the 90th percentile of statewide performance for a set of 10 measures are awarded additional funds through the DSRIP High Performance Fund.

If the state fails to meet any of the four statewide milestones, federal DSRIP funding is reduced by 5 percent in DY3, 10 percent in DY4, and 20 percent in DY5.⁹ If federal funding is reduced, the state must equally apportion reductions across PPSs.

Funds flow. New York’s DSRIP demonstration allows PPS lead entities to decide how to allocate DSRIP funds among their partners in a manner that will promote successful implementation of DSRIP projects. PPSs may exercise some discretion in designing the funds flow process, developing

contracts with partners, determining how partners earn dollars, and deciding when dollars flow to partners (KPMG 2014b). However, per the demonstration special terms and conditions (STCs), PPSs cannot distribute more than 5 percent of their total valuation to providers that do not qualify as safety net providers, as defined by the state, sometimes called the “95/5 rule” (Centers for Medicare & Medicaid Services and New York State Department of Health 2017).

Promoting VBP. To sustain delivery system reforms after the demonstration ends, the state proposed that, by the end of the demonstration in March 2020, 80 to 90 percent of all Medicaid payments to providers by MCOs would be paid via VBP models. To meet this goal, since 2015, the state has distributed an annual VBP roadmap that defines three VBP levels (Table 1). It also created a VBP work group, subcommittees, and advisory groups tasked with implementing the roadmap.

According to the state’s VBP roadmap (Year 2 update), the state’s targets call for at least 10 percent of total managed care payments to be made through Level 1 or above by the end of DY3 (New York State Department of Health, Medicaid Redesign Team 2016). By the end of DY4, the state expects

BASELINE VBP PERFORMANCE

In its Year 2 update to the VBP roadmap, the state reported results from a survey of MCOs in New York. According to the survey, 25.5 percent of total Medicaid payments by all types of MCOs were made through VBP Level 1 or higher in calendar year 2014. Thus, at baseline, the state had already exceeded its DY3 target, although there was considerable geographic variation.

that at least 50 percent of total managed care payments will be made through Level 1 or above and that at least 15 percent of payments for full capitation plans will be made through Level 2 and above. Finally, by the end of DY 5, the state expects that 80 to 90 percent of total payments will be made through Level 1 and above VBP arrangements, of which 35 percent will be through Level 2 or higher VBP arrangements for fully capitated plans and 25 percent will be through Level 2 or higher VBP arrangements for partially capitated plans, such as plans covering long-term services and supports.

Table 1. Definitions of VBP levels

VBP levels	Model features
Level 1	<ul style="list-style-type: none"> • FFS with upside-only shared savings available when outcome scores are sufficient • (For PCMH/IPC, FFS may be complemented by PMPM subsidy)
Level 2	<ul style="list-style-type: none"> • FFS with risk sharing (upside available when outcome scores are sufficient) • Upside and downside risk
Level 3	<ul style="list-style-type: none"> • Prospective capitation PMPM or bundle (with outcome-based component) • Prospective total budget payments • Upside and downside risk

Source: New York State Department of Health, Medicaid Redesign Team (2016).

Note: Level 3 is feasible after experience with Level 2; requires mature contractors.

FFS = fee-for-service; IPC = Integrated Primary Care; PCMH = patient-centered medical home; PMPM = per member, per month; VBP = value-based payment

Findings

By the midpoint in New York’s DSRIP demonstration, the state, PPSs, and other partners have made considerable progress toward achieving system transformation. However, some initial implementation challenges persisted into the second and third years, and it remains an open question whether the demonstration will achieve all of its goals by the sixth year in 2020.

A. Statewide demonstration successes

Overall, New York’s DSRIP demonstration has achieved significant accomplishments in several important areas.

Connecting individual providers and initiatives in more systematic ways.

Although providers were involved in various pilot projects and initiatives aimed at improving care delivery before DSRIP started, they typically approached these activities separately and independently. DSRIP has offered a forum and structure for providers to integrate their work across initiatives and collaborate with one another more easily. Further, the state has positioned DSRIP within a body of initiatives that are strengthening primary care capacity and shifting Medicaid payment models from paying for volume to rewarding value.

Expanding and developing health system capabilities to deliver more care in community settings.

Providers involved in 44 delivery transformation projects are changing how they deliver care to align with DSRIP

goals. Stakeholders reported that DSRIP projects have helped an increasing number of providers achieve PCMH certification, implement care navigator programs, and integrate behavioral health with primary care, which providers expect will help reduce preventable hospital use.

Educating providers on value-based care and risk sharing. DSRIP has increased providers’ awareness of what VBP means and the practical changes associated with VBP. PPSs and their partners have assembled and analyzed claims data and clinical information to identify opportunities to improve care outcomes and reduce costs. Providers are also learning about the opportunities and challenges in accepting financial risk for patient care. The state and PPSs offer data, training, and other support to their provider partners to help them successfully enter into VBP contracts with MCOs and other payers. For instance, the state held a series of VBP “boot camps,” created an online VBP resource library, and developed a VBP university—a training program to develop VBP knowledge and expertise.

Making progress toward achieving statewide milestones. DY3 marks the first year that the state is assessed on aggregate performance on four key performance milestones. In Table 2, we summarize the state’s progress on its statewide performance milestones at the start of DY3 in April 2017.¹⁰ As of April 2017, the state expected to meet the threshold for Milestone 1 (a composite of delivery system performance measures), as PPSs were maintaining or improving performance on 7 of 11 measures for which data were available for comparison to the prior year (comparable data were not available for 7 other measures) (New York State Department of Health, Medicaid Redesign Team 2017a). The state also reported considerable progress on six behavioral health–related measures evaluated as part of Milestone 2 (a composite of project-specific and population-wide quality metrics), compared to the previous year. However, the state did not report details on progress towards the other two milestones – Medicaid spending growth and use of VBP by MCOs.

In addition to the statewide performance milestones, the state made notable progress toward reducing avoidable hospital use by 25 percent. By April 2017, the state achieved a 16.5 percent reduction in potentially preventable hospital readmissions and a 12.5 percent reduction in potentially preventable ED visits.

Despite these positive indicators of success, signs suggest that the state may not be making enough progress to achieve its demonstration goals and statewide milestones. For example, the state’s performance had worsened since MY2 (July 1, 2015, through June 30, 2016) on four system transformation measures of pediatric and adult access to preventive or ambulatory care and the composite of pediatric measures. In addition, overall progress on Milestone 2 was not projected to achieve its goal at the start of DY3; for each of seven measures the state identified as being most influential to Milestone 2,¹¹ between 3 and 14 PPSs were not on track to meet their annual improvement targets. In addition, the state noted that if the current rate of reduction in ED use continued, the state would not meet its ED reduction goal. Finally, although the statewide goal for reducing hospital readmissions was on track, the degree of change in hospital use achieved by PPSs varied significantly, with 7 PPSs experiencing no improvement or an increase in readmissions by the start of DY3. Thus, the results at the start of DY3 suggest that the state and PPSs need to strengthen their efforts to reduce avoidable hospital use and maintain progress in achieving—and continue improving—key system transformation, clinical outcomes, and population health measures.

B. PPSs’ demonstration achievements

The PPSs, as the primary organizing structure for carrying out New York’s DSRIP demonstration, report notable accomplishments in several areas: (1) creating effective governance structures, (2) building large provider networks, and (3) earning most of the available funding through DY2.

Table 2. State-reported progress on statewide performance milestones

Statewide performance milestones	State-reported progress as of the 9th month of MY3
Milestone 1: Delivery system improvement metrics	<ul style="list-style-type: none"> On track – more metrics were improving than were worsening
Milestone 2: Project-specific milestones and population-wide improvement	<ul style="list-style-type: none"> Not on track; for each pay-for-performance measure in DY3, between 13 and 23 PPSs were not yet meeting the annual improvement target

Source: New York State Department of Health, Medicaid Redesign Team (2017a).
DY = demonstration year; MY = measurement year

Table 3. Percentage of funding earned through DY2, by funding type

Funding type	Percentage earned (through DY2)
DSRIP pay for reporting (Domains 1 through 4)	98.3%
DSRIP pay for performance (Domains 2 and 3)	51.7%
DSRIP High Performance Fund	52.6%
Supplemental—Equity Infrastructure Program	100.0%
Supplemental—Equity Performance Program	97.0%
Supplemental—Additional High Performance Program	100.0%

Source: New York State Department of Health, Medicaid Redesign Team (2017b).

Note: Domain 1 includes project implementation, Domain 2 includes system transformation, Domain 3 includes clinical improvements, and Domain 4 includes population-wide improvements. Supplemental funds are not directly funded through the section 1115 demonstration.

DSRIP = Delivery System Reform Incentive Payment; **DY** = demonstration year.

PPSs created effective governance structures.

By most accounts, most PPSs swiftly established effective governance structures to lead and carry out the DSRIP work, including forming clinical quality committees for each DSRIP project (Public Consulting Group 2016).

To strengthen their governance structures and relationships with their partners, PPSs have put considerable effort into making decisions transparently and fostering communication between PPS leaders and participating organizations. All PPSs have created their own websites to share information about governing body meetings, contracts, and reporting requirements, along with the development of newsletters, videos, fact sheets, and other resources. Many PPSs also hold regular in-person and webinar forums to solicit and promote partner participation in work groups and subcommittees.

PPSs built large provider networks. PPSs have created large provider networks by partnering with hundreds and, in some cases, thousands of individual providers (especially FQHCs and community-based organizations [CBOs]) that provide services to help address the social determinants of health (for example, housing, nutrition, employment, education, and environmental factors), which PPSs consider important for addressing DSRIP goals. Even though many PPSs struggled with how best to engage CBOs, those that achieved early successes with CBO engagement dedicated staff or work groups specifically to engaging CBOs. In addition, some PPS leaders detected gaps in the number of behavioral health providers in their networks and therefore made concerted efforts to recruit more of them.

Providers and CBOs involved in PPS projects are typically those that find the project goals and objectives to be aligned with their own missions. Participation has allowed them to demonstrate the value they provide (for example, their contributions to reducing hospitalization) and helped them form relationships with the PPS lead and other partners, which may result in patient referrals or other roles in the future.

“[The PPS] had a strategic leader that understood the value of other provider types. And there was the initial thought that this cannot be achieved by one type of entity—that there are existing talents, resources, and expertise available and it made more sense to bring them into the fold than to create things themselves.”

—CBO participant

PPSs earned most of the available funding through DY2. In DY1, PPSs’ payments were based on meeting milestones for organizational process measures, which included activities such as the development of PPS governance structures, funds flow policies, contracts with partners, affiliation with regional health information organizations, and strategies to engage providers and patients and improve population health. According to state-reported data through DY2, PPSs received 96 percent of possible incentive funding by meeting 95 percent of all project implementation milestones (Table 3.) (New York State Department of Health, Medicaid Redesign Team 2017b).

C. Challenges affecting implementation progress and strategies for addressing them

Despite progress and early successes, the state and PPSs have faced several challenges that they have sought to address over the course of the demonstration.

Meaningfully involving partners. Meaningfully engaging providers in delivery system reform within large networks formed by PPSs was challenging. Consequently, some partners play significant roles in PPS projects and governing board committees, while others have little or no involvement in PPS activities. Engaging CBOs has been particularly difficult when the lead hospitals in the PPSs did not have previous referral relationships with the organizations or the hospitals viewed the CBOs as competitors for outpatient care. Further, many CBOs either

provide services that are not reimbursable through Medicaid or might not contract with Medicaid for other reasons.¹² Several PPS leaders also said that contracting with partners takes a great deal of time and that many community-based providers are reluctant to make commitments without knowing in advance how much funding they will earn. Even when partners are involved, some reported that they are expected to do more than they can afford to do due to limited capacity and resources to take on new projects without upfront funding from the PPS for hiring new staff and preparing/submitted required reports and data analysis, among other requirements.

Addressing competition among partners. The state encouraged competing hospitals and other providers to come together under single PPSs given their overlapping service areas or other factors (Bachrach et al. 2016)—what some respondents referred to as “forced marriages.” However, outside of the PPS context, antitrust laws require providers to remain competitors. Thus, PPSs have had to reconcile the tension between enabling providers to collaborate on PPS projects and providers’ need to remain competitive for patients and revenues.

In addition, new competition between hospitals and partners has emerged with the addition of services aimed at supporting DSRIP goals. Some hospitals chose to develop new ambulatory care capacity rather than work with existing providers, such as FQHCs, which are major PCPs in PPS networks, or with community-based behavioral health providers. Hospitals are motivated to “make” rather than “buy” these services in order to exert more control over how they provide such services and to generate revenue tied to outpatient services to compensate for DSRIP activities that effectively reduce readmissions and unnecessary ED and inpatient use. Although the other providers typically acknowledge that additional services could improve access among Medicaid and uninsured patients, they also question hospitals’ ability to provide these services as effectively as organizations with extensive expertise and long-standing relationships in the community. Community-based providers also view themselves as better-positioned to provide the related supportive services (for instance, care coordination, housing, and food services) that low-income patients need.

“It’s more of a quality-of-care issue because the providers in the community have been doing this for many years. And it’s hard to just take a model and replicate it within your own infrastructure because we’re built on years and years of working with these individuals.”

—Behavioral health provider

Allocating funds fairly and effectively. PPS leads have considerable latitude in how they distribute funds. However, PPS hospital leads and their partners have experienced tension over how DSRIP funds should be allocated.

At the midpoint of the demonstration, PPS Project Management Offices (PMO) and hospitals received 70 percent of DSRIP funds, while other providers received 30 percent. In particular, FQHCs thought that they received less funding than was merited because of the size of their attributed patient populations and the costs they incur to meet reporting requirements and participate in projects. Indeed, the Independent Assessor’s midpoint assessment recommended an increase in the funds flowing to primary care providers, behavioral health providers, and CBOs because these entities deliver the primary and preventive services needed to avert unnecessary hospital and ED use (Public Consulting Group 2016).

At the same time, PPSs reported several reasons for not distributing more funding to their partners. For example, given that hospital lead organizations typically account for the large share of provider capacity (hospitals, primary care physician groups, and other providers), they have the largest number of attributed lives. In addition, the PPSs (especially through their PMOs) spent money on staff and activities that benefited several partners; for instance, they created data reporting and analytics infrastructure and provided technical assistance. However, DSRIP accounting practices reportedly attributed such expenditures to the PPS lead hospital such that it may appear that the funds support only the hospitals. Finally, PPSs have tended to target funding to clinical care providers over CBOs that provide nonmedical support services, because many of the DSRIP projects and early milestone requirements were closely linked to clinical changes; moreover, it was difficult for PPSs to find ways to link CBO activities directly to these efforts.

Since the midpoint of the demonstration, the PPSs have increased the flow of funds to partners. For example, PPSs reported a 112 percent increase in the amount of funds provided to partners through the first quarter of DY3 relative to amounts allocated through the first quarter of DY2 (New York State Department of Health, Office of Health Insurance Programs 2017). This increase is related to a combination of factors, including the Independent Assessor’s report, feedback from associations representing the community partners, and the natural progression of DSRIP implementation—particularly the evolution from process milestones to performance measures that require a more holistic approach to addressing clinical, behavioral, and social needs. In addition to changing their funds flow methodologies, some PPSs have established innovation funds, encouraging partners to apply to launch new activities that are not tied to specific projects in the DSRIP project menu or that could help achieve the DSRIP goals more broadly.

Collaborating and changing care delivery within regulatory restrictions. PPS leaders and their partners face well-intentioned but onerous regulations that sometimes convey mixed messages. As part of the DSRIP design, New York included a regulatory waiver process that allowed PPSs to request a waiver of certain state regulations in order to increase flexibility in implementing coordinated and innovative models of care. However, the state may not waive federal regulations governing billing policies. In instances in which several federal and state agencies impose regulations, the PPSs and partners are sometimes confused about which delivery system changes are permissible, perceiving a lack of alignment across regulating bodies. For example, staff licensing and credentialing, such as scope-of-practice rules, limit how PPSs may use staff on their care teams. These challenges are especially prevalent in efforts to integrate primary care and behavioral health through the collocation of services or the sharing of space. Although the state issued guidance on shared space arrangements for several provider types in 2016 (New York State Department of Health, New York State Office of Mental Health, and New York State Office of Alcoholism and Substance Abuse Services 2016), barriers persist. For example, FQHCs, as federally designated entities, face additional federal requirements governing waiting rooms and other features with respect to colocating services with a separately licensed provider. The state rules about collocation and shared space are less onerous, however, and allow for regulatory waivers; the state has approved such waivers, which the PPSs assign to individual provider sites by project within their network (New York State Department of Health, Office of Health Insurance Programs 2017). Further, the state implemented a billing policy to allow providers integrating physical and behavioral health that elect the Ambulatory Patient Groups (APG) payment methodology to bill for two professional services on the same day on a single claim, thereby eliminating the billing barriers of providing integrated clinical services.

“Projects are too fine a lens to view success.”

—PPS lead

Meeting new performance-based requirements. As incentive awards are increasingly based on performance as the demonstration progresses, PPSs face greater challenges in earning all of the available funding through DSRIP. In DY2, 60 percent of payments were tied to project milestones, 25 percent to reporting, and 15 percent to quality and performance metrics. Although PPSs earned 98.3 percent of funds tied to pay-for-reporting measures through DY2, they earned only 51.7 percent of available funds tied to pay-for-performance measures. As the percentage of funding tied to performance grows—reaching

85 percent by DY5—PPSs may experience greater difficulty in earning most of the available incentive funds.

PPSs have raised two main concerns about the transition to earning incentive funds based on their performance on quality measures. First, they reported that some of the targets are out of reach because they were based on the experience of outliers—particularly high-performing PPSs—or inaccurate assumptions about patient characteristics and preferences (for example, the extent to which patients would welcome in-home visits or the extent to which a reasonably sized population would have only one chronic condition). As a result, some PPSs plan to focus on the measures that they view as achievable given available time and resources. In addition, the state asked CMS to consider allowing for “partial achievement values” for pay-for-performance measures, so that PPSs that fall short of their annual improvement targets could earn some incentive funding for the improvements they were able to make. Second, PPSs find the focus on individual measures and the 10 or 11 discrete projects somewhat narrowly focused, administratively burdensome, and restrictive. For example, many of the clinical improvement projects target particular health conditions, detracting from efforts to address patients’ needs more holistically. Instead, PPSs would prefer to implement projects as “bundles,” such as care management and care transitions that collectively contribute to improved quality and reduced avoidable hospital use.

Using data to make informed decisions at the point of care. PPSs and their partners face challenges in obtaining timely and useful data at the appropriate level. Such data would help them understand how they are performing relative to quality targets and thereby permit them to identify areas for improvement. They find the dashboard available through the state’s Medicaid Analytics Performance Portal (MAPP) system¹³ helpful for providing a general, high-level picture of how they are performing at the PPS level. However, given that the MAPP data do not indicate the performance of particular organizations, some partners believe that the data are not actionable. For example, data on PCPs combine information for primary care physician practices with information for FQHCs.

PPSs need more granular provider and patient-level data that they can share with providers in order to pinpoint areas for improvement. At the same time, providers need patient-level information in order to coordinate patient care effectively. Despite the state’s investment in regional health information organizations and some PPSs’ involvement with them, the PPSs still lack common health IT systems, hindering information sharing within the PPSs. Further, providers find it difficult to balance the expectations for data sharing with New York’s data privacy regulations, which are stricter than the requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). Some stakeholders suggested that state agencies may be interpreting the regulations differently and often more stringently than necessary.

Despite these challenges, PPSs are providing more data to partners through their own dashboards or through new population health data systems that enable them to provide more real-time data to partners. Furthermore, both PPSs and partners reported that the state is working to improve data availability.

Transitioning to VBP. One challenge for the PPSs in moving toward VBP is that, due to legal barriers, they are unable to serve as the contracting entities for VBP arrangements as originally planned. Thus, they had to find other ways to help providers learn about and begin to prepare for VBP. Some PPSs, or the lead entities that sponsor them, are creating separate legal entities, such as independent practice associations (IPA) and ACOs, in order to enter into VBP contracts with payers. Hospitals and health systems with existing, affiliated IPAs are adding physicians to these networks for this purpose, and groups of FQHCs and groups of behavioral health providers are forming separate IPAs. Some PPSs that lead or participate in an ACO (for example, a Medicare Shared Savings ACO) are expanding their ACOs to include Medicaid patients.

Yet, many providers face challenges in negotiating VBP contract arrangements because of inexperience, weak financial status, or their relatively small size—all of which make it difficult to assume and manage downside financial risk (although providers can choose to limit VBP arrangements to Level 1 (upside risk-only models that do not require providers to bear financial risk for costs incurred in excess of expected costs). Furthermore, CBOs without existing relationships with MCOs, and those that lack billing experience because they rely on lump-sum grants, have to value and price their services to enter into fair and reasonable contracts. Although many providers think that VBP bonuses and payment arrangements could give them the flexibility needed to deliver services not currently covered by Medicaid, such as housing and social services, they are concerned that the payments may not adequately cover the scope of their efforts.¹⁴

Some PPS leads and partners reported that greater involvement on the part of MCOs at the start of the DSRIP demonstration would have been helpful in planning a course for moving to VBP, selecting appropriate partners, and developing contracting mechanisms that would align with the VBP goals. Another state program, separate from DSRIP, has started to help with the DSRIP VBP goal. New York's Quality Improvement Program provides state and federal Medicaid supplemental funding through MCOs to work with PPSs and their hospital partners in severe financial distress (New York State Department of Health, Medicaid Redesign Team 2017c). The program has enabled these hospitals to maintain operations and vital services while they work toward VBP contracting and long-term sustainability. Although the MCOs now appear to be making good progress toward VBP adoption, VBP penetration varies significantly across the state, and it is too soon to know whether the state is on track to meet its 2020 VBP goal.

Lessons and Implications for Other States Implementing Delivery System Reforms

Lessons from New York's experience in implementing its DSRIP demonstration, and its successes and challenges at the midpoint, may be informative to other states pursuing delivery system and payment reforms in Medicaid.

Align delivery system activities, performance measures, and demonstration goals to facilitate the achievement of targeted outcomes. To engage providers and gain their commitment to system transformation goals, it is important to help participating providers see how the delivery reform projects they undertake and the associated measures contribute directly to these goals. New York PPSs and their partners viewed the initial focus of the demonstration on project implementation and projects as helpful for building infrastructure and capacity, improving clinical processes, and strengthening partnerships. As system transformation efforts progress, however, it may be helpful for states to broaden their focus and identify a set of core capabilities that span individual projects and align with the vision for high-performing delivery systems. These capabilities might include care management focused on high-cost, high-need beneficiaries, care transition support to ensure continuity of care across settings, and forums to coordinate care plans for patients shared by providers (that is, medical neighborhoods).

Clearly define the role of lead provider entities in Medicaid delivery system reform. While PPSs are accountable for achieving performance metrics during the DSRIP demonstration, their role after the conclusion of the demonstration is less clear. States that use provider networks to lead delivery system reforms should clarify their roles during and after the demonstration. For example, states will need to resolve whether entities like PPSs can legally bear financial risk and contract with MCOs on behalf of network providers, or whether they will function solely as conveners and facilitators of delivery system change. Early clarification of roles and expectations for these entities will help them plan for sustainability down the road.

Align program participation and funding requirements with program goals. Even though New York gave all types of providers a chance to lead regional PPS networks, hospitals sponsor most PPSs, leading some stakeholders to charge that the reform process is too hospital-centric. Concurrent efforts to bolster safety net hospitals, which play a critical role in their communities, and strengthen the role of community-based providers can pose a challenge, often leading to competing priorities. However, if the goal is to reduce avoidable hospital use—as it is in New York's DSRIP demonstration—rules governing program participation and

the allocation of incentive funds among provider partners should give community-based providers an equal chance to lead reforms and ensure that such providers have sufficient capacity to deliver comprehensive primary care and social support services. To create equity among safety net hospitals and community-based providers, policymakers may need to implement policies such as (1) setting ranges for the share of DSRIP funding that flows to community providers, (2) ensuring transparency in how funding is used across networks, and (3) establishing parameters for hospitals' "make" versus "buy" decisions when expanding primary care services.

Support the development of robust health information exchange and technology. Providers that are jointly accountable for the care of attributed patient populations need to be able to share patient information in order to coordinate patient care effectively. Coordination activities require robust health information exchange capabilities and clarity on regulations governing patient data sharing. For example, at the start of a delivery system reform demonstration, policymakers should proactively address regulatory barriers to sharing patient health information and clarify requirements with participating providers. Further, lead provider entities should develop interoperable health IT capabilities, such as partner portals, that enable partners to share data that can be used to address patient care in real time.

Enable cross-sector collaboration and service coordination. CMS's and the states' removal of regulatory and financing barriers could help support the efforts of those states interested in promoting greater integration of services, particularly behavioral health and primary care. For example, policymakers should revisit requirements about how physical space must be configured for these services and determine if the requirements could be relaxed without compromising patient confidentiality or patient care. In addition, policymakers can help facilitate patient information sharing, promote the advancement of payment models that reimburse care coordination and care management activities, and address workforce issues through aligned licensing and credentialing requirements (Edwards 2017; Zivin et al. 2016). If providers have the ability to integrate services under current rules but are not sure how to do so, they may need cross-agency coordination to provide clear guidance to support these efforts.

Consider the needs of financially vulnerable safety net providers, particularly related to the transition to risk-based payment. As states seek to implement VBP for providers, certain safety net providers may be less prepared to assume downside financial risk in certain APMs. New York has made additional funding available to financially distressed hospitals to ease their transition to performance- and value-driven payment models. Policymakers should consider how delivery system changes will affect those safety net providers least prepared to change in the near term, encouraging a flexible

approach to meet providers where they are. Further, New York's experience points to the importance of obtaining baseline data on the current state of VBP adoption among different types of providers as an important first step in setting realistic VBP goals and guiding activities to bolster VBP readiness and participation. Through readiness assessments, states can identify which providers have the least capacity and experience to engage in VBP contracts and then target needed technical assistance and resources to such providers. States can also set different VBP targets for providers with the least capacity, ensuring that they do not assume more risk than is appropriate.

Ensure rapid-cycle feedback and monitoring of delivery system initiatives. With feedback from the independent midpoint assessment, the state and PPSs have already started to make changes to address implementation challenges. Given that many factors are at play in delivery system initiatives, it is critical to institute monitoring to determine whether programs are on track to meet goals, understand barriers and challenges, and identify midcourse corrections and improvements.

Proactively plan for sustainability in designing a delivery system reform initiative. When states pin the sustainability of delivery reforms on payment reform by MCOs, they should consult with managed care program managers in the Medicaid agency and in MCOs to coordinate the respective sets of policies in advancing the movement to VBP.

Looking Ahead

New York is implementing an ambitious delivery system reform agenda while promoting payment reform through Medicaid managed care. It is too early to tell if New York's DSRIP achievements will be sustainable beyond 2020. Although the formation of PPSs, and their ability to involve numerous providers in delivery reform projects, is a significant achievement of the demonstration, it is unclear how the PPS structure will be sustained after 2020. Some PPS respondents were confident about their ability to maintain partnerships; others were less sure. Further, some PPSs were optimistic about their ability to maintain care delivery changes but uncertain about whether they would continue to provide costly new services.

The state recently released a "Medicaid Redesign Team Structural Roadmap" for public comment. It delineated the roles and responsibilities of all key players, including PPSs, in a postdemonstration, VBP context (New York State Department of Health, Medicaid Redesign Team 2018). The roadmap expects PPSs to develop sustainability plans that define how they will help the state and other intermediaries, including MCOs, Health Homes, ACOs, IPAs, and other entities that coordinate services,

carry out their respective roles effectively. If a PPS decides to cease operations, it is expected to do so responsibly by transferring infrastructure to others in the community to retain critical functions aimed at improving population health.

In the near term, some PPSs and partners are exploring new partnerships, such as joining or forming Medicare ACOs. Still, some partners question the sustainability of activities that shift care away from hospitals to the community—particularly if hospitals no longer receive funding to make up for revenues

lost as a result of reduced utilization and if safety net hospitals continue receiving supplemental or other designated Medicaid payments not tied to performance incentives to reduce inpatient and ED services. And, even though the state, PPSs, and their partners view VBP adoption as the primary strategy to sustain delivery system reforms, significant challenges remain—including whether certain safety net providers are ready to accept risk-based payment and how various health care and social service providers will collaborate under these new models.

METHODS AND DATA SOURCES

The information in this brief is based on data gathered from document reviews and from key informant interviews with stakeholders involved in implementing New York's DSRIP demonstration. We collected data in three sequential phases:

- 1. Document review:** Between March 2017 and January 2018, we collected information from several publicly available sources on the progress, challenges, and outcomes of New York's DSRIP demonstration at the midpoint. To compile information consistently across each PPS, we extracted information for 18 categories (for example, program features, projects selected by PPSs, required projects, milestones) and several subcategories (for example, successes, challenges, and facilitators). We synthesized the major themes in each category and subcategory across all sources and compiled themes across PPSs. A full list of reviewed references is available in the appendix.
- 2. Key informant interviews with state consultants and evaluators:** Between April and June 2017, we conducted interviews with five state consultants or evaluators to understand key issues affecting implementation of the state's DSRIP demonstration.
- 3. Key informant interviews with PPS leads and their partners:** Between June and August 2017, we conducted 13 interviews with (1) leaders of seven PPSs located in geographically diverse regions of the state and with (2) primary care, mental health, other community-based providers, and other organizations involved in the PPS networks. Although we sought to interview community-based providers in each of those seven PPS networks, we were unable to schedule interviews in all regions.

Our interview protocols included questions on (1) PPS governance, network formation, and engagement; (2) project performance, DSRIP funds flow, and incentive design; (3) efforts to build capacity to engage in value-based payment with MCOs, share data, and conduct analytics; and (4) recommendations for improvements to the DSRIP model.

We also reviewed notes from semistructured interviews conducted during the same period with officials from New York State, provider associations, and MCOs. The purpose of these interviews was to provide information for another issue brief (Heeringa et al. 2018) that examines incentive design issues in six states with DSRIP demonstrations.

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Appendix: Full Reference List

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Endnotes

¹ Demonstration Year 3 ran from April 2017 through March 2018.

² Value-based payment encompasses a range of purchasing strategies that hold providers accountable for the cost and quality of care. Alternative payment models are a payment approach that includes incentives for providers to deliver high quality and cost-efficient care. Various APMs exist, with more advanced models involving greater financial risk for participating providers. APMs may apply to a specific clinical condition, a care episode, or a population (Centers for Medicare & Medicaid Services 2017a).

³ For state fiscal year 2017, which began April 1, 2016, the growth cap was 3.4 percent, with 3.2 percent projected in 2018, 3.0 percent in 2019, and 2.8 percent in 2020.

⁴ Total federal and state Medicaid spending in New York was \$59.68 billion in federal FY 2015 (Centers for Medicare & Medicaid Services 2017b).

⁵ It is not a requirement that hospitals lead PPSs, but if the lead entity is a hospital, it must (1) qualify as a public, critical access, or sole community hospital; or (2) have at least 30 percent of inpatients and 35 percent of all patient volume be Medicaid beneficiaries, uninsured individuals, or dual eligibles; or (3) serve at least 30 percent of all Medicaid beneficiaries, uninsured individuals, and dual eligibles in their region. Lead entities also had to pass financial tests to ensure that they could meet fiduciary responsibilities for receiving and distributing DSRIP funds, secure the participation of community-based providers and organizations, and demonstrate their commitment to contract on the basis of VBP with MCOs.

⁶ The state gave first priority for the 11th project to PPSs in each region with major public hospital systems. In regions that did not have a public hospital in a PPS or where the public PPS did not pursue the 11th project, the state allowed nonpublic PPSs in the region to carry out the 11th project (New York State Department of Health, Medicaid Redesign Team 2014).

⁷ PPSs that have met all project implementation milestones and that either (1) close the gap between their prior-year performance and the state's performance goal by at least 20 percent or (2) achieve the state performance goal for the measurement year are eligible for additional funds up to 30 percent of their total DSRIP valuation (New York State Department of Health, Medicaid Design Team 2015a).

⁸ Results released in September 2017 indicated that 10 out of 25 PPSs achieved performance targets in at least 50 percent of their measures, resulting in a distribution of \$11.8 million of earned Additional High Performance Program (AHPP) DY2 funds to these 10 PPSs. The remaining \$38.2 million in unearned funds were redistributed to these 10 PPSs, based on each successful PPS's relative award weightings within AHPP. Details are available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/vbp_initiatives/ahpp/docs/2017-09-06_ahpp_webinar_update.pdf.

⁹ The state's section 1115 demonstration special terms and conditions specify that the state's Designated State Health Program (DSHP) funding is also at risk based on state performance on the four milestones. DSHPs are state-specific health programs that are typically funded by the state. Before December 2017, DSHPs could qualify for federal matching funds when integrated into section 1115 demonstrations (McGinnis and Houston 2016; Neale 2017).

¹⁰ Data presented here show the nine-month trend in Measurement Year (MY) 3 (which corresponds to July 1, 2016 through June 30, 2017). The ninth month of MY3, April 2017, is the start of DY3. The state assesses measure improvement from MYs 1 and 2.

¹¹ These measures include potentially preventable readmissions, potentially preventable emergency room visits, Prevention Quality Indicator (PQI) 90, Pediatric Quality Indicator (PDI) 90, potentially preventable emergency room visits for the behavioral health population, adherence to antipsychotic medications for people with schizophrenia, and diabetes screening for people with schizophrenia or bipolar disorder using antipsychotic medication.

¹² The state defines three types of CBOs: Tier 1: Nonprofit, non-Medicaid-billing, community-based social and human service organizations (for example, housing, social services, religious organizations, food banks); Tier 2: Nonprofit, Medicaid-billing, nonclinical service providers (for example, transportation, care coordination); and Tier 3: Nonprofit, Medicaid-billing, clinical and clinical support service providers (licensed by the New York State Department of Health, New York State Office of Mental Health, New York State Office for Persons with Developmental Disabilities, or New York State Office of Alcoholism and Substance Abuse Services) (New York State Department of Health 2017).

¹³ Example views of the dashboard are available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/presentations/docs/2017-01_dashboard_overview.pdf.

¹⁴ According to the state's managed care VBP requirements, more advanced VBP arrangements must include at least one Tier 1 CBO as of January 1, 2018. The state hopes that the inclusion of CBOs in VBP arrangements will stimulate interventions to address the social determinants of health. Because of this requirement, the state has issued planning grants in several regions to help CBOs overcome contracting and administrative challenges related to VBP participation. However, a critical issue remains regarding how to reimburse CBOs for services provided to Medicaid beneficiaries (New York State Department of Health, Medicaid Redesign Team 2016).