



Frequently Asked Questions (FAQs) - New York's MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan

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Frequently Asked Questions (FAQs)

New York's MRT Waiver Amendment Delivery System
Reform Incentive Payment (DSRIP) Plan



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Medicaid Redesign Team (MRT) Background

Q: What is the MRT Waiver Amendment?

A: The MRT Waiver Amendment will allow the state over five years to reinvest \$8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms to implement an action plan to save and transform the state's health care system, bend the Medicaid cost curve, and assure access to quality care. The \$8 billion reinvestment will be allocated in the following ways:

- **\$500 Million for the Interim Access Assurance Fund** – temporary, time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without unproductive disruption
- **\$6.42 Billion for Delivery System Reform Incentive Payments (DSRIP)** – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs
- **\$1.08 Billion for other Medicaid Redesign purposes** – this funding will support Health Home Development through a State Plan Amendment, and investments in long term care workforce and enhanced behavioral health services through managed care contract payments

Q: How does the Waiver Amendment relate to the Medicaid Redesign Team?

A: Established by Governor Cuomo in January 2011, the MRT brought together stakeholders and experts from throughout the state to work cooperatively to both reform New York State's health care system and reduce costs. The MRT was charged with addressing underlying health care cost and quality issues in New York's Medicaid program to craft a first year Medicaid budget proposal as well as develop a multiyear reform plan.

The MRT waiver amendment is an agreement that allows the state to reinvest over a five-year period \$8 billion of the \$17.1 billion in federal savings generated by MRT reforms. This reinvestment will lead to system transformation that will preserve essential safety net providers across the state and increase access for all New Yorkers to high-quality health care.

The MRT waiver amendment will enable New York to fully implement the groundbreaking MRT action plan to permanently restructure our health care system and continue to make New York a national model.



Interim Access Assurance Fund (IAAF)

Q: What is IAAF?

A: IAAF stands for “Interim Access Assurance Fund”. This is temporary funding to be awarded to select Medicaid providers to protect against degradation of current access to key health care services, limit unproductive disruption, and avoid gaps in the health delivery system until DSRIP is implemented. The IAAF is available to provide supplemental payments that exceed upper payment limits, DSH limitations, or state plan payments, to ensure that certain current Medicaid safety net providers remain viable so they can more fully participate in DSRIP.

Q: Is there a time and dollar amount limit on IAAF funding?

A: New York may expend up to \$500 million in FFP for Interim Access Assurance payments for the period of the date of approval of the IAAF expenditure authority until March 31, 2015.

Q: Who qualified to receive IAAF funding?

A: Please visit the IAAF website for a detailed description of the IAAF guidelines. http://www.health.ny.gov/health_care/medicaid/redesign/iaaf/

Q: Do you need to submit an application to receive IAAF funding? If so, how long will providers have to do so (deadline to submit application)?

A: Final IAAF applications were due on May 30, 2014 and \$462 million of these funds have been awarded. More information on awards can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/iaaf/iaaf_awards.htm

Q. Can a non-hospital based provider apply for IAAF?

A. No. IAAF funding was only made available to hospital based providers. Non-hospital based providers in need of funding to protect against degradation of current access to key health care services are encouraged to apply for funding through the Vital Access/Safety Net Provider Program (VAP).

Q. How does the IAAF funding affect the ability to apply for DSRIP funding?

A. Any applicant who applied and received IAAF funding must subsequently become part of a DSRIP Performing Provider System that submits a DSRIP Project Plan application. Receipt of IAAF funding does not limit eligibility for DSRIP Project Design Grants. However receipt of IAAF funding *does* limit ability to serve as a lead applicant.



Q. How does IAAF funding affect a PPS' applicant status?

A. In certain instances, receipt of IAAF funding *does* impact an organization's ability to serve as a lead applicant. Only public hospitals are able to receive IAAF funding and also serve as lead applicant. Any non-public recipient of IAAF funding may not serve as a PPS lead applicant.

Q. What happens to my IAAF grant if my PPS merges and I am no longer the lead?

A. Any applicant who applied and received IAAF funding must subsequently become part of a DSRIP Performing Provider System that submits a DSRIP Project Plan application. IAAF recipients that merge with other entities, will still keep their IAAF award as long as they are still participating in a DSRIP PPS.

DSRIP Background

Q: What is DSRIP?

A: Delivery System Reform Incentive Payment Program (DSRIP). DSRIP is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) Waiver Amendment.

DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to \$6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.

Q: What is considered avoidable hospital use?

A: Avoidable hospital use encompasses not only avoidable hospital readmissions, but also inpatient admissions that could have been avoided if the patient had received proper preventative care services. The following four measures will be used to evaluate DSRIP's success in reducing avoidable hospital use:

1. Potentially Preventable Emergency Room Visits (PPVs),
2. Potentially Preventable Readmissions (PPRs),
3. Prevention Quality Indicators- Adult (PQIs),
4. Prevention Quality Indicators- Pediatric (PDIs).

Q: How does the Statewide Health Innovation Plan (SHIP) relate to DSRIP?

A: SHIP and DSRIP can be considered synergistic. SHIP focuses on leveraging the work done with the state on the Patient Centered Medical Home (PCMH) by



all payers as well as the HIT connectivity being built through the Statewide Health Information Network of New York (SHIN-NY). In this context, SHIP will focus, in part, on building the Advanced Primary Care Model from the work done on the PCMH, building the All Payer Database (APD) to further build the analytics on health care in New York State, and enhancing the reach and utilization of the SHIN-NY to enhance the coordination and transparency of health care. With these three key pieces in place, quality of care can be monitored more efficiently and effectively allowing payment reform to focus on payment for outcomes/payment for performance, one other key goal of SHIP. Please review the SHIP documents on the New York State DOH website for additional details:

https://www.health.ny.gov/technology/innovation_plan_initiative/

Q: Where can I get information on DSRIP?

A: The state will provide information through three venues:

1. The DSRIP website: <http://www.health.ny.gov/dsrrip>
2. The state utilizes a listserv to notify interested parties of updates including webinars:
http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm
3. In addition, there is a dedicated DSRIP email to which questions can be submitted: dsrip@health.ny.gov

Q: Is there a DSRIP Program timeline available?

A: Yes, it is available on the DSRIP website: <http://www.health.ny.gov/dsrrip>

Q: How long does the DSRIP program last? What's a DSRIP year?

A: The DSRIP program will last just over 5 1/2 years. The years are structured as follows:

- Year 0: April 14, 2014 - March 31, 2015
- Year 1: April 1, 2015 - December 31, 2015
- Year 2: January 1, 2016 - December 31, 2016
- Year 3: January 1, 2017 - December 31, 2017
- Year 4: January 1, 2018 - December 31, 2018
- Year 5: January 1, 2019 - December 31, 2019

Q. What is DSRIP Year 0? How does it differ from the other years?

A: DY 0 is the year for planning, assessment & project development for Performing Provider Systems. Moving forward, the other years, DSRIP Years 1 through 5 (DY 1-5) are for project implementation, performance evaluations &



measurement as well as metric & milestones achievement. Note that Year 1 starts April 1, 2015 and goes to December 31, 2015. Subsequent years will follow calendar years.

DSRIP Eligibility

Q: What type of providers/care settings can submit an application to participate in DSRIP?

A: The DSRIP program is open to an array of providers across the state; however, different types of providers have to meet different criteria to be deemed eligible as a DSRIP safety net provider. Being deemed a DSRIP safety-net provider allows an organization to be an active participant who is eligible to not only to lead, but also share in the full amount of potential performance payments of a Performing Provider System (PPS) in the DSRIP program.

Eligibility Criteria for Hospitals - Hospitals can to qualify as a DSRIP eligible provider by passing at least one of the three tests below.

- Hospital Test #1: Must be either a public hospital, Critical Access Hospital or Sole Community Hospital.
- Hospital Test #2: *(Note that a hospital needs to meet both of these qualifications to pass this test)*
 - At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible* individuals.
 - At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible* individuals; or
- Hospital Test #3:
 - Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible* members in the proposed county or multi-county community. *(The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.)*

Eligibility Criteria for Non-hospital based providers – Those not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business associated with Medicaid, uninsured and Dual Eligible* individuals.

*Dual Eligible Individual: Refers to a Medicaid beneficiary who is also eligible to receive another type of health insurance, including commercial insurance or Medicare.



Q: How do I find out if my organization meets the DSRIP safety-net qualifications?

A: A list of DSRIP eligible safety-net providers is available on the DSRIP website. The lists are divided by provider type into separate PDF documents. Each PDF document contains a complete list of entities within the state for that provider type, regardless whether or not the entity meets the DSRIP safety-net provider definition. If a provider sees “True” listed in the “final results” column, then the provider has passed at least one of the eligibility tests and has qualified to be a DSRIP safety-net provider.

The DSRIP safety-net list website can be viewed at:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_safety_net_definition.htm

Q: Is there a way my organization can still participate in DSRIP even if it does not meet the eligibility requirements to be a safety-net provider or qualify for a VAP Exception?

A: Yes. As stated in the STCs, non-safety-net providers can participate in Performing Providers Systems. However, non-safety-net providers are eligible to receive, in aggregate, DSRIP payments totaling no more than 5 percent of a project’s total valuation. CMS can approve payments above this amount if it is deemed in the best interest of Medicaid members attributed to the Performing Provider System.

Q: How is the 5 percent limit on non-safety net provider performance payments applied?

A: Each Performing Provider System’s DSRIP Project Plan receives a maximum monetary valuation during the application process. All providers within a PPS that did not meet DSRIP eligible safety-net provider definition, in aggregate, are only able to receive 5% of the performance payments from a project’s total valuation. 95% of the performance payment may be made to the safety-net qualified PPS.

Q: If private doctors are not considered qualifying safety net providers, would they be subject to the 5% cap?

A: If a private doctor does not meet the DSRIP safety-net provider qualifications, they can still participate in a DSRIP PPS either as a non-qualifying provider (subject to the 5% earnings limit) or they can apply to be part of the PPS through meeting the DSRIP VAP exception criteria.



Q: Since an Independent Provider Association (IPA) is not a Medicaid provider per se, can it be a PPS partner because its physician members are Medicaid providers or do the physicians need to participate in the PPS as individual practitioners?

A: The IPA would be a non-qualifying partner, and would be limited to 5% of total project valuation. However, the IPA can assist qualifying providers in their network. Examples include:

1. Helping members qualify as safety net providers,
2. Provide technical assistance on meeting DSRIP project goals, and
3. Negotiation on their members' behalf in establishing Performing Provider Systems.

DSRIP Eligibility Appeals

Q: Based on the safety-net list on the DSRIP website, my organization was listed, but did not meet the qualifications to be a safety-net provider in the DSRIP program. Can my organization appeal if we feel there was an error in the data used to determine eligibility?

A: Please review the DSRIP Safety Net Provider lists available on the DSRIP website:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_safety_net_definition.htm

The second and final DSRIP safety net appeal process is now closed. Providers who are not included on the eligible provider lists above, and believe they had met the safety net definition had the opportunity to appeal their safety net provider status. These appeals were due August 27, 2014. Late appeals will not be accepted. Please note that the safety-net appeals process was NOT for entities who are looking to pursue the DSRIP Vital Access Provider (VAP) Exception.

A final posting of Safety Net lists and VAP exceptions will be finalized and posted in late November 2014.

To sign-up for the MRT listserv, please visit:

https://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm



Q: What is the DSRIP VAP Exception and how does it pertain to DSRIP safety-net eligibility?

A: Under the DSRIP Vital Access Provider (VAP) Exception, the state will consider exceptions (to the safety net definition) on a case-by-case basis if it is deemed in the best interest of Medicaid members and made clear that the provider system in question provides essential benefits within the larger system. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. If a provider receives a DSRIP VAP exception, they will be viewed as a qualifying safety-net provider in regards to the DSRIP program and will be eligible to share in safety-net portion (95%) of performance payments allotted to a PPS.

There are three allowed reasons DOH & CMS will grant a VAP exception in the DSRIP Program:

1. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.
2. Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.
3. Any state-designated Health Home or group of Health Homes.*

*The Department has submitted a draft list to CMS of those State Designated Health Homes and Network Care Management Agencies (CMAs) that have been previously approved as safety net providers, as well as those that are presently pending approval by CMS. The draft list of State Designated Health Homes and CMAs will be posted to the Safety Net section of the DSRIP website. You do not need to submit a VAP Exception form if:

- Your Health Home appears on the draft list as pending approval, as you will be granted a VAP Exception following CMS approval.
- The organization operating your Health Home/CMA already appears on another safety net provider list.

If your Health Home organization does not appear on the draft Health Home list pending CMS approval, or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete the VAP Exception form.

Q: How do I apply for a Vital Access Provider Exception?

A: The form to apply for a VAP Exception will be posted on the DSRIP website in late September 2014. VAP Exception applications will be due mid-October 2014 and will be made public on the DSRIP site immediately for a 30-day comment



period. CMS approval of exceptions and a final posting of Safety Net lists, including exceptions, will be released late November 2014. Refer to the final Safety Net provider list posting to check your organization's exception status.

To sign-up for the MRT listserv, please visit:

https://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm

Performing Provider Systems (PPS)

Q: What is a Performing Provider System?

A: The entities that are responsible for creating and implementing a DSRIP project are called "Performing Provider Systems", abbreviated "PPS". Performing Provider Systems are providers that form partnerships and collaborate in a DSRIP Project Plan. PPS include both major public hospitals and safety net providers, with a designated lead provider for the group. Safety net partners can include an array of providers: hospitals, health homes, skilled nursing facilities, clinics & FQHCs, behavioral health providers, community based organizations and others. Performing Provider Systems must meet all requirements described in the STCs, including the safety net definition described in STC 2.

Q: What is required of a DSRIP Performing Provider System?

A: It is important to understand that DSRIP payments are made based upon performance. A PPS will be required to perform a community assessment of need, identify DSRIP strategies that are most consistent with addressing that need, develop a Project Plan incorporating those strategies, implement that Project Plan and monitor milestones and metrics to ensure the implementation is successful. There are certain strategies that will be required of all PPS. It is expected that at the end of the DSRIP Program, the health care delivery system for Medicaid members and other New Yorkers will look fundamentally different, with greater focus on high quality ambulatory care and a de-emphasis on hospital inpatient and ED care, helping to meet the state goal of reducing avoidable hospital use, including emergency department and inpatient, by 25%.

Q. If Medicaid makes up only a portion of a provider's book of business, what are the impacts of the DSRIP program on the rest of a provider's business?

A: The DSRIP Program is an initiative specifically targeted to the Medicaid and uninsured population. However, as PPS entities work to transform their service delivery system and payment structure, the state expects that the DSRIP program will act as a catalyst for change to other parts of a provider's book of business. In addition, pay for performance or value based purchasing by government and private insurers is becoming much more widespread, supporting the transformative changes from DSRIP.



Q. Can a provider be a member of more than one PPS?

A: Yes. There is no requirement in the DSRIP program stating that a provider or organization can only join one PPS. Providers that serve large geographic areas which cross medical markets may join two (or more) PPS networks to best serve their patients.

However, providers who are considering joining multiple PPS should understand that there can be some drawbacks. Firstly, the attribution an organization brings to a PPS will diminish with each additional PPS the provider/organization joins. For example, if a clinic joins two PPS in the same county, the clinic's attributed members will most likely be split between the two PPS networks it is partnered with. This could harm the clinic's performance payment negotiations with each PPS, because the clinic will bring fewer lives to each PPS. Additionally, the clinic may see that there are greater administrative and reporting demands placed on the entity as it has to be responsive to two PPS.

For more information on attribution logic, see section titled "Attribution" or the presentation on Attribution and Valuation found here:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_attrib_and_valuation_webinar_slides.pdf

Q: Are providers encouraged to work together? If so, what types of providers can collaborate as partners?

A: It is a requirement that eligible providers within a region/service area work together on a DSRIP project. Significant community collaboration by Medicaid providers is a key theme of DSRIP and is necessary in order to meet the performance aims of DSRIP. The state will not accept applications from single entities.

Q: Will there be collaboration between PPS?

A: Yes. Collaboration between PPS is critical to the overall success of DSRIP. Collaboration in general is seen as necessary for ensuring downstream providers are able to achieve clinical integration with PPS, particularly since many downstream providers may be engaged with multiple PPS. For this reason, the extent to which there is project overlap between regions with a similar patient base (based on a single community needs assessment as has been done in Westchester, Brooklyn and Long Island, for example), collaborative efforts between PPS will be a key lever to making sustainable change in a region.

Also, from DY1-DY5, PPS will be required to take part in DSRIP Learning Collaboratives. These Learning Collaboratives will take place in person no less



than once a year and will foster an environment of mutual assistance. PPS will be encouraged to share best practices and struggles, and receive assistance and guidance from other PPS counterparts on how to best implement and meet the objectives of their DSRIP Project Plans. This will be particularly important as starting in DSRIP DY3, CMS will be evaluating summative statewide performance on DSRIP benchmarks. There will be performance payment reductions across the board to all PPS if those statewide benchmarks are not met.

Q: Are there any signed attestations required to confirm DSRIP Partnership?

A: Yes:

Every lead PPS partner will be required to submit an attestation statement documenting that each member included in its Network Tool partner list has formally consented to be part of the PPS. Attestation will be required BOTH times the Network Tool is used- for initial and final attribution. PPS lead partners will also be responsible for maintaining a file of signed partnership agreements from all partner organizations that can be made available to the State and/or CMS upon request.

If for any reason it is found that partner lists have been manipulated or inappropriately prepared, the Office of the NYS Medicaid Inspector General as well as CMS will be notified and appropriate action will be taken. If the Lead PPS Partner does not have a signed partnership agreement with provider, the lead entity should refrain from adding that provider to their partner list in the Network Tool.

Q: What is the DSRIP Network Tool?

A: The DSRIP Network Tool is an electronic tool housed in New York's Medicaid Analytics Performance Portal (MAPP), a web-based portal accessed through the Health Commerce System (HCS). The Network Tool will be the means by which PPS entities will update/replace their list of partner organizations for the remainder of the DSRIP planning process. Providers are **required** to update their partner organization list, using this tool, by September 29th, so that the state can begin the process of running *initial attribution*. PPS can continue to edit their partner organization lists via the Network Tool until December 1st when the tool will be closed for the state to run *FINAL attribution*.

At launch, the Network Tool will display pre-loaded PPS partner data submitted during the DSRIP Planning Design Grant. The Network Tool will be the means by which PPS entities will update/replace their list of partner organizations for the remainder of the DSRIP planning process. Partner



organizations include those that bill Medicaid providers as well as other non-Medicaid billing providers.

For more information on the DSRIP Network Tool, please visit the MAPP page on the DSRIP website:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_medicaid_analytics_performance_portal.htm.

Q. How is a partner defined for the network list?

A: The DSRIP program is open to an array of health providers and health related and community service entities/providers across the state. These providers come together and partner in a PPS to develop and implement a DSRIP Project Plan. In the context of DSRIP, PPS partners are those providers that a PPS submits as part of its PPS in the DSRIP Network Tool. PPS partners included in the Network Tool can be DSRIP safety net qualified and non-safety net qualified entities as well as providers who do not directly bill Medicaid.

What a PPS should consider in making an entity a partner rather than an outside contractor is whether or not the PPS will be in a performance based relationship with the PPS in implementing its DSRIP Project Plan. If the entity will be held accountable for performance in helping the PPS reach its DSRIP objectives, it will be important for the entity to be included as a partner to ensure alignment and should sign a formal participation agreement with the PPS documenting this participation and alignment. PPS should not include entities that they do not have a signed formal participation agreement in their networks for final attribution.

Q: What is required for the network partnership agreements?

A: All PPS leads will be required to have signed partnership agreements from each partner in their files by the time they submit their final partner list via the Network Tool on December 1. Partnership agreements must relate to the DSRIP program and connect the entities together for DSRIP attribution and program purposes. The State is not providing a standardized template, but has issued the following guidance:

1. PDF copies of the signed agreements are sufficient (meaning all these agreements can be kept electronically).
2. These agreements do not have to be notarized.
3. Each individual physician in a practice group does not have to submit their own letter; but rather, a signed letter from the practice CEO stating that all the practitioners in a practice/organization are authorized to be added to a PPS list is sufficient.



For IPAs, if they have opt-out rules, then the PPS requires one letter from the IPA CEO to add all providers to the PPS. If the IPA has opt-in rules, then the PPS will need to collect signatures from each member of the IPA that they wish to include in their network.

Q: What happens if a partner drops out of the DSRIP process due to financial issues?

A: Financial sustainability is a key end point that the PPS will need to attain. It is expected that the transformation of the health care system will result in changes in provider mix, some increases and some decreases. These should be well understood based upon the comprehensive community needs assessment and considered in the developing of projects. PPS should do its best to try to limit the risk of partners leaving the PPS due to financial issues by (1) allocating DSRIP performance funds within the PPS to aid partners in this situation, as well as (2) help those providers set up adequate restructuring plans to secure financial sustainability over the course of DSRIP and beyond.

Additionally, PPS governance plans must address how it proposes to manage lower performing / financially distressed members within the PPS network. This plan must include progressive sanctions prior to any action to remove a member from the performing provider system. Unless the partner organization closes or there is some other extreme circumstance, PPS will not be able to alter its partner lists until the mid-point assessment in DY3.

Q: Can you remove partners after finalizing your partner list?

A: Once PPS networks are submitted for final attribution via the DSRIP Network Tool on December 1, 2014, the PPS cannot remove any partner from its PPS until Year 3 (DSRIP Mid-Point Assessment).

At DY3, Performing Provider Systems may submit proposed modifications to an approved DSRIP project plan for state and CMS review, including removing PPS partners. These Project Plans modifications may not decrease the scope of the project unless, the modification also proposes to decrease the project's valuation.

Removal of any Performing Provider System member organization requires a proposed modification and removal of any such lower performing member must follow the required governance procedures including progressive sanction requirements.



Q: Can you add partners after finalizing your partner list?

A: Partners may only be added to a PPS network after the final partner lists are submitted on December 1, 2014 if the new partner was not a Medicaid provider before finalized partner lists were submitted for final attribution. No more than once a year, a PPS may submit a proposal to add new partners to their network which will be subject to reviewed and approval by the state and CMS. However, all other existing Medicaid providers who did not join a PPS network in DY0, during the network formation process, may only be added at Year 3 (DSRIP Mid-Point Assessment). Adding partners will not increase valuation.

Q: What provider types qualify to be lead applicants in a DSRIP Performing Provider System?

A: Any qualifying DSRIP safety-net provider can be a lead applicant, regardless of provider type. However, in the DSRIP Project Plan, the lead applicant will be assessed on its ability to fulfill the role as the lead entity within the Performing Provider System. Qualifications that could allow an entity to fulfill the role as the lead applicant may include, but are not limited to:

1. Previous collaborative experience,
2. Unique leadership capabilities,
3. Administrative capabilities,
4. Financial stability.

It should be noted that while all PPS entities, as a whole, will undergo a financial evaluation to ensure the entity's ability to complete the program, lead organizations will undergo a more intensive, individual financial assessment to ensure fiscal stability for the PPS through the DSRIP program. Furthermore, the State is in dialogue with CMS on allowing new governing structures, rather than individual safety-net providers, to serve as leads for Performing Provider Systems in the DSRIP Program.

Q: Is there a state mandated or preferred legal structure for a Performing Provider System (LLC, corporation, partnership, etc.)?

A: The State is not mandating a legal structure for DSRIP Performing Provider Systems; however, the State prefers structures that support shared governance and allows providers to act as a truly integrated delivery system.

Q: Is there a mandated or preferred governing body structure?

A: Again, the State is not mandating a specific governing structure for DSRIP Performing Provider Systems; however, the State prefers structures that support shared governance. The state will be providing some example governance models for consideration by emerging Performing Provider Systems.



Q: Within a PPS network, how much autonomy does a PPS have in distributing these funds?

A: A PPS has the autonomy to allocate performance funds how it best sees fit, as long as 95% of performance payments go to safety-net qualified partners and the remaining 5% go to non-qualifying safety net partners. However, PPS funds allocation must be described in the DSRIP Budget & Flow of Funds section of the Project Plan Application and include a description of how DSRIP performance payments will be distributed amongst providers, and how the distribution of funds is consistent with the governance structure and DSRIP goals. In general, PPS revenue is flexible and can fund anything the PPS decides that would advance the PPS' DSRIP projects and goals.

The state has issued some guidance on how a PPS might want to consider allocating performance payments to help PPS, but this was by no means prescriptive direction. Areas the state suggested included: Project Costs, Revenue Loss, Pay for Performance among the PPS partners, non-qualifying partner pool (5%) and special consideration funds (helping financially distressed partners). DSRIP governance materials should address the proper fiduciary responsibilities of the lead PPS to the downstream network.

Q: Will PPS networks be protected from laws on anti-competitive behavior?

A: Yes, in instances where a DSRIP PPS can show that a potential collaboration between providers will benefit the community, there will be an opportunity for the state to provide protections for a PPS. This protection will come in the form of a Certificate of Public Advantage (COPA), which will be granted if it appears that the benefits of a collaboration between PPS partners will outweigh any disadvantages attributable to their anticompetitive effects and will be subject to active state supervision. COPA regulations are explicated in Article 29-F of New York's Public Health Law. More information on COPA in relation to DSRIP is available at:
http://www.health.ny.gov/health_care/medicaid/redesign/copa/index.htm.

Q: Will a data sharing agreement with the state be required?

A: Yes. The state will be delivering provider specific Medicaid information through a DSRIP portal, Medicaid Analytics and Performance Portal (MAPP). Minimally, a Data Exchange Application and Agreement (DEAA) will need to be executed with the state for data available in the portal and any data sharing outside of the portal. Additionally, PPS are required to have established Health Commerce System (HCS) accounts to access the DSRIP portal (MAPP).



Q: As a partnering provider, what happens if the emerging PPS I choose to join does not receive approval to operate a PPS? Am I going to be left out of DSRIP?

A: The State has been proactive in working with, and providing planning resources to, emerging PPSs so that these emerging PPS applicants have an understanding of what will be expected in, as well as the means to create, a thorough/approvable Project Plan Application. Some of these resources include, but are not limited to, the state's launch of a DSRIP Support Team in addition to planning funds via DSRIP Design Grants. Furthermore, the State will be publishing a draft of the applicant scoring tool in September that will be due in December, so applicants will see the metrics which their application will be scored against.

The state has also built several "rounds" into the DSRIP application process to ensure, to the best of its ability, that the most viable applicants are building partner networks. That being said, there is no way for the State to ensure that every emerging PPS entity will make it through the entire DSRIP application process. While applicants have been approved to proceed through other rounds of the DSRIP application process, in the end, if their PPS Project Plan application does not meet the standards set forth in the application scoring tool, the emerging PPS will not be approved as an official PPS entity to participate in the DSRIP program.

However, from the experience of other DSRIP application rounds, if a provider is a member of an emerging PPS that does not receive approval for a DSRIP Project Plan application, more likely than not, the non-approved PPS (and its provider network), will join and be merged with another PPS that is serving counties in close proximity.

Therefore, in choosing which emerging PPS network to join, a provider should focus on aligning with the emerging PPS they have the most clinical relationships with to maintain continuity of care for their patients, rather than worrying about partnering with multiple emerging PPS networks in fear of being left out of the DSRIP Program.

Project Advisory Committee

Q: What is the Project Advisory Committee?

A: Each emerging Performing Provider System (PPS) is required to form a Project Advisory Committee (PAC). The PAC will advise emerging Performing Provider Systems on all elements of their DSRIP Project Plans and should include representation from each of the emerging PPS partners as well as



workers and/or relevant unions. The PACs are a requirement for the DSRIP Design Grant application and are expected to be in place over the duration of the DSRIP program.

Q: What is the scope of the Project Advisory Committee?

A: The PAC serves as an advisory entity within the PPS that offers recommendations and feedback on PPS initiatives. The PAC should be involved in the various facets of developing a PPS' DSRIP Project Plan and then engaged in the implementation and oversight of the Project Plan.

PAC meetings/conference calls serve as forum to share and review proposals as well as discuss ideas that will affect the PPS and its workforce. PACs may choose to form sub-committees around various issues or projects, but sub-committees should attempt to maintain their representativeness of the PAC stakeholders. PACs should meet no less than once a month during the DSRIP planning phase and no less than once a quarter during the implementation and oversight phases.

Q: How should Project Advisory Committee representatives chosen?

A: PAC Representatives should be determined using the following process:

1. Organizational representatives:
 - a. Emerging PPS partners with more than 50 employees are required to have an organizational (managerial) representative participate in the PAC.
 - b. Emerging PPS partners with less than 50 employees have the option of selecting an organizational (managerial) representative to participate in the PAC.
2. Worker representatives:
 - a. Partner organizations that are not unionized and have over 50 employees must develop a process to elect a worker (non-managerial employee) representative to participate in the PAC.
 - b. For non-unionized partner organizations with less than 50 employees, the employees have the option of electing a worker (non-managerial employee) representative to participate in the PAC if they so choose.
3. Union Representatives:
 - a. Partner organizations that are unionized and have over 50 employees must designate a union representative to participate in the PAC. If a particular union represents workers from multiple emerging PPS partners, one representative from that union is sufficient to satisfy PAC requirements.



- b. For unionized partner organizations with less than 50 employees, the union has the option of designating a union representative to participate in the PAC if they so choose.

Q: Is there any flexibility in Project Advisory Committee membership composition?

A: While there is no set minimum/maximum number regarding PAC members, the State understands that it may become impracticable to require larger emerging PPS to have all the partner, union and worker representatives included in the PAC, while expect the committee to be efficient and effective. For an emerging PPS with over 20 partnering organizations, a qualifying PPS may propose an alternative PAC committee structure that will allow for a leaner committee, as long as the proposed structure is still representative of all key parties within the PPS.

Finalized alternative PAC proposals must be submitted to the state as a DSRIP Project Design Grant award mid-point deliverable. The state will approve Final PPS PACs after reviewing the final submissions.

Q: Is there any additional guidance for the Alternative Project Advisory Committee (PAC) Structures?

A: The state offers PPS the flexibility to structure its PAC how it sees fit (as long as representativeness among partners and workers/unions is maintained). The state further offers the following suggestions to PPS' after a thorough review of all submitted alternative PAC structures from the Design Grant, as well as taking public comment into consideration.

Suggested Structure:

- i. To maintain a manageable and effective PAC, the State recommends alternative PAC structures be divided into a smaller Governing Committee that will work in conjunction with unrestricted sub-committees.
- ii. Governing and sub-committee members should be selected from within the larger pool of representatives that would have been generated based on the standard PAC formation process.
- iii. The Governing Committee should:
 - a. consist of no more than 25 members
 - b. represent key partners proportional to the number of Medicaid patients they serve
 - c. represent key labor organizations proportional to the number of workers represented
 - d. be regionally representative
 - e. include subject-matter experts



- iv. Sub-committees may be organized according to scope of care, project domains, or other method which achieves adequate stakeholder representation, partner collaboration, and comprehensive oversight of DSRIP initiatives.
- v. The PPS must explicate how the Governing and sub-committees will collaborate within the PAC structure.

Further Considerations:

- i. When forming an alternative PAC structure, the PPS should consider the following:
 - a. The PAC should include sufficient representation from partners who serve the greatest proportion of the Medicaid population.
 - b. The PAC should include sufficient representation from all safety net providers.
 - c. The PAC should include sufficient representation from Behavioral Health partner organizations to suitably align with DSRIP goals.
 - d. The PAC should be demographically and geographically representative of the community served by the PPS.
 - e. The PAC should facilitate engagement with frontline staff and non-partner stakeholders (e.g., community members).
 - f. There should be occupational diversity within the PAC (e.g., include both administrators and practitioners).

Community Needs Assessment

Q: Can you provide information about conducting and using a Community Needs Assessment?

A: Each project a Performing Provider System selects must be responsive to a thorough community needs assessment that ties to the DSRIP goals of system transformation and reducing avoidable hospital use, including emergency department and inpatient. More information and guidance on the requirements of the DSRIP Community Needs Assessment can be found in the Community Needs Assessment Guidance document:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/community_needs_assessment_guidance.pdf

Additionally, two webinars explaining the Community Needs Assessment process have been recorded and provided on the DSRIP Webinars and Presentations site:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrp_webinars_presentations.htm



Q: Does the currently required Hospital Needs Assessment suffice for the DSRIP Needs Assessment?

A: While the hospital needs assessment can be a good starting point for the community assessment, it will not likely be sufficient. DSRIP’s focus is health care for the population served by Medicaid. Their service needs may be different from that of the composite total population served by a hospital. For example, when performing zip code analysis of service utilization, there may be marked population differences. In addition, since DSRIP is about service delivery transformation, the community assessment must not be done as a hospital-centric assessment, but as a total community service provider assessment.

Domains, Strategies & Projects

Q: What are the DSRIP Project Plan, Domains, Projects and strategies?

A: A DSRIP Project Plan is the overall plan that a performing provider system submits to the state. The project plan is composed of at least 5 projects, but no more than 11 projects, based upon projects chosen from a predetermined list (See DSRIP Project Toolkit:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrp_project_toolkit.pdf).

There are four Domains in DSRIP that represent groupings of project milestones and associated metrics. The four Domains are:

- Domain 1 – Project progress milestones – measurement on completion of project plan
- Domain 2 – System transformation milestones – measurement of system transformation
- Domain 3 – Clinical improvement milestones – disease focused clinical improvements
- Domain 4 – Population-wide strategy implementation milestones – Prevention Agenda improvements

All DSRIP Project Plans will have metrics attached to each Domain. Domain 1 metrics are measures of the completion of the DSRIP Project Plan. Domains 2, 3 and 4 have strategy sublists identifying specific strategies. For example, under Domain 2, there is a strategy sublist A called “Create Integrated Delivery Systems”. Under each strategy sublist is a selection of projects that can be used to meet that goal of an integrated delivery system.



Q: Are there minimum/maximum number of projects that are required?

A: Yes. DSRIP project plans must include a minimum of five and no more than ten projects valuation purposes. However, if a PPS is eligible to pursue Project 2.d.i. the Project Plan may include 11 projects. At least two (and no more than four) system transformation projects (unless Project 2.d.i is included in which up to five system transformation projects can be involved) in (Domain 2), at least two (and no more than four) clinical improvement projects (Domain 3), and at least one (and no more than two) population-wide project(s) (Domain 4).

One of the required Domain 2 projects must be chosen from strategy sublist A. The other required Domain 2 project can be selected from either strategy sublists B or C. One of the required Domain 3 projects must be chosen from the Behavioral Health strategy sublist.

As described further in the project valuation section of Attachment I, a maximum of 10 projects will be considered for project valuation scoring purposes, with the exception being those PPS pursuing Project 2.d.i. Additional projects may be included in the application; however, a maximum of 10 projects will be used to assess application valuation.

Please refer to “Project 2.d.i.” section for further regulations regarding selecting the eleventh project.

Q: For PPS picking 10 projects, is there any opportunity to pick more from Domains 2 and 3 instead of Domain 4?

A: No. Not including the 11th project, the PPS can pick a maximum of: four Domain 2 projects; four Domain 3 projects and two Domain 4 projects. This is a requirement of the STCs.

Q: If a PPS has multiple hubs (or sites), will it need to do all of the chosen projects in each hub?

A: No. A PPS will not need to do each project in each hub or each site. The community needs assessment should identify the most significant health related problems for a PPS and the sites where these problems are most significant. Targeted implementation of a project at such a site or sites would make the most impact. For example, the 11th project must be implemented in a way that benefits all uninsured and low/non Medicaid utilizers in the geography served by the public PPS. However, not every site will serve many people from this PPS’ sub-population. Hence, as the project’s description suggests, a "hot spot" approach could make the most sense. However, PPS should always keep in mind that while a “hot-spot” approach makes sense to efficiently allocate and managed resources to where they will be needed most, the project’s metrics will



be measured based upon the entire PPS population attributed to that project.

Q: Can a Performing Provider Systems' DSRIP funds be used to supplant other, existing programs?

A: All projects undertaken by a performing provider system must be a new initiative for the entity and must be substantially different from other initiatives funded by CMS. If the Performing Provider System is building on a pre-existing, non-CMS funded initiative, the PPS must demonstrate in their DSRIP Project Plan application how the coalition is significantly augmenting the initiative, allowing for substantial transformation over the status quo.

Project 2.d.i.

Q: What is Project 2.d.i, or the “eleventh project?”

A: This new Domain 2 project was created with the goal of incorporating uninsured (UI) members into DSRIP, and ensuring that the UI population along with the non-utilizing (NU) and low-utilizing (LU) members gain access to and utilize the benefits associated with DSRIP PPS projects. This project focuses on increasing patient and community activation related to health care, paired with increased resources that can help the UI, NU, and LU better access particularly primary and preventative services.

Q. Can any PPS select to pursue the eleventh project?

A: No, a PPS must receive state approval to pursue Project 2.d.i in a specified county. Major public hospitals have the right of first refusal in taking on the additional 11th project. If the public chooses to pursue the 11th project, no other PPS in that county may pursue it. If no public hospital exists in a county, or the public hospital chooses not to pursue the 11th project, then one or more non-public PPS serving that county may be approved to pursue the project in that county. Approval to take on Project 2.d.i may be granted if:

- The PPS has elected to pursue a 10 project DSRIP application (not including 2.d.i.).
- The PPS can demonstrate its network is capable of handling the 11th project.
- The PPS can demonstrate how its network is suited to serve the UI, NU and LU populations in it's the counties it will be pursuing the 11th project.

Q. How does the state define non-utilizing and low-utilizing Medicaid members?

A: Non-utilizing members are those which are enrolled in Medicaid yet do not use any services in a given year. Low-utilizing members are those which the state defines as utilizing three or fewer services per year and have little to no connectivity with their PCP or care manager.



Q. How will the pool of UI, NU, and LU members be attributed in accordance with the eleventh project?

A: *Only* those PPS which are approved to pursue the 11th project will be attributed the UI population. The NU and LU Medicaid members will be removed from the pool of utilizing Medicaid (UM) members that will go through the attribution logic and a state determined portion of the NU/LU members will be reattributed to the PPS approved to operate Project 2.d.i.

Attribution of 100% of the UI population and a portion of state determined reattributed LU and NU members will be granted to a PPS approved for the 11th project that is one of the following:

1. A region’s public hospital (as lead, co-lead, or network partner).
2. A non-public PPS in a region that is the only non-public approved to pursue the 11th project, or exists in a region where the public hospital opted out.

Attribution of less than 100% of the UI population and less than the full percentage of the state determined reattributed portion of NU/LU members will occur when multiple non-public PPS in a given region are approved to pursue the 11th project. The share of both the UI members and the NU and LU members from the state-set portion will be relative to the percentage of utilizing Medicaid members assigned to their approved PPS region. Refer to chart below for clarification.

PPS Type	Utilizing Medicaid (UM) Members	Non/Low ¹ Utilizing Member Attribution	Uninsured Attribution
Single PPS in Region	All UM members in a region attributed to PPS	All state defined NU/LU members attributed (regardless of whether or not PPS opts for 11 th project)	All UI in region attributed to PPS if PPS is approved for 11 th project.
Multi PPS in Region - Public Led/Involved	UM members in region attributed to PPS based on loyalty logic	Public PPS w/11 th : Given the full state determined reattributed percentage of the NU/LU population in region if PPS is approved for 11 th project.	Public PPS w/11 th : All UI in region attributed to PPS if PPS is approved for 11 th project.
Multi PPS – Non Public (NP) Involved	UM members in region attributed to PPS based on loyalty logic.	NP PPS w/o 11 th : None Single NP PPS w/ 11 th : Given the full state determined reattributed percentage of the NU/LU population in the region if PPS is approved for 11 th .	NP PPS w/o 11 th : None Single NP PPS w/11 th : All UI in region attributed to PPS if PPS is approved for 11 th project. Multiple NP PPS w/11 th : If approved for 11 th project, each PPS will receive a



PPS Type	Utilizing Medicaid (UM) Members	Non/Low ¹ Utilizing Member Attribution	Uninsured Attribution
		Multiple NP PPS w/11 th : Given a portion of the state determined reattributed percentage of NU/LU population based on relative percentage of UM in the region that was attributed to PPS.	percentage of the UI population in the region based on the relative percentage of UM in the region that were attributed to the PPS.

Further clarification for Project 2.d.i. (“the 11th project”), may be found in the DSRIP Attribution and Valuation webinar posted here:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_webinars_presentations.htm

Metrics

Q: Pay for performance metric targets (“goal”) need to be based on “higher of top decile of performance for state or national data, or alternative method” (Attachment I, page 8). When will the state be releasing the data to allow the PPS to see what performance targets are?

A: The Performance goals for DSRIP will be preliminarily released in November 2013. There are a small number of measures which will have the 2013 performance goal finalized by March 2015, prior to the start of the PPS’ initiating activities. Several measures do not have baseline data to allow performance goals to be established. These measures will have a preliminary goal of 100% or 0% until the DY 1 results are available. These are primarily associated with satisfaction survey measures and new clinical measures. The 2012 and 2013 data is currently available on Health Data NY by county and zip code. The individual PPS baseline results will be finalized late in the first quarter 2015 and will be used for project approval as well as establishing the annual improvement target for the first measurement year.

Q: Some of the metrics are based on 3M proprietary software (PPV, PPR). Will the PPS have access to this software or data output? If so, how far in advance? (i.e. are we expected to move the metric by measuring proxy data of can we know real-time where we stand in PPV/PPR for our attributed population)?

A: The potentially preventable events (PPV and PPR) are calculated annually using the 3M proprietary logic. The latest annual results will be made available to the PPS with some information about observed and expected events to provide



PPS with information about improvement opportunities. Ongoing PPV and PPR results will not be available throughout the measurement year. Ongoing monitoring for readmissions and ED visits may be done using the events without the logic. Proxy PQI and PDI results for the PPS will be available with the other quality measures which will be made available to the PPS in the MAPP, but will not be the same file that is used for calculation of PPS results for payment.

Q: There are 4 metrics that indicate avoidable hospital use (PPV, PPR, PQI, and PDI). Is it expected that 25% reduction will be realized in each of the 4 metrics and will these metrics be measured per project or by the PPS as a whole?

A: These four metrics are in Domain 2, System Transformation. As with other metrics, each PPS will be given a target gap to goal to close each year. The denominators will be based upon the entire eligible population from the PPS, which for these measures is the PPS' full population. The 25% reduction is the total state goal.

Q: We have multiple projects around redirecting patients from ED to more appropriate urgent care or BH services. Since all patients must be evaluated and a bill is generated, does this count as an ED "visit"? How does this impact the metric for 25% reduction in avoidable hospital use and PPV (treat and release)?

A: PPV is a measure of avoidable ED visits. Visits such as sore throat would be considered avoidable; trauma such as a fracture would not. The goals of these projects are to have patients become part of a primary care practice and learn how to use the health care system more effectively. Depending on the structure developed around these projects, the first ED visit, even though potentially requiring only a medical screening examination to identify if an emergency condition is present, may result in a low level medical claim that will be counted as an ED visit. If the condition meets the metrics for avoidable ED visit, it will count in that metric. It is anticipated that once the patient is engaged with a primary care physician, future ED visits for non-urgent conditions will be avoided.

Q: The specific metrics for Domain 4 are divided into groups (a,b,c,d). However, as there are multiple projects in each group (b1, b2 etc.), do all the group b metrics count for any group b project? For example, project 4.b.i is around tobacco cessation, but many of the group b metrics are not related to tobacco in any way.

A: Domain 4 is based upon the Prevention Agenda and includes a subset of projects listed in the Agenda and relevant metrics for the subset of projects. The metrics apply to all projects within the group. The PPS, however, is responsible for the full suite of metrics in Domain 4, i.e., those from all the groups. We recognize that there are many factors involved in moving this complete suite of metrics. As noted, these are pay for reporting, but, in fact, the state is the one



responsible for reporting. The state will continue to monitor the Prevention Agenda as it always has and all metrics from Domain 4 will be reported by the state for the PPS. The PPS does not need to report metrics. Also note, the Prevention Agenda includes all New York State residents and projects in this area should be inclusive of the total population. What the PPS will be monitored for Domain 4 is how the PPS meets the milestones for the implementation of its chosen project(s), including number of sites, impact on full population, etc.

Attribution

Q: What is DSRIP Member Attribution?

A: Member attribution refers to how Medicaid beneficiaries are assigned to Performing Provider Systems. Members are assigned to a given PPS using geography, patient visit information, and health plan PCP assignment. Additionally, patient visit information is used to establish a “loyalty” pattern based on where most of the member’s services are rendered. This is discussed in Attachment I to the Statement of Terms and Conditions, and further updates provided in the Attribution and Valuation webinar on the DSRIP website, found here respectively:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/program_funding_and_mechanics.pdf

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrp_attrib_and_valuation_webinar_slides.pdf

Q. Can a beneficiary be attributed to more than one PPS?

A: No. A beneficiary can only be attributed to one Performing Provider System.

Q: Are there any changes to attribution guidelines based on Project 2.d.i.?

A: Now, portions of the uninsured individuals in a given region may be attributed to a PPS in a given region based on their approval to undertake Project 2.d.i. Three PPS “types” will be referred to for attribution of uninsured individuals (UI), non-utilizing (NU) and low-utilizing (LU) members which are as follows:

1. Single PPS in a Region (Public Hospital Led/Involved or Non-Public)
2. Multi PPS in a Region- Public Hospital Led/Involved
3. Multi PPS in a Region- Non-Public Hospital Involved.

For further guidelines on attribution following Project 2.d.i., please refer to the above “Project 2.d.i.” section.



Q. How are members attributed when there is one PPS in a defined region?

A: Given the instance when a PPS is the sole one in a region, it would be attributed all Medicaid members (UM+ NU+LU) for valuation purposes, regardless of whether the PPS pursues project 2.d.i or not. If the sole PPS pursues project 2.d.i, the sole PPS will be attributed 100% of the uninsured in the county as well.

Q. If there is only one PPS in a region, does the geography trump the loyalty aspect of the attribution algorithm? In other words, even if patients in that geography are frequenting another PPS further away, will they still be attributed to the one PPS?

A: In sole PPS counties, for attribution for valuation purposes, the PPS would receive the attribution of all Medicaid members who receive “most” of their health care services in that county. Most is defined in relation to the Medicaid member and how many counties they receive Medicaid services in (serve as the denominator). Hence, if a Medicaid member has claims or encounters in two or three counties, if the member receives the highest percentage of claims in the sole PPS counties, relative to any other county they have received services in (regardless of the logic hierarchy), that member will be attributed to the sole PPS for valuation calculations.

Q. How are members attributed when there is more than one PPS in a defined region?

A: When there is more than one PPS in a county, the attribution loyalty logic will be followed, which is illustrated in the Attribution and Valuation webinar, further explicated in the section “Project 2.d.i.” and shown below in the next question.

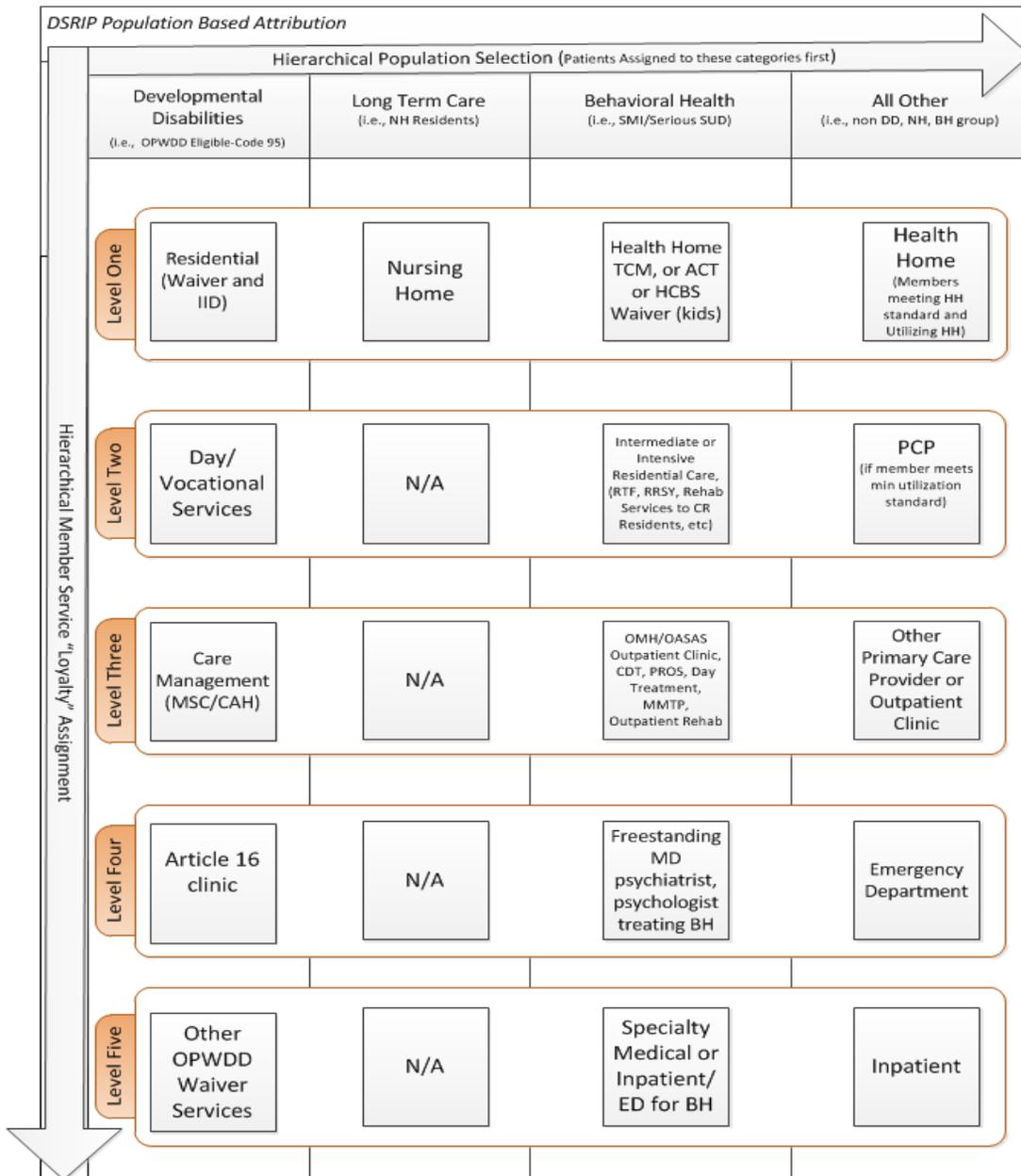
https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_attrib_and_valuation_webinar_slides.pdf

Q. How are members matched to a PPS network through the loyalty logic?

A: Recipient loyalty is assigned based on a patient’s claim and encounter data to a specific provider in a PPS network based on a hierarchy of the population categories and their specific attribution logic. A patient is attributed to a category (DD, LTC, BH, All Other) based upon the hierarchy of population categories. A patient is attributed to the first category they have a claim in based on the category hierarchy logic. Once attributed to a population category, the patient will then be assigned to a specific population subcategory. Patients are assigned to a specific subcategory based on a subcategory hierarchy logic (similar to the process that matched patients to a category). A patient is attributed to the first



subcategory category they have a claim in (based on the subcategory hierarchy logic). The DSRIP loyalty logic hierarchy flow chart proceeds. If the patient has claims in the same category bucket that is tied to a provider(s) in two different PPS, the tie-break logic will be used to assign the patient.





Q: What happens when following the attribution loyalty logic produces a tie?

If more than one PPS has the highest number of visits based on the highest priority services, the methodology will re-run to determine the following:

Tie-break level 1:

- If additional visits in other service types will cause one PPS to accumulate more visits.

Tie-break level 2:

- If a tie still results the recipient will be temporarily removed from the count and assigned at the end of the attribution process. Those recipients with no predominant provider utilization pattern will be assigned to the PPS in which most recipients in their zip code have already been assigned.

Please refer to the Attribution and Valuation webinar for further clarification:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrp_attrib_and_valuation_webinar_slides.pdf

Q. Is there a minimum number of members required in a region to support a PPS?

A: Performing Provider Systems must have a minimum of 5,000 attributed Medicaid beneficiaries a year in outpatient settings per attachment I. In order to ensure a meaningful presence in the county that the PPS hopes to serve, a PPS must have at least 1,000 attributed members in the county AND a PPS must serve at least 5% of the total attributed members for that county. If a PPS does not have a meaningful presence in a county, that PPS will have the county removed from its service area and hence, the PPS will not be eligible to receive attribution from that county. The exceptions to this threshold rule are for Lewis and Hamilton counties, which have no minimum attributed membership required. In addition, the state reserves the right to alter these thresholds based on attribution results.

Q: What is the DSRIP measurement population?

A: The population of Medicaid recipients attributed to the PPS. The attributed Medicaid population will be used to calculate the process and outcome population metrics as well as overall project values for DSRIP. The protocol for identifying this population will be found in Attachment I to the STCs. The state has been working on possible ways to include measurement for the uninsured population, but the lack of standardized data confounds this, so most measures will be related to impact on Medicaid recipients.



Q: For PPS pursuing the 11th project, how will non-utilizers be attributed for valuation and performance measurement?

A: Non-utilizers are defined in a specific manner for valuation. In performance measurement, non-utilizers will be identified with somewhat different criteria (i.e. no qualifying or other service use in 12 months nor an assigned PCP). In addition, non-utilizers will be attributed to the PPS that is either the single for the county or has the most members assigned from the member's zip code. This may no longer be the PPS that they were attributed to for valuation. Non-utilizers are included in the performance measures that apply to the whole population. Performance measures that apply to everyone, like preventive quality indicators, would include non-utilizers. Many performance measures have additional criteria making the person eligible for the measure, such as a diagnosis or use of a particular service. Non-utilizers would not have had a service that would allow them to qualify for the eligible group of these sorts of episode-based measures in the measurement period. PPS doing the 11th project will have performance measures associated with the project, but these measures do not require diagnoses or use of a particular service to be included in the measure.

Q: If attribution valuation is as part of the PPS application approval done in DSRIP Year 0, what happens if a PPS greatly expands during the DSRIP program?

A: Attribution related to project valuation occurs during the application process in DSRIP Year 0. This prospective attribution value will serve as the fixed valuation denominator for DY 1, 2 and 3. During the mid-point assessment, there may be adjustments made to a PPS' attribution for project valuation purposes if there is a valid reason (increase/decrease in providers; a surge in Medicaid beneficiaries within the PPS due to major changes in PPS network).

Letter of Intent & Project Design Grant

Q: How have the Letters of Intent been used to inform application development?

A: The letters of intent served two main purposes:

1. To help entities interested in participating in DSRIP to become aware of one another. Every letter of intent (including their list of their partners) has been posted online and categorized by region:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip_loi_received/

The state hoped that this would not only produce transparency, but also encourage dialogue between providers to form partnerships before the DSRIP Project Design Grant applications were due.



2. To help the state not only identify interested parties throughout the state, but to also assist the state in seeing areas that might need help to bring providers together to form a DSRIP PPS.

Q: Is there funding available to help with ‘start-up’ activities?

A: Funding has been made available through the previously mentioned DSRIP Project Design Grants. These grants will enable providers to develop specific and comprehensive DSRIP Project Plan Applications. The providers and coalitions that receive DSRIP Project Design Grants must use their grant funds to prepare and are required to submit a DSRIP Project Plan application. DSRIP Project Design Grants were announced on August 6, 2014 and a list of awardees is available here:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_design_grant_app.html

Q: How does my PPS apply for a DSRIP Project Design Grant?

A: DSRIP Project Design Grant applications were due on June 26, 2014. The state is no longer accepting applications for Design Grant awards.

Q: Will an emerging Performing Provider System be able to change its list of selected DSRIP projects after the DSRIP Project Design Grant application is submitted?

A: Yes. The DSRIP Project Design Grant’s Project selection was used to gauge PPS Project interest in order for the state to deploy project planning resources accordingly. Final DSRIP Project selection will be made in the submission of the Project Plan application due on December 22, 2014.

Q: Does an emerging Performing Provider System need to identify all their partners in their DSRIP Project Design Grant application? Can more partners be added in their DSRIP Project Plan application as projects become more defined?

A: The list of PPS partners submitted in a DSRIP Project Design Grant application was non-binding and can be adjusted as emerging PPS gain a better understanding of the projects they should undertake (and the partners they will need to implement a that project) based on information from their community needs assessment. Finalized PPS partnership rosters are due on December 1, 2014.



Project Plan & Support Team

Q: Do we need to submit a DSRIP Project Plan application? If so, when is it due?

A: Yes, submission of a formal DSRIP Project Plan is the final step in the DSRIP application process. Emerging Performing Provider Systems will need to submit their Project Plans to the state **by 5pm on December 22, 2014**. The Final DSRIP Project Plan Application will be submitted electronically through the DSRIP/Health Home Portal currently under development.

Draft versions of the DSRIP Project Plan application and Review Tool will be made available in late September 2014 and finalized versions of the DSRIP Project Plan application and Review Tool will be made available by November 14, 2014.

Q: What needs to be contained in the DSRIP Project Plan?

A. The DSRIP Project Plan must provide *rationale for project selection* including target population, strategies, specific milestones, goals, how project will change the system, how stakeholders are engaged in the process; *description of project activities* including outcome metrics; and *justification of the project funding*, including a detailed project specific budget. More details on the DSRIP Project Plan application format and models of good Project Plans will be developed and shared via the DSRIP website.

Finalized versions of the DSRIP Project Plan application and Review Tool will be made available by November 14, 2014. These documents will indicate precisely what needs to be included in the DSRIP Project Plan, as well as how the Project Plans will be evaluated and scored.

Q: Is there help available to assist providers with completing the DSRIP Project Plan application?

A: New York has hired a contractor, KPMG, to serve as the DSRIP Support Team (DST). The role of the DST is to help Performing Provider Systems with technical assistance in developing their DSRIP Project Plan. In addition, the state has allocated a portion of the DSRIP funding to assist Performing Provider Systems with their DSRIP Project Plan development in the form of DSRIP Project Design Grants. Project Design Grant awards were made on August 6, 2014 to 42 of the Emerging PPS. More information on these awards can be found here:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_design_grant_appl.htm



Funding from these grants must be used to prepare the DSRIP Project Plan application for participation in DSRIP. Recipients of these awards are expected to submit a DSRIP Project Plan application.

Q: What is the role of the DSRIP Support Team (DST)?

A: On July 29, 2014, the state announced the award of DSRIP Support Team (DST) funding to KPMG, LLP, contingent upon successful negotiation of a contract. The DSRIP Support Team has been engaged by the Department of Health to support PPSs in the Planning efforts. The DST fulfills 4 specific roles:

1. Serve as designated contact for any Department of Health-related DSRIP Communications e.g. answer any questions or concerns the PPS may have regarding DSRIP and the Planning Application Process.
2. Perform periodic reviews of PPS Planning Grant Application as it develops to help the PPS assemble an application that is of high quality and in accordance with DSRIP guidelines and the guidance put forth by the Independent Assessor. The aim is to prevent surprises once the application is submitted on December 22nd and enters the scoring process. The DST will also be putting together a mock application based on the Independent Assessor guidelines once these are published which will allow for detailed guidance in this process.
3. Provide how-to guides and support materials for all PPSs to use to assist them in the Planning Grant Application process.
4. If needed and as indicated by the PPS, the DST may also provide on-the-ground support, which may range from basic to intense, in order to assist the PPS in its Planning Grant Application efforts. This may range from weekly check ins to answer key questions to intense workshops with subject matter experts in areas of need to facilitate conversations and help apply DSRIP guiding principles to the PPS application. These options will be discussed in detail with each of the PPS leads during initial kick off meetings to match DST support to need.

To contact the DSRIP Support Team at KPMG, please email:
us-albadvrcdsripsup@kpmg.com.



Q: Can a group of providers come together and submit a DSRIP Project Plan even if they did not apply for the Project Design Grant?

A: Yes. A PPS applicant can submit a DSRIP Project Plan without having submitted a DSRIP Project Design Grant application. However, the proposed PPS will not have access to planning funds or have access to the DSRIP Support Team to help them with their DSRIP Project Plan application or prepare for DSRIP implementation.

Additionally, a new PPS applicant would have to submit a letter stating its intent to form a new PPS to the New York State Medicaid Director via the DSRIP Team e-mail account (dsrip@health.ny.gov) before October 1, 2014. The letter should include the PPS Name, Lead Entity Information, Lead and Secondary Contacts for the new emerging PPS, as well as proposed counties of service for the entity. The new PPS would also be required to submit a list of network providers (the state will provide a template upon receipt of the official letter) and a signed attestation stating that the providers listed in the applicant's proposed network list have agreed to partner with the emerging PPS. New applicants would also be responsible for setting-up the necessary Health Commerce System (HCS) accounts (a process that could potentially take over a month) to again access to the online network tool and Project Plan application. Every PPS must have HCS access in order to submit their partner networks by the time the network tool closed (to perform final attribution) on December 1, 2014.

Furthermore, if the newly emerging PPS is an entity that was turned down for a Project Design Grant, the entity must still submit all of the materials stated above as well as provide an explicit explanation to the state responding how it remedied the issues the state brought forth when not approving the applicant for the DSRIP Project Design Grant. Specific guidance will be given to these applicants on a case-by-case basis.

Q: Are there any signed Attestations required for the DSRIP Project Plan?

A: Yes:

Project Plan Application Attestation:

The lead PPS partner will submit an attestation statement documenting that the information provided in the Project Plan Application is accurate at the time of submission and that the PPS, if accepted into the DSRIP, will cooperate fully with the state in the implementation and monitoring of this project and participate in the required learning collaboratives related to this project. If the Performing Provider System is receiving funds from the Public DSRIP pool it will also provide a description of the IGT source identified for the project and attest that this IGT derives from local, public funds.



Q: What type of clinical information is required in the DSRIP Project Plan application, if any?

A: Since DSRIP is about system transformation, it will be important for performing provider systems to identify the most critical structural and clinical issues in their service area that affect their performance as a system. In essence, the Performing Provider System will need more information than just clinical information to develop a successful application. Performing Provider Systems will need to complete a current community health assessment including population demographics, types and numbers of medical, behavioral health and community service providers and services, cost profile, designation as Health Professional Shortage Area, mortality and morbidity statistics, and health disparities. Refer to the Community Needs Assessment Guidance and associated webinars for additional specifics (link below). The state will assist Performing Provider Systems by providing a significant amount of this information through the DSRIP Performance Data site (link below, respectively). Providers should not rely on community needs assessments required for hospitals as these will not provide the breadth of information required in DSRIP.

From this information, emerging PPS will need to choose critical issues causing poor performance, which they will align with their chosen DSRIP projects. These critical issues will need to be supported/defended in the application by an assessment of patient co-morbidities, patient characteristics, social system support, system capacity for primary care and disease management, and institutional issues such as finances, confounders to health care system improvement including fragmentation of services, competition, and assessment of regional planning issues.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_community_needs_assessment.htm

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_performance_data

Q: What is the relationship between DSRIP application budget and the capital budget for state allocation?

A: Under Sections 8, 8-a, 8-b, and 9 of the Health Article VII bill (S.6914/A.9205) in the Governor's 2014-15 budget, the Department of Health was awarded \$1.2 billion over a period of seven years to establish a Capital Restructuring Financing Program that will support capital projects in an effort to strengthen and promote access to essential health services. The majority of funding is aligned with DSRIP and will support projects that will improve infrastructure and other capital investments aimed at promoting integrated health systems and developing additional primary care capacity. Further information regarding capital funds will be provided via the listserv.



Q: What qualifies as capital under the budget section of the DSRIP Project Plan application?

A: In relation to the budget section of the DSRIP Project Design Grant, capital refers specifically to funding for “bricks and mortar” infrastructure and the capital cost portion of IT investment needed to achieve DSRIP principled goals.

Project Plan Assessment

Q: What is the role of the Independent Assessor?

A: The DSRIP assessor’s tasks include, but are not limited to:

- Creating an application and application review tool;
- Creating a process for a transparent and impartial review of all proposed project plans;
- Reviewing all proposed Project Plans and making project approval recommendations to the state using CMS-approved criteria;
- Assembling a Project Plan application review panel based on standards set forth in the DSRIP STCs;
- Convening a series of DSRIP learning collaboratives to share best practices and receive assistance in implementing DSRIP projects;
- Conducting a transparent and impartial mid-point assessment of project performance during the third year to determine whether the DSRIP project plans merit continued funding or need plan alterations;
- Assisting with the ongoing monitoring of performance and reporting deliverables for the duration of the DSRIP program.

Q: Has the Independent Assessor been selected?

A: The state announced the award of DSRIP Independent Assessor procurement to Public Consulting Group (PCG) Inc., contingent upon successful negotiation of a contract, on August 1, 2014.

Q: How are the submitted DSRIP Project Plan applications reviewed and evaluated for selection?

A: The state will develop a standardized application review tool that the DSRIP Independent Assessor will use to review DSRIP Project Plans and to ensure compliance with all terms, conditions and protocols agreed to between CMS and the state. The application review tool (which will include a project scoring guide) will be completed and made available for public comment for a 30 day period on September 29, 2014, and may be revised based upon public comments received. It is expected the review tool will be approved by CMS by November 7, 2014 and



a finalized version posted to the DSRIP site by November 14, 2014. The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor. Each factor will address the anticipated impact of the project on the Medicaid and uninsured populations consistent with the overall purpose of the DSRIP program.

After DSRIP Project Plans are submitted by Performing Provider Systems on or before December 22, 2014, the Independent Assessor will conduct an initial screen to ensure that they meet the minimum submission requirements. The Independent Assessor will notify the Performing Provider System in writing of any initial questions or concerns identified with the provider's submitted DSRIP Project Plan and provide a 14 day period for Performing Provider Systems to address these concerns. All submitted DSRIP Project Plans will be posted for a 30 day public comment period.

The Independent Assessor will use the review tool to score all submitted DSRIP Project Plans. After scoring, the state will convene a panel of non-conflicted relevant experts and public stakeholders with significant health care transformation experience. The panel will hold an open public meeting to review the assessor's recommendations. The Independent Assessor will present each submitted DSRIP Project Plan with its score and recommendation for approval or rejection to the panel. The panel will have the opportunity to accept, reject, or modify the Independent Assessor's recommendation.

The Independent Assessor will then forward the panel's recommendations to the New York State Commissioner of Health regarding approvals, denials, or recommended changes to Project Plans. The Commissioner will then accept or reject the panel's recommendations. Any deviations from the Independent Assessor's recommendations will need to be explained to, and approved by, CMS which will maintain its own monitoring process of these reviews. Awards will be made prior to the start of DSRIP Year 1 (April 1, 2015.)

Q: Can a DSRIP Project Plan be modified or changed during the 5 year period after it is approved?

A: No more than once a year, Performing Provider Systems may submit proposed modifications to an approved DSRIP Project Plan for state and CMS review. These modifications may not decrease the scope of the project unless they also propose to decrease the project's valuation. Removal of any Performing Provider System member organization requires a proposed modification and removal of any such lower performing member must follow the required governance procedures including progressive sanction requirements.

Also, if a DSRIP PPS has not successfully met its milestones, modifications may be allowed with the approval of the state and CMS. Based on the information



contained in the Performing Provider System's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation.

DSRIP Project Valuation

Q: What is DSRIP Project Valuation?

A: The DSRIP project valuation will be calculated by the state with the assistance from the independent assessor according to the methodology described in Attachment I to the Special Terms and Conditions. The maximum valuation for a project will be calculated based on the projects chosen, the external valuation benchmark, the application score and the number of Medicaid beneficiaries attributed to each project.

A maximum valuation for each DSRIP application is calculated based on a formula described in Attachment I. The maximum application value represents the highest possible financial allocation a Performing Provider System can receive for their plan over the duration of their participation in the DSRIP program. Performing Provider Systems may receive less than their maximum allocation if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty.

Q: What is a Project Index Score?

A: The value of a single project is expressed as an index score. Project index scores are based upon a grading rubric that evaluated the project's ability to transform the health care system. The State has assigned an index score to each project based on the grading rubric and the given project's relative value to the other projects in the state's menu. The final project index scores are presented in decimal form for valuation purposes and are available to providers in the DSRIP Project Toolkit.

Q: Can the State provide a calculation example for a DSRIP Project Plan Valuation?

A: There is an example of a DSRIP Project Plan valuation available in Attachment I on the DSRIP website. Additionally, the DSRIP Overview PowerPoint on the DSRIP website also offers a detailed walk-through of the valuation process using a specific example. New valuation examples are provided subsequent to the creation of Project 2.d.i. in the attribution and valuation webinar. The three presentations are provided below, respectively. As well, the State is also creating a project valuation tool that will help providers estimated project application values. See also proceeding Valuation example.



DSRIP SCENARIO 1: MAXIMUM PROJECT VALUATION (W/ 11TH PROJECT)

HPI Project Plan	Project Index Score	Valuation Benchmark (11 Projects)	Project PMPM	Project Plan Application Score (w/ Bonus)	# of Attributed Utilizing MA Beneficiaries	# of Attributed NU+LU+UI Beneficiaries	# of DSRIP Months	Maximum Project Valuation
Project 1: 2.a.i	0.93	\$4.88	\$4.53	.80 + .10 = .90	50,000	20,000	60	\$17,123,400
Project 2: 2.a.ii	0.62	\$4.88	\$3.02	.80 + .10 = .90	50,000	20,000	60	\$11,415,600
Project 3: 2.b.vii	0.68	\$4.88	\$3.32	.80 + .10 = .90	50,000	20,000	60	\$12,549,600
Project 4: 2.c.ii	0.62	\$4.88	\$3.02	.80 + .10 = .90	50,000	20,000	60	\$11,415,600
Project 5: 2.d.i	0.93	\$4.88	\$4.53	.80 + .10 = .90	0	20,000	60	\$4,892,400
Project 6: 3.a.i	0.65	\$4.88	\$3.17	.80 + .10 = .90	50,000	20,000	60	\$11,982,600
Project 7: 3.b.ii	0.43	\$4.88	\$2.10	.80 + .10 = .90	50,000	20,000	60	\$7,938,000
Project 8: 3.c.i	0.50	\$4.88	\$2.44	.80 + .10 = .90	50,000	20,000	60	\$9,223,200
Project 9: 3.d.iii	0.52	\$4.88	\$2.54	.80 + .10 = .90	50,000	20,000	60	\$9,601,200
Project 10: 4.a.i	0.33	\$4.88	\$1.61	.80 + .10 = .90	50,000	20,000	60	\$6,085,800
Project 11: 4.b.ii	0.28	\$4.88	\$1.37	.80 + .10 = .90	50,000	20,000	60	\$5,178,600

Maximum Application Value: \$107,406,000*

Note: UM and NU, LU, UI are added together in valuation calculation.

*The maximum application value represents the highest possible financial allocation a Performing Provider System can receive for their project plan over the duration of their participation in the DSRIP program.

Performing Provider Systems may receive less than their maximum allocation if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty).

https://www.health.ny.gov/health_care/medicaid/redesign/docs/program_funding_and_mechanics.pdf

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_hpi_case_study.pdf

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_attrib_and_valuation_webinar_slides.pdf



DSRIP Reporting & Payments

Q: Will providers be required to submit data and/or progress reports? If so, how often and will it be required to be submitted in a secured manner?

A: Providers will be required to submit progress reports at least twice a year, or as required by the state and/or assessor. The reports shall be submitted using the standardized reporting form approved by the state and CMS.

Q: How will the State evaluate the providers DSRIP project data, after it is collected and submitted?

A: Upon the approval of each DSRIP Project Plan, project specific metric baselines will be identified. In addition, the target high performance goal for each metric will be established. From those baselines, PPS will have to reach the pre-defined goal/benchmark targets in given metrics. Some metrics will be met based upon reporting specific data; some metrics will be met based upon actual progress to a predefined goal. This predefined goal will generally be closing the gap between current PPS performance and the performance of a high performing system.

Q: Are DSRIP payments tied to the performance of the Performing Provider System?

A: Yes. DSRIP is specifically engineered to reward measurable outcomes. Each Performing Provider System will have process and outcome metric milestones that must be met in order to receive DSRIP payments. For some outcome metrics, success will be considered closing part of the gap of the provider compared to the goal.

Q: What is the difference between a Process Milestone versus an Outcome Milestone?

A: A process milestone is a milestone that denotes changes that are being made to the system such as training programs, realignment of clinics, adoption of appropriate EHRs, creating patient registries, etc. An outcome milestone is evidence of an actual change in the health care system such as improved control of diabetes or blood pressure or reduction in avoidable hospital use.

Q: Are there criteria for achieving incentive payments? Is there performance allocation?

A: At least two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones



and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The Performing Provider System shall have available for review by the state or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones.

Incentive payments will be calculated based upon the progress of process milestones/metrics and outcome milestones/metrics. The value of each type of metric type is noted below. As the projects progress, less payment will be allocated to process milestones/metrics and more will be allocated to outcome milestones/metrics. Some payments will be based on submitting required reporting only (Pay for Reporting) and others will be based on attaining specific outcome targets (Pay for Performance). Please note that the DSRIP performance payment distribution (highlighted in the chart below) for the duration of the DSRIP program is based on the overall application value, not the valuation of individual projects.

Metric/Milestone Domains	Performance Payment*	Year 1 (CY 15)	Year 2 (CY 16)	Year 3 (CY 17)	Year 4 (CY18)	Year 5 (CY 19)
Project progress Milestones (Domain 1)	P4R/ P4P	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%

* P4P is pay for performance; P4R is pay for reporting.

Q: How does the State’s High Performance Fund work?

A: A portion of DSRIP funds will be set aside to reward high performing systems. The high performance fund will be “seeded” with 10 percent of the available DSRIP performance funding and will also include “deposits” from performance payments surrendered by PPS’ that do not meet their performance targets. The total amount of funding paid out of the high performance fund shall be based on actual high performance goals met and will be distributed to qualifying providers based on meeting a specific set of Domain 2 and 3 metrics identified as a high



performance metrics by the state with input from the quality and measures committee.

Additional funds will be set aside within each fund for performing provider systems reaching stretch/ bonus level targets for significant improvement in avoidable hospitalization reduction for their attributed behavioral health population.

For additional details on the DSRIP High Performance Fund, please refer to Attachment I.

https://www.health.ny.gov/health_care/medicaid/redesign/docs/program_funding_and_mechanics.pdf

Q: Will the State provide tools, baseline/benchmark data, and progress & feedback reports, educational materials to providers, throughout the Program?

A: The state will support the projects in a number of ways:

- As noted earlier, the state has award DSRIP Project Design Grants to assist PPS in planning their projects.
- The state has deployed a DSRIP Support Team, KPMG, throughout the state to help emerging PPS in their planning efforts.
- The state has developed a number of data resources for the Performing Provider Systems (PPS). Initially, these data resources were static data books. More recently, the state has unveiled its web-based performance dashboards with drillable data on member counts by region and baseline performance data.
- The state will be launching a performance portal that will allow PPS access to current metrics based upon data in the Medicaid Data Warehouse and supported by the analytical capabilities of Salient® software.
- The state will support regular learning collaboratives through the duration of the DSRIP program. The learning collaboratives, which will be a required activity for all Performing Provider Systems, will be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects.

Q: What are the intergovernmental transaction (IGT) risks for public providers?

A: Public providers do not have any risk associated with IGTs. If public providers achieve performance measures then they get their full award and make the full IGT required (which includes the safety-net IGT). If public providers do not achieve performance measures then they are under no obligation to provide an IGT.



Q: What is the role of the DSRIP Independent Evaluator?

A: The DSRIP Evaluator will conduct an interim and final summative statewide evaluation of the DSRIP program. The goals of the interim and summative statewide evaluations will be to examine the effect of DSRIP activities on achieving the State goals of (1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform.

Q: What is the role of Managed Care Organizations in DSRIP?

A: One of the goals of the DSRIP program is focused on ensuring sustainability of delivery system transformation through leveraging managed care payment reform. To do so, the state will reform managed care contracts to promote DSRIP objectives. The state will accomplish this by developing and executing payment arrangements and accountability mechanisms with its managed care contractors, ensuring that managed care payment systems recognize, encourage and reward positive system transformation. This includes, but is not limited to, promoting the establishment and continuation of integrated service delivery systems, procedures to reduce avoidable hospital use, as well as to ensure improvements in other health and public health measures.

In the broader context of Medicaid redesign, one of the core goals of MRT was to end Medicaid fee-for-service by moving all populations and services into managed care. Managed care organization can help the state in achieving its DSRIP goals by aligning payments to PPS and by making sure that Medicaid beneficiaries have access to the full spectrum of health services that produce better health outcomes.

In the future state, meaning the NYS health system after the DSRIP program, managed care companies will pay PPS directly for care on a PMPM basis for the people whose care the PPS is responsible for maintaining. This future state would be a true value and performance based health care system where silos across the health system have been broken down and where shared accountability exists at the provider level. The MCO payments to PPS would include not only traditional health care providers, but other non-traditional providers that impact health outcomes (like supportive housing providers).



IT Communications & Investments

Q: What sort of communication systems will be needed to make this program run effectively?

A: PPS Project Plans must include provisions for appropriate data sharing arrangements, including connections to RHIOs, that drive towards a high performing PPS while appropriately adhering to all federal and state privacy regulations. The PPS plan must include a process for rapid cycle evaluation (RCE) and indicate how it will tie into the state's requirement to report to DOH and CMS on a rapid cycle basis.

Q. In what ways can the state offer support on the side of the IT investments that are most likely needed to help achieve real-time secure data sharing and clinically integrated network formation?

A: Network formation and IT investments can come out of the DSRIP Performance Payments. As well, the capital cost portion of IT investment needed to achieve DSRIP principled goals is an eligible cost within the scope of a Capital Restructuring Financing Program project, which can also be used for bricks and mortar. The state expects PPS to use some portion of capital funds and performance payments to further develop HIT capabilities, especially in the early stages of implementation as networks develop interoperability amongst their partners.

Workforce Strategy

Q: In some instances care management agencies haven't been able to meet all of the requirements mentioned. In the future, do you have a plan for care management agencies to grow to meet the demand for care management under DSRIP?

A: Yes, we certainly expect for there to be growing demand for care management services due to the DSRIP program. The overarching DSRIP goal of a 25% reduction in avoidable hospital use (emergency department and admissions) will result in the transformation of the existing health care system - potentially impacting thousands of employees. This system transformation will create significant new and exciting employment opportunities for appropriately prepared workers. PPS Project Plans must identify all impacts on their workforce that are anticipated as a result of the implementation of their chosen projects as well as a workforce plan for repurposing jobs that will free up as we lower avoidable hospitalization. One clear area to repurpose those jobs to will be care management. Training and outreach for care management will be needed. The state is already working with health homes to have them staff up for the demands of DSRIP, HARPs and the community transition activities related to Olmstead.



Health Home Infrastructure

Q: Previous communication from the State indicated that significant funding was planned to enhance the existing health home infrastructure (+/- \$300m). What is the current status and plans for infrastructure build out?

A: \$190.6M is available under the MRT waiver to fund health home infrastructure (i.e., member engagement, staff training/retraining, HIT implementation and joint governance/start up). These funds will be distributed through an add-on to the health home care management fee. Before the state can implement the add-on, we must receive approval from CMS for an amendment to the Medicaid State Plan. We are actively working with CMS on this state plan and hope to have approval this fall.