# New York State's 1115 Waiver and DSRIP – Initial Summary

This week, Governor Andrew Cuomo announced that the Centers for Medicare and Medicaid Services (CMS) had approved the final Terms and Conditions of New York's 1115 Medicaid Waiver, which will provide $8 billion over a five-year period. The following is a summary of our ***initial*** review of the final Terms and Conditions. We have included references to the T&Cs and Attachments. Please note that the State will be releasing additional detailed information, hosting webinars, and providing assistive tools to stakeholders in the coming weeks and months.

***Please contact us with any questions or to schedule a detailed discussion.***

## Resources

Preliminarily, we note that materials related to the Waiver are publicly available at http://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm. Materials at this link include the following:

- *Special Terms and Conditions.*
- *Program Funding and Mechanics (Attachment I).*
- *DSRIP Strategies and Metrics Menu (Attachment J).*
- *Stakeholder hearings.* The Department of Health (DOH) began holding public hearings related to the Waiver on April 15th. The hearing schedule is available at the referenced link, as is the presentation being used at the hearings.
- A detailed *Pre-recorded webinar*.
- *Databooks* that contain provider and performance data by region.
- State-identified lists of *Safety Net Providers.*
- *DSRIP Glossary.*
- *DSRIP Timeline* (note that the timeframes are fluid).
- Links to *Population Health Data Sources.*

## Waiver At a Glance

The following parts constitute the full Waiver funding:

- $6.42 billion – Delivery System Redesign Incentive Payment (DSRIP) program
- $500 million – Interim Access Assurance Fund (IAAF). This is a **new** aspect to the Waiver. The dollars would be available to financially distressed safety net providers.

- $1.08 billion – for programs and investments related to health homes, long term care workforce and enhanced behavioral health services (to be accomplished via state plan amendment (SPA) or managed care contract changes).

## Non-DSRIP Components

The $1.08B for non-DSRIP Waiver elements is broken down as follows:

- Health Home Development funds. There is $190.6 million over five years for the purpose of member engagement and health home promotion, workforce training and retention, clinical connectivity (health information technology implementation), and joint governance technical assistance and implementation. The dollars will be distributed via a rate add-on. A SPA will be required for this purpose. The State believes Health Homes will also be an important player in the State's future health care infrastructure, including participating in DSRIP.
- Managed Care Contract Amendments. While the original Waiver application would have used the managed care contract amendments to address access to primary care issues, the final T&Cs limit the managed care contract amendments as vehicles to implementing 1915i Waiver Services (home and community based related to the behavioral health carve-in to Medicaid managed care) ($645.9M) and long term care workforce strategies ($245M). (Both of these purposes are already being addressed in managed care contracts, where the primary care proposals were not.) Funds would flow through the plans to the providers contracting with the plans.

## Interim Access Assurance Fund (IAAF) (Page 49)

The Waiver allocates $500 million for this temporary, time-limited funding. IAAF funds will be available through December 31, 2014[1] for the purpose of protecting access to, limiting "unproductive disruption to," and avoiding gaps in "key health care services." While not required by the T&Cs, the State has said the fund will be divided evenly between public hospitals and non-public hospitals. The State has indicated that eligible providers must be expected to face imminent financial threats within the next 12 months.

Dollars will go directly to safety net providers that:

- Serve significant numbers of Medicaid beneficiaries
- Have "financial hardship in the form of financial losses or low margins"
- The State determines needs the funding to preserve access to Medicaid beneficiaries and uninsured persons
- Are part of a submitted DSRIP application.

[1] The T&Cs allow a one-time extension of IAAF to March 31, 2015.

The State, however, will post more specific qualifications on the web and allow for public comment for 14 days, and must take into account the public comment prior to distributing funds. After the 14-day comment period, the State will take applications.

Any IAAF dollars not expended will be allocated to the DSRIP pool. IAAF dollars cannot be duplicative of other funds.

## DSRIP

The final Terms and Conditions identify the following overarching **DSRIP goals**:

1. Safety Net System Transformation at both the system and **statewide** level;
2. Accountability for reducing avoidable hospital use (reducing by 25%) and improvements in other health and public health measures at both the system and state levels;
3. Efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform; and
4. Near-term financial support for vital safety net providers.

***GOVERNING DSRIP THEMES***

- **Collaboration** between providers
- Understanding project valuation driven by
  - Number of persons served and who serves them
  - Number of projects and how transformative those projects are
  - Quality of the application
- Payments are based on performance
- State-wide **accountability**
- Sustainability – Performing Provider Systems will establish permanent, sustainable integrated delivery systems

### A Note About the DSRIP Timeframe

DSRIP projects will begin April 2015 (DSRIP Year 1). This year, 2014, will serve as a planning year – or, as DOH has said, "DSRIP Year 0." In DY0, stakeholders are encouraged to begin discussions *immediately* to begin to form DSRIP coalitions, review population health data, and begin to develop DSRIP projects. Letters of Intent will be due in May, applications for Planning Grants and initial applications will be due in June, and applications for the IAAF will also be due soon (specific dates TBD).

### Two Main DSRIP Pools and Eligible Applicants (Page 52)

DSRIP will be divided into two pools: one for major public hospital systems,[2] and one for Safety Net Performance Provider Systems. The State will determine allocation between the two pools after applications are received and valuated.

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[2] The T&Cs define major public hospital systems to include: Health and Hospitals Corp. of NYC, SUNY Medical Centers, Nassau University Medical Center, Westchester County Medical Center, Erie County Medical Center. Page 52.

There will also be a Performance Pool for high-performing DSRIP projects.

### Definition of Safety Net Provider (Page 50-51)

The final T&Cs provide the following definitions of safety net provider. *Please note that the Department has posted on its website lists of entities by provider type which it has determined meet these definitions*.

A **safety net hospital** (page 51) must meet one of the following criteria:

1. Must be a public hospital, critical access hospital or sole community hospital; OR
2. Have both of the following elements:
    a. At least 35% of all patient volume in the hospital's out-patient lines of business be "associated" with Medicaid, uninsured and dual eligibles; AND
    b. At least 30% of the hospital's inpatient treatment must be "associated" with Medicaid, uninsured and dual eligibles; OR
3. Serve at least 30% of all Medicaid, uninsured and dual eligibles in the proposed county or multi-county community, although the State reserves the right to increase this percentage on a case-by-case basis.

A **non-hospital safety net provider not participating in a health home** must have at least 35% of all patient volume in their primary lines of business associated with Medicaid, uninsured and dual eligibles.

***COLLABORATION***
Single provider systems will not be eligible for DSRIP. Successful applications will be collaborative and include a wide array of providers and partners.

A provider that falls under the **Vital Access Provider Exception.**[3] Under this exception, the State will consider exceptions to the safety net definitions on a case-by-case basis, and any exceptions must be posted for public comment and approved by CMS. Bases for an exception are:

- A community that will not be served without granting an exception because no other eligible provider is willing or capable of serving the community;
- A hospital that is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or a clear track record of success in reducing avoidable hospital use; or
- Any health home or group of health homes.

Safety net providers funded to participate in DSRIP will be called "**Performing Provider Systems.**"

[3] Please note that the use of "Vital Access Provider" in the context of the T&Cs does not specifically reference or assume the same definition as the State's Vital Access Provider program.

## Coalitions (Page 52-53; Attachment I)

Individual providers will not be successful applicants. Applications must consist of a coalition of safety net providers or public hospitals and safety net providers that will operate as a **Performing Provider System (PPS)**.

No more than 5% of DSRIP funds can go to entities not eligible for DSRIP (i.e., non-public hospitals or non-safety net providers). Stated another way, a majority of a lead applicant's DSRIP partners must be independently eligible to apply for DSRIP.

Coalitions must:

1. Designate a **lead coalition provider**. This provider will be responsible for adherence to all conditions, metrics and other requirements of DSRIP as well as State and CMS rules.
2. Establish a **clear business relationship** between component providers. This shall include
    a. Developing joint budgeting
    b. Developing a funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The distribution plan must comply with all applicable laws and regulations (e.g., fraud and abuse rules, anti-kickback laws, physician self-referral prohibitions, gainsharing civil penalties, beneficiary inducement prohibitions).
3. Have a plan for reporting, decision-making, change management and dispute resolution on performance and incentive payments
4. Identify a proposed DSRIP population that does not duplicate another DSRIP population and meets minimum outpatient beneficiary requirements (see Population Attribution, below)
5. Establish a data agreement to share and manage data on system-wide performance.

***I DO!***
The application requires that PPS partners commit to each other for the life of the DSRIP project.

## DSRIP Pre-Implementation Activities

CMS is requiring the State to meet implementation milestones before it authorizes DSRIP funding for all five years.

- **Public Comment Period.** There must be a 30-day public comment period (running from April 14, 2014). Comments and any *technical* changes resulting therefrom must be posted. The State cannot make changes to the protocols and menu unless those changes originate from public comment. CMS must take action on any requested changes within 30 days of the State's submission of the same.
- **Baseline Data.** Metrics on which DSRIP providers are measured must be developed and based on data collected by the State prior to the DSRIP start period. This process will take into account that there may be high

performers already in the system, and that those entities cannot select projects in which they are already high performing.

- **Contracted Assistance.** The State must identify, describe the functions of, and describe the administrative costs anticipated for entities to serve as:
  - **An independent assessor** (to review DSRIP project plans and make recommendations to the State)
  - **An independent evaluator** (to assist with continuous quality improvement activities). The State must submit for CMS approval an evaluation plan, and an independent evaluator must be selected within 120 days of April 14, 2014.
- **Updating Quality Strategy.** The State is required to update its comprehensive quality strategy to ensure that DSRIP will be supported by managed care, health home and MRT quality activities.
- **Establishing DSRIP Operational Protocol.** The State must submit this protocol to CMS within 90 days of April 14, 2014. The Protocol will govern baseline data and ongoing reporting.
- **Project Design Grants ("Planning Grants").** $100 million may be distributed in 2014 to providers to develop specific, comprehensive DSRIP Project Plans, and the State has indicated it will release $70 million for this purpose. The Grant payments will be counted against the total DSRIP award. Statements of intent will be due **in May** and Planning Grant applications will be due in **June**. The State anticipates that planning grants will average $500,000 per PPS.
  - **How to Apply for a Grant:** Eligible providers and coalitions will submit a DSRIP Design Proposal, which the State will review. Awards can be made any time in 2014.
  - **Use of Grant Funds:** Grant funds must be used to prepare a DSRIP project plan and application. *If a provider or coalition receives a grant, it must submit an application.*

***Start Talking and Exploring Resources***

What should providers be doing **today?**

- Talking to each other about forming coalitions, understanding what services are provided and populations served, and what population health data is saying about community need.
- If you cannot analyze the population health data yourself, consider hiring a firm that can.
- If you are considering being a lead, examine whether you have or can obtain resources for complex project management (see Project Design grants, below).

## DSRIP Projects

Performing Provider Systems must develop and implement multiple projects based upon the needs of the community and which are designed to meet the core DSRIP goals. Projects will begin on **April 1, 2015.**

Every DSRIP project **must** meet the following **objectives**:

- **Infrastructure.** Each project must create an infrastructure and processes based on community need to promote operational efficiency and support prevention and early intervention;
- **Integration of care.** Each project must integrate care settings "through the cooperation of inpatient and outpatient, institutional and community-based providers, in coordination and providing care for patients across the spectrum of settings . . . while managing the total cost of care."
- **For a defined population, employ Population Health Management.**
- **Workforce strategies.** Each plan must include a workforce strategy.

## Developing a DSRIP Project Plan

Performing Provider Systems must develop a DSRIP Project Plan by selecting projects from a menu as specified in Attachment J of the Terms and Conditions. As described below ("DSRIP Projects and Milestones"), every DSRIP Project Plan must meet certain objectives and contain projects focused on creating integrated delivery systems and address behavioral health issues. Every plan must contain at least five but no more than ten projects selected from the DSRIP Attachment J. If a Performing Provider System is already performing at a high level on a certain initiative, the project likely will not be approved because the purpose is to improve outcomes and performance.

### Basics

Plans must be developed based on objective population health data to ensure that the plan reflects the needs of the community. Additionally, the Performing Provider Groups must obtain community input, and this community input must be reflected in the plan.

The projects must be a new initiative for the Performing Provider System OR be substantially different from other initiatives. This could include a change in scope to an existing project.

The partners should demonstrate a commitment not just to the project(s) throughout the Waiver period, but beyond to establish long-term sustainability.

Applications **must** be collaborative. Applications from single providers will not be successful.

***IMPORTANT DATES***

**May:** Letter of Intent Due. This is non-binding, and partnerships can continue to evolve. DOH will provide format for this letter.
**June**: Planning grant planning applications will be due.
**December 2014**: Final applications due with completed networks.

## Community Assessment (Attachment I, Page 10)

Projects (see below) selected MUST be supported by data demonstrating that the goal is both relevant to the community served and the providers participating in the system. A specific community needs assessment must be conducted with a focus on behavioral health. The State will not dictate the form of the community assessment, but applicants are expected to use data sets provided by the State and be able to document how population health data sets the foundation for DSRIP project proposals.

## Organizing Your Project Plan

Each plan must include the following sections, and applications will be scored on adherence to format. Applicants should pay attention to the quality of their application, because it will count towards the overall valuation of the applicant's DSRIP plan.

- A DSRIP Face sheet
  - Applicant's name
  - Executive Summary of 1000 words or less
- Provider Demographics
  - Contact information for the lead DSRIP contact
  - Names and contact information of all the participating DSRIP partners, including the lead provider, and including provider identification numbers
  - The defined service area and how the provider partners relate to that service area
  - An explanation of how participating providers qualify as safety net providers
  - Patient population demographic information and payer mix.
- Clear statement of goals and how the projects contribute to the goals of, and expected results for
  - Creating and sustaining an integrated, high performing health care delivery system, improving care and lowering costs
  - How the project will engage in system transformation (e.g., linking across setting, building capacity, accountability for populations)
  - Governance strategies to ensure that all participants work as a system, and plans to ensure that this governance is strengthened throughout the Waiver period.
  - Goals must be mapped to research hypotheses.
- Performance Assessment. This section must include the following elements:
  - Current **community health needs assessment**, which will look at population demographics, types and numbers of providers and services, cost profiles, designation as Health Professional Shortage Areas, mortality and morbidity statistics, and health disparities. Additionally, State public health concerns will be addressed (esp. behavioral health). This assessment will establish the baseline for the projects.

  - Evidence of regional planning and analysis of issues causing poor performance in the region (including assessment of patient co-morbidities, patient characteristics, social systems supports, capacity for primary care and disease management). Additionally issues such as financing, delivery fragmentation, and competition between providers[4] must be addressed.
  - **Comprehensive workforce strategy**, which will identify workforce issues and a plan to address how existing workforce strengths will be leveraged in the new delivery system.
  - **Review of Financial Stability**, which will include a review of the financial conditions of financially challenged safety net and public providers in the PPS, as well as goals or plans to address financial stability issues.
  - **Evidence of Public Input.** The plan must document collaboration with local departments of public health, workforce, public stakeholders, and consumers. Additionally, there must be a plan for ongoing community engagement, including active participation in any **regional health planning** initiatives. It is suggested that a PPS establish a website for posting of materials to the public.
- **Work plan development**. This section will follow a State-designated format to establish a high-level DSRIP project work plan identifying community needs and how they will be addressed by selected DSRIP projects over five years. Systems changes must be completed in DY 1 and 2, and outcome metrics will begin in DY2. Plans must include not less than 5 projects and not more than 10, and must include certain projects, as identified below. Plans must specify the likelihood for success of projects.
- **Rapid Cycle evaluation** to inform the system of progress in a timely fashion.
- **Clearly established milestones and metrics (see below)**.
- **Budget**. The PPS must provide a detailed 5-year budget. All funding requests must be justified. The budget must include information necessary to describe and detail mechanisms for the state to receive intergovernmental transfers. The plan must identify project valuation and how funds will be distributed to participating stakeholders in accordance with project valuation (see below). To assist PPS in this task, DOH will post a Budget Funding allocation calculator online at DOH. DOH has reminded potential participants that budgeting should take into account the attribution of members to providers, as well as the role of a particular provider member in achieving the outcomes of a particular project.
- **Governance**. The plan must explain existing governance structures as well as how the PPS will evolve into an Integrated Delivery System (i.e., beyond the DSRIP period). Decision-making authority and accountability must be clearly delineated. Applications with weak governance structures will be

[4] None of the materials provided by the State to date have addressed anti-trust issues.

rejected, and strong centralized control is encouraged. The plan should include how low performing providers within the PPS will be addressed, including removal of that provider from the PPS.

- **Data sharing and confidentiality**. The plan must detail how data will be collected in a "uniform and valid fashion across all members" of the PPS in a HIPAA-compliant manner.
- **Explain how the projects and outcomes will be sustained after the five-**year period.
- **Attest that projects are not duplicative**.
- **Commitment to participation in a learning collaborative** related to the project.

## DSRIP Projects and Milestones (Attachment J)

Performing provider systems must design and implement **at least five but no more than ten DSRIP projects** (selected from Attachment J). DSRIP projects and their milestones are organized into four "Domains." Each project is scored and weighted by the State. Certain projects are weighted more heavily than others. The applicant must identify baseline data for all measures, and demonstrate the ability to provide benchmarks and valid data for each measure.

Domain 1: Overall Project Progress

*What*: Investments in technology, tools and human resources to strengthen the Performing Provider System, serve the target population and pursue DSRIP goals. ***Domain 1 metrics assess <u>any</u> DSRIP project – e.g., those picked from other domains, in addition to metrics specific to another Domain.***

*Performance Measurements Include*:[5]

- Monitoring project spending
- Post-DSRIP sustainability
- Semi-annual reports (pay for reporting)
- Approval of DSRIP plan (DY 1 only)
- Workforce milestones (including progress on a workforce plan and changes in numbers of providers hired)
- System integration plan progress
- Project-specific metrics.

***MODIFYING PLANS***
A PPS can modify its DSRIP plan no more than once a year, subject to State and CMS approval.

Domain 2: System Transformation Projects (Must pick **two**)

[5] All metrics for each Domain described in this document are detailed in Attachment J of the final Terms and Conditions, including whether payment for meeting a measure in a given DSRIP Year is based on reporting or performance requirements. Attachment J gives the specific measure and the source of information the State will use to determine whether the measure has been met.

*What:* A DSRIP application can include **up to four** of the following projects, but each DSRIP **must include** two of the following projects based on community needs assessment.

- Create integrated delivery systems (**must pick at least one** from the list below)
  - Create integrated delivery systems focused on evidence-based medicine/population health management; or
  - Increase PCMH certification of primary practitioners and/or certification as Advanced Primary Care models; or
  - Establish a Health Home at-risk intervention program (which would require proactive management of higher risk patients not currently eligible for Health Homes; or
  - Create a medical village using existing hospital infrastructure; or
  - Create a medical village or alternative housing using existing nursing home infrastructure.
- Connecting Settings (must either pick one from this list, or one from the list below)
  - Development of community-based health navigation services
  - Expand usage of telemedicine in underserved areas
- Implement care coordination and transitional care programs (must either pick one from this list, or one from the Connecting Settings list above)
  - Ambulatory ICUs
  - Develop co-located primary care in the ED
  - ED care triage for at-risk populations
  - Care transitions intervention model to reduce 30-day readmissions for chronic health conditions
  - Care transitions for skilled nursing facility residents
  - Transitional supportive housing services
  - Implement the INTERACT project
  - Hospital-Home Care Collaboration Solutions
  - Implementation of observations programs in Hospitals

***DSRIP IS "PAY FOR ACHIEVEMENT"***
Payment is based on outcomes. There will be no appeals process if metrics are not met. If there are failures state-wide -- because there is state-wide accountability -- there could be **state-wide reductions** in DSRIP funds starting in DY 3.

*Performance Measures include:*

- Inpatient/outpatient balance, including avoidable ED visits and avoidable re-hospitalizations and PQIs (pay for performance DY 3-5)
- Increased primary care/community-based service utilization (e.g., CAHPS measures and percentage of PCPs meeting PCMH/Advanced Primary Care)
- Access to care measured by HEDIS scores (pay for performance DY 3-5)
- Rates of global capitation, partial capitation and bundled payments (pay for reporting all five years)

- Patient engagement
- Creating an integrated setting and care coordination, measured by CAHPS scores (pay for performance DY 3-5)

*Payment and Timing notes:* All Domain 2 metrics are pay for reporting in DY1 & 2.

Domain 3: Clinical Improvements (Must pick **two**)

*What:* Based on the community assessment, all DSRIP plans **must include at least two** projects from the following menu (and up to four), but **all DSRIP applications must include at least one behavioral health project.**

- Behavioral health (**must pick one of the of the following**)
  - Integration of primary care services and behavioral health
  - Behavioral health community crisis stabilization services
  - Implementation of evidence-based medication adherence program (MAP) in community-based settings
  - Development of community-based withdrawal management
  - Behavioral Interventions Paradigm in Nursing Homes (BIPNH)

The other clinical improvement projects that can be chosen include options in the fields of:

- Cardiovascular health
- Diabetes care
- Asthma management
- HIV/AIDS strategies
- Perinatal care
- Palliative care
- Renal Care

***Mid-point Assessment***
All DSRIP plans approved by the State must be *re-approved* in 2017 in order to continue to receive funding in DY4-5.

*Performance Measures include:*

- For non-behavioral health projects, the metrics will be specific to the project but generally will measure
  - improved quality of care and reduced avoidable ED visits,
  - hospital admissions and readmissions based on objective demonstration of improvement over a baseline using a standardized method.
- Behavioral health projects additionally will be measured on
  - anti-depressant medication management (pay for performance DY2-5)
  - follow up hospitalizations for mental illness (pay for performance DY2-5)
  - initiation and engagement of alcohol and other drug dependence treatment (pay for performance DY2-5)
  - diabetes monitoring for people with diabetes and schizophrenia (pay for performance DY2-5)
  - cardiovascular monitoring for people with schizophrenia and CVD (pay for performance DY 2-5)

- additional behavioral health measures specific to BIPNH (pay for performance DY 2-5)

If a system is already high performing in these areas, it must look to alternative projects or partner with lower performing entities so that there is room for improvement.

*Payment and Timing note:* All Domain 2 metrics are pay for reporting in DY1.

Domain 4: Population-Wide Projects (Must pick **one**)

*What:* These are projects related to the State's Prevention Agenda (available HERE) and are to be aimed at specific populations. This population-wide approach is broader than the clinical improvements in Domain 3. Every DSRIP **must include at least one project below (but can include up to four)**, based on the community assessment:

- Activities to promote mental health and prevent substance abuse (strengthening infrastructure, prevention activities, wellness activities)
- Programs to prevent chronic disease through tobacco cessation and/or increasing access to high quality chronic disease preventive care and management in clinical and community based settings
- Preventing STDs and HIV (focus on decreasing morbidity, decreasing disparities, and/or increasing early access to and retention in HIV care)
- Reducing premature births.

*Performance Measures include:* Metrics specific to the project, specific to the geography, as identified in the Prevention Agenda.

### DSRIP Member Attribution (Attachment I, Page 3-6)

Members will be assigned to each PPS according to the following methodologies, although the State may adjust this method later on. A Medicaid beneficiary will only be assigned to one PPS. There will be a collective target population per PPS, with subset target populations for particular DSRIP projects. **A PPS must have a minimum of 5000 Medicaid members.**

***ATTRIBUTION CONSIDERATION***
Volume matters in DSRIP for attribution, outcome, efficiency and valuation purposes. Providers with large volumes of Medicaid beneficiaries will be critical to include in a PPS coalition in a given geographic region.

If there is only one PPS in a region, all members will be assigned to that PPS. ***It is the State's strong preference that there be one PPS per region*** *(which will greatly simplify attribution determinations).*

If there are multiple PPSs in a region, the following methodology will be utilized, which is based on loyalty to providers and is similar to the Health Home attribution methodology.

First, there will be a matching goal, where the assignment is based on the patient's current utilization patterns, assigned PCP and geography. A plurality of visits will be examined.

Second, the following service groupings will be used in the following priority.

- 1st – care management provider
- 2nd – outpatient (physical and behavioral health), including PCPs and other practitioners
- 3rd – Emergency room visits
- 4th – Inpatient stays.

Networks need to be finalized before attribution can be made.

Third, once the PPS network is finalized, the network will be loaded into the attribution system for recipient loyalty, and adjustments may be made. Then the system determines the PPS with the highest number of visits per recipient.

Fourth, the state will use hierarchical matching based on case management connectivity, or, if none, outpatient connectivity, ER and then inpatient stays.

Fifth, if more than one PPS has the highest number of visits, logic is re-run.

Finally, if beneficiaries are unmatched at the end of the process, they will be assigned based on their Medicaid MCO-assigned PCP, or, if none, by the number of other persons in their zip code assigned to a PPS.

Medicaid MCOs will be asked to review the attribution lists to ensure that members are not disrupted.

### Project Scoring and Valuation (Attachment I, page 13-18)

DSRIP Projects will be scored according to the following formula. Additional detail will be released, particularly around scoring of the application (step 3). ***We strongly recommend that potential DSRIP participants should review DOH's presentation detailing the valuation process, including an example applying the methodology to a hypothetical.*** Additionally, detail is provided on each of the following elements in Attachment I to the Terms and Conditions.

| | |
|---|---|
| Step 1 | Each project is assigned a **project index score** (out of 60 possible points = x/60) |
| Step 2 | The State has established a project PMPM, which is a set dollar PMPM depending on the **total number of DSRIP projects in an application.** The project PMPM decreases with the number of projects in an application, recognizing efficiencies of scale. |
| Step 3 | DSRIP project applications will be scored up to 100 points, so pay attention to application requirements (application scores = x/100). *Complete, data-supported applications that adhere to required formats are important in ensuring maximum valuation.* |
| Step 4 | **Maximum project value** is calculated by multiplying **project PMPM, the** |

| | |
|---|---|
| | **plan application score,** the **number of Medicaid beneficiaries attributed to the particular project,** and the **duration of the project.** A PPS will receive a payment based on the performance of each particular project. |
| Step 5 | **Maximum application value** = the addition of each of the **maximum project values.** This is the most money available for the total application, but a PPS will receive less if it fails to meet metrics in particular projects. |

Please note that creating integrated delivery systems and medical villages[6] have the highest project index scores.

### DSRIP Metrics (Attachment I, Page 19)

**Pay for performance** metrics will be based on a decile of state or national data, depending on the metric, and the annual improvement targets will be established using a methodology of reducing the gap goal by 10%. Attachment I gives the following **EXAMPLE:**

> If baseline data for a measure is 52% and goal is 90%, the gap to the goal is 38. The target for year one would be 3.8% increase (55.8%). Each subsequent year would continue to be set with a target using the most recent year's data.

If Performing Provider System meets the 10% target for the year, it will "pass" the milestone. That is, milestones are pass/fail. Performing Providers Systems scoring 20% or more on a metric may be eligible for additional payments form the high performance fund.

If a PPS only partially meets a DSRIP project metric target, each milestone within a project will be equally weighted. If, for example, a project has five milestones, and the PPS only meets two, it will receive 40% of the value for that project.

The table below describes how funds will be distributed over the five-year period for all DSRIP projects, generally.

| Metric/Milestone Domains | Performance Payment | Year 1 (2015) | Year 2 (2016) | Year 3 (2017) | Year 4 (2018) | Year 5 (2019) |
|---|---|---|---|---|---|---|
| Project progress (Domain 1) | P4R/P4P | 80% | 60% | 40% | 20% | 0 |
| System Transformation | P4P | 0 | 0 | 20% | 35% | 50% |

[6] Bed buy-back is contained in the medical village proposal.

| | | | | | | |
|---|---|---|---|---|---|---|
| & Financial Stability (Domain 2) | P4R | 10% | 10% | 5% | 5% | 5% |
| Clinical Improvement (Domain 3) | P4P | 0 | 15% | 25% | 30% | 35% |
| | P4R | 5% | 10% | 5% | 5% | 5% |
| Population Health Outcomes (Domain 4) | P4R | 5% | 5% | 5% | 5% | 5% |

## Statewide Performance (Attachment I, Page 33)

If the State *as a whole* fails to meet certain overall metrics via the DSRIP program, DSRIP funding will be impacted for all DSRIP PPSs, regardless of how successful a particular PPS might be. The State must pass all four of the following milestones, or suffer penalties of 5% (DY3), 10% (DY4), and 20% (DY5):

- Statewide improved performance on a universal set of delivery system improvement metrics (Domain 2) (measured against DY1). To *pass* the State needs to demonstrate improvement on more factors than those for which it cannot.
- Composite success of DSRIP projects across PPSs. To *pass* the State needs to demonstrate success with more projects of a given type than failure.
- Growth in total statewide Medicaid spending at or below a target trend rates, including total inpatient and ED spending.
- Implementation of managed care plan. The State will need to demonstrate continued progress in moving the Medicaid population to a system of managed care.

***REPORTING, MONITORING AND SITE VISITS***
A PPS will be subject to rigorous and regular reporting requirements, State and federal monitoring requirements, and site visits.

Additionally, the State must pass 50% of the IP/ED spending reduction goals to avoid a separate penalty (in equal proportions per DSRIP year) to a Designated State Health Program Fund.

## DSRIP High Performance Fund (Attachment I, Page 31)

Performing Provider Systems that exceed their target metrics will be eligible for additional funding out of a high performance fund. There are two ways to qualify: if the PPS exceeds the benchmark for a particular goal or if certain behavioral goals are met. The fund is seeded by 10% of overall DSRIP funds, as well as from PPS that fail to meet their goals (dollars not awarded to fully-performing PPSs will be invested into the high performance fund).

## Managed Care and DSRIP (Page 78-79)

The State is developing a "road map" for amending managed care contract terms to "reflect new provider capacities and efficiencies in managed care rate-setting," which CMS must approve before SFY 2015-16. The plan will identify how the State will move 90% of managed care payments to actuarially sound, value-based reimbursement within the Waiver period, and how such a change will impact plans.

***WAIVER IS ABOUT PAYMENT REFORM***

The State has committed that by the end of the Waiver period, 90% of all Medicaid payments will be value-based payments, non-fee-for-service. The State anticipates that Performing Provider Systems will enter into value-based contracts with managed care organizations.

## Conclusion

We emphasize that this document reflects an *initial* review of the State's Waiver materials. More updates will be forthcoming as DOH continues to release details in the coming days/weeks. While this is probably the most complex waiver CMS has ever approved for New York, we encourage our clients to become fully engaged immediately, or risk missing an important funding opportunity.