Table 1. Comparison of Triple Aim Preconditions in DSRIP 1.0 and DSRIP 2.0

Triple Aim Preconditions	DSRIP 1.0	DSRIP 2.0
Defined Population- tracking a specific population over time (Berwick et al. 2008).	• DSRIP program was focused on the Medicaid Low-Income and Uninsured (MLIU) populations. • Providers created projects which defined project populations. • Quality/health outcome improvements require defining denominator populations for health improvements. • **Result:** DSRIP 1.0 encompassed many diverse populations within the broader MLIU patient group. • *Example Diabetes:* Many providers focused projects on primary care. These projects and corresponding metrics defined subpopulations for providers. For example, some providers opened same day clinics increasing access to patients but realized there needed to be a focus on diabetes and so chose diabetes metrics.	• The target population continues to be MLIU individuals. • Providers must define a "system" and account for individuals in the system. The system includes all essential services performed by providers. • Providers must improve health outcomes in this population. • **Result:** Providers are required to define a population through their system definitions and need to keep track and better understand their populations to make changes and achieve funds. • *Example Diabetes:* Providers have the ability to choose a measure bundle or measure associated with diabetes and track outcomes of everyone in the system. Thus, providers must implement changes to diabetes care if this measure bundle or related measures are chosen.
External Policy Constraints- processes coming out from political decision making. External policy constraints are the realities stemming from politics and community views that shape the processes surrounding healthcare (Berwick et al. 2008).	• Providers across Texas participated in DSRIP using protocols defined by the state and federal governments. • Payment was based on achievements in access, infrastructure, and quality as defined by DSRIP protocols. • The majority of participants are hospitals. • **Result:** DSRIP 1.0 introduced participants to the DSRIP program. The program allowed for more collaboration, highlighted challenges with integration, and identified the needs for the MLIU population. • *Example Diabetes:* DSRIP program structure enabled providers to implement diabetes focused	• Providers must focus on changing population health outcomes to achieve funds. • Menu for measures and measure bundles was chosen based on what the state believes is important and restricted choice of options. No measures or measure bundles focus directly on social determinant of health. • Because the rules tie funds predominantly with achieving health outcomes, providers may try to choose measures or measure bundles that have achievable goals rather than where the need exists for the community. • **Result:** DSRIP 2.0 forces providers to account for the entire MLIU population their system touches and

	projects as there was a need in the community. The majority of payment for these projects was tied to increasing access and implementation, with fewer funds tied to population quality outcomes (though the funding allocation for this category increased each demonstration year).	encourages increased collaboration to achieve goals. • *Example Diabetes:* The state has included diabetes in the menu for DSRIP 2.0 and made it a state priority, increasing the incentive for providers to select it.
Existence of an Integrator- an entity responsible for all aspects of the Triple Aim (increased quality, increased patient experience, and reduced cost) for a defined population (Berwick et al. 2008).	• Providers increased their focus on quality and patient access (all elements of patient experience). • There was a focus on controlling cost as each goal had a certain dollar value associated payment cap. • Ultimate goal of program was to improve care for the MLIU population while reducing healthcare costs. The Waiver was approved to be budget neutral. • **Result:** Projects focused predominantly on access though the emphasis on quality grew as the Waiver continued. • *Example Diabetes:* Provider projects were mainly primary care and had many metrics focused on access. From chosen projects, Providers choose diabetes metrics appropriate for their population and were paid for achieving certain metrics.	• Providers are tasked with defining a system and implementing health outcome changes. • A greater portion of the incentive is tied with health outcomes though there is still incentive tied to access for the MLIU population. • Patient experience scores expanded to all provider types. Providers also need to report on cost analysis for their interventions. • **Result:** Providers need to understand their system population in order to create changes for certain measures. The state enforces elements of cost, making global cost control within their purview. DSRIP 2.0 is focused on what interventions must be and how to report them and puts more of the responsibility of effective interventions and cost management on the providers. • *Example Diabetes:* Providers choosing diabetes measures may need to better integrate their populations in order to achieve their measure goals and need to think about cost, quality and experience. There may also be may need to target social determinants of health to change outcomes.