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TO: **Memo Distribution List**

FROM: Hinman Straub P.C.

RE: MRT Waiver Amendment and Delivery System Reform Incentive Payment ("DSRIP") Program

DATE: April 18, 2014

NATURE OF THIS INFORMATION: This memo provides an overview of the MRT Waiver Amendment and the Delivery System Reform Incentive Payment ("DSRIP") program documents released to-date.

DATE FOR RESPONSE OR IMPLEMENTATION: Immediately.

HINMAN STRAUB CONTACT PEOPLE: Sean Doolan and Meghan McNamara

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #2 Providers and payments to them
#3 Plan Management, operations and structure
#9 Medicaid and Medicare Suggested Key Word(s):

On April 14, 2014, Governor Cuomo announced that New York State finalized the terms and conditions with the federal government (Centers for Medicare and Medicaid Services or "CMS") for the New York's Partnership Plan 1115 Waiver Amendment that will allow the State to draw down up to $8 billion in federal funds generated by New York's Medicaid Redesign Team (MRT) reforms (hereafter referred to as the "MRT Waiver Amendment"). A copy of the Governor's press release is **attached.**

Executive Summary

This memo provides an overview of the MRT Waiver Amendment and the Delivery System Reform Incentive Payment ("DSRIP") program documents released to-date.

The State has indicated that the ultimate goal of the Waiver, and specifically the DSRIP program, is to fundamentally change the payment system for Medicaid services in New York. As highlighted at recent public hearings, upon completion of the now six year DSRIP funding timeline, New York's approximately $55 billion Medicaid program will be realigned to coincide with the goals of DSRIP. The Performing Provider Systems ("PPS") developed through the DSRIP process, discussed further below, are intended to be permanent (extending beyond the duration of DSRIP) and are ultimately expected to contract as **a single entity** with Medicaid Managed Care programs using value-based payment methodologies. As a result, it is critical that all providers and third party payor stakeholders across the spectrum of care, assess the impact of the DSRIP and determine whether a role in the DSRIP application process is appropriate.

As discussed further below, in addition to DSRIP funding, immediate funding will be made available through the Interim Access Assurance Fund (IAAF), which is intended to be a bridge for certain eligible hospitals that are in danger of closing over the next year. **The State anticipates releasing a draft IAAF application for comment within the next week**. In addition, DSRIP planning grant funding will now be made available, with a non-binding letter of interest due **May 15th**, and a planning grant application due **June 17th**. The DSRIP application submission date has been moved to **December 2014**, and DSRIP project funds are expected to be distributed in **April 2015**.

The Department of Health will implement a stakeholder engagement process on the MRT Waiver Amendment and DSRIP Program, with public hearings that began this week. The public hearing is available on the **DSRIP website.**

Public comment will be accepted regarding the MRT Waiver Amendment/DSRIP Special Terms and Conditions (STCs) through **April 29, 2014** and with respect to the Program Funding and Mechanics Protocol **(Attachment I)** and Strategies and Metrics Menu **(Attachment J)** through **May 14, 2014**. Comments should be submitted to **DSRIP@health.state.ny.us**.

1. MRT Waiver Amendment Funding

The MRT Waiver Amendment/DSRIP Special Terms and Conditions ("STCs") describe the structure under which the federal government has agreed to allow the state to reinvest $8 billion in Medicaid funds for MRT activities, including delivery system reform, managed care programming, and state plan amendment activities, as described below.

Pursuant to the STCs, only initial funding of this structure is authorized in 2014. Continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.

A. Interim Access Assurance Fund (IAAF) - $500 Million

This time limited funding is targeted at hospitals ($250 million for public hospitals, $250 million for non-public) and is designed to help ensure Medicaid safety net providers at risk of closure receive temporary funding to allow them to fully participate in Delivery System Incentive Payments (DSRIP) without disruption. The IAAF is available to provide supplemental payments that exceed upper payment limits, DSH limitations, or state plan payments.

The State anticipates releasing a draft IAAF application for comment within the next week and plans to hold a public meeting with potential applicants to provide additional information. The draft application will include a list of the qualifications that providers must meet to receive IAAF payments. A short comment period is anticipated so that the funding can be released to assist financially challenged providers. However, the STCs require the State to consider public comment received regarding the proposed qualifications when qualifying providers and distributing funds from the IAAF.

The State will make all decisions regarding eligibility and distribution, and the funding will be limited to providers serving significant numbers of Medicaid members who are at high financial risk. In determining the qualifications of a provider eligible for this program and the level of funding to be made available, the State is required to take into consideration whether the funding is necessary to provide access to Medicaid and uninsured individuals (based on current financial information and community needs and services).

In addition, the State is required to ensure that IAAF payments supplement but do not replace other funding sources. Any IAAF payments must remain with the provider receiving the payments to be used for health care related purposes, and may not be transferred back to any unit of government, directly or indirectly, or redirected for other purposes.

IAAF Awardees must ultimately be part of a submitted DSRIP application. Providers may receive both funding through this special fund as well as a planning grant as part of the DSRIP program, discussed further below.

B. Delivery System Reform Incentive Payment (DSRIP) Fund - $6.42 Billion

Up to $6.42 billion of federal funding is available for *Performing Provider Systems* ("PPS") that consist of *safety net providers* whose DSRIP *project plans* are approved and funded through the process outlined in the STCs and who meet particular *milestones* described in their approved DSRIP *project plans*. These terms are further defined in the attached documents and are discussed further below.

a. DSRIP Goals

The purpose of the Delivery System Reform Incentive Payment (DSRIP) program is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health, and reducing costs.

The DSRIP program is focused on the following three goals: 1) safety net system transformation, 2) accountability for reducing avoidable hospital use (25% over five years) 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.

b. Safety Net Provider Definition

In order to be considered a provider eligible to receive DSRIP funding, the STCs require providers to either meet the "safety net provider" definition or qualify for the "Vital Access Provider Exception." A "safety net provider" is defined as either a hospital or non-hospital based provider that meets certain defined parameters.

Preliminary lists of eligible safety net providers (including hospitals, clinics, nursing homes, LTHHCPs, CHHAs) are **available on the DSRIP website**. In addition, lists of eligible OMH, OASAS and OPWDD providers will be posted to the DSRIP website shortly.

Safety-Net Hospitals

A hospital must meet one of the following three definitions in order to be considered a "safety-net" provider:

1. Must be a public hospital, Critical Access Hospital or Sole Community Hospital; or

2. Must pass two tests:

a. At least 35% of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals; and
b. At least 30% of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or

3. Must serve at least 30% of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community.

Non-hospital based Safety-Net Providers

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

Vital Access Provider Exception

In addition, the state will consider exceptions to the safety net provider definition on a case-by-case basis through the "Vital Access Provider Exception" for the following reasons:

- A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community (i.e., to achieve the required state wide participation).

- Any hospital that 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.

- Any state-designated health home or group of health homes.

Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

Non-qualifying providers (i.e., those that do not meet the "safety-net provider" definition) can also participate in a DSRIP project plan; however, no more than 5% of a project's total valuation may be paid to non-qualifying providers. This 5% limit applies to non-qualifying providers as a group. CMS can approve payments above this amount if it is deemed in the best interest of the Medicaid members attributed to the PPS.

c. Performing Provider Systems ("PPS")

DSRIP requires eligible safety net providers to form coalitions that will apply for DSRIP funding as a single "Performing Provider System" (PPS), with a designated lead provider who will be responsible under the DSRIP for ensuring that the coalition

meets all requirements of the PPS, including reporting to the state and CMS. The coalition PPSs are the only entities that are eligible to receive DSRIP incentive payments. Single entity applicants, even those with their own "integrated system of care," will not receive DSRIP funds.

Coalitions must establish clear business relationships between component providers, including a joint budget and funding distribution plan that specifies in advance methodology for distributing funds to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including the federal anti-kickback statute, physician prohibition on self-referral, the gainsharing civil monetary penalty (CMP) provisions, and the beneficiary inducement CMP.

In addition, each PPS will be required to have a data agreement in place to share and manage data on system-wide performance.

i. Lead Providers

Pursuant to the STCs, both public and private safety net providers may serve as DSRIP Project Plan "lead providers." However, for coalitions that involve public hospitals, the STCs state that "the public entity providing [Intergovernmental Transfer (IGT) funding for a project] will generally be the lead coalition provider." This provision appears to indicate that when a proposed PPS includes a public hospital, it will be encouraged to be the DSRIP project lead.

ii. Role of PPS

The goal of DSRIP is to have each PPS responsible for most or all Medicaid beneficiaries in a designated "geographic area" or "medical market area." The use of the term "medical market area" in the STCs appears to account for the possibility that the population served by the PPS may not align with a traditional geographic region, or extend beyond a single region; the term "medical market area," however, is undefined. If possible, the State would like to see one single PPS within a geographic region, but has acknowledged that this may not be possible in particular areas of the state, such as NYC.

Providers who have a significant number of Medicaid beneficiaries as patients and who have not joined a PPS will be identified by the state and will be strongly encouraged to join an appropriate PPS in their region.

iii. Medicaid Member Attribution

Each PPS must identify a proposed population to be targeted for the DSRIP, and must have a minimum of 5,000 attributed Medicaid beneficiaries a year in outpatient settings. Upon approval of the DSRIP application, Medicaid members will be assigned to a PPS through the proposed attribution methodology specified in the **Program Funding and Mechanics Protocol (Attachment I).**

It is expected that most of the Medicaid beneficiaries in the state will be attributed to a PPS, with possible exceptions being beneficiaries that are primarily being served by providers not participating in any PPS. However, given the comprehensive nature of DSRIP, it is expected that each approved PPS will include all of the major providers of Medicaid services in their region.

iv. Medicaid Managed Care Plan Involvement in Attribution Process

The results of the preliminary attribution process will be shared with each Medicaid Managed Care Plan for their enrolled membership. Plans will be asked to review the assignment list and make any necessary corrections, as practicable. Plans will each submit to the state a recommended final DSRIP attribution list for each PPS for each enrolled member as appropriate to the target population for the given DSRIP project. The state will review the plan recommendation and make modifications if needed to assure better balance between DSRIP projects, especially where there are multiple MCOs in a given region. The goal of MCO involvement in the attribution process is to ensure that most recent member access patterns are taken into account in developing attribution and to begin to better connect MCOs to the DSRIP projects as performance improvement and payment reform components of the overall DSRIP program take place.

d. Project Design Grants ("Planning Grants")

DSRIP funding will also include DSRIP planning grants awarded prior to the anticipated submission of DSRIP Project Plan Applications in **December 2014** to help providers begin to collaborate and form PPSs to plan DSRIP projects. The State has indicated in recent webinars that it anticipates providing approximately $50 million in planning grant funding, with approximately $500,000 available for each approved applicant. The STCs authorize up the State to pay up to $100 million in total FFP for planning grant funding.

In addition, the **State has announced that it will be requesting that interested applicants submit a non-binding letter of intent to apply for planning grant funding by May 15th** so that the State can begin to assess provider group interest and collaboration. However, the failure to submit a letter of interest will not preclude applicants from submitting a planning grant application.

At this time, the State anticipates the submission of DSRIP grant applications June 17, 2014.

The providers and coalitions that receive DSRIP project design grants must use their grant funds to prepare a DSRIP project plan to prepare the provider's application for a DSRIP award. Providers and coalitions that receive DSRIP project design grants must submit a DSRIP application.

e. DSRIP Funding Pools

A PPS will be able to apply for funding from one of two DSRIP pools:

(1) Public Hospital Transformation Fund, which will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this pool include:

a. Health and Hospitals Corporation
b. State University of New York Medical Centers
c. Nassau University Medical Center
d. Westchester County Medical Center
e. Erie County Medical Center

(2) Safety Net Performance Provider System Transformation Fund, which will be available to all other DSRIP eligible providers.

Funding allocation between the two DSRIP pools will not be determined until after applications have been submitted. PPSs that exceed their metrics and achieve high performance by exceeding a preset higher benchmark for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health population will also be eligible for additional DSRIP funds from the high performance fund.

f. DSRIP Project Plans

As part of the DSRIP Project Plan that will be submitted to the State for approval, the PPS must design and implement at least 5 and no more than 10 DSRIP projects, selected from the **Strategies Menu and Metrics (Attachment J)** and that complies with all requirements specified in the **DSRIP Program Funding and Mechanics Protocol (Attachment I).**

Project selection by the PPS is required to be driven by a mandatory community needs assessment of baseline data and the target population selected by the PPS, and the rationale and starting point for each project must be described in the DSRIP project plan. Projects will be valued with a five-step process set forth in **Attachment I**.

All DSRIP project plans must include:

- At least two system transformation projects (including one project to create integrated delivery systems as well as another project for either the care coordination or connecting settings strategies list);
- Two clinical improvement projects (including one behavioral health project); and

- One population-wide project.

While the applicant's project plan must include projects that meet the above-listed criteria, the PPS may choose from a menu of additional projects as desired to meet the identified needs of the population served by the PPS.

The State will develop a Project Toolkit that will more fully describe the core components of each DSRIP project listed on the DSRIP project menu**.** It is important to note that the DSRIP project menu includes projects that engage Medicaid providers across the spectrum of care, and also includes specific projects engaging long term care providers, such as: Creating a medical village/alternative housing using existing nursing homes, Care transitions intervention for skilled nursing facility residents, Behavioral intervention paradigms in nursing homes, and Hospital-home care collaboration solutions.

The project must be:

- A new initiative for the PPS;
- Substantially different from other initiatives funded by CMS, although it may build on or augment such an initiative;
- Documented to address one or more significant issues within the PPS service area and be based on a detailed community needs assessment using objective data sources;
- A substantial, transformative change for the PPS;
- Demonstrative of a commitment to life-cycle change and a willingness to commit sufficient organizational resources to ensuring project success; and
- Developed, in concert, with other providers in the service area with special attention paid to coordination with Health Homes actively working in their area.

Each project selected by the PPS will be developed into a specific set of focused milestones and metrics that will be part of the Performing Provider System's proposed DSRIP project plan application. The state will also develop a Metric Specification Guide that provides additional information on these metrics. As part of the application, the PPS will be required to submit a work plan to document their plans to address and implement the project, meet metrics and milestones, and also identify resources available to complete projects.

g. Project Review Process/Timeline

The timeline for the DSRIP application process will now be a 6 year process, rather than the 5 years previously contemplated. The MRT-DSRIP Deliverables Schedule and review process is set forth in the **STC 40**, and is summarized below.

- December 2014: DOH Accepts DSRIP applications

- Application will undergo review by an Independent Assessor as well as a panel of outside non-conflicted independent health care entities and consumer advocates.
- Independent Assessor makes project approval recommendations to the State.
- State makes its official, initial determination based on findings of Independent Assessor and outside review panel. Any deviations from independent assessor's recommendations must be clearly explained to CMS.
- A feedback loop will be built in to allow plan and/or network provider improvement. The State has indicated that this may include requesting multiple PPSs to come together to expand their footprint.
- State will notify the PPS in writing that the plan has been approved and submitted to CMS.
- CMS will review a sample of plans to determine whether the protocol was followed. If CMS finds that reviews are consistent with the review protocol, CMS will accept the State's recommendations for approval, with exceptions available (e.g., in the event the state's decision regarding approval is not consistent with the independent assessor).
- April 2015: State Distributes DSRIP Project Plan awards for approved PPS
- 2015-2020: Project implementation, performance evaluation and measurement, and metric and milestone achievement

h. Use of DSRIP Funding

DSRIP Funding will be used to fund DSRIP provider incentive payments and state administrative costs. In addition, in order to facilitate workforce transformation through the state, each DSRIP project plan must contain a "comprehensive workforce strategy" and present a plan for how workers will be trained to meet patient needs in the new delivery system.

Provider DSRIP Funding

Use of Incentive Payments. DSRIP payments are **not** direct reimbursement for expenditures and payments for services. Payments from the DSRIP Fund are intended to support and reward performing providers for improvements in their delivery systems. While not specifically addressed in the STCs, the State has previously indicated that CMS will not allow the use of DSRIP funds for items such as capital and health information technology. As the STCs do not appear to explicitly restrict the ultimate use of incentive payments received by providers, this is a necessary point of clarification with the State.

Schedule of Payment. Payments are based on performance on process and outcome milestones, as further the described in the **Program Funding and Mechanics Protocol – Attachment I**. However, some upfront funding of approved DSRIP applications is authorized. Specifically, half of the incentive funding for project progress milestones in Year 1 will be awarded upon approval of the DSRIP plan.

State DSRIP Funding

Administrative Costs. DSRIP funding can be used for State administrative costs associated with implementing DSRIP, including contracting with independent assessors, independent evaluators, and administrative costs the state incurs associated with the management of DSRIP reports and other data.

Designated State Health Programs (DSHP). In addition, the state may claim FFP in support of DSRIP for certain Designated State Health Programs (DSHPs) not normally eligible for matching federal funds, as set forth in **STC 15**. This includes, but is not limited to, programs such as Health Care Reform Act programs, State Office on Aging Programs, and Early Intervention Program Services. There are specific restrictions regarding the use of DSHP funds by the state. For example, DSRIP funding cannot be used for grant funding to test new models of care, construction costs, HIT/HIE expenditures, and costs to close facilities.

i. State and Provider Accountability

Continued federal funding is subject to the PPS meeting ongoing milestones. In addition, statewide achievement of performance goals and targets must be achieved and maintained for full access to the funding level as specified in the STCs. Specific reductions from statewide funds are taken from the state starting in Year 3 if these targets are not achieved.

In addition, the STCs commit New York to continue its efforts to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap, including more stringent requirements for inpatient and emergency room spending. If penalties are applied by CMS for failure to meet statewide performance objectives, CMS will require the state to reduce funds in **equal** distribution across all DSRIP projects. As a result, DSRIP is intended to encourage provider systems to share experiences and replicate successful initiatives throughout the state.

j. State Managed Care Contracting reforms to establish and promote DSRIP objectives

As a condition of receiving DSRIP project funding, the STCs require the state to develop and execute payment arrangements and accountability mechanisms with its managed care contractors. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the state must submit a roadmap for how they will amend contract terms and reflect new provider capacities and efficiencies in managed care rate-setting (See **STC 39**).

As a result, the State will begin formulating a multi-year plan that must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year toward the goal of achieving 90 percent of managed care payments to providers using value-based payment methodologies by the end of the five-year

period. The state has identified that the following possible payment methodologies: 1) sub-capitation, 2) bundled payments, and 3) pay-for-performance.

C. Other Medicaid Redesign Purposes - $1.08 Billion

This funding will be used to support health home development ($190.6 million over five years through a State Plan approved rate add-on), investments in the long term care workforce ($245 million) and facilitating the provision of enhanced behavioral health (1915(i)-like) services ($645.9 million), both also over five years. As these items are not appropriately funded through DSRIP, it is anticipated that they will be funded through: 1) State Plan amendments and 2) Managed care contracts amendments. The state plans to provide additional detail regarding this funding, as well as separate webinars.

Finally, the state has highlighted other key initiatives that support the MRT Waiver Amendment implementation in New York: 1) $1.2 billion in capital reinvestment enacted in the 2014-15 State budget as well as 2) regulatory relief provided through the budget to support provider collaboration on DSRIP projects.

2. MRT Waiver Amendment and Delivery System Reform Incentive Payment (DSRIP) Documents

The official MRT Waiver Amendment and DSRIP documents are listed below and attached, and can also be found on New York's **DSRIP website**.

- **DSRIP Special Terms and Conditions ("STCs")**
- **Attachment I – Program Funding and Mechanics Protocol**
- **Attachment J – DSRIP Strategies and Metrics Menu**
- **Safety Net Definition**
- **Eligible Safety Net Hospitals**
- **Eligible Safety Net Clinics**
- **Eligible Safety Net Nursing Homes**
- **Eligible Safety Net LTHHCPs**
- **Eligible Safety Net CHHAs**

These lists are **preliminary** and do not include OMH, OASAS and OPWDD providers, which will be added shortly.

In addition, the following additional documents can be found at the **DSRIP website**:

- DSRIP Timeline and Deliverables Schedule
- DSRIP Glossary
- Final Waiver Amendment Presentation
- A two part, pre-recorded webinar providing an overview of the Amendment.
- DSRIP Data Workgroup Series

It is expected that the following items will also soon be posted:

- DSRIP Project Toolkit
- DSRIP Metric Specification Guide
- DSRIP Project Value Calculator
- Process for Submission of Letter of Intent to File Grant Application
- Planning Grant Application
- DSRIP Application and Scoring Tool

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Andrew M. Cuomo - *Governor*

Governor Cuomo Announces Final Approval of $8 Billion MRT Waiver to Protect and Transform New York's Health Care System

Printer-friendly version

Albany, NY (April 14, 2014)

Governor Andrew M. Cuomo today announced that New York has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment will transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members.

"We will finally be able use the billions in savings we generated by reforming the state's Medicaid system to protect and improve health care services for millions of New Yorkers," said Governor Cuomo. "In 2011, New York did what people said couldn't be done: we overhauled our Medicaid system to save taxpayers billions while delivering better health care. This waiver amendment allows us to invest these savings in keeping Brooklyn's hospitals open, providing new community based primary care clinics in neighborhoods that need them and preserving health care services across our state."

New York City Mayor Bill de Blasio said, "Today's announcement is a major milestone that will help break the vicious cycle of heedless hospital closures across our city. With this funding, we can pivot from reacting to crises to proactively transforming our healthcare system for the long-term. Our administration is proud to have worked alongside Governor Cuomo to ensure New York received what it deserved. Thanks to the Governor's leadership, and the collaboration of Senator Schumer and Secretary Sebelius, we can reinvest in our community hospitals—particularly those threatened in Brooklyn--and deepen our commitment to neighborhood healthcare. The City stands ready to work with our State partners to ensure we invest these resources wisely and make the most of this historic opportunity."

The Medicaid 1115 waiver amendment will enable New York to fully implement the MRT action plan, facilitate innovation, lower health care costs over the long term, and save scores of essential safety net providers from financial ruin. The waiver allows the state to reinvest over a five-year period $8 billion of the $17.1 billion in federal savings generated by MRT reforms.

The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

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 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, and investments in long term care, workforce and enhanced behavioral health services

In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

Governor Cuomo has aggressively advocated for waiver amendment approval over the past 18 months and repeatedly made the case to HHS Secretary Kathleen Sebelius on the state's need for MRT savings reinvestment to transform the health care delivery system. Today's

announcement will pave the way to continue the efforts of the MRT in advancing reform and transformation in New York's health care delivery system.

Public comment on the MRT waiver amendment will be solicited through the MRT website, webinars and public hearings to take place over the next several weeks. Additional information, including the waiver special terms and conditions, list of eligible safety net providers, descriptions of eligible projects, and other overview documents are available at: http://www.health.ny.gov/health_care/medicaid/redesign/.

About the Medicaid Redesign Team:

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. In January and February 2011, the MRT held a series of public meetings across the State, which provided New Yorkers valuable opportunities to share their ideas and comments. Meetings were also broadcast on the Internet and informational materials were posted on the MRT web page. In all, the MRT received more than 4,000 ideas from citizens and stakeholders.

The MRT worked in two phases. Phase 1 provided a blueprint for lowering Medicaid spending in State fiscal year 2011-12 by $2.3 billion. Phase 1 was completed in February 2011 when the MRT submitted an initial report in line with the Governor's Medicaid spending target contained in his 2011-2012 budget. The report included 79 recommendations to redesign and restructure the Medicaid program by bringing efficiencies and by generating better health outcomes for patients. The Legislature, as part of the budget process, approved 78 of the 79 recommendations it considered; these initiatives are now being implemented.

In Phase 2, to address additional issues and to monitor the implementation of key recommendations enacted in Phase 1, the MRT divided into 10 work groups. As part of their work, the groups provided 175 additional stakeholders the opportunity to participate in the MRT process. A number of public hearings were held across the state. Following these sessions, MRT recommendations were compiled and included in a final report. The report is available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.

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Attachment I - NY DSRIP Program Funding and Mechanics Protocol

I. Preface

a. Delivery System Reform Incentive Payment Fund

On April 14, 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's request for an amendment to the New York's Partnership Plan section 1115(a) Medicaid demonstration extension (hereinafter "demonstration") authorizing the creation of a Delivery System Reform Incentive Payment (DSRIP) Fund. This demonstration is currently approved through December 31, 2014. DSRIP Funds will not be made available after December 31, 2014 unless the state's demonstration renewal is approved by CMS.

Section IX of the Special Terms and Conditions (STC) describes the general rules and requirements of the Delivery System Reform Incentive Payment (DSRIP) Fund.

b. DSRIP Strategies Menu and Metrics and Program Funding and Mechanics Protocol

The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The Program Funding and Mechanics Protocol (this document, Attachment I) describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, reporting requirements, and penalties for missed milestones. The DSRIP Strategies Menu and Metrics (Attachment J) details the specific delivery system improvement activities that are eligible for DSRIP funding.

This version of the DSRIP Program Funding and Mechanics Protocol is approved April 14, 2014. In accordance with STC 10.b in section IX, the state may submit modifications to this protocol for CMS review and approval in response to comments received during the post-award comment period and as necessary to implement needed changes to the program as approved by CMS.

II. DSRIP Performing Provider Systems

The entities that are responsible for performing a DSRIP project are called "Performing Provider Systems." Performing Provider Systems must meet all requirements described in the STCs, including the safety net definition described in STC 2 is section IX. This section provides more detail about the specific criteria that performing provider systems must meet in order to receive DSRIP funding and the process that the state will follow to assure that performing provider systems meet these standards.

The state will determine the types of providers eligible to participate as a Performing Provider System, as described in paragraph (a) below. All providers are required to form coalitions of providers that participate in DSRIP as a single Performing Provider System, as described in paragraph (b) below. Coalitions must specify their outpatient beneficiary population based on the attribution model described in paragraph (c) below.

a. Assessment of Safety Net Provider Status

The state will use data from DSH audits and other available information to make an assessment of which providers in the state could be eligible for DSRIP funding, consistent with STC 2 in section IX. This list of providers will be submitted to CMS and will be publicly available on the state's website. Performing Provider Systems are expected to continue serving a high proportion of Medicaid and uninsured patients throughout the duration of the demonstration, and significant deviation from these standards will be cause to discontinue DSRIP funding for the Performing Provider System after the mid-point assessment.

b. Coalitions

Eligible major public general hospitals and other safety net providers are encouraged to form coalitions that apply collectively as a single Performing Provider System. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System. Coalitions are subject to the following conditions:

i. Coalitions must designate a lead coalition provider who is primarily responsible for ensuring that the coalition meets all requirements of performing provider systems, including reporting to the state and CMS.
ii. Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, without limitation, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.
iii. Coalitions must have a plan for reporting, decision-making, change management, and dispute resolution on performance and incentive payments.
iv. Each coalition must in the aggregate meet the minimum outpatient beneficiary

requirements specified in paragraph (d) below.

v. For coalitions that involve public hospitals that are providing Intergovernmental Transfer (IGT) funding for a project, the public entity providing IGT funding will generally be the lead coalition provider for the Performing Provider System that is directly using the IGT match. Private safety net providers can also service as coalition leads as provided in paragraph (d) below.

vi. Each coalition must have a data agreement in place to share and manage patient level data on system-wide performance consistent with all relevant HIPAA rules and regulations.

c. DSRIP Beneficiary Attribution Method

The goal of DSRIP is to have each Performing Provider System responsible for most or all Medicaid beneficiaries in the given geography or medical market area. It is expected that most of the Medicaid beneficiaries in the state will be attributed to a Performing Provider System. The possible exceptions are beneficiaries that are primarily being served by providers not participating in any Performing Provider System, however it is expected that given the comprehensive nature of DSRIP that each approved Performing Provider System will include all of the major providers of Medicaid services in their region which will greatly reduce the number of beneficiaries not attributed to a Performing Provider System. A beneficiary will only be attributed to one Performing Provider System, based on the methodology described below.

Performing Provider Systems must include a proposed target population including a specific geography and population for the overall performing provider effort. This target population will be the collective focus for all projects within the Performing Provider System project plan although some strategies may focus on a population subset (e.g., individuals with asthma) that subset will be chosen from within the overall Performing Provider System target population. Utilizing the proposed geography and proposed population as appropriate, for each DSRIP Project Plan submitted by a given Performing Provider System, the department will identify the Medicaid beneficiaries' population that will be attributed to that system prospectively at the start of each measurement year. This prospective attribution denominator for DY 1 will be used in valuation for payment purposes without any adjustments applied, except at the midpoint evaluation as specified in section VI.d. below.

Although the patient populations targeted for Performing Provider System measurement are determined as of January 1 (or other date specified) of the measurement year for valuation purposes, patient attribution for Performing Provider System quality measurement should be defined as of December 31 of the measurement year and that population will serve as the denominator base pool for domain 2 and 3 metrics. This will provide an initial, prospective attribution at the start of the measurement year to determine the populations to be included and a final attribution at the end of the year for evaluation and measurement. So, for measurement purposes, this prospective attribution, depending on the measure, may be adjusted at the end of each performance year ("attribution true up") to remove beneficiaries that that were not enrolled in Medicaid per the specific measure specification for continuous enrollment criteria and add new Medicaid beneficiaries attributed to the Performing Provider System during the year and

any other adjustments necessary to assure a proper measurement denominator (as further described in the Metric Specification Guide described in Attachment J). This denominator base may be further subdivided as needed to identify target populations (such as beneficiaries with diabetes or behavioral health) when that is appropriate for a metric associated with a particular project measure.

Attribution will be done utilizing a hierarchical geographic and service loyalty methodology (as described below) to ensure that a beneficiary is only assigned to one Performing Provider System. The results of the preliminary attribution process below will be shared with the Medicaid Managed Care organizations for their enrolled members. The MCOs will review the state's attribution logic and suggest any needed changes based on more current member utilization information including more recent PCP assignment or specialty service access. In advance of this attribution process the state will share the DSRIP Performing Provider System network with the plan to identify any network alignment gaps that may exist so that the DSRIP Performing Provider System and the MCOs can work together to align service delivery and plan contracted networks as appropriate.

Preliminary Attribution:

i. Beneficiaries who receive plurality of their qualifying services from providers that are not participating in any DSRIP Performing Provider System will be excluded from attribution.
ii. When there is only one Performing Provider System in a defined geographic area/geopolitical area, the entire matched Medicaid beneficiary population will be the assigned population in that geographic/geopolitical area.
iii. When there are more than one Performing Provider Systems in a defined geographic/geopolitical area, the following methodology will be utilized which has been derived from the New York State Health Home attribution protocol:
    1. Matching Goal - The goal is to make the best assignment to a Performing Provider System based on the recipient's current utilization patterns, assigned primary care provider as well as the geographical appropriateness of that system. This means beneficiaries will be assigned to Performing Provider Systems, in their region, which include the providers most responsible for their care (as determined based on visits to primary service types, as described below). The attribution logic will test for a plurality of visits within the Performing Provider System. Plurality means a greater proportion of services as measured in qualifying visits within the Performing Provider System than from services outside the Performing Provider System.
    2. Service Groupings - To meet this goal, the methodology will aggregate patient service volume across four different groups of services and assign attribution using a hierarchical service priority as follows:
        A. 1st priority - care management provider;
        B. 2nd priority - outpatient (physical and behavioral health) including Primary Care Providers and other practitioners ;
        C. 3rd priority - emergency room; and
        D. 4th priority - inpatient.

3. Attribution Method – Once the Performing Provider System network of service providers is finalized that overall Performing Provider System service network will be loaded into the attribution system for recipient loyalty to be assigned based on total visit counts to the overall Performing Provider System network in each of the above hierarchical service categories. Once the initial attribution is calculated for the purposes of setting DSRIP application values, the performing provider system network may only be changed with a DSRIP plan modification (as described in section X.a below). . For each of these service categories, the algorithm will check the services provided by each provider and accumulate these visits to the Performing Provider System the given provider is partnered with. If a recipient is currently outside the Performing Provider System geographic area, the visits are excluded (e.g. recipient traveling from upstate to NYC for special surgery). Each Performing Provider System associated with the matched provider accumulates the total number of visits for each service/provider combination. Adjustments to attribution based on known variables (e.g, recent changes to the recipient's address) may be made by the state with MCO input if deemed appropriate by data. After all visits against all providers are tallied up for a given service type, the methodology finds the Performing Provider System with the highest number of visits for the recipient. This process helps ensure that the Performing Provider System that is the best fit for the recipient is chosen.
4. Hierarchical matching - The method first tries to assign a recipient to a performing provider first based on case management connectivity, if no case management visits exist the method then moves on to try to assign based on outpatient connectivity (all visits physical and behavioral count), if no case management or outpatient visits exists the method then moves on to try to assign based on ER connectivity and then moves on accordingly for inpatient last. This tries to connect a beneficiary to the most critical service from a patient management perspective first and then uses volume from within those hierarchical categories.
5. Finalizing Match and Ties - If more than one Performing Provider System has the highest number of visits based on the highest priority service types noted above in sub paragraph 4, the methodology re-runs the above logic across all Medicaid service types. This process could break a tie if additional visits in other service types cause one Performing Provider System to accumulate more visits. If, however, this still results in a tie, the methodology will place the recipient in a separate bucket to be assigned at the end of the process.
6. Unmatched Recipients - If a recipient only has claims associated with providers that have no relationship with a Performing Provider System, the recipient is placed in a "no visits" bucket.
7. Assignment of Unmatched and Ties - Recipients who have no predominant demonstrated provider utilization pattern or no visits will be assigned to a Performing Provider System in their geographic region by first looking to see if the beneficiary has any primary care provider (PCP) assigned by a Medicaid health plan; if the beneficiary has an assigned PCP the beneficiary will be matched to the Performing Provider System that has that PCP in their network (a method will be developed to address PCPs that are in more than one Performing Provider System). If the beneficiary cannot be matched by PCP, then the beneficiary will be assigned to the

Performing Provider System with the most beneficiaries already assigned (by the visit attribution method) in their specific zip code or other relevant geographic area. Except for beneficiaries who are explicitly excluded because they receive the majority of their services (more than 50%) at providers that are not participating in DSRIP, all beneficiaries will be attributed.

Final Attribution with MCO Input:

The results of the preliminary attribution process (geographic and service utilization matching) will be shared with each Medicaid Managed Care plan for their enrolled membership. The plans will be asked to review the assignment list, make and necessary corrections, as practicable, based on more current beneficiary utilization information including more recent PCP assignment or specialty service access that may have occurred after the preliminary attribution data was run. The plans will each submit to the state a recommended final DSRIP attribution list for each Performing Provider System for each enrolled member as appropriate to the target population for the given DSRIP project. The state will review the plan recommendation and make modifications if needed to assure better balance between DSRIP projects, especially where there are multiple MCOs in a given region. This MCO input into the attribution process will ensure that the most recent member access patterns are taken into account in developing the attribution and will begin to better connect MCOs to the DSRIP projects as performance improvement and payment reform components of the overall DSRIP are actuated.

Providers who have a significant number of Medicaid beneficiaries as patients and who have not joined a Performing Provider System will be identified by the state and the MCOs. The department will strongly encourage these providers to join an appropriate Performing Provider System in their geographic/geopolitical region.

d. Minimum Outpatient Service Level

Performing Provider Systems must have a minimum of 5,000 attributed Medicaid beneficiaries a year in outpatient settings.

e. Performing Provider System Relation to IGT Entities

Intergovernmental transfer (IGT) entities are entities that are eligible to contribute allowable governmental funds for use by the state for the non-federal share of DSRIP payments for a Performing Provider System. They include government-owned Hospitals and other government entities such as counties.

The non-federal share of DSRIP payments to providers will be funded through the use of intergovernmental transfers (IGTs) that are derived from state or local tax revenues that have been contributed to government-owned providers including major public general hospitals or IGTs from their sponsoring governmental entity or another governmental entity that comport with federal requirements in section 1903(w) of the Act. Such IGTs will not be represented on any financial statement by the public hospital as a cost of patient care, overhead, tax, or administrative cost; instead it shall be reflected as a transfer to the state government.

No portion of a DSRIP payment paid to a Private Performing Provider system may be redirected to the public entity that is supplying IGTs to finance the non-federal share of such payments. Also, no private provider that is included in a coalition of providers that includes public providers can transfer DSRIP funds to those public providers.

The state encourages public and private providers to collaborate where appropriate and will work with Performing Provider Systems to clarify the flow of IGT funding to avoid impermissible provider donations.

III. Projects, Metrics, and Metric Targets

a. Projects

Performing provider systems will design and implement at least five and no more than 10 DSRIP projects, selected from the Strategies Menu and Metrics (Attachment J). Each project will be based on a particular strategy from Attachment J and will be developed to be responsive to community needs and the goal of system transformation, as defined by the objectives in STC 6 in section IX.

All the DSRIP projects for a Performing Provider System will be part of the Performing Provider System's overall DSRIP Project Plan.

There are projects described in Attachment J that are grouped into different strategies, such as behavioral health, within each Domain (System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). For each strategy, there is a set of metrics that the performing provider system will be responsible for if they do any one of the projects within that strategy.

As described in Attachment J, Performing Provider Systems will select at least two system transformation projects (including one project to create integrated delivery systems as well as another project from either the care coordination or connecting settings strategies list), two clinical improvement projects (including a behavioral health project), and one population-wide project. The selection of all projects must be based on the community needs assessment of the baseline data and as the target population selected by the performing provider system. Performing Provider Systems may choose additional projects as appropriate.

b. Metrics

In order to measure progress towards achieving each objective, each project must include metrics in all four of the following domains. Performing Provider Systems will report on these metrics in their semi-annual reports (described in VI.a below) and will receive DSRIP payment for achievement of these milestones (based on the mechanism described in VII.a below).

i. Overall project progress metrics (Domain 1)
ii. System transformation metrics (Domain 2)
iii. Clinical improvement metrics (Domain 3)
iv. Population-wide metrics (Domain 4)

Performing Provider Systems that exceed their metrics and achieve high performance by exceeding a preset higher benchmark for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health population will be eligible for additional DSRIP funds from the high performance fund, described in paragraph VIII.b. below.

The Strategies Menu and Metrics (Attachment J) describes the specific metrics that will be used to assess performance under each domain and specifies which metrics are pay-for-reporting and which are pay-for-performance. Additional measure specifications, including the process for addressing small n issues is described in the Metric Specification Guide supplement to Attachment J.

As described in STC 12.e. in section IX, the state or CMS may add domain 1 metrics to a project prospectively in order to address implementation concerns with at risk projects.

c. Metric Targets

All performing provider systems must have a target for all pay-for-performance metrics, which will be used to determine whether or not the performance target for the metric was achieved. Performance targets should be based on the higher of top decile of performance for state or national data, or an alternative method approved by CMS. NY DSRIP goals for metrics may be based on NYS Medicaid results or national data where possible and on DSRIP DY1 results for metrics where state or national data are unavailable. Annual improvement targets for Performing Provider System metrics will be established using the methodology of reducing the gap to the goal by 10%. The Performing Provider System baseline data will be established as soon as complete data is available for the baseline period (as specified in the Metric Specification Guide supplement to Attachment J) and will be used as the foundation to determine the gap to goal to set the improvement target. For example if the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 3.8 percent increase in the result (target 55.8 percent). Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

In general, Performing Provider System that achieve their target for the DY will be considered to have reached the annual milestone for the metric, and Performing Provider System that achieve 20 percent gap to goal or the 90th percentile of the statewide performance for the high performance metrics listed in Attachment J may be eligible for additional payment for high performance. If more frequent reporting (more than annual) of metric results are required for projects, the reported results for payment should be based on a standard twelve month period.

IV. DSRIP Project Plan Requirements

a. Project Plan Development Process

The proposed project plans should be developed in collaboration with community stakeholders and responsive to community needs. Performing Provider Systems have the option to seek DSRIP design grants described in STC 10 in section IX.

According to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX, Performing Provider Systems must submit a final DSRIP Project Plan to the state for review with a complete budget and all other items described below, consistent with the requirements in STC 8 in section IX.

It is expected that the transformational nature of the activities to be undertaken in these projects will require a strict adherence to disciplined project management. The DSRIP Project Plan must provide evidence that the Performing Provider Systems has a clear understanding of the needs of the service area (based on objective data specific to the service area as well as community input), that the project will address these needs in a significant manner, that the Performing Provider System understands the metrics that will need to be monitored and the methodology that will be used to do such, and that the Performing Provider System has internal and/or external resources that will be available for project management and the required rapid cycle improvements inherently needed in these projects.

b. Organization of DSRIP Project Plan

DSRIP Project Plans must be submitted in a structured format agreed upon by the state and CMS. At a minimum, the plan shall include the following sections:

1) **DSRIP Face Sheet**
   This face sheet will list the documents included within the package and include the applicant's name and a brief (no more than 1000 word) executive summary of the submitted project.
2) **Provider Demographics** including:
   a) Name, Address, Senior level person responsible for the DSRIP project and to whom all correspondence should be addressed
   b) The name of providers and their identification numbers participating in the project plan, including the lead provider in the case of a coalition.
   c) Definition of service area (according to the specifications in the DSRIP Strategies Menu and Metrics) and a discussion of how the providers in the coalition relate to (or inform) the service area definition. As further described in the DSRIP Strategies Menu and Metrics, Performing Provider Systems are accountable for improving the quality of care for all Medicaid and low-income uninsured beneficiaries in their service area as defined in the DSRIP Member Attribution Method above.
   d) Identification as a safety net provider with documentation supporting that identification as described in paragraph II.a above.
   e) Current patient population including demographic information, payer mix to document qualification as described in paragraph II.c above.
3) **Identification of Provider Overarching Goals:** The Performing provider system will need to identify its goals for the project, as well as how the project contributes to achieving the overall goals (defined in STC 1 in section IX) to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries in their local communities by improving care, improving health and reducing costs. More specifically, the

Performing provider system should demonstrate how the project will engage in system transformation (including linking across settings, ensuring appropriate capacity, and taking responsibility for a population), as demonstrated by achievement of avoidable events [including addressing behavioral health]. The Performing provider system will need to demonstrate that it has a governance strategy that ensures that participating providers work together as a "system" and not as a series of loosely aligned providers nominally committed to the same goal. Plans to progressively move from a loosely organized network of affiliated entities to an actual Integrated Delivery System must be evident in the goals.

The Performing provider system will need to provide objective data-driven evidence that this is a relevant goal for the Performing provider system and its service area. The performing provider system must demonstrate that all relevant Domain 3 metrics for the projects selected align with community needs and that these areas have room for improvement. With the exception of behavioral health Domain 3 measures, for which the following will not apply, if the Performing provider system's performance on the most recent available data (as specified in the Metric Specification Guide supplement to Attachment J) for the majority of any chosen Domain 3 metric set is within 10 percentage points or 1.5 standard deviations to the high performance goal described in section III.c above (whichever is greater) , the project would not be approved.

4) **Identification of Provider Project to meet identified goals,** including brief rationale for project choice and summary (including citations) of existing evidence showing that project can lead to improvement on goals of project. Logic models such as driver diagrams may be helpful to demonstrate how the elements of the project all contribute to the central goals. Further information will be provided in the detailed assessment provided in (5) and must include all relevant domains outlined in the Strategies Menu and Metrics.
5) **Performance Assessment**
    a) Current community health needs (population demographics, types and numbers of providers and services, cost profile, designation as Health Professional Shortage Area, mortality and morbidity statistics, and health disparities) This will include a discussion of a designated list of public health concerns determined by the state, including behavioral health. The selection of these concerns should be supported by baseline data on current performance on targeted health indicators and quality metrics.
    b) Evidence of regional planning including names of partners involved in the proposed project (in addition to any coalition members in the Performing Provider System in accordance with the process described in paragraph II.b above) Detailed analysis of issues causing poor performance in the project area. These must include 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.
    c) Comprehensive workforce strategy - this strategy will identify all workforce implications – including employment levels, wages and benefits, and distribution of skills – and present a plan for how workers will be trained and deployed to meet

patient needs in the new delivery system based on the performance assessment of community health needs, and how the strengths of current workforce will be leveraged to the maximum degree possible under current state law and regulations.

d) Review of Financial stability – A complete review of the financial condition of all financially challenged safety net and public providers in the performing provider system.

e) Evidence of public input into the project. This should include documentation of collaboration with local departments of public health, public stakeholders and consumers. In addition, the provider will need to document how there will be ongoing engagement with the community stakeholders, including active participation in any regional health planning activities currently underway in their community. Applicants will need to include workers and their representatives in the planning and implementation of their overall project with particular emphasis on the comprehensive workforce strategy. The state may require Performing Provider Systems to maintain a website including contact information, overview of public comment opportunities, results of public processes, application materials, and required reporting.

6) **Work Plan Development:** In this section the provider will provide an initial high-level work plan in a state-approved format using the domains of milestones identified in the DSRIP Strategies Menu and Metrics.

   i. Project progress milestones (Domain 1)
   ii. System transformation and financial stability milestones (Domain 2)
   iii. Clinical improvement milestones (Domain 3)
   iv. Population-wide Milestones (Domain 4)

   The Performing Provider System will need to document their plans to address and implement the project including each of the confounders identified in the Performance Assessment section. This should include resources available to complete the project. The time frame for the work plan will be five years. It is expected that no more than the first two years will be utilized to implement major system changes related to the project. In addition, it is expected that improvements in outcome metrics will begin to occur in that first two year period.

7) **Rapid cycle evaluation:** The plan must include an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

8) **Establishment of Milestones and Metrics:** A section of the work plan must provide documentation of the monitoring strategy for the project including significant milestones and associated metrics, as specified in the DSRIP Strategies Menu and Metrics.

9) **Budget:** Performing Provider Systems must provide a detailed budget for all 5 years of their DSRIP project. For Performing Provider Systems that were awarded HEAL

grants, a detailed budget report along with a description of the similarities or differences must be included.

10) **Governance:** The plan must include a detailed description of how the system will be governed and how it will evolve into a highly effective Integrated Delivery System. A clear corporate structure will be necessary and all providers that participate in the project will need to commit to the project for the life of the waiver. Weak governance plans that do not demonstrate a strong commitment to the success of the project will be rejected. Strong centralized project control will be encouraged especially for projects that require the greatest degree of transformation. Coalitions must define the members of the coalition and submit all supporting information about coalition governance including the business relationship, as described in Section II.b. The governance plan must address how the performing provider system proposes to address the management of lower performing members within the Performing Provider System network. This plan must include progressive sanctions prior to any action to remove a member from the performing provider system. The governance plan must also include a process by which the Performing Provider System will progressively advance from a group of affiliated providers to a high performing Integrated Delivery System.
11) **Data sharing and confidentiality**: Metrics will be collected in a uniform and valid fashion across all members of a Performing Provider System. The plan must include provisions for appropriate data sharing arrangements that permit this and appropriately address all HIPAA privacy provisions.
12) **Expectation of Sustainability:** Performing Provider Systems are asked to explain how the outcomes of this project will be sustained at the end of DSRIP and how gains can be continued after the conclusion of the project period. This should include a financial forecast of expected savings related to the implementation.
13) **Signed Attestations*:***
    The Performing Provider System will submit a description of any initiatives that the provider is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiative currently in place. The Performing Provider System will, by signature, attest that the submitted DSRIP project is not a duplication of a project from these other funded projects and does not duplicate the deliverables required by the former project (s). It should be noted if this project is built on one of these other projects or represents an enhancement of such a project that may be permissible, but it must be clearly identified as such in the DSRIP project plan.

    The provider will submit an attestation statement documenting that the information provided in this document is accurate at the time of submission and that the provider, 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.

V. Project Valuation

The DSRIP project and application valuations will be calculated by the state (with assistance from the independent assessor) according to the methodology described below.

A maximum valuation for each DSRIP application is calculated based on the formula described in (a) below. Once the overall application value is determined, the value for the individual metrics of the DSRIP project plan is determined based on the distribution method described in (b) below. Project values are subject to monitoring by the state and CMS, as described in (c) below, and Performing Provider Systems may receive less than valuation described in their DSRIP plan if they do not meet metrics and/ or if DSRIP funding is reduced because of the statewide penalty (described in Section IX.d below)

As a reminder, a performing provider system can submit a minimum of 5 and a maximum of 10 projects for scoring purposes. Additional projects can be included in the application, but they will not be included in application valuation. If more than 10 projects are chosen, those with the highest index scores, that meet the project selection requirements, will be selected for application valuation purposes. Please see below for project selection requirements per domain.

- Domain 2 Projects - Applicants must select at least two projects from this domain (one of which must be from sub-list *A* and one of which must be from sub-list *B* **or** *C*) but can submit up to 4 projects from Domain 2 for scoring purposes
- Domain 3– Applicants must select at least two projects from this domain (one of which must be *A. Behavioral Health*), but can submit up to 4 projects from Domain 3 for scoring purposes
- Domain 4 – Applicants must select at least one project from this domain, but can submit up to 2 projects from Domain 4 for scoring purposes.

a. Valuation for DSRIP Application

The maximum DSRIP project and application valuation will follow a five-step process.

1. The first step assigns each project in the Strategy Menu (Attachment J) a *project index score* which is a ratio out of a total of 60 possible points of each project (X/60 = project index score).
2. The second step creates a *project PMPM* by multiplying the project index score by the state's valuation benchmark. The valuation benchmark is pre-set by the state and varies based upon the number of projects proposed by an applicant.
3. The third step determines the *plan application score* for the performing provider's application based on a total of 100 points possible for each application (X/100 = Application Score)
4. In the fourth step, the *maximum project value* is calculated by multiplying the project PMPM, the plan application score, the number of Medicaid beneficiaries attributed to the project, and the duration of the DSRIP project (see example below).

5. Once the maximum project values have been determined, the *maximum application value* for a Performing Provider System is calculated by adding together each of the maximum project values for a given Performing Provider System's application.

The maximum application value represents the highest possible financial allocation a Performing Provider System can receive for their project 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 (described in Section IX below).).

Step 1: Calculating Project Index Score

The value of a single project is expressed as an index score (see below). 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 index scores will be available to providers for each project before the submission of their application, as part of the DSRIP project toolkit, described in Attachment J.

The formula for the index score for each project on the menu consists of the following elements:

a. Potential for achieving DSRIP goal of system transformation, including the three objectives, as described in STC 6 in section IX (Score 1 (lowest) – 30 (highest))
b. Potential for achieving DSRIP goal of reducing preventable events, as described in STC 1a in section IX (Score 1– 10)
c. Scope of project and capacity of project to directly affect Medicaid and uninsured population (1-10)
d. Potential Cost Savings to the Medicaid Program (1-5)
e. Robustness of evidence base (1-5)

Adding up the scores for each element for a given project will give each project an index score of X/60. The project index score (out of the 60 possible points) will be expressed in decimal form for calculation purposes.

Step 2: Calculating Project PMPM

Each project will be assigned a valuation benchmark based on the number of projects proposed in the application as described in Table 1 below.

By no later than 15 days after the public comment period for initial DSRIP applications, the state will establish a state-wide valuation benchmark based on its assessment of the cost of

similar delivery reforms. This value will be expressed in a per member per month (PMPM) format and may not exceed $15 PMPM, as described in STC 9 in section IX.

For the purposes of the example described later in this section, an initial $8 PMPM valuation benchmark is used in Table 1 below. However, because projects serving more beneficiaries will have synergistic properties and economies of scale that will lower a project's per member per month cost, the final valuation benchmark will be set based on the overall scope of applications received. Table 1 (below) will be updated to reflect the final valuation benchmark developed by the state in accordance with CMS's guidelines.

Because additional projects will have synergistic properties, from leveraging shared infrastructure and resources, the valuation benchmark is discounted as follows for Performing Provider Systems selecting multiple projects. Although the project PMPM levels drop with the inclusion of additional projects, the overall Performing Project System valuation will generally increase (depending on the value of the actual projects selected) as more projects are added to the overall PPS effort. If the valuation benchmark is adjusted based on the process described above, the relative discount factor for additional projects beyond will remain the same.

Table 1. Valuation benchmark table (PMPMs may be revised according to the schedule described above, subject to the standards described in STC 9 in section IX)

Number of projects	Valuation Benchmark
5 (minimum)	$8.00
6	$7.20
7	$6.80
8	$6.65
9	$6.50
10 (maximum)	$6.50

The valuation benchmark is then multiplied by the project index score to create a project PMPM for each project.

Step 3: Plan Application Score

Based on their submitted application, each project plan will receive a score based on the fidelity to the project description, and likelihood of achieving improvement by using that project. This plan application score will be used as a variable in calculating the maximum project value.

Each plan application score will be expressed as a score out of 100, which will drive the percent of the maximum project valuation for each project that will be allocated to that individual project plan. The plan application score (out of the 100) will be expressed in decimal form when

calculating the maximum application valuation. The state will develop a rubric for the individual plan application score in collaboration with CMS. This rubric must include an assessment of whether each proposed project is sufficiently different from other DSRIP projects selected (and other existing projects being funded by other sources) so as to ensure that the performing provider system does not receive double-credit for performing similar activities.

Performing provider systems are encouraged to partner providers participating in the IAAF program as part of their DSRIP performance network. The plan application score rubric developed by state in collaboration with CMS may include bonus points for addressing sustainability issues in communities served by IAAF providers. Applications will also be scored based on an applicant's commitment to developing a capability to responsibly receive risk-based payments from managed care plans through the DSRIP project period.

Step 4: Calculating Maximum Project Value

The number of Medicaid beneficiaries attributed to the project (based on the attribution method described in Section III above) and the anticipated duration of the applicant's participation in DSRIP program will also be used to calculate the maximum value for each project as follows.

Maximum Project Value = [Project PMPM] x [# of Medicaid Beneficiaries] x [Plan Application Score] x [DSRIP Project Duration]

Step 5: Calculating Maximum Application Value

Once the maximum project values for each of the projects in the Performing Provider System application is calculated, the maximum project values for each of the project are then added together to provide the Maximum application value for the DSRIP application.

Example: Putting it all together - here is an example of the DSRIP valuation calculation:

For illustration purposes, a performing provider system submits six projects in their application. Two projects are from Domain Two; Creating an Integrated Delivery System, and Expand Access to Primary Care , and three projects from Domain Three; Integration of Behavioral Health in Primary care, Development of Evidence Based Medicine Adherence programs, and HIV Services Transformation and one project from Domain Four; Evidence Based Strategies to Prevent Substance Abuse and Other Mental/Behavioral Disorders. Scoring steps are included below but all numbers are for illustration purposes only and do not reflect on the actual values that the example projects will receive.

Step 1: Calculating Project Index Scores (for illustration purposes) Project Index Scores

- Project 1: Creating an Integrated Delivery System 56/60=.93
- Project 2: Transitional Supportive Housing Services 54/60=.9
- Project 3: Integration of Behavioral Health in Primary care 47/60=.78
- Project 4: Evidence Based Medicine Adherence 40/60=.67
- Project 5: HIV Services Transformation 40/60=.67
- Project 6: Strategies to Prevent SUD and BH Disorders 24/60=.4

Step 2: Calculating Project PMPM (numbers below are for illustration only):

Since there are six projects in this example application, the valuation benchmark is $7.20 (for a six project application - from the table in step 2 above). Each of the Project Index Scores (from Step 1) are then multiplied by Valuation Benchmark to compute the individual Project PMPMs.

[Project Index Score] X [Valuation Benchmark] =Project PMPM (see table below)

	Project Index Score	Valuation Benchmark	Project PMPM
Project 1	0.93	$7.20	$6.72
Project 2	0.9	$7.20	$5.40
Project 3	0.78	$7.20	$6.48
Project 4	0.67	$7.20	$4.80
Project 5	0.67	$7.20	$4.80
Project 6	0.4	$7.20	$2.88

Step 3: Calculating Plan Application Score

Performing Provider System submits a six project Performing Provider System application and receives a plan application score of 85/100. As part of the 15 point reduction from a perfect score, the Performing Provider System received a reduction because the Performing Provider System selected two projects that share the same metric set.

Step 4 and 5: Calculating Maximum Project Value and Maximum Application Valuation

The attribution assessment completed by the provider in their application (and subsequently verified by the State's attribution method and independent assessors) shows 100,000 Medicaid members are expected to be served by the applicant's DSRIP project.

As a result, the maximum application value is calculated as 158,508,000, as illustrated below.

	Project PMPM	**# of Medicaid Beneficiaries**	**Project Plan Application Score**	**# of DSRIP Months**	**Maximum Project Value**
Project 1	$6.72	100,000	0.85	60	$34,272,000
Project 2	$5.40	100,000	0.85	60	$27,540,000
Project 3	$6.48	100,000	0.85	60	$33,048,000
Project 4	$4.80	100,000	0.85	60	$24,480,000
Project 5	$4.80	100,000	0.85	60	$24,480,000
Project 6	$2.88	100,000	0.85	60	$14,688,000
			Maximum Application Valuation		**$158,508,000**

b. Metric valuation

Once the overall project valuation is set, incentive payment values will be calculated for each metric/milestone domain in the DSRIP project plan by multiplying the total valuation of the project in a given year by the milestone percentages specified below.

Metric/Milestone Domains	Performance Payment*	Year 1 (CY 15)	Year 2 (CY 16)	Year 3 (CY 17)	Year 4 (CY 18)	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.*

Within each metric/milestone domain and pay-for-performance/ pay-for-reporting grouping, the value for each metric/milestone will be equally divided between all metrics in a given grouping per the process that follows.

Providers will receive DSRIP payments based on achievement of reporting milestones (P4R) and/or performance targets for metrics (P4P) for a given project during a performance period. Within each project, the value for achieving each performance target/milestone is the same (evenly weighted) and will be calculated as "meeting" or "not meeting" the performance target/milestone. The points given for reaching a specified performance target/milestone will be called an Achievement value and will be calculated as a 0 or 1 value. If a performance target or reporting milestone is met, the Performing Provider System will receive an AV of 1 for that performance target/milestone in that reporting period. If the Performing Provider System does not meet its milestone or performance target, the Performing Provider System will receive an AV of 0 for that reporting period. This will be done across every project in every domain. Performing Provider System improvement targets will be established annually using the baseline data for DY 1 and then annually thereafter for DY2-5. High level performance targets will be provided by the State using results from managed care reporting data in DY1 and using results from DSRIP projects in DY2-DY5 as described in metric targets in Section III c. The Achievement value for P4P metrics will be established by comparing the Performing Provider System result for the reporting period with the improvement target for the Performing Provider System. If the Performing Provider System meets the improvement target for the metric, the Performing Provider System will receive an AV of 1. If the Performing Provider System result also meets a high performance threshold, there may be additional payment through High Performance fund, which is not included in this part of the payment calculation.

AVs will then be grouped into either a pay-for-reporting (P4R) or a pay-for-performance (P4P) bucket for each domain. The P4P and P4R AVs in each domain will be summed to determine the Total Achievement Value (TAV) for the domain. A Percentage Achievement Value (PAV) will then be calculated by dividing the TAV by the maximum AV (the total number of metrics) for P4P and P4R in each domain. The PAV will demonstrate the percentage of achieved metrics within the P4R and P4P metrics for each domain for that reporting period.

Example: A Performing Provider System has a project in year one with a project level valuation of $100,000 for year one. If the Performing Provider System achieves two out of five of its metrics/milestones for that project it would receive 40 percent of the $100,000 or $40,000. The metrics/milestone value would be assigned AV and PAVs as follows:

Metric/Milestone	***Achievement***	***AV***
Milestone 1	*Achieved*	*1*
Milestone 2	*Achieved*	*1*
Milestone 3	*Not Achieved*	*0*
Milestone 4	*Not Achieved*	*0*
Milestone 5	*Not Achieved*	*0*
	TAV	*2*
	PAV 2/5	*40%*

The PAV will be used to determine the level of the total payment the provider has earned for that reporting period based upon the performance payment distribution provided under the metric valuation. The level of payment for a provider within a domain will be proportionate to the PAV allocated to that domain. Additionally, the Performing Provider System will be eligible for bonus payments by reaching separate high performance targets described in Section III and Attachment J.

c. Project Value Monitoring

Performing Provider Systems will be required to develop budgets and report on DSRIP project spending throughout the demonstration. As described in paragraph VI.c below, CMS reserves the right to review project values to ensure that the project value index, the population denominator, and the overall project valuation are calculated correctly.

VI. DSRIP Project Plan Review Process

a. Overview of Review Responsibilities

Each Performing Provider System that elects to participate in the DSRIP program must submit a DSRIP Plan in accordance with the DSRIP Plan guidelines outlined in section IV of this Project Funding and Mechanics protocol, Attachment J: DSRIP Strategies Menu and Metrics, and the demonstration's Special Terms and Conditions. Performing Provider Systems are expected to provide accurate information in their DSRIP plans and respond to the state and CMS's requests for additional information and/or plan revisions in accordance with the timelines specified.

The state is responsible for reviewing all DSRIP plans using a CMS-approved checklist and other review process requirements described below. The state's review will be supplemented by

an independent assessment of DSRIP plans and a public engagement period, which should inform the state's decision of whether to approve a DSRIP plan.

CMS will monitor the state's review process and approve projects in accordance with section VI.c. below.

All Performing Provider Systems will be subject to addition review during the mid-point assessment, at which point the state may require DSRIP plan modifications and may terminate some DSRIP projects, based on the feedback from the independent assessor, the public engagement process and the state's own assessment of project performance. CMS will also monitor this mid-point assessment review process and make determinations in accordance with V.d

b. State-level Review Process

i. *DSRIP plan review checklist*

On or before July 1, 2014, the state will submit the state's approach and review criteria for reviewing DSRIP Project Plans, as well as a draft DSRIP Plan Initial Review Checklist that will be used in the state's initial review of DSRIP Plans to CMS.

CMS and the state will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist to support a robust review process and compelling justification for approval of each project. The state (with support from the independent assessor) will apply the CMS approved review process to ensure that DSRIP Plans are thoroughly and consistently reviewed.

At a minimum, the DSRIP Plan Checklist shall include the following criteria:

A. The plan is in the prescribed format and contains all required elements described herein and is consistent with special terms and conditions.
B. The plan conforms to the requirements for Domains 1, 2, 3, and 4 as described herein, as well as in Attachment J: DSRIP Strategies Menu and Metrics
C. The plan clearly identifies goals, milestones, metrics, and expected results.
D. The description of the project is coherent and comprehensive and includes a logic model clearly representing the relationship between the goals, the interventions and the measures of progress and outcome.
E. The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim), and while at the same time charting a path towards future sustainability.
F. The likelihood for success of this intervention is based on, where available, accurate and robust citations to the evidence base.
G. The plan includes an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

H. The plan includes a detailed description of project governance. Included in the description will detailed accounting of how decisions will be made and what corporate structure will be used throughout the life of the project. A clear description of the powers granted to the project's corporate entity by participating providers must be described as well as what the governance plan is beyond the waiver period. The governance plan must address how the Performing Provider System will address management of lower performing providers in the Performing Provider System network.
I. The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
J. There is a coherent discussion of the Performing Provider System's participation in a learning collaborative that is strongly associated with the project and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the project and to make significant improvement in the outcome measures specified.
K. The amount and distribution of funding is in accordance with Section V of this protocol "Project Valuation."
L. The plan, project, milestones, and metrics are consistent with the overall goals of the DSRIP program.
M. The plan where necessary includes specific goals, projects, milestones and metrics focused on directly and aggressively addressing any provider financial stability issues.

ii. Independent assessment and public engagement process

The state must identify an independent entity ("independent assessor") to conduct an impartial review of all submitted DSRIP plans. The independent assessor will first conduct an initial screen of DSRIP plans 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 Plan and provide an opportunity for Performing Provider Systems to address these concerns.

After determining which DSRIP plans meet the minimum submission criteria, the independent assessor will convene a panel of relevant experts and public stakeholders to assist with the scoring of projects, in a manner similar to a federal grant review process. The independent assessor will ensure that standards are followed to prevent conflict of interest in the panel scoring process.

iii. State assessment

According to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX, the state will make its official, initial determination on each timely submitted DSRIP Plan based on the findings of the independent assessor and the outside review panel. Any deviations from the independent assessor's recommendations should be clearly explained to CMS.

The state will notify the provider system in writing that the plan has been approved and submitted to CMS.

During the state review process, including by the independent assessor and before the state notifies the provider system of an approval, the state will make adjustments to these reviews to accommodate any systemic gaps that CMS identifies in its review of a sample of plans as provided in VI.c. Any revisions to the reviews will be applied to all plans.

c. CMS Monitoring Process

In addition to approving the review protocol, CMS will review a sample of plans reviewed by the independent assessor and by the state to determine whether the protocol was followed, will identify any systematic gaps between the protocol and the actual reviews, and will provide such findings to the state to address these gaps in reviews by the independent assessor and by the state. CMS reserves the right to do a second sampling following notification by the state that the review processes were revised and after the independent assessor and the state complete additional reviews. Assuming that CMS finds that the reviews are consistent with the review protocol, CMS will accept the state's recommendations for approval with the following possible exceptions which will be applied at CMS's discretion:

i. The state's decision about approval is not consistent with the independent assessor
ii. The plan is an outlier in the valuation schema
iii. There is evidence in the plan, or exogenous information made available to CMS that calls into question for the independent assessor or the state of funding duplication
iv. There is evidence in the plan, or exogenous information made available to CMS calls into question whether the project is new or significantly expanded or enhanced from a project already underway.

CMS will complete its review according to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX. CMS reserves the right to conditionally approve plans, and to allow modifications to plans to resolve issues it identifies in its review provided that the modifications are made to the plan and found acceptable by CMS according to the timeline provided by CMS.

d. Mid-point Assessment

The state's mid-point assessment review will be developed in collaboration with CMS. All DSRIP plans initially approved by the state must be re-approved by the state in accordance with the CMS approved review protocol in order to continue receiving DSRIP funding in DY 4 and 5. The state will use and independent assessor and public engagement process similar to the process used for the initial approval of projects, described in paragraph b.ii above.

The state will submit to CMS for approval, on or before October 1, 2016, draft mid-point assessment review criteria, a description of its approach to review, and a draft DSRIP Plan Mid-point Assessment Checklist that will reflect the approved criteria and will be used in the assessment. CMS and the state will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist. The state will apply these criteria to ensure that DSRIP projects are

thoroughly and consistently reviewed. Where possible, the state will notify providers in advance of the mid-point assessment if providers need to make changes in order to comply with the approved review criteria.

During DY 3, the independent assessor will work with the state to conduct a transparent mid-point assessment of all DSRIP projects using CMS-approved criteria. This review will provide an opportunity to modify projects and/or metrics in consideration of learning and new evidence. The independent assessor will conduct a focused review of certain high-risk projects identified by the state, CMS or the independent entity based on information provided for all projects in the provider's monitoring reports.

The mid-point assessment review will, at a minimum, include an assessment of the following elements:

i. Compliance with the approved DSRIP project plan, including the elements described in the project narrative;
ii. Compliance with the required core components for projects described in the DSRIP Strategies Menu and Metrics, including continuous quality improvement activities;
iii. Non-duplication of Federal funds;
iv. An analysis and summary of relevant data on performance on metrics and indicators to this point in time;
v. The benefit of the project to the Medicaid and uninsured population and to the health outcomes of all patients served by the project (examples include number of readmissions, potentially preventable admissions, or adverse events that will be prevented by the project);
vi. An assessment of project governance including recommendations for how governance can be improved to ensure success. The composition of the performing provider system network from the start of the project until the midpoint will be reviewed. Adherence to required policies regarding management of lower performing providers in the network will be reviewed with a special focus on any action with regard to removing lower performing members prior to DY 4 and 5. (Note: Modifying coalition members requires a plan modification);
vii. The opportunity to continue to improve the project by applying any lessons learned or best practices that can increase the likelihood of the project advancing the three part aim; and
viii. Assessment of current financial viability of all providers participating on the DSRIP project.

Based on the recommendations by the independent assessor, the state or CMS may require prospective plan modifications that would be effective for DYs 4 and 5, including adjustments to project metrics or valuation. Significant changes to the number of Medicaid beneficiaries attributed to a Performing Provider System will require adjustments to the project valuation.

The state will review all modifications resulting from the mid-point assessment prior to CMS review and consideration, consistent with the process for review of plan modifications, described in section X. Future DSRIP payment for a provider may be withheld until the necessary changes

as identified by the mid-point assessment are submitted (and all other requirements for DSRIP payment are met).

VII. Reporting Requirements and Ongoing Monitoring

Performance management and assessment of DSRIP will occur throughout its duration and will take several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning. The final project work plans will provide the basis for monitoring each project.

1. Ongoing provider-level evaluations will occur on a regular basis, as described below, and seek to provide timely and actionable feedback on the initiative's progress, in terms of infrastructure changes, implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, performance on objective attainment and overall progress towards achieving a health care system based on the improving health, improving care, and reducing costs, and progress toward achieving the primary goals of DSRIP, to reduce avoidable hospitalization and seek improvements in other health and public health measures by transforming systems.
2. Learning collaboratives will be implemented to seek peer-to-peer (provider-to-provider) input on project level development of action plans, implementation approaches and project assessment. New York will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results). The schedule for the collaboratives meeting will be shared with CMS.
3. On a quarterly basis, the state will publish on its website project-by-project status updates which will show available data that reflects each strategy's progress on metrics and indicators, as relative to pre-approved targets.
4. A mid-point assessment (end of the third year) will be completed by an independent assessor. The midpoint assessment which will provide independent quantitative analysis of DSRIP planning and implementation through December 2016, as well as timely qualitative research findings which will provide context for reports on provider's progress in planning and implementing selected DSRIP programs. The qualitative findings will contribute to understanding implementation issues which go beyond the quantitative analyses. In addition, the qualitative analysis will inform and sharpen analytic plans for the summative evaluation. The mid-point assessment will be submitted by the end of June 2017.
5. In addition to monitoring, an interim and final summative statewide evaluation of DSRIP will be completed by the independent evaluator 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. The data and findings of the mid-point assessment will be among the information used by the independent evaluator for the interim evaluation. Among other things, the interim evaluation will provide broad learning both within the state and across the nation. Part of this interim evaluation will examine issues overlapping with ongoing provider-

level evaluations, and part of this effort will examine questions overlapping with the final evaluation.

a. Semi-annual Reporting on Project Achievement

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 the milestones and metrics described in their approved DSRIP plan. 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 in accordance with Section VII "Disbursement of DSRIP Funds". 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 be due as indicated below after the end of each reporting period:

- Reporting period of January 1 through June 30: the reporting and request for payment is due July 31.
- Reporting period of June 30 through December 31: the reporting and request for payment is due January 31.

These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones. The state shall have 30 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. If additional information is requested, the Performing Provider System shall respond to the request within 15 days and the state shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. The state shall schedule the payment transaction for each Performing Provider System within 30 days following state approval of the Performing Provider System's semi-annual report.

As part of CMS's monitoring of DSRIP payments, CMS reserves the right to review a sample of the Performing Provider System Reports and withhold or defer FFP if DSRIP milestones have not been met.

Note: Because many domain 2, 3, and 4 metrics are annual measures, these annual measures will only be available to be reported once a year for purposes of authorizing and determining incentive payments.

b. State Monitoring Reports

The state, or its designee, will conduct robust monitoring and assessment of all submitted reports, Performing Provider System progress, challenges and completion no less frequently than quarterly, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each Performing Provider System is making towards meeting each milestone
- the specific activities that appear to be driving measureable change

- the key implementation challenges, including governance issues, associated with specific activities designed to drive improvement
- the identification of adjustments to the DSRIP program, and/or projectsas observed through the analysis of submitted provider-level data and/or onsite findings as they occur

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various project stakeholders to help facilitate learning at the Performing Provider System level, as well as the DSRIP program level. The reports will be used to drive peer-to-peer discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The state, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the health care industry at-large, or individual project participants if significant issues are observed.

i. Operational Report

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to Performing Provider Systems performing the same project. This report will also include an Executive Summary which will be used by CMS, senior state officials and the public as a means of following the overall progress of the DSRIP demonstration. This report will include the following data elements:

1. Identification of participating providers
2. Completion factor of providers, by provider
3. Dashboard of project-specific measure results, aggregated at project, plan, regional and state levels
4. Summary of applied interventions
5. Summary of pilot models
6. Summary of reported challenges
7. Summary of reported successes
8. Update on governance
9. Noted best practices
10. Summary of approved payments (compared to the valuation in the DSRIP project plan), which should reconcile to the DSRIP funding reported on the CMS-64

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across Performing Provider Systems and act as a platform for discussion during monthly conference

calls and quarterly in-person collaboration meetings. This report may be utilized by the Performing Provider System project personnel as a primary tool to aid routine collaboration among Performing Provider Systems implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the Performing Provider System.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst Performing Provider Systems who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

ii. Consumer Level Report

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which providers in their area are driving to improve quality and the area of focus for that Performing Provider System. The report may include:

1. County-level map that indicates all New York hospitals
2. County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology, current performance, and expected results of each Performing Provider System.

c. Learning Collaboratives

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing based on data transparency within the New York healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in New York.

The Learning Collaborative will be managed by the state and/or its independent assessor through both virtual and in-person collaboration that both builds relationships as well as facilitates project analysis and measurement. The Learning Collaborative will be designed to promote and/or perform the following:

1. Sharing of DSRIP project development including data, challenges, and proposed solutions based on the Performing Provider Systems' quarterly progress reports
2. Collaborating based on shared ability and experience
3. Identifying key project personnel
4. Identification of best practices
5. Provide updates on DSRIP program and outcomes
6. Track and produce a "Frequently Asked Questions" document
7. Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by Performing Provider Systems. For each collaborative, the state will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.
An online, web-based tool will be utilized in order to effectively manage the collection and the dissemination of information related to the DSRIP and projects. A key component of the online tool will be a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP program. This tool will act as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

d. Program Evaluation

As described in STC 10.e. in section IX, the state will identify an independent evaluator to provide an interim and summative evaluation. The interim evaluation will consider among other things the findings of the mid-point assessment conducted by the independent assessor. The evaluations must be in accordance with the evaluation STCs 19-30 in section IX and as approved by CMS through the evaluation design phase provided in STC 20 in section IX.

The interim evaluation will be due one year prior to the expiration of the demonstration and will include data from DY 1, 2, and 3. The final, summative evaluation will be completed by the end of March 2020.
The interim and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

e. Overall Data Standards

The state will collect data from providers often as is practical in order to ensure that project impact is being viewed in as “real time” a fashion as possible. Collecting and analyzing data in this fashion will allow for rapid, life-cycle improvement which is an essential element of the DSRIP project plan.

Since managed care is an important component of the state’s quality improvement strategy, the state will implement a provider/plan data portal that will allow access to appropriately permissioned patient and provider specific data in the Medicaid Data Warehouse. Role based access to this portal will allow providers and their partnering health plans access to current Medicaid claims and encounters data and eventually real time EMR and care management data provided through connectivity with local regional health organizations (RHIOs). Faster access to more real time clinical and managed care data will be particularly relevant to this project and is also the rationale for using state-measured health plans metrics or Quality Assurance Reporting

Requirements (QARR) as a major data source for this project. In addition, providers and their partnering health plans will have access to the analytical capabilities of 3M and Salient suite of performance tools through the portal. This will allow DSRIP providers and the health plans to partner with the state to measure case mix adjusted avoidable hospitalization metrics at the local level using standardized definitions and eventually with more real time updates.

The state will use the Quality Committee, established in 2013 to assist NYSDOH on quality measurement and improvement that will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Quality Committee includes representatives from various sectors of healthcare including hospitals, nursing homes, managed care plans, provider organizations and consumer representation. The current charge of the Committee is to provide NYSDOH with expertise in various sectors of health care quality, assist on proposed quality improvement goals and provide guidance on measuring and reporting quality information to the public. The Quality Committee will serve as an advisory group for DSRIP offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

Final decision-making authority will be retained by the state and CMS, although all recommendations of the committee will be considered by the state and CMS.

Specifically, the Quality Committee will provide feedback to the state regarding:

i. Development of attribution models
ii. Selection of metrics
iii. Selection of the high performance target goals including the behavioral health high performance avoidable hospitalization threshold for bonus payment purposes.

Data and metrics that form the basis of incentive payments in DSRIP should have a high degree of accuracy and validity. Consistent with current requirements for MCO and PIHPs under 438.242, the state must ensure, through its contracts with the Performing provider systems, that each Performing provider system receiving payments under DSRIP maintains (or participates in) a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this DSRIP. The state must require that each Performing provider system ensure that data received from providers within the system is accurate and complete by ensuring that Performing Provider Systems have appropriate data agreements in place (as described in section IV.b) and verifying the accuracy and timeliness of reported data (including such data that contributes to chart review metrics), screening the data for completeness, logic, and consistency. To the degree that the data and metrics are generated and obtained via managed care systems already subject to 438.242, no additional validation of the data is required.

For data and metrics reported in systems not subject to 438.242, these agreements between the state and Performing provider systems should also be accompanied by validation process performed by the independent assessor to ensure that the processes are generally valid and accurate. Penalties will be applied to Performing provider systems that are not reporting data that are valid and accurate as described.

VIII. DSRIP Funding Limits

a. Statewide limit on DSRIP Funding

Total DSRIP Fund expenditures are limited as specified in STC 14 in section IX. In addition to this limit, DSRIP Fund expenditures cannot exceed the lesser of the aggregate valuation of DSRIP projects as adjusted to include DSRIP planning funding and funds allocated to the High Performance Fund. Allowable expenditures are further limited by the availability of non-federal funding (through proper IGT or other funding), and provider performance on DSRIP milestones and metrics.

b. Public Hospital and Safety Net Provider Performance Provider System Transformation Funds

All Performing Provider Systems with approved DSRIP Project Plans will be eligible to apply for funding from one of two DSRIP pools. The first, Public Hospital Transformation Fund, will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this fund include:

i. Health and Hospital Corporation of New York City
ii. State University of New York Medical Centers
iii. Nassau University Medical Center
iv. Westchester County Medical Center
v. Erie County Medical Center

The second fund Safety Net Performance Provider System Transformation Fund, would be available to all other DSRIP eligible providers.

Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool.

c. High performance fund

A portion of the Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund will be set aside to reward high performing systems according to the process specified below. The high performance fund will be made up of the following funds:

1. For DY 2-5, up to 10 percent of the total DSRIP funds set aside for the high performance fund
2. Target Funds that are forfeited from providers that do not achieve project milestones and metrics, less any prior year appealed forfeited funds where the appeal was settled in the current demonstration year in favor of the Performing Provider System.

The total amount of funding allocated for the high performance fund shall 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. The metrics for the high performance fund are specified in Attachment J.

Additional funds will be set aside within each fund for performing provider systems reaching stretch/ bonus level targets (set by the state with input from the quality and measures committee)

for significant improvement in avoidable hospitalization reduction for their attributed behavioral health population.

IX. Disbursement of DSRIP Funds

a. Total Available DSRIP Incentive Payments for a Project based on Project Valuation

Aggregate incentive payments available over the 5 year demonstration period to a Performing Provider System will be based on the project valuation approved by the state, subject to the limits set forth in section V above

b. Payment Based on Milestone Achievement for DY 1 – DY 5

Incentive payments are calculated separately for each project. The amount of the incentive funding paid to a provider will be based on the amount of progress made within specific milestones and the valuation of those milestones.

Half of the incentive funding for Domain 1 in DY 1 will be awarded for approval of the DSRIP plan. Fifteen percent will be paid upon the delivery of an acceptable first semiannual report. Fifteen percent will be paid upon the delivery of an acceptable second semiannual report.
For each metric, the provider will include in the required DSRIP provider report the progress made in completing each metric along with sufficient supporting documentation. Progress for a given metric will be categorized as fully achieved or not achieved. If a provider has previously reported progress in a domain and received partial funding after the first semi-annual reporting period, only the additional amount is eligible for funding in the second semi-annual reporting period.

c. Payments from the High Performance Fund

Performing Provider Systems who have achieved performance improvement beyond the stated target improvement value in their approved DSRIP project plan will be eligible for additional payment from the DSRIP high performance fund, not to exceed 30 percent of their DSRIP project value.
A half of the high performance fund will be available for tier 1 payments, and half will be available for tier 2 payments which will be distributed as follows:

- Higher performing participating providers whose performance closes the gap between their current performance and the high performance level by 20 percent shall receive Tier 1 level reward payments.
- Higher performing participating providers whose performance meets or exceeds the high performance level (90^{th} percentile of statewide performance) shall receive Tier 2 level reward payments.

High performance fund payments shall be adjusted based on Medicaid and indigent population size served by the project being implemented by the provider. The percentages above may be adjusted up or down by the State for each metric as appropriate to account for volume of demand on the high performance fund.

The state, working with the quality committee, will set a high performance threshold for the measures described in attachment J specifically avoidable hospitalizations for the entire

attributed population and separate high performance targets (physical and behavioral metrics) for the behavioral health population subset. High Performance payments will be based on attaining 20 percent gap to goal or the 90th percentile of statewide performance on the high performance metrics listed in attachment J.

d. Accountability for state performance

As described in STC 14 in section IX, providers and the state are accountable for statewide performance. DSRIP funding for providers may be reduced based on poor performance statewide described below.

If any of the four milestones below are not met, then DSRIP payments to providers will be reduced by the amount specified in STC 14 in section IX. DSRIP payment reductions will be applied proportionately to all DSRIP Performing Provider Systems based on the valuation of their DSRIP project plans. DSRIP reductions will not be applied to the DSRIP high performance fund payments.

Achievement of the statewide milestones is calculated as follows:

1. ***Statewide performance on universal set of delivery system improvement metrics.*** The core set of delivery system improvement metrics in domain 2 of attachment J will be assigned a direction for improving or worsening and will be calculated to reflect the performance of the entire state. This milestone will be considered passed in any given year if more metrics in this domain are improving on a statewide level than are worsening (i.e. the performance level is the same or better, no error bar applied), as compared to the prior year as well as compared to initial baseline performance (DY 1).

2. ***A composite measure of success of projects statewide on project-specific and population-wide quality metrics.*** The number of metrics met by each Performing Provider System in a given year based on the project-specific improvement standards specified in their approved DSRIP project plan will be added together to determine the composite success of all DSRIP projects. For the purposes of this addition, pay for reporting measures will only be counted once in the aggregate for each domain. This statewide milestone will be considered passed in any given year if the number of metrics met by all Performing Provider Systems in the aggregate is greater than the number of metrics that were not met.

3. ***Growth in statewide total Medicaid spending that is at or below the target trend rate.*** As further described in STC 14 in section IX, statewide performance on this milestone will be considered passed if the state improves on the following two metrics on a per member per month (PMPM) basis, comparing the most recent state fiscal year to the year that immediately precedes it:

    a. Growth in statewide total inpatient and emergency room spending that is at or below the target trend rate (Measure applies in DSRIP Year3, DSRIP Year 4 and DSRIP Year 5).

    b. Growth in statewide total Medicaid spending that is at or below the target trend rate (measure applies in DSRIP Year 4 and DSRIP Year 5). PMPM amounts will be adjusted

to exclude growth in federal funding associated with the Affordable Care Act. The state will not be penalized if it uses these higher FMAP rates generated by the ACA to reinvest in its Medicaid program.

For total Medicaid spending, the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year), for DSRIP Years 4 and 5 only. For inpatient and emergency room spending the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year) minus 1 percentage points for DSRIP Year 3 and 2 percentage points for DSRIP Years 4 and 5.

4. ***Implementation of the managed care plan.*** This milestone will be measured by targets agreed upon by CMS and the state after receipt of the managed care strategy plan in STC 39 in section IX related to reimbursement of plans and providers consistent with DSRIP objectives and measures. These targets will include one associated with the degree to which plans move away from traditional fee for service payments to payment approaches rewarding value.

e. Intergovernmental Transfer Process

The state will calculate the nonfederal share amount to be transferred by an IGT Entity in order to draw the federal funding for the incentive payments related to the milestone achievement that is reported by the Performing Provider System and approved by the IGT Entity and the State. Within 14 days after notification by the state of the identified nonfederal share amount, the IGT Entity will make an intergovernmental transfer of funds. The state will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the Performing Provider System. If the IGT is made within the appropriate 14-day timeframe, the incentive payment will be disbursed within 30 days. The total computable incentive payment must remain with the Performing Provider System.

X. DSRIP Project Plan Modifications

a. Modifying Existing Project Plans in Limited Circumstances

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.

The state and CMS will follow the same review process described in section VI above, except that the independent assessor will not be expected to convene review panels.

b. Reinvestment of Unused DSRIP Funds in DY4 and DY5

Unused DSRIP funding for DY 4 and 5 (including funding allocated to projects that were terminated as part of the midpoint assessment) may be directed towards further replicating high performing DSRIP projects that have proven to be particularly successful and can be implemented elsewhere (in approved Performing Provider System' that are not currently employing such projects) and achieve results within two years. The state will develop its methodology for expanding successful projects and submit this to CMS in DY 2 for review and approval before the midpoint assessment is completed in DY 3.

Attachment J - NY DSRIP Strategies Menu and Metrics

Preface

a. Delivery System Reform Incentive Payment Fund

On April 14, 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's request for an amendment to the New York's Partnership Plan section 1115(a) Medicaid demonstration extension (hereinafter "demonstration") authorizing the creation of a Delivery System Reform Incentive Payment (DSRIP) Fund. This demonstration is currently approved through December 31, 2014. DSRIP Funds will not be made available after December 31, 2014 unless the state's demonstration renewal is approved by CMS.

Section IX of the Special Terms and Conditions (STC) describes the general rules and requirements of the Delivery System Reform Incentive Payment (DSRIP) Fund.

b. DSRIP Strategies Menu and Metrics and Program Funding and Mechanics Protocol

The DSRIP requirements specified in the STCs are supplemented by two attachments to the STCs. The Program Funding and Mechanics Protocol (Attachment I) describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, reporting requirements, and penalties for missed milestones. The DSRIP Strategies Menu and Metrics (this attachment, Attachment J) details the specific delivery system improvement projects and metrics that are eligible for DSRIP funding. The projects are listed in Part I and the metrics are listed in Part II. Additional information is provided in two additional documents as described below.

This version of the DSRIP Strategies Menu and Metrics is approved April 14, 2014. In accordance with STC 10.b, the state may submit modifications to this protocol for CMS review and approval in response to comments received during the post-award comment period and as necessary to implement needed changes to the program as approved by CMS.

c. Supporting operational guides

This attachment will be supplemented by two additional operational guides developed by the state and approved by CMS, which will assist performing provider systems in developing and implementing their projects and will be used in the state's review of the approvability and the valuation of DSRIP projects.

First, the state will develop a ***Project Toolkit*** that will describe the core components of each DSRIP project listed on the DSRIP project menu below (Part I). This supplement will also describe how DSRIP projects are distinct from each other and the state's rationale for selecting each project (i.e. the evidence base for the project and its relation to community needs for the Medicaid and uninsured population). The core components and other elements of the project description will be used as part of the DSRIP plan checklist (described in section V of Attachment I). To assist providers in valuing projects, this supplement will also include the index score of transformation/ health care improvement potential determined by the state (according to the process described in section IV.c. of Attachment I).

Second, the state will develop a ***Metric Specification Guide*** that provides additional information on the metrics described in the metrics list below (Part II). Specifically, the state will specify the data source for each measure (specifically whether the measure is collected by the state or providers), the measure steward for each metric (if applicable), the National Quality Forum reference number (if applicable), and the high performance level for each pay-for-performance metric. The high performance level for each metric will be used to establish outcome targets for all pay-for-performance measures, as described in Attachment I.

Part I – Projects Menu

Each Performing Provider System will employ multiple projects both to transform health care delivery as well as to address the broad needs of the population that the performing provider system serves. These projects described in Attachment J are grouped into different strategies, such as behavioral health, within each Domain (System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). For each strategy, there is a set of metrics that the performing provider system will be responsible for if they do any one of the projects within that strategy.

Each project selected by a Performing Provider System will be developed into a specific set of focused milestones and metrics that will be part of the Performing Provider System's DSRIP project plan. Project selection will be driven by the mandatory community needs assessment, and the rationale and starting point for each project must be described in the DSRIP project plan, as described in Attachment I.

DSRIP project plans must include a minimum of five projects (at least two system transformation projects, two clinical improvement projects, and one population-wide project). As described further in Attachment I, a maximum of 10 projects will be considered for project valuation scoring purposes. Additional projects can be included in the application, but they will not affect the project valuation.

Domain 2: System Transformation Projects

All DSRIP plans must include at least two of the following projects based on their community needs assessment. At least one of those projects must be from sub-list A and one of these projects must be from sub-list B or C, as described below. Performing Provider Systems can submit up to 4 projects from Domain 2 for valuation scoring purposes (as described in attachment I).

A. Create Integrated Delivery Systems (required)

- 2.a.i Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management
- 2.a.ii Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))
- 2.a.iii Health Home At-Risk Intervention Program –Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services. 2.a.iv Create a medical village using existing hospital infrastructure
- 2.a.v Create a medical village/ alternative housing using existing nursing home

B. Implementation of care coordination and transitional care programs

- 2.b.i Ambulatory ICUs

2.b.ii Development of co-located of primary care services in the emergency department (ED)
2.b.iii ED care triage for at-risk populations
2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
2.b.v Care transitions intervention for skilled nursing facility residents
2.b.vi Transitional supportive housing services
2.b.vii Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii Hospital-Home Care Collaboration Solutions
2.b.ix Implementation of observational programs in hospitals

C. Connecting settings

2.c.i. Development of community-based health navigation services
2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services

Domain 3: Clinical Improvement Projects

All DSRIP plans must include at least two projects from this domain, based on their community needs assessment. At least one of those projects must be a behavioral health project from sub-list A, as described below. Performing Provider Systems can submit up to 4 projects from Domain 3 for valuation scoring purposes (as described in Attachment I).

A. Behavioral health (required)

3.a.i Integration of primary care services and behavioral health
3.a.ii Behavioral health community crisis stabilization services
3. a.iii. Implementation of evidence based medication adherence program (MAP) in community based sites for behavioral health medication compliance
3.a.iv Development of withdrawal management (ambulatory detoxification) capabilities within communities
3.a.v Behavioral Interventions Paradigm in Nursing Homes (BIPNH)

B. Cardiovascular Health

Note: Performing provider systems selecting cardiovascular health projects will be expected to utilize strategies contained in the Million Hearts campaign as appropriate (http://millionhearts.hhs.gov/index.html).

3.b.i Evidence based strategies for disease management in high risk/affected populations (adult only)

3.b.ii Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adult only)

C. Diabetes Care

3.c.i Evidence-based strategies for disease management in high risk/affected populations (adults only)

3.c.ii Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adults only)

D. Asthma

3.d.i Development of evidence-based medication adherence programs (MAP) in community settings –asthma medication
3.d.ii Expansion of asthma home-based self-management program
3. c.iii Evidence based medicine guidelines for asthma management

E. HIV

3.e.i Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for management of HIV/AIDS

F. Perinatal

3.f.i Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

G. **Palliative Care**

3.g.i IHI "Conversation Ready" model
3.g.ii Integration of palliative care into medical homes
3.g.iii Integration of palliative care into nursing homes

H. Renal Care

3.h.i Specialized Medical Home from Chronic Renal Failure

Domain 4: Population-wide Projects

The following represent priorities in the State's Prevention Agenda with health care delivery sector projects to influence population-wide health (available at :

http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm). The alignment of these projects with the New York State Prevention Agenda (including focus areas, etc.) is described further in the Project Description Supplement.

All DSRIP plans must include at least one project from this domain, based on their community needs assessment. Performing Provider Systems can submit up to 2 projects from Domain 4 for valuation scoring purposes (as described in Attachment I).

A. Promote Mental Health and Prevent Substance Abuse (MHSA)

4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities
4.a.ii. Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
4.a.iii. Strengthen Mental Health and Substance Abuse Infrastructure across Systems

B. Prevent Chronic Diseases

4.b.i. Promote tobacco use cessation, especially among low SES populations and those with poor mental health

4.b.ii. Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3.b., such as cancer)

C. Prevent HIV and STDs

4.c.i Decrease HIV morbidity
4.c.ii Increase early access to, and retention in, HIV care
4.c.iii Decrease STD morbidity
4.c.iv Decrease HIV and STD disparities

D. Promote Healthy Women, Infants and Children

4.d.i Reduce premature births

II. Metrics

The domains of metrics here are intended to provide specificity to the overall intent to promote system transformation, using measures of system transformation as well as including avoidable events as a marker for positive transformation. Items associated with pay for reporting or pay for performance are described in requirements for all domains as well.

An overview of the metric domains from the funding and mechanics protocol is below:

i. Overall project progress metrics (Domain 1)
ii. System transformation metrics (Domain 2)
iii. Clinical improvement metrics (Domain 3)
iv. Population-wide project implementation metrics (Domain 4)

All DSRIP plans must include all core metrics in Domain 1, all metrics in Domain 2, and all core metrics in Domain 4. DSRIP plans must also include the behavioral health metrics in Domain 3.a. and strategy-specific metrics based on the Domain 3 and 4 projects selected, as further described in the Project Toolkit. The state or CMS will add project-specific Domain 1 metrics to DSRIP project plans as necessary to address concerns with "at risk" projects, based on input from the independent assessor. Behavioral health metrics are included because those diagnoses are highly correlated with avoidable events.

A subset of these metrics related to avoidable hospitalizations, behavioral health and cardiovascular disease will also be part of the high performance fund, described in attachment I and as noted below: These latter markers align with the nationwide Million Hearts Initiative on cardiac outcomes, in order to tackle the leading cause of mortality in New York State.

Metric	Domain reference
Avoidable ED Visits (All Population)	2.a
Avoidable Re-hospitalizations (All Population)	2.a
Avoidable ED Visits (BH Population)	3.a
Avoidable Re-hospitalizations (BH Population)	3.a
Follow-up for Hospitalization for Mental Illness	3.a
Antidepressant Medication Management	3.a
Diabetes Monitoring for People with Diabetes and Schizophrenia	3.a
Cardiovascular Monitoring for People with CVD and Schizophrenia	3.a
Controlling Hypertension (NQF 0018)	3.b.

Tobacco Cessation (NQF 0027) (component on discussing smoking and tobacco use cessation strategies)	3.b.

Domain 1. Overall Project Progress Metrics

Domain 1 metrics assess overall implementation of all DSRIP projects (regardless of whether the project was developed from a project selected from Domain 2, 3, or 4 listed above). All

Core Domain 1 Metrics (for all providers):

1. Semi-annual reports (pay for reporting), which will include:
    a. Project narrative on status and challenges
    b. Information on project spending/budget and any other financial information requested by the state, including financial sustainability of system and projects.
    c. Documentation on the number of beneficiaries served through the projects
    d. Update on project governance
    e. Update on workforce strategy implementation
    f. Percent of providers that are reporting relevant DSRIP project data
    g. Description of steps taken by the system to prepare for non-FFS reimbursement systems (including an update on any on-going negotiations with Medicaid managed care plans)
    h. Engagement in learning collaboratives

2. Approval of DSRIP Plan (DY 1 only)

3. Workforce milestones (P4P/ P4R, as specified in the Metrics Specification Guide)
    - Percent Complete of System's preapproved Workforce Plan Number of health care workers retrained/redeployed vs. # eligible based on system service changes
    - Net change in number of new MDs hired – PCP; specialty
    - Net change in number of new mid-levels providers hired (RPA, NP, NM)
    - Net change in number of other mid-level providers hired

4. System Integration milestones (P4P/ P4R, as specified in the Metrics Specification Guide)
    - Percent complete of preapproved system integration plan in the PPS project plan
    - For HH population, % in O/E; % in Active Care Management; % with Care Plan

Additional project-specific Domain 1 metrics:

5. Additional project-specific metrics, established by the state or CMS for a particular project, especially "at risk" projects. (Pay for performance, i.e. achievement of corrective action as specified by the state or CMS for "at risk" projects) The state's independent assessor will develop a rubric for assessing semi-annual reports, workforce milestones, and system integration milestones to identify at risk projects.

Domain 2. System Transformation Metrics

All Domain 2 metrics are pay-for-reporting in DY 1 and 2. As described below, some metrics become pay-for-performance in DY 3-5. All of these metrics will be assessed on a statewide level as part of the statewide Domain 2 performance test described in STC 14.g.i in section IX, with the exception of the Medicaid spending metric and the provider reimbursement metric and (which are included as part of other statewide accountability tests described in STC 14.g.iii and 14.g.iv in section IX respectively).

Domain 2 – System Transformation Metrics						
				DSRIP Year 2		**DSRIP Years 3 - 5**
State-wide Measure	**Measure Name**	**Measure Steward**		**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
A. Create Integrated Delivery System						
Potentially Avoidable Services						
X	Potentially Avoidable Emergency Room Visits	3M		Reporting		Performance
X	Potentially Avoidable Readmissions	3M		Reporting		Performance
X	PQI Suite – Composite of all measures	AHRQ		Reporting		Performance
X	PDI Suite – Composite of all measures	AHRQ		Reporting		Performance
Provider Reimbursement						
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement			Reporting		Reporting
System Integration						
X	Percent of Eligible Providers with participating agreements with RHIO's; meeting MU Criteria and able to participate in bidirectional exchange			Reporting		Reporting
Primary Care						
X	Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)			Reporting		Reporting
X	CAHPS Measures including usual source of care Patient Loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)			Reporting		Performance
Access to Care						
X	HEDIS Access/Availability of Care; Use of Services			Reporting		Performance

Domain 2 – System Transformation Metrics						
				DSRIP Year 2		**DSRIP Years 3 - 5**
State-wide Measure	**Measure Name**	**Measure Steward**		**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
A. Create Integrated Delivery System						
X	CAHPS Measures: - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours - Wait Time (days between call for appointment and getting appoint for urgent care)			Reporting		Performance
Medicaid Spending for Projects Defined Population on a PMPM Basis						
	Medicaid spending on ER and Inpatient Services			Reporting		Reporting
	Medicaid spending on PC and community based behavioral health care			Reporting		Reporting
B. Implementation of care coordination and transitional care programs						
Performing Provider Systems will be required to meet all of the above metrics with the addition of the following:						
Care Transitions						
	H-CAHPS – Care Transition Metrics	AHRQ		Reporting		Performance
X	CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers	AHRQ		Reporting		Performance
C. Connecting Settings						
Performing Provider Systems will be required to meet all of the above metrics for A and B.						

Domain 3. Clinical Improvement Metrics

All Domain 3 metrics are pay-for-reporting in DY 1. As described below, some metrics continue as pay-for-reporting in DY 2-3 but become pay-for-performance in DY 4-5. In general, provider systems will include all metrics associated with the project selected, unless otherwise specified below.

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
A. Behavioral Health (Required) – All behavioral health projects will use the same metrics except for SNF programs implementing the BIPNH project. These providers will include the additional behavioral health measures below in A-2.								
	PPV (for persons with BH diagnosis)	3M		Claims	Outcome	Performance		Performance
	Antidepressant Medication Management	NCQA	0105	Claims	Process	Performance		Performance
	Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA	1934	Claims	Process	Performance		Performance
	Diabetes Screening for People with Schizo./BPD Using Antipsychotic Med.	NCQA	1932	Claims	Process	Performance		Performance
	Cardiovascular Monitoring for People with CVD and Schizo.	NCQA	1933	Claims	Process	Performance		Performance
	Follow-up care for Children Prescribed ADHD Medications	NCQA	0103	Claims	Process	Reporting		Performance
	Follow-up after hospitalization for Mental Illness	NCQA	0576	Claims	Process	Performance		Performance
	Screening for Clinical Depression and follow-up	CMA	0418	Medical Record	Process	Reporting		Performance
	Adherence to Antipsychotic Medications for People with Schizophrenia	NCQA	1879	Claims	Process	Performance		Performance
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	0004	Claims	Process	Performance		Performance
A – 2. Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm in Nursing Homes (BIPNH) project								
	PPR for SNF patients	3M		Claims	Outcome	Performance		Performance
	Percent of Long Stay Residents who have Depressive Symptoms	CMS		MDS 3.0	Process	Performance		Performance
B. Cardiovascular Disease								
	PQI # 7 (HTN)	AHRQ		Claims	Outcome	Performance		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	PQI # 13 (Angina without procedure)	AHRQ		Claims	Outcome	Performance		Performance
	Cholesterol Management for Patients with CV Conditions	NCQA		Medical Record	Outcome	Reporting		Reporting
	Controlling High Blood Pressure (Provider responsible for medical record reporting)	NCQA	0018	Medical Record	Outcome	Reporting		Performance
	Aspirin Discussion and Use	CAHPS		Survey	Process	Reporting		Performance
	Medical Assistance with Smoking Cessation	NCQA	0027	Survey	Process	Reporting		Performance
	Flu Shots for Adults Ages 50 – 64	NCQA	0039	Survey	Process	Reporting		Performance
	Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse	CAHPS		Survey	Process	Reporting		Performance
C. Diabetes Mellitus								
	PQI # 3 (DM Long term complications)	AHRQ	0274	Claims	Outcome	Performance		Performance
	Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	NCQA		Medical Record	Process	Reporting		Reporting
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Medical Record	Outcome	Reporting		Performance
	Comprehensive diabetes care - LDL-c control (<100mg/dL)	NCQA	0064	Medical Record	Outcome	Reporting		Reporting
	Medical Assistance with Smoking Cessation	NCQA	0027	Survey	Process	Reporting		Performance
	Flu Shots for Adults Ages 50 – 64	NCQA	0039	Survey	Process	Reporting		Performance
	Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the	CAHPS		Survey	Process	Reporting		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	instructions and instruction about when to return to the doctor if condition gets worse)							
D. Asthma								
	PQI # 15 Adult Asthma	AHRQ	0283	Claims	Outcome	Performance		Performance
	PDI # 14 Pediatric Asthma	AHRQ	0638	Claims	Outcome	Performance		Performance
	Asthma Medication Ratio	NCQA	1800	Claims	Process	Performance		Performance
	Medication Management for People with Asthma	NCQA	1799	Claims	Process	Performance		Performance
E. HIV/AIDS								
	HIV/AIDS Comprehensive Care : Engaged in Care	NYS		Claims	Process	Performance		Performance
	HIV/AIDS Comprehensive Care : Viral Load Monitoring	NYS		Claims	Process	Performance		Performance
	HIV/AIDS Comprehensive Care : Syphilis Screening	NYS		Claims	Process	Performance		Performance
	Cervical Cancer Screening	NCQA	0032	Claims	Process	Reporting		Performance
	Chlamydia Screening	NCQA	0033	Claims	Process	Performance		Performance
	Medical Assistance with Smoking Cessation	NCQA/	0027	Survey	Process	Reporting		Performance
	Viral Load Suppression	HRSA	2082	Medical Record	Outcome	Reporting		Performance
F. Perinatal Care								
	PQI # 9 Low Birth Weight	AHRQ	0278	Claims	Outcome	Performance		Performance
	Prenatal and Postpartum Care—Timeliness and Postpartum Visits	NCQA	1517	Medical Record	Process	Reporting		Performance
	Frequency of Ongoing Prenatal Care	NCQA	1391	Medical Record	Process	Reporting		Reporting
	Well Care Visits in the first 15 months	NCQA	1392	Claims	Process	Reporting		Performance
	Childhood Immunization Status	NCQA	0038	Medical Record	Process	Reporting		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	Lead Screening in Children	NCQA		Medical Record	Process	Reporting		Performance
	PC-01 Early Elective Deliveries	Joint Commission	0469	Vital Records	Process	Reporting		Reporting
G. Palliative Care – All projects will use the same metric set.								
	Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain.	NYS		UAS	Process	Reporting		Performance
	Risk-Adjusted percentage of members who had severe or more intense daily pain	NYS		UAS	Process	Reporting		Performance
	Risk-adjusted percentage of members whose pain was not controlled.	NYS		UAS	Process	Reporting		Performance
	Advanced Directives – Talked about Appointing for Health Decisions	NYS		UAS	Process	Reporting		Performance
	Depressive feelings - percentage of members who experienced some depression feeling	NYS		UAS	Process	Reporting		Performance
H. Renal Care								
	Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	NCQA		Medical Record	Process	Reporting		Reporting
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Medical Record	Outcome	Reporting		Performance
	Comprehensive diabetes care - LDL-c control (<100mg/dL)	NCQA	0064	Medical Record	Outcome	Reporting		Reporting
	Annual Monitoring for Patients on Persistent Medications – ACE/ARB	NCQA		Claims	Process	Reporting		Reporting
	Controlling High Blood Pressure	NCQA	0018	Medical Record	Outcome	Reporting		Performance
	Flu vaccine 18-64	NCQA	0039			Reporting		Performance

Domain 3 – Clinical Improvement Metrics								
						DSRIP Years 2 – 3		**DSRIP Years 4 - 5**
	Measure Name	**Measure Steward**	**NQF#**	**Source**	**Measure Type**	**Pay for Reporting/Pay for Performance**		**Pay for Reporting/Pay for Performance**
	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027			Reporting		Performace

Domain 4. Population-Wide Metrics

This domain includes pay-for-reporting for relevant measures from the New York State Prevention Agenda related to the Domain 4 projects selected. All Domain 4 metrics will be measured by a geographical area denominator of all New York State residents that New York State has already developed for the Prevention Agenda. Some metrics are not collected on an annual basis but will be reported on their usual collection cycle. For example, the BRFSS is done biannually.

The metrics that are part of the New York State Prevention Agenda are available here: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm and will be further described in the metric specification guide.

		Source	Geographic Granularity
Improve Health Status and Reduce Health Disparities (required for all projects)			
1.	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics	State, County
2.	***Ratio of Black non-Hispanics to White non-Hispanics***		
3.	***Ratio of Hispanics to White non-Hispanics***		
4.	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	SPARCS	Statewide Region County
5.	***Ratio of Black non-Hispanics to White non-Hispanics***		
6.	***Ratio of Hispanics to White non-Hispanics***		
7.	Percentage of adults with health insurance - Aged 18-64 years	US Census	
8.	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	BRFSS	Statewide NYC/ROS County
Prevent Chronic Diseases			
21.	Percentage of adults who are obese	BRFSS	Statewide NYC/ROS County

22.	Percentage of children and adolescents who are obese	BRFSS	Statewide NYC/ROS County
23.	Percentage of cigarette smoking among adults	BRFSS	Statewide NYC/ROS County
24.	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	BRFSS	Statewide
25.	Asthma emergency department visit rate per 10,000	SPARCS	Statewide Region County
26.	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS	Statewide Region County
27.	Age-adjusted heart attack hospitalization rate per 10,000	SPARCS	Statewide Region County
28.	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS	Statewide Region County
29.	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	SPARCS	Statewide Region County
Prevent HIV/STDs			
33.	Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System	
34.	***Difference in rates (Black and White) of new HIV diagnoses***		
35.	***Difference in rates (Hispanic and White) of new HIV diagnoses***		
36.	Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD	

		Surveillance System	
37.	Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System	
38.	Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	
39.	Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance System	
40.	Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System	
Promote Healthy Women, Infants, and Children			
41.	Percentage of preterm births	NYS NYSDOH Vital Statistics	State, County
42.	***Ratio of Black non-Hispanics to White non-Hispanics***		
43.	***Ratio of Hispanics to White non-Hispanics***		
44.	***Ratio of Medicaid births to non-Medicaid births***		
45.	Percentage of infants exclusively breastfed in the hospital	NYS NYSDOH Vital Statistics	State, County
46.	***Ratio of Black non-Hispanics to White non-Hispanics***		
47.	***Ratio of Hispanics to White non-Hispanics***		
48.	***Ratio of Medicaid births to non-Medicaid births***		
49.	Maternal mortality rate per 100,000 births	NYS NYSDOH Vital Statistics	State, County
54.	Percentage of children with any kind of health insurance - Aged under 19 years	U.S. Census Bureau,	State, County

		Small Area Health Insurance Estimates	
55.	***(Metric Deleted from DSRIP)***		
56.	***Ratio of low-income children to non-low income children***		
57.	Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	NYS NYSDOH Vital Statistics	State, County
58.	***Ratio of Black non-Hispanics to White non-Hispanics***		
59.	***Ratio of Hispanics to White non-Hispanics***		
60.	Percentage of unintended pregnancy among live births	Pregnancy Risk Assessment Monitoring System	State
61.	***Ratio of Black non-Hispanics to White non-Hispanics***		
62.	***Ratio of Hispanics to White non-Hispanics***		
63.	***Ratio of Medicaid births to non-Medicaid births***		
64.	Percentage of women with health coverage - Aged 18-64 years	U.S. Census Bureau Small Area Health Insurance Estimates	State, County
65.	Percentage of live births that occur within 24 months of a previous pregnancy	NYS NYSDOH Vital Statistics	State, county
Promote Mental Health and Prevention Substance Abuse			
66.	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS	Statewide NYC/ROS County

67.	Age-adjusted percentage of adult binge drinking during the past month	BRFSS	Statewide NYC/ROS County
68.	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics	State, county

m. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for parents and caretaker relatives with incomes above 133 percent of the FPL through 150 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible but who are parents or caretaker relatives of individuals under the age of 21; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 150 percent of the FPL. Federal financial participation for the premium assistance portion of QHP subsidies for citizens and eligible qualified aliens will be provided through the Designated State Health Programs pursuant to this STC. Authority to claim federal matching for this program will end on December 31, 2014.

n. The state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide FHPlus benefits to parents and caretaker relatives with incomes up to and including 150 percent of the FPL who are no longer eligible under the demonstration. Authority to claim federal matching for this program will end on December 31, 2014.

13. Designated State Health Programs (DSHP) Claiming Process.

a. Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 12 of this section. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHPs listed in STC 12 of this section, they shall not be used as a source of non-federal share.

d. The administrative costs associated with DSHPs in STC 12 of this section and any others subsequently added by amendment to the demonstration shall not be included in any way as demonstration and/or other Medicaid expenditures.

e. Any changes to the DSHPs listed in STC 12 of this section shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

VIII. DELIVERY SYSTEM REFORM PROGRAM DESCRIPTION AND OBJECTIVES

1. Medicaid Redesign Team (MRT)

a. BACKGROUND

The purpose of this demonstration amendment is to describe a structure under which the federal government will provide up to $8 billion in new federal funds for all Medicaid Redesign Team (MRT) activities including delivery system reform in the waiver, managed care programming and state plan amendment (SPA) activities. The purpose of one component of MRT, the

Delivery System Reform Incentive Payment (DSRIP) program, is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. Up to $6.42 billion of the new MRT funding is available for DSRIP payments to providers. An additional $500 million in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term. And, up to $1.08 billion in federal funding for non-DSRIP Medicaid Redesign purposes, with specific uses of that funding still to be discussed and finalized.

Only initial funding of this structure is authorized in 2014; continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.

The DSRIP program is focused on the following goals: (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.

i. **Safety Net System Transformation.** The DSRIP funds provider incentive payments to reward safety net providers when they undertake projects designed to transform the systems of care that support Medicaid beneficiaries and low income uninsured by addressing three key elements, which must be reflected in all DSRIP projects proposed by safety net providers participating in DSRIP (referred to as "Performing Provider Systems"). DSRIP projects will be designed to meet and be responsive to community needs while ensuring overall transformation objectives are met. As such, all projects must include the following elements, whose core components and associated outcome measures are further described in the DSRIP Strategies Menu and Metrics (Attachment J):

   A. **Element 1: Appropriate Infrastructure.** The DSRIP will further the evolution of infrastructure and care processes to meet the needs of their communities in a more appropriate, effective and responsive fashion to meet key functional goals. This will include changes in the workforce. Infrastructure evolution must support the broader goals of DSRIP, and key outcomes reflect the kinds of infrastructure to be supported under DSRIP. Appropriate infrastructure should ensure access to care, particularly to outpatient resources as well as effective care integration. In support of linking settings, the transforming infrastructure should place more emphasis on outpatient settings. Also, critical services such as care coordination may need to be expanded to meet the broad needs of the population served.

Indicators related to this objective are included in the System Transformation Milestones (Domain 2) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Because many of these indicators are difficult to benchmark, the state will be

accountable for ensuring that these indicators are moving overall in the right directions across all systems as part of the statewide accountability described in STC 14 (f) of this section.

B. Element 2: Integration across settings. The DSRIP will further the transformation of patient care systems to create strong links between different settings in which care is provided, including inpatient and outpatient settings, institutional and community based settings, and importantly behavioral and physical health providers. The goal will be to coordinate and provide care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while also managing total cost of care. The DSRIP will fund projects that include new and expanded care coordination programs, other evidence based, data driven interventions and programs focused on key health and cost drivers and opportunities for providers to share information and learn from each other.

Key outcomes to be measured are expected to reflect this ongoing transformation. Integration across settings will create alignments between providers. The DSRIP will include restructuring payments to better reward providers for improved outcomes and lower costs.

Indicators related to this objective are included in the Clinical Improvement Milestones (Domain 3) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Each system will be accountable for these indicators, and in addition, because the state should also work to support this goal, the state will also be accountable for statewide performance on these outcomes as described in STC 14(g) of this section.

C. Element 3: Assuming responsibility for a defined population. The DSRIP projects will be designed in ways that promote integrated systems assuming responsibility for the overall health needs of a population of Medicaid beneficiaries and low income uninsured people, not simply responding to the patients that arrive at the doors of a hospital. The state will approve a defined population for each DSRIP project based on geographic and member service loyalty factors, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I). Safety net providers may propose to develop integrated systems that target the individuals served by a set of aligned community-based providers, or more ambitious systems to tackle accountability for an entire geographic population. Patient and beneficiary engagement through tools including community needs assessment and responsiveness to public health needs will be an important element of all DSRIP projects.

Each indicator used to determine DSRIP awards should reflect a population, rather than the patients enrolled in a particular intervention. In addition, DSRIP performing provider systems will be required to report on progress on priorities related to the Prevention Agenda as included in the Population-wide Strategy

Implementation Milestones (Domain 4) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J).

D. Element 4: Procedures to reduce avoidable hospital use: guidepost for statewide reform. New York has identified a statewide goal of reducing avoidable hospital use and improving outcomes in other key health and public health measures. Effectively reducing avoidable hospital use requires alignment of outpatient and inpatient settings, requires systems that can take responsibility for a population, and requires investments in key infrastructure--and so this is a guidepost that can ensure that these transformations are aligned with our shared goals of better health, and better care at lower cost.

Consistent with the fact that this is an integral guidepost to system transformation, key improvement outcomes for avoidable hospital use and improvements in other health and public health measures will be included for each project, and the state will be held accountable for these measures as part of the statewide accountability described in STC 14 (f) of this section.

E. Element 5: State managed care contracting reforms to establish and promote DSRIP objectives. The state must also ensure that its managed care payment systems recognize, encourage and reward positive system transformation. To fully accomplish DSRIP goals and ensure sustainability of the initiatives supported by this demonstration, as a condition of receiving DSRIP project funding, the state shall develop and execute payment arrangements and accountability mechanisms with its managed care contractors. These payment and accountability changes, described further in STC 39 of this section, must be reflected in the state's approved state plan and managed care contracts, and are funded through the approved state plan (without separate DSRIP funding). These changes are a condition for overall DSRIP project funding to be released.

This goal will also be monitored as part of the statewide accountability test described in STC 14(f) of this section and will be tracked not at a DSRIP project level, but at the state level. The state must ensure state payments to managed care plans reflect and promote the establishment and continuation of integrated service delivery systems and procedures to reduce avoidable hospital use and ensure improvements in other health and public health measures.

ii. State and Provider Accountability. Overall DSRIP project funding is available up to the amounts specified in the special terms and conditions. Such funding is subject to the Performing Provider System meeting ongoing milestones established pursuant to this demonstration, and the state meeting overall state milestones as described in the STCs and DSRIP Program Funding and Mechanics Protocol (Attachment I). In addition, statewide achievement of performance goals and targets must be achieved and maintained for full access to the funding level as specified in the STCs. Specific reductions from statewide funds are taken from the state starting in Year 3 accordance with STC 14 (h) of this section if these targets are not achieved.

Individual projects are awarded based on the merit of the proposal itself, its support of the overall DSRIP goals, and the projected breadth and depth of the impact on Medicaid beneficiaries. Public transparency, a process that allows for community input, and independent expert evaluation are critical to the approval and funding levels for each project.

It should be noted that federal funding for DSRIP activities is limited in any phase of the demonstration period to the amounts set forth in this demonstration authority, subject to all of the reductions based on milestones, even if the state expenditures exceed the amount for which federal funding is available.

b. Interim Access Assurance Fund (IAAF). Temporary, time limited, funding is available from an IAAF to protect against degradation of current access to key health care services in the near term. The IAAF is available to provide supplemental payments that exceed upper payment limits, DSH limitations, or state plan payments, to ensure that current trusted and viable Medicaid safety net providers, according to criteria established by the state consistent with these STCs, can fully participate in the DSRIP, transformation without unproductive disruption. The IAAF is authorized as a separate funding structure from the DSRIP program to support the ultimate achievement of DSRIP goals. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself. In addition, a separate fund is authorized to make DSRIP project design grants to providers. The IAAF and the design grant funds are both part of the overall DSRIP total funding.

i. Interim Access Assurance Fund. To protect against degradation of current access to key health care services, limit unproductive disruption, and avoid gaps in the health delivery system, New York is authorized to make payments for the financial support of selected Medicaid providers.

A. Limit on FFP. New York may expend up to $500 million in FFP for Interim Access Assurance payments for the period from the date of approval of the IAAF expenditure authority until December 31, 2014. Contingent upon renewal of the demonstration, the authority could be extended until March 31, 2015. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself.

B. Funding. The non-federal share of IAAF payments may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any IAAF payments must remain with the provider receiving the payment to be used for health care related purposes, and may not be transferred back to any unit of government, directly or indirectly, or redirected for other purposes. The IAAF payments received by providers cannot be used for the non-federal share of any expenditures claimed under a federally-supported grant.

ii. Interim Access Assurance Fund Requirements.

A. The state will make all decisions regarding the distribution of IAAF payments to ensure that sufficient numbers and types of providers are available to Medicaid beneficiaries in the geographic area to provide access to care for Medicaid and uninsured individuals while the state embarks on its transformation path. The IAAF payments shall be limited to providers that serve significant numbers of Medicaid individuals, and that the state determines have financial hardship in the form of financial losses or low margins. In determining the qualifications of a safety net provider for this program and the level of funding to be made available, the state will take into consideration both whether the funding is necessary (based on current financial and other information on community need and services) to provide access to Medicaid and uninsured individuals. The state will also seek to ensure that IAAF payments supplement but do not replace other funding sources.

B. Before issuing any payments to providers, the state must post on its Website a list of qualifications that providers must meet to receive payments under this section, provide an opportunity for public comment for at least 14 days, and consider such comments. On the day the proposed qualifications list is posted, the state must provide to CMS the URL where the list can be found. The state must take the public comments into account when qualifying providers and distributing funds from this account.

C. Following the end of the public comment period in (ii), the state will initiate an open application period of at least 14 days duration for providers to submit applications.

D. If a provider otherwise meeting the qualifications of this section is also receiving funds through the state's vital access program, or any other supplemental payment program for which the federal government provides matching funds, or Medicaid disproportionate share hospital payments, the state must assure CMS of non-duplication. As part of the reporting requirements described in (iii) below, the state assures that the payment information for the IAAF will be maintained, as the reporting information is subject to CMS audit. A provider may receive both funding through this special fund and a planning grant as part of the DSRIP program.

iii. Reporting.

A. Within 10 days of initiating payments under this section to a provider, the state must submit a report to CMS that states the total amount of the payment or payments, the amount of FFP that the state will claim, the source of the non-Federal share of the payments, and documentation of the needs and purposes of the funds to assure CMS of non-duplication. The state should document all other Medicaid payments (e.g. base, supplemental, VAP, DSH) the provider receives to demonstrate that existing payments are not sufficient to meet financial needs of

the providers.

B. In each quarterly progress report, the state will include a summary of all payments under this section made during the preceding quarter, including all information required in (A), and attach copies all reports submitted under (A) for payments made during the quarter.

C. When reporting payments under this section on the CMS-64, the state must include in Form CMS-64 Narrative a table that lists all payments by date, provider, and amount (broken down by source), and a reference to the quarterly progress report(s) where the payments and all of their required supporting documentation is presented.

iv. IAAF payments. The IAAF payments are not direct reimbursement for expenditures or payments for services. Payments from the IAAF are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the state plan.

c. Delivery System Reform Incentive Payment (DSRIP) Fund. The terms and conditions in Section c apply to the State's exercise of Expenditure Authority 9: Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Fund. These requirements are further elaborated by Attachment I, "NY DSRIP Program Funding and Mechanics Protocol," Attachment J "NY DSRIP Strategies Menu and Metrics," and Attachment K "DSRIP Operational Protocol." For purposes of this section, the DSRIP program will have its own demonstration years (DY) and any reference to DY is in reference to the DSRIP portion of the Partnership Plan demonstration and not the entire Partnership Plan demonstration. DSRIP funding for demonstration year DY 1 through DY 5 is contingent on renewal of the demonstration no later than December 31, 2014 and the revision of Attachments I, J and K based on the pre-implementation activities described in this section.

As described further below, DSRIP funding is available to *Performing Provider Systems* that consist of *safety net providers* whose *project plans* are approved and funded through the process described in these STCs and who meet particular *milestones* described in their approved DSRIP *project plans*. DSRIP project plans are based on the evidenced-based *projects* specified in the DSRIP Strategies Menu and Metrics (Attachment J) and are further developed by Performing Provider Systems to be directly responsive to the needs and characteristics of the low-income communities that they serve and to achieve the transformation objectives furthered by this demonstration.

2. Safety Net Definition: The definition of safety net provider for hospitals will be based on the environment in which the performing provider system operates. Below is the safety net definition:

a. A hospital must meet the following criteria to participate in a performing provider system:

i. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or

ii. Must pass two tests:
A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.
B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or

iii. 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.

b. Non-hospital based providers, 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 and must be associated with Medicaid, uninsured and Dual Eligible individuals.

c. Vital Access Provider 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. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are:

i. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.

ii. 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.

iii. Any state-designated health home or group of health homes.

d. Non-qualifying providers can participate in Performing Providers Systems. However, non-qualifying providers are eligible to receive 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.

3. Performing Provider Systems. The safety net providers that are funded to participate in a DSRIP project are called "Performing Provider Systems." Performing Provider Systems that complete project milestones and measures as specified in Attachment J, "DSRIP Strategies

Menu and Metrics", are the only entities that are eligible to receive DSRIP incentive payments.

4. **Two DSRIP Pools**. Performing Provider Systems will be able to apply for funding from one of two DSRIP pools: Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund.

   a. The Public Hospital Transformation Fund will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this pool include:

   i. Health and Hospitals Corporation of New York City
   ii. State University of New York Medical Centers
   iii. Nassau University Medical Center
   iv. Westchester County Medical Center
   v. Erie County Medical Center

   b. The Safety Net Performance Provider System Transformation Fund would be available to all other DSRIP eligible providers.

   c. Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool. The valuation framework is described in STC 9 of this section and will be further specified in the Program Funding and Mechanics Protocol.

   d. There is also a Performance Pool within the two DSRIP pools, as described in the Program Funding and Mechanics Protocol (Attachment I).

5. **Coalitions and Attributed Population**. Major public general hospitals and other safety net providers are strongly required to form coalitions that apply collectively as a single Performing Provider System. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System. Coalitions are subject to the following conditions in addition to the requirements specified in the Program Funding and Mechanics Protocol:

   a. Coalitions must designate a lead coalition provider who will be held responsible under the DSRIP for ensuring that the coalition meets all requirements of Performing Provider Systems, including reporting to the state and CMS.

   b. Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1)

and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.

c. Each Performing Providers System must, in the aggregate, identify a proposed population for DSRIP. The proposed population will be aligned with the population attribution methodology specified in the Program Funding and Mechanics Protocol. The attribution methodology will assure non-duplication of members between DSRIP Performing Providers Systems.

d. Each coalition must have a data agreement in place to share and manage data on system-wide performance.

6. **Objectives**. Performing Provider Systems will design and implement projects that aim to achieve each of the following objectives or sub-parts of objectives, which are elaborated further in the DSRIP Strategies Menu and Metrics (Attachment J). To put in the context of the overall three objectives below, each performing provider system is responsible for project activity that addresses the first two objectives, for a defined population as specified in the third objective.

   a. The creation of appropriate infrastructure and care processes based on community need, in order to promote efficiency of operations and support prevention and early intervention.

   b. The integration of settings through the cooperation of inpatient and outpatient, institutional and community based providers, in coordinating and providing care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while managing total cost of care.

   c. Population health management as described in the attribution section of the Program Funding and Mechanics Protocol.

7. **Project Milestones.** Progress towards achieving the goals specified above will be assessed by specific milestones for each project, which are measured by particular metrics that are further defined in the DSRIP Strategies Menu and Metrics (Attachment J). These milestones are organized into the following domains:

   a. *Project progress milestones (Domain 1).* Investments in technology, tools, and human resources that will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Performance in this domain is measured by a common set of project progress milestones, which will include milestones related to the monitoring of project spending and post-DSRIP sustainability. This includes at least semi-annual reports on project progress specific to the performing provider system's DSRIP project and its Medicaid and uninsured patient population.

b. *System transformation milestones (Domain 2).* As described further in the Project Menu, this includes outcomes that reflect the four subparts of the goal on system transformation, including measures of inpatient/ outpatient balance, increased primary care/community-based services utilization, and rates of global capitation, partial capitation and bundled payment of providers by Medicaid managed care plans, and measures for patient engagement.

c. *Clinical improvement milestones (Domain 3):* As described further in the Project Menu, this domain includes metrics that reflect improved quality of care for Medicaid beneficiaries; including the goal of reducing avoidable hospital use and improvements in other health and public health measures. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over a baseline, using a valid, standardized method. Systems that are already high performers on these metrics, with the exception of avoidable hospitalization metrics, before initiation of projects must either explore alternative projects or align with lower performing providers such that the system as a whole has adequate room for improvement (as defined in DSRIP Program Funding and Mechanics Protocol (Attachment I).

d. *Population-wide Strategy Implementation Milestones (Domain 4).* DSRIP Performing Provider Systems will be responsible for reporting on progress on strategies they have chosen related to the Prevention Agenda as identified in DSRIP Strategies Menu and Metrics (Attachment J) for relevant populations as identified in DSRIP Program Funding and Mechanics Protocol (Attachment I) and as approved in their project plan.

8. DSRIP Project Plan Performing Provider Systems must develop a DSRIP project plan that is based on one or more of the projects specified in the DSRIP Strategies Menu and Metrics (Attachment J) and complies with all requirements specified in the DSRIP Program Funding and Mechanics Protocol. Performing Provider Systems should develop DSRIP project plans, while leveraging community needs, including allowing community engagement during planning, to sufficiently address the delivery system transformation achievement that is expected from their projects. DSRIP project plans will be provided in a structured format developed by the state and approved by CMS and must be tracked by the state over the duration and close out of the program. DSRIP project plans must be approved by the state and may be subject to additional review by CMS, DSRIP project plans must include the following elements:

a. *Rationale for Project Selection.*

i. Each DSRIP project plan must identify the target populations, program(s), and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Strategies Menu and Metrics.

ii. Goals of the project plan should be aligned with each of the objectives as described in STC 6 of this section.

iii. Milestones should be organized as described above in STC 7 of this section reflecting

the three overall goals and subparts for each goal as necessary.

iv. The project plan must describe the need being addressed and the starting point (including baseline data consistent with the agreement between CMS and the state) of the performing provider system related to the project. The starting point of the project plan must be after April 1, 2015.

v. Based on the starting point the performing provider system must describe its 5-year expected outcome for each of the domains described in STC 7 of this section. Supporting evidence for the potential for the interventions to achieve these changes should be provided in support of this 5 year projection for achievement in the goals of this DSRIP.

vi. The DSRIP Project Plan shall include a description of the processes used by the Performing Provider System to engage and reach out to stakeholders, including a plan for ongoing engagement with the public, based on the process described in the Operational Protocol (Attachment K).

vii. Performing Provider Systems must demonstrate how the project will transform the delivery system for the target population and do so in a manner that is aligned with the central goals of DSRIP, and in a manner that will be sustainable after DY5. The projects must implement new, or significantly enhance existing health care initiatives; to this end, providers must identify the CMS and HHS funded delivery system reform initiatives in which they currently participate or in which they have participated in the previous five years, and explain how their proposed DSRIP activities are not duplicative of activities that are already or have recently been funded.

viii. The plan must include an approach to rapid cycle evaluation that informs the system in a timely fashion of its progress, how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

ix. The plan must contain a comprehensive workforce strategy. This strategy will identify all workforce implications – including employment levels, wages and benefits, and distribution of skills – and present a plan for how workers will be trained and deployed to meet patient needs in the new delivery system. Applicants will need to include workers and their representatives in the planning and implementation of their workforce strategy.

b. *Description of Project Activities.*

i. Each project must feature strategies from all domains described in STC 7 of this section and the DSRIP Strategies Menu and Metrics.

ii. For each domain of a project, there must be at least one associated outcome metric that must be reported in all years, years 1 through 5. The initially submitted DSRIP project plan must include baseline data on all measures, should demonstrate the ability to provide valid data and provide benchmarks for each measure. Baseline measurements should be based on the most recently available baseline data, as agreed to by CMS and the state.

c. *Justification of Project Funding.*

i. The DSRIP project plan shall include a detailed project specific budget as provided for in DSRIP Program Funding and Mechanics Protocol (Attachment I) and a description of the performing provider system or provider coalition's overall approach to valuing the project. Project valuations will be subject to a standardized analysis by the state as described below and further specified in the Program Funding and Mechanics Protocol.

ii. DSRIP project plans shall include any information necessary to describe and detail mechanisms for the state to properly receive intergovernmental transfer payments (as applicable and further described in the program funding and mechanics protocol).

9. Project Valuation. DSRIP payments are earned for meeting the performance milestones (as specified in each approved DSRIP project plan). The value of funding for each milestone and for DSRIP projects overall should be proportionate to and its potential benefit to the health and health care of Medicaid beneficiaries and low income uninsured individuals, as further explained in the Program Funding and Mechanics Protocol (Attachment I).

a. *Maximum project valuation*. As described further in the Program Funding and Mechanics Protocol, a maximum valuation for each project on the project menu shall be calculated based on the following valuation components as specified in the Program Funding and Mechanics Protocol (Attachment I).

i. Index score of transformation potential. The state will use a standardized index to score each project on the project menu, based on its anticipated delivery system transformation. This index will include factors of anticipated transformation, such as potential for achieving the goals of DSRIP outlined in STC 6 of this section, expected cost savings, potential to reduce preventable events, capacity of the project to directly affect Medicaid and uninsured beneficiaries and robustness of evidence base. The index scoring process is described in the DSRIP Program and Funding and Mechanics Protocol and will be available for public comment in accordance with STC 10 of this section.

ii. Valuation benchmark. The project index score will be multiplied by a valuation benchmark in combination with the components below for all DSRIP projects in order to determine the maximum valuation for the project, as specified in the Program Funding and Mechanics Protocol (Attachment I). The valuation benchmark should be externally justified based on evidence for the value and scope of similar system

transformations and delivery system reforms, and may not be based on the total statewide limit on DSRIP funding described in STC 14 of this section. By no later than 15 days after the public comment period for initial DSRIP applications, the state will establish a state-wide valuation benchmark based on its assessment of the cost of similar delivery reforms. This value will be expressed in a per member per month (PMPM) format and may not exceed $15 PMPM, calculated multiplying paragraphs (iii)(B) and (C) below.

iii. DSRIP Project Plan Application Score. Based on the Performing Provider System's application, each project plan will receive a score based on the following:

A. The fidelity to the project description, and likelihood of achieving improvement by using that project.
B. Number of beneficiaries attributed to each performing provider's project plan.
C. Number of DSRIP months that will be paid for under the DSRIP project plan.

b. *Progress milestones and outcome milestones.* A DSRIP project's total valuation will be distributed across the milestones described in the DSRIP project plan, according to the specifications described in the Program Funding and Mechanics Protocol (Attachment I). An increasing proportion of DSRIP funding will be allocated to performance on outcome milestones each year, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I).

c. *Performance based payments*. Performing Provider Systems may not receive payment for metrics achieved prior to the baseline period set by CMS and the State in accordance with these STCs and the funding and mechanics protocol and achievement of all milestones is subject to audit by CMS, the state, and the state's independent assessor described in STC 10 of this section. The state shall also monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring reporting required under STC 12 of this section. In addition to meeting performance milestones, the state and performing providers must comply with the financial and reporting requirements for DSRIP payments specified in STC 13 of this section and any additional requirements specified in the Program Funding and Mechanics Protocol (Attachment I).

10. Pre-implementation activities. In order to authorize DSRIP funding for DY 1 to 5, the state must meet the following implementation milestones according to the timeline outlined in these STCs and must successfully renew the demonstration according to the process outlined in STC 8 in Section III. Failure to complete these requirements will result in a state penalty, as described in paragraph (vi) below.

a. *Project Design Grants*. During calendar year 2014, the state may provide allotted amounts to providers for DSRIP Design Grants from a designated Design Grant Fund. These grants will enable providers to develop specific and comprehensive DSRIP Project Plans. New York may expend up to $100 million in FFP for the grant payments from the

Design Grant Fund. Unspent funds will be carried over to DSRIP. DSRIP Project Design Grant payments count against the total amounts allowed for DSRIP under the demonstration.

i. Submitting a proposal for a DSRIP Project Design Grant. Providers and coalitions must submit a DSRIP design proposal as an application for a design. The state will review proposals and award design grants at any time during the pre-implementation activities.

ii. Use of Design Grant Funds. The providers and coalitions that receive DSRIP project design grants must use their grant funds to prepare a DSRIP project plan to prepare the provider's application for a DSRIP award. Providers and coalitions that receive DSRIP project design grants must submit a DSRIP application.

b. *Public comment period.* The state must engage the public and all affected stakeholders (including community stakeholders, Medicaid beneficiaries, physician groups, hospitals, and health plans) by publishing the development of the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J), including all relevant background material, and providing a public comment period that will be no less than 30 days that includes submission of comments through electronic means as well as public meetings across the State.

c. *Allowable changes to DSRIP protocols.* The state must post the public comments received and any technical modifications the state makes to the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J). Only changes to the protocol and menu that are related to the public comments will be allowed and incorporated into final protocols for DY 1 to DY 5. The state will submit the final protocols and menu and CMS will review and take action on the changes (ie. approve, deny or request further information or modification) no later than 30 days after the state's submission.

d. *Baseline data on DSRIP measures.* The state must use existing data accumulated prior to implementation to identify performance goals for performing providers. The state must identify high performance levels for all anticipated measures in order to ensure that providers select projects that can have the most meaningful impact on the Medicaid population, and may not select projects for which they are already high performers, with the exception of projects specifically focused on avoidable hospitalization.

e. *Procurement of entities to assist in the administration and evaluation of DSRIP.* The state will identify independent entities with expertise in delivery system improvement, including an independent assessor, an independent evaluator and any other an administrative costs. The independent entities will work in cooperation with one another to do the following:

i. Independent Assessor: Conduct a transparent review of all proposed DSRIP project plans and make project approval recommendations to the state.

ii. Independent Evaluator: Assist with the continuous quality improvement activities.

iii. Administrative Costs: Administrative costs the state incurs associated with the management of DSRIP reports and other data.

A. The state must describe the functions of each independent entity and their relationship with the state as part of its Operational Protocol (Attachment K)

B. The state may elect to require IGTs to be used to fund the non-federal share of the administrative activities, as permitted under the state plan.

C. Spending on the independent entities and other administrative cost associated within the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund.

f. *Submit evaluation plan*. The state must submit an evaluation plan for DSRIP consistent with the requirements of STC 19 of this section no later than 120 days after award of the DSRIP program and must identify an independent evaluator. The evaluation plan, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 21 of this section, is subject to CMS approval.

g. *Update comprehensive quality strategy*. The state must update its comprehensive quality strategy, defined in Section VI, to ensure the investment in DSRIP programs will complement and be supported by the state's managed care quality activities and other quality improvements in the state, including the state's Medicaid Redesign Team and Health Homes initiatives.

h. *DSRIP Operational Protocol.* The state shall submit for CMS approval a draft operational protocol for approving, overseeing, and evaluating DSRIP project grants no later than 90 days after the award of the Demonstration. The protocol is subject to CMS approval. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days. This protocol will become an appendix to Attachment K of these STCs.

i. The Operational Protocol, including required baseline and ongoing data reporting, independent assessor protocols, performing provider requirements, and monitoring/evaluation criteria shall align with the CMS approved evaluation design and the monitoring requirements in STC 34 of this section.

ii. The state shall make the necessary arrangements to assure that the data needed from the Performing Provider Systems, and data needed from other sources, are available as required by the CMS approved monitoring protocol.

iii. The Operational Protocol and reports shall be posted on the state Medicaid website within 30 days of CMS approval.

i. *CMS Oversight of Pre-implementation Activities*. CMS reserves the right to provide oversight over the state's pre-implementation activities in order to document late submissions and missed deliverables without notice of a delay from the state. Notice of delay from of any deliverable must be received by CMS no less than 10 days before the due date of the deliverable. As part of CMS' review of the state's deliverables, CMS will assess completeness based on listed deliverable requirements in the STCs.

11. DSRIP proposal and project plan review. In accordance with the schedule outlined in these STCs and the process described further in the Program Funding and Mechanics Protocol (Attachment I), the state and the assigned independent assessor must review and approve DSRIP project plans in order to authorize DSRIP funding for DY 1, DY 2, and DY 3 and must conduct ongoing reviews of DSRIP project plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 4 and DY 5. The state is responsible for conducting these reviews for compliance with approved protocols. CMS reserves the right to review projects in which the state did not accept the finding of the independent assessor or other outlier projects, as specified in the Program Funding and Mechanics Protocol (Attachment I).

a. *Review tool.* The state will develop a standardized review tool that the independent assessor will use to review DSRIP project plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment for a 30 day period according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment I). 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.

b. *Role of the Independent assessor*. An independent assessor will review project proposals using the state's review tool and consider anticipated project performance. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of DSRIP project plan.

c. *Public comment.* Project proposals will be public documents and subject to public comment. The public will have no less than30 days from the date of project posting to submit comments for specific project proposals, according to the process described in the Operational Protocol (Attachment K). After the comment period for the projects closes, a method for which the public can continue to comment must remain available, to obtain feedback on the ongoing implementation of the projects. The state must periodically compile comments received over the life of the demonstration and ensure that responses to comments are provided and released for public view.

d. *Mid-point assessment.* During DY 3, the state's independent assessor shall assess project performance to determine whether DSRIP project plans merit continued funding and

provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment I).

12. Monitoring. With the assistance of the independent assessor, the state will be actively involved in ongoing monitoring of DSRIP projects, including but not limited to the following activities.

a. *Review of milestone achievement.* 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 New York 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.

b. *Quarterly DSRIP Operational Protocol Report.* The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

c. *Learning collaboratives*. With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be a required activity for all Performing Provider Systems, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects as described in the DSRIP Strategies Menu and Metrics (Attachment J). Learning collaboratives are forums for Performing Provider Systems to share best practices and get assistance with implementing their DSRIP projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help providers share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals (regional "innovator agents") with training in quality improvement who can travel from site to site in the network to rapidly answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

d. *Rapid cycle evaluation.* In addition to the comprehensive evaluation of DSRIP described

in STC 22 of this section, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.

e. *Additional progress milestones for at risk projects.* 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. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment, described in STC 11 of this section.

f. *Annual discussion and site visits*. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned. The state, the independent assessor, and CMS will conduct annual site visits of a subset of Performing Providers to ensure continued compliance with DSRIP requirements.

g. *Application, review, oversight, and monitoring database.* The state will ensure that there is a well maintained and structured database, containing as data elements all parts and aspects of Performing Provider Systems' DSRIP project plans including the elements discussed in paragraph 8; independent assessor, state, and CMS review comments and scores; project planning, process, improvement, outcome, and population health milestones, with indicators of their required timing, incentive payment valuation, and whether or not they were achieved; and any other data elements required for the oversight of DSRIP. Along with the database, the state will develop software applications that will support:

i. Electronic submission of project plans by Performing Provider Systems;

ii. Public comment on project plans;

iii. Review of project plans by the independent assessor, state, and other independent participants in project plan review and scoring;

iv. Electronic submission by Performing Provider Systems of their performance data;

v. Generation of reports, containing (at a minimum) the elements in STC 36 of this section, that can be submitted to CMS to document and support amounts claimed for DSRIP payments on the CMS-64;

vi. Summaries of DSRIP project plans submissions, scoring, approval/denial, milestone

achievement, and payments that can be accessed by the public;

vii. Database queries, and export all or a portion of the data to Excel, SAS, or other software platforms; and

viii. On-line access rights for CMS.

13. Financial Requirements applying to DSRIP payments generally.

a. The non-Federal share of Fund payments to providers may be funded by state general revenue funds, and transfers from units of local government consistent with federal law. Any DSRIP payment must remain with the provider specified in the DSRIP project plan, and may not be transferred back to any unit of government, including public hospitals, either directly or indirectly. In the case of coalitions that are performing DSRIP projects collectively, the DSRIP funding will flow to the participating providers and/or the coalition coordinating entity according to the methodology specified in the DSRIP project plan but may not be transferred between coalition providers.

b. The state must inform CMS of the funding of all DSRIP payments to providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, as required under STC 36 of this section. This report must identify the funding sources associated with each type of payment received by each provider. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

d. The state may not claim FFP for DSRIP Payments until both the state and CMS have concluded that the performing providers have met the performance indicated for each payment. Performing providers' reports must contain sufficient data and documentation to allow the state and CMS to determine if the performing provider has fully met the specified metric, and performing providers must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved DSRIP project plan.

e. Each quarter the State makes DSRIP Payments or IAAF payments and claims FFP, appropriate supporting documentation will be made available for CMS to determine the appropriate amount of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for

payments will also identify all other funds transferred to such fund making the payment. This documentation should be used to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

f. DSRIP Payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP Fund are intended to support and reward performing providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Fund are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

14. Limits on Federal Financial Participation.

a. Use of FFP. The state will receive up to a total of $8 billion FFP to support MRT activities: $6.92 billion for DSRIP, $500 million of which will be for the IAAF, and the remaining amount to be allocated by the state for remaining MRT activities (with no more than $1.08 billion for such other activities).

b. MRT Cap. The State can claim FFP for MRT expenditures in each DSRIP Year up to the limits shown in the table below. Each DSRIP Project Plan must specify the DSRIP Year to which each milestone pertains; all incentive payments associated with meeting the milestone must count against the annual limit for the DSRIP Year identified. The state or its contractor shall monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring and reporting required under STC 35 of this section.

c. One-year DSRIP funding carry-over. If a performing provider system does not fully achieve a metric in Domains 2, 3 or 4 that was specified in its approved DSRIP project plan for completion in a particular DSRIP year, the performing provider system must report on the missed metrics in the given DSRIP year. Performing Provider Systems that do not meet annual milestones for a given metric will not be eligible to receive incentive payments for the missed metrics in that given DSRIP year. Any funding that would have been allocated to the performing provider system during that DSRIP year will be placed in the performance pool fund to be redistributed to Performing Provider Systems that have exceeded their set performance benchmarks for that DSRIP year. When a performing provider system does not meet its DSRIP year performance metrics, the missed metrics milestone will be recalibrated based on the procedures in DSRIP Program Funding and Mechanics Protocol (Attachment I) for the next DSRIP year and the performing provider system will be eligible to receive payments from the DSRIP payment pool for that next year if it reaches the recalibrated milestone in that next DSRIP year.

d. Fund Allocations According to MRT Demonstration Year

($ millions)

	Year-0	Year-1	Year-2	Year-3	Year-4	Year-5	Total
Sources of Funding							
Public Hospital IGT Transfers (Supports DSRIP IGT Funding for Public Performing Provider Transformation Fund, Safety Net Performance Provider System Transformation Fund, DSRIP, State Plan and Managed Care Services)	$512.0	$878.1	$933.0	$1,481.8	$1,317.1	$878.1	$6,000.0
State Appropriated Funds	$188.0	$345.4	$476.6	$467.8	$343.5	$178.7	$2,000.0
Total Sources of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**
Uses of Funding							
DSRIP Expenditures	$620.0	$1,007.8	$1,070.7	$1,700.6	$1,511.6	$1,007.8	$6,918.5
Interim Access Assurance Fund (IAAF)	$500.0	$0.0	$0.0	$0.0	$0.0	$0.0	$500.0
Planning Payments	$70.0	$0.0	$0.0	$0.0	$0.0	$0.0	$70.0
Performance Payments	$0.0	$957.8	$1,020.7	$1,650.6	$1,461.6	$957.8	$6,048.5
Administration	$50.0	$50.0	$50.0	$50.0	$50.0	$50.0	$300.0
Health Homes	$80.0	$66.7	$43.9	$0.0	$0.0	$0.0	$190.6
MC Programming	$0.0	$149.0	$294.9	$249.0	$149.0	$49.0	$890.9
Health Workforce MLTC Strategy	$0.0	$49.0	$49.0	$49.0	$49.0	$49.0	$245.0
1915i Services	$0.0	$100.0	$245.9	$200.0	$100.0	$0.0	$645.9
Total Uses of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**

**Includes costs associated with State based planning in Year-0.*
**New York State may spend up to 5% of annual costs on Administration.*

e. Notwithstanding the limits in STC 1.a and 14.a, to the extent that the state elects to limit supplemental payments to an institutional provider class otherwise authorized under its state plan in any state fiscal year during which the DSRIP demonstration is in effect, an amount equal to the federal share of the amount not paid to such providers, up to $600 million may be added to the overall MRT and DSRIP limits on federal funding. This election will be available only to the extent that the state does not increase the authorized levels of such supplemental payments, or initiate new supplemental payments, during the authorized demonstration period. The state must develop and use a tracking spreadsheet (following a format approved by CMS) to ensure that the amounts of the DSRIP increase

do not exceed the amount of authorized but unpaid supplemental payments.

f. Statewide accountability. Beginning in DSRIP Year 3, the limits on DSHP funding and on total DSRIP payments described in paragraph (a) above may be reduced based on statewide performance, according to the process described in the Program Funding and Mechanics Protocol.

g. Statewide performance will be assessed on a pass or fail basis, for a set of 4 milestones.

i. Statewide performance on universal set of delivery system improvement metrics (as defined in Attachment J). Metrics for delivery system reform will be determined at a statewide level. Each metric will be calculated to reflect the performance of the entire state. Each of these statewide metrics will be assigned a direction for improving and worsening. This milestone will be considered passed in any given year if more metrics in these domains are improving on a statewide level than are worsening, as compared to the prior year as well as compared to initial baseline performance.

ii. A composite measure of success of projects statewide on project-specific and population wide quality metrics. This test is intended to reflect the success of every project in achieving the goals that have been assigned to each project, including pay for reporting for certain outcome measures as specified in DSRIP Strategies Menu and Metrics (Attachment J). As described in DSRIP Program Funding and Mechanics Protocol (Attachment I), each metric that determines project level incentive payments for each project will be determined at the project level to be meeting the improvement standards. This statewide milestone will be considered passed in any given year if the number of metrics for each project that trigger award as the improvement standards in DSRIP Program Funding and Mechanics Protocol (Attachment I) are greater than the number of metrics for each project that fail to trigger an award as per the improvement standard in DSRIP Program Funding and Mechanics Protocol (Attachment I).

iii. Growth in statewide total Medicaid spending, including MRT spending, that is at or below the target trend rate (Measure applies in DY4 and DY5). The per member per month (PMPM) amounts will be adjusted to exclude growth in federal funding associated with the Affordable Care Act. The state will not be penalized if it uses these higher FMAP rates generated by the Affordable Care Act to reinvest in its Medicaid program.

Growth in statewide total inpatient and emergency room spending that is at or below the target trend rate (Measure applies in DY 3, DY 4 and DY 5).

Both of the above measures will be measured on a PMPM basis in the most recent state fiscal year from the state fiscal year that immediately precedes it, with applicable spending including both federal and non-federal shares combined. Per member per month spending in each measure is determined by dividing statewide total spending by the number of person-months of Medicaid eligibility in the state for

the state fiscal year. The most recent state fiscal year is the last state fiscal year ending prior to the start of the DSRIP Year. For total Medicaid spending, the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year), for DYs 4 and 5 only. For inpatient and emergency room spending the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year) minus 1 percentage points for DY 3 and 2 percentage points for DYs 4 and 5.

iv. Implementation of the managed care plan, including targets agreed upon by CMS and the state after receipt of the managed care contracting plan in STC 39 of this section related to reimbursement of plans and providers consistent with DSRIP objectives and measures. These targets will include one associated with the degree to which plans move away from traditional fee for service payments to payment approaches rewarding value.

h. The state must pass all four milestones to avoid DSRIP reductions. If the state fails on any of the 4 milestones, the amount of the potential reduction is set as follows:

The state must pass 50 percent of the inpatient/emergency room spending reduction goals to avoid DSHP penalties. This will be the sole test for any DSHP penalty. The amount of the potential reduction is set as follows:

	DSRIP Year 3	DSRIP Year 4	DSRIP Year 5
DSHP Penalty	$23.39 million (5 percent)	$34.35 million (10 percent)	$35.74 million (20 percent)
DSRIP Penalty	$74.09 million (5 percent)	$131.71 million (10 percent)	$175.62 million (20 percent)

If DSRIP and DSHP penalties are applied, the state reduce funds in an equal distribution of projects, and will not affect the high performance fund.

15. Designated State Health Programs (DSHP). The state may claim FFP for certain DSHP expenditures, following procedures and subject to limits as described below.

a. Limit on FFP for DSHP. The amount of FFP that the state may receive for DSHP may not exceed the limit described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

$ millions

Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total
188.0	345.4	476.6	467.8	343.5	178.7	2,000

The FFP limit for 2014 is the lowest of the following amounts:

i. $188 million,

ii. The combined non-Federal share of IAAF Payments, DSRIP Project Design Grant payments and DSRIP administrative costs in 2014, and

iii. The federal share of total matchable DSHP expenditures in 2014 as outlined below.

b. DSHP List 1. The state may claim FFP in support of DSRIP for List 1 DSHP expenditures made after March 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP.

i. Health Care Reform Act programs

A. AIDS Drug Assistance
B. Tobacco Use Prevention and Control
C. Health Workforce Retraining

ii. State Office on Aging programs
A. Community Services for the Elderly
B. Expanded In-Home Services to the Elderly

iii. Office of Children and Family Services: Committees on Special Education direct care programs

iv. State Department of Health, Early Intervention Program Services

c. DSHP List 2. The state may claim FFP in support of DSRIP for List 2 DSHP expenditures made after December 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Homeless Health Services

ii. Childhood Lead Poisoning Primary Prevention

iii. Healthy Neighborhoods Program

iv. Cancer Services Programs

v. Obesity and Diabetes Programs

vi. TB Treatment, Detection and Prevention

vii. TB Directly Observed Therapy

viii. General Public Health Work

ix. Newborn Screening Programs

d. DSHP List 3. The state may claim FFP in support of DSRIP for List 3 DSHP expenditures not used for DD Transformation. The state may not claim FFP until after the **date** on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Office of Mental Health

A. Licensed Outpatient Programs
B. Care Management
C. Emergency Programs
D. Rehabilitation Services
E. Residential (Non-Treatment)
F. Community Support Programs

ii. Office for People with Developmental Disabilities

A. Day Training
B. Family Support Services
C. Jervis Clinic
D. Intermediate Care Facilities
E. HCBS Residential
F. Supported Work (SEMP)
G. Day Habilitation
H. Service Coordination/Plan of Care Support
I. Pre-vocational Services
J. Waiver Respite
K. Clinics - Article 16

iii. Office of Alcoholism and Substance Abuse Services

A. Outpatient and Methadone Programs
B. Prevention and Program Support Services

e. DSHP Claiming Protocol. The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for DSRIP. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment L of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

i. The sources of non-federal share revenue, full expenditures and rates.

ii. Program performance measures, baseline performance measure values, and improvement goals. (CMS may, at its option, approve the DSHP Claiming Protocol

for a DSHP without this feature.)

iii. Procedures to ensure that FFP is not provided for any of the following types of expenditures:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures
M. Rent and utility subsidies normally funded by the United State Department of Housing and Urban Development
N. Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave
O. Revolving capital fund
P. Expenditures made to meet a maintenance of effort requirement for any federal grant program
Q. Administrative costs
R. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
S. Cost of services for which payment was made by Medicare or Medicare Advantage
T. Funds from other federal grants

f. DSHP Claiming Process.

i. Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS.

ii. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to document through an Accounting and Voucher system its request for DSHP payments. The vouchers will be detailed in the services being requested for payment by the state and will be attached to DSHP support.

iii. Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP.

iv. Federal funds are not available expenditures disbursed before April 1, 2014, or for

services rendered prior to April 1, 2014.

v. Federal funds are not available for expenditures disbursed after December 31, 2014, or for services rendered after December 31, 2014.

vi. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share.

vii. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures.

viii. Any changes to the DSHP listed above shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

g. Reporting DSHP Payments. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSRIP DSHP" (if in support of DSRIP) or "IAAF DSHP" (if in support of Interim Access Assurance Fund payments) as well as on the appropriate forms CMS-64.9I and CMS-64PI.

16. Budget Neutrality Review. In conjunction with any demonstration renewal beyond December 31, 2014, CMS reserves the right to modify the budget neutrality agreement consistent with budget neutrality policy.

17. Improved Management Controls. The state and CMS agree that, in conjunction with any Partnership Plan demonstration renewal beyond December 31, 2014, the state will undertake additional activities and steps to strengthen internal controls, compliance with federal and state Medicaid requirements and financial reporting to ensure proper claiming of federal match for the Medicaid program, and to self-identify and initiate timely corrective action on problems and issues. To support the development of these additional special terms and conditions, the state will provide a report to CMS by October 1, 2014, outlining its assessment of current strengths and weaknesses of the state's system of internal and financial management controls (taking into account any audit findings from federal or state oversight agencies including the HHS Office of Inspector General, the state Office of Inspector General, and CMS); the steps the state proposes to take to strengthen compliance, documentation and transparency; and the expected path for resolution of any outstanding deferrals or disallowances initiated by CMS as of the date of this amendment.

18. DSRIP Transparency. During the 30 day public comment period for the DSRIP Program Funding and Mechanics protocol (Attachment I), DSRIP Strategies Menu and Metrics (Attachment J), the state must have conducted at least two public hearings regarding the state's DSRIP amendment approval. The state must utilize teleconferencing or web capabilities for at least one of the public hearings to ensure statewide accessibility. The two public hearings must be held on separate dates and in separate locations, and must afford the

public an opportunity to provide comments. Once the state develops its standardized review tool the independent assessor will use for the DSRIP project plans, the tool must also be posted for public comment for 30 days.

a. Administrative Record. CMS will maintain, and publish on its public Web site, an administrative record that may include, but is not limited to the following:

i. The demonstration application from the state.
ii. Written public comments sent to the CMS and any CMS responses.
iii. If an application is approved, the final special terms and conditions, waivers, expenditure authorities, and award letter sent to the state.
iv. If an application is denied, the disapproval letter sent to the state.
v. The state acceptance letter, as applicable.
vi. Specific requirements related to the approved and agreed upon terms and conditions, such as implementation reviews, evaluation design, quarterly progress reports, annual reports, and interim and/or final evaluation reports.
vii. Notice of the demonstration's suspension or termination, if applicable.

b. CMS will provide sufficient documentation to address substantive issues relating to the approval documentation that should comprehensively set forth the basis, purpose, and conditions for the approved demonstration.

19. Submission of Draft Evaluation Design. The state shall submit a draft DSRIP evaluation design to CMS no later than 120 days after the award of the demonstration, including, but not limited to data that the state proposes to be used to evaluate DSRIP. The state must employ aggressive state-level standards that align with its managed care evaluation approach.

20. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design and the final evaluation plan will be included as Attachment M of these STCs.

21. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

22. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration, including:

i. safety net system transformation at both the system and state level;

ii. accountability for reducing avoidable hospital use and improvements in other health an public health measures at both the system and state level and

iii. efforts to ensure sustainability of transformation of/in the managed care environment at the state level.

The research questions will be examined using appropriate comparison groups and studied in a time series.

b. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

c. Performance Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration in terms of cost of services and total costs of care, change in delivery of care from inpatient to outpatient, quality improvement, and transformation of incentive arrangements under managed care. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state will incorporate comparisons to national data and/or measure sets. A broad set of metrics will be selected. To the extent possible, metrics will be pulled from nationally recognized metrics such as from the National Quality Forum, Center for Medicare and Medicaid Innovation, meaningful use under HIT, and the Medicaid Core Adult sets, for which there is sufficient experience and

baseline population data to make the metrics a meaningful evaluation of the New York Medicaid system.

d. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

i. Medicaid encounter and claims data in TMSIS,
ii. Enrollment data,
iii. EHR data, where available
iv. Semiannual financial and other reporting data
v. Managed care contracting data
vi. Consumer and provider surveys, and
vii. Other data needed to support performance measurement

e. Assurances Needed to Obtain Data: The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available

f. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, health plan and program level, as appropriate, and shall include population and intervention-specific stratifications, for further depth and to glean potential non-equivalent effects on different sub-groups. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

g. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

h. Evaluator: This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

23. Interim Evaluation Report. The state is required to submit a draft Interim Evaluation Report 90 days following completion of DY 4 of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 24 of this section for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The state shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

24. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from DY 5. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding

assessments due to data lags to complete the summative evaluation. Within 360 days of the end for DY 5, the state shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.

25. The Final Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waiver sand other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

26. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan at post approval. The state will present on its interim evaluation report that is described to in STC 23 of this section. The state will present on its summative evaluation in conjunction with STC 24 of this section.

27. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website

within 30 days of approval by CMS.

28. **CMS Notification**. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

29. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

30. **Cooperation with Federal Evaluators**. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of DSRIP, the state and its evaluation contractor shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

31. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

32. **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

33. **Deferral for Failure to Provide Summative Evaluation Reports on Time.** The state agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

34. **DSRIP Implementation Monitoring.** The state must ensure that they are operating its DSRIP program according to the requirements of the governing STCs. In order to demonstrate adequate implementation monitoring towards the completion of these requirements, the state will submit the following:

    a. DSRIP monitoring activities, in STC 35 of this section as a part of the operational protocol in STC 10 (h) of this section indicating how the state will monitor compliance with demonstration requirements in the implementation of this demonstration, including monitoring and performance reporting templates. Monitoring and performance templates are subject to review and approval by CMS.

b. Data usage agreements demonstrating the availability of required data to support the monitoring of implementation.

c. Quarterly Report Framework indicating what metrics and data will be available to submit a quarterly report consistent with STC 36 of this section.

35. DSRIP Monitoring Activities. As part of the state's Operational Protocol described in STC 10 (h) of this section and Attachment K, the state will submit its plans for how it will meet the DSRIP STCs through internal monitoring activities. The monitoring plans should provide, at a minimum, the following information:

a. The monitoring activities aligned with the DSRIP deliverables as well as the CMS evaluation design to ensure that entities participating in the DSRIP process are accountable for the necessary product and results for the demonstration.

b. The state shall make the necessary arrangements to assure that the data needed from the performing providers, coalitions, administrative activities, independent assessor and independent evaluator that are involved in the process for DSRIP deliverables, measurement and reporting are available as required by the CMS approved monitoring protocol.

c. The state shall identify areas within the state's internal DSRIP process where corrective action, or assessment of fiscal or non-fiscal penalties may be imposed for the entities described in STC 10(e) of this section, should the state's internal DSRIP process or any CMS monitored process not be administered in accordance with state or federal guidelines.

d. The monitoring protocol and reports shall be posted on the state Medicaid website within 30 days of submission to CMS.

36. DSRIP Quarterly Progress Reports. The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter along with the Operational Protocol Report described above. The first DSRIP quarterly reports will be due by August 30, 2014. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the three goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment L, must include, but are not limited to the following reporting elements:

a. Summary of quarterly expenditures related to IAAF, DSRIP Project Design Grant, and the DSRIP Fund;
b. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
c. Summary of activities associated with the IAAF, DSRIP Project Design Grant, and the DSRIP Fund. This shall include, but is not limited to, reporting requirements in STC 3 of this section and Attachment K, the Operational Protocol:

i. Provide updates on state activities, such as changes to state policy and procedures, to support the administration of the IAAF, DSRIP Project Design Grant and the DSRIP Fund;
ii. Provide updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
iii. Provide summary of state's analysis of DSRIP Project Design;
iv. Provide summary of state analysis of barriers and obstacles in meeting milestones;
v. Provide summary of activities that have been achieved through the DSRIP Fund; and
vi. Provide summary of transformation and clinical improvement milestones and that have been achieved.

d. Summary of activities and/or outcomes that the state and MCOs have taken in the development of and subsequent approval of the Managed Care DSRIP plan; and

e. Evaluation activities and interim findings.

The state may comment and submit a revised Attachment L no later than 30 days after approval of these STCs. CMS will approve necessary changes and update the attachment as necessary. Any subsequent changes to Attachment L must be submitted to CMS prior the end of the reporting period in which the change to the Quarterly Report would take place.

37. Annual Onsite with CMS. In addition to regular monitoring calls, the state shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

38. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

39. Medicaid Managed Care DSRIP Contracting Plan. In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the state's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the state must submit a roadmap for how they will amend contract terms and reflect new provider capacities and efficiencies in managed care rate-setting.

Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year. The state shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

a. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
b. How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
c. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
d. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
e. How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
f. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.
g. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.
h. How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

40. New York MRT-DSRIP Deliverables Schedule.

Due Date/Submission Date	Activity/Deliverable
April 14, 2014	CMS approves STCs and DSRIP Attachments
	New York posts the DSRIP Funding and Mechanics Protocol and the DSRIP

	Strategies Menu and Metrics for public comment for 30 days
	New York posts IAAF Qualifications and Application on for public comment for 14 days;
	14 day IAAF application period begins once comment period closes
	IAAF awards can be distributed after 14 day application period closes
	State has 10 days to submit its first report for IAAF payments (STC 1(b)(iii)(A) of this section)
	State will make baseline data for DSRIP measures available
	State submits its proposed independent assess statement of work (SOW) for its independent assessor contract procurement
May 1, 2014	State must accept DSRIP STCs or offer technical corrections, including for the DSRIP Operational Protocol and the Quarterly Reporting formats
	State has 10 days to submit changes to the DSRIP Funding and Mechanics Protocol and the DSRIP Strategies Menu and Metrics once public comment period closes
	CMS will review changes to the DSRIP Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics and take action no later than 30 days after state submits changes
	State accepts DSRIP Design Grant applications and make Design Grant awards
	State posts DSRIP Project Plan Review Tool that independent assessor will use to score submitted DSRIP Project Plan applications for 30 days
August 1, 2014	State submits draft DSRIP evaluation design
August 30, 2014	State submits its first quarterly report, including its operational report (STCs 35 & 36)
October 1, 2014	State submits its Improved Management Controls report to CMS
	State accepts DSRIP Project Plan applications
	State will perform initial review of submitted DSRIP Project Plan applications

	Independent assessor will perform full review of DSRIP project plan applications
	Independent assessor will post reviewed DSRIP Project Plan applications for public comment for 30 days
New York Partnership Plan Renewal Period – January 1, 2015	
	Independent assessor approval recommendations made public
	State Distributes DSRIP Project Plan awards for approved performing provider systems
Quarterly Deliverables – Quarterly Report and Operational Report	
August 30, 2014	
November 30, 2014	
February 28, 2015	
May 30, 2015	

***Note**: Activities/Deliverables without a specific Due Date/Submission Date could occur at any time during the timeframes with dates certain, for example the public comment period for the DSRIP Funding and Mechanics Protocol could occur any time after April 14, 2014, based on the state's discretion, so long as the activities are completed and related deliverables are submitted. Should the state renew the demonstration, the quarterly reporting will continue during the renewal period.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements**. The state must comply with all general financial requirements set forth in Section X.

2. **Reporting Requirements Related to Budget Neutrality**. The state must comply with all reporting requirements for monitoring budget neutrality set forth in section XI.

3. **Monthly Calls**. CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment of individuals using LTSS and non-LTSS users broken out by duals and non-duals, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to Section V, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

4. **Quarterly Operational Reports**. The state must submit progress reports in accordance with the guidelines in Attachment D taking into consideration the requirements in STC 7 of this section, no later than 60 days following the end of each quarter (December, March, and June

2. **Safety Net Definition:** The definition of safety net provider for hospitals will be based on the environment in which the performing provider system operates. Below is the safety net definition:

   a. A hospital must meet the following criteria to participate in a performing provider system:

      i. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or

      ii. Must pass two tests:
         A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.
         B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or

      iii. 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.

   b. Non-hospital based providers, 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 and must be associated with Medicaid, uninsured and Dual Eligible individuals.

   c. Vital Access Provider 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. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are:

      i. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.

      ii. 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.

      iii. Any state-designated health home or group of health homes.

   d. Non-qualifying providers can participate in Performing Providers Systems. However, non-qualifying providers are eligible to receive 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.