



**Department
of Health**

DSRIP Frequently Asked Questions (FAQs)

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

August 2015

health.ny.gov

Document Control Log

Version	Date	Details
Original	10/08/2014	<ul style="list-style-type: none"> • Original
Version 2 – November Update	11/19/2014	<ul style="list-style-type: none"> • Added question 8 to IAAF (Page 4) • Added question 3 to PPS (Page 10) • Added question 6 to PPS (Page 11) • Added questions 9 and 10 to PPS (Page 13) • Added questions 11 and 12 to PPS (Page 14) • Added question 13 to PPS (Page 15) • Added question 17 to PPS (Page 16) • Added questions 3 and 4 to Domains, Strategies & Projects (Page 22) • Added Metrics section with 5 new questions (Page 25) • Added question 5 to Attribution (Page 28) • Added questions 9 and 11 to Attribution (Page 30) • Added question 8 to Reporting & Payments (Page 43) • Added IT Communications & Investments section with 2 new questions (Page 45) • Added Workforce Strategy section with 1 new question (Page 45) • Added Health Home Infrastructure section with 1 new question (Page 46)
Version 3 – December Update	12/4/2014	<ul style="list-style-type: none"> • Revised question 2 of IT Communications & Investments section (Page 45)
Version 4 – December Update	12/9/2014	<ul style="list-style-type: none"> • Revised question 9 of Project Plan & Support Team (Page 37) • Revised question 18 of PPS (Page 16)
Version 5 – August Update	08/28/2015	<ul style="list-style-type: none"> • Revised questions 6-7 of DSRIP Background (Page 3-4) • Revised questions 1, 3, and 4 of DSRIP Eligibility (Page 4-5) • Revised questions 1-3 of DSRIP Eligibility Appeals (Page 5-6) • Revised questions 1, 6-9, 11-14, and 16-17 of Performing Provider Systems (Page 7-11) • Added questions 2, 10, and 15 of Performing Provider Systems (Page 7-10) • Added section New Governing Structures (“NewCo”) (Page 12) • Revised question 1 of Project Advisory Committee (Page 12) • Revised question 1 of Community Needs Assessment (Page 13) • Added question 3 of Community Needs Assessment (Page 13) • Revised question 3 of Domains, Strategies & Projects (Page 14) • Added questions 6-11 of Domains, Strategies & Projects (Page 15-16) • Revised question 2 of Project 2.d.i. (“Project 11” or “The 11th Project”) (Page 16) • Added questions 1, 3-4 and 7 of Metrics & Milestones (Page 17-18) • Revised questions 3, 5-6 and 11 of Attribution (Page 19-21)

		<ul style="list-style-type: none"> • Revised questions 1-6 and 8 of Project Plan & Support Team (Page 21-24) • Revised questions 2-3 of Project Plan Assessment (Page 24-25) • Revised questions 1-3 of DSRIP Project Valuation (Page 25-26) • Revised question 1, 13-15, 17-19 and 22 of DSRIP Reporting & Payments (Page 27-32) • Added questions 2-12 of DSRIP Reporting & Payments (Page 27-29) • Revised question 5 of IT Communications & Investments (Page 32) • Added questions 1-3 of IT Communications & Investments (Page 32) • Revised question 1 of Workforce Strategy (Page 33) • Revised question 1 of Health Home Infrastructure (Page 33) • Added Additional DSRIP Funds section (Page 33) • Added Data Sharing and Security section (Page 34-37) • Outdated questions moved to Appendix (Page 38-42) <ul style="list-style-type: none"> • Revised question 1 of Performing Provider Systems (Page 40)
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DSRIP Frequently Asked Questions (FAQs)

Medicaid Redesign Team (MRT) Background

1. Q: What is the MRT Waiver Amendment?

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

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

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

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

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

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

DSRIP Background

1. Q: What is DSRIP?

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

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

2. Q: What is considered avoidable hospital use?

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

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

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

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

Please review the SHIP documents on the New York State DOH website for additional details:

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

4. Q: Where can I get information on DSRIP?

A: The state will provide information through three venues:

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

5. Q: Is there a DSRIP Program timeline available?

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

6. Q: How long does the DSRIP program last? What's a DSRIP year? (Revised 8/28/2015)

A: The DSRIP program is a 5 year program; however, it will include one year for planning. The years are structured as follows:

DSRIP Year 0 (DY0): April 14, 2014 - March 31, 2015
DSRIP Year 1 (DY1): April 1, 2015 - March 31, 2016
DSRIP Year 2 (DY2): April 1, 2016 - March 31, 2017
DSRIP Year 3 (DY3): April 1, 2017 - March 31, 2018
DSRIP Year 4 (DY4): April 1, 2018 - March 31, 2019
DSRIP Year 5 (DY5): April 1, 2019 - March 31, 2020

7. Q. What was DSRIP Year 0? How does it differ from the other years? (Revised 8/28/2015)

A: DSRIP Year (DY) 0 was the year for planning, assessment & project development for Performing Provider Systems. Moving forward, the other years, DYs 1 through 5 are for project implementation, performance evaluations & measurement as well as metric & milestones achievement. DSRIP Year 1 started April 1, 2015 and goes to March 31, 2016.

DSRIP Eligibility

1. Q: What type of providers/care settings were able to submit an application to participate in DSRIP? (Revised 8/28/2015)

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

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

Hospital Test #1:

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

Hospital Test #2: *(Note that a hospital needs to meet both of these qualifications to pass this test)*

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

Hospital Test #3:

- Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible* members in the proposed county or multi-county community. *(The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.)*

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

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

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

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

The DSRIP safety net list website can be viewed at:

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

3. Q: Is there a way my organization can still participate in DSRIP even if it does not meet the eligibility requirements to be a safety net provider or qualify for a VAP Exception? (Revised 8/28/2015)

A: Yes. As stated in the STCs, non-safety net providers can participate in DSRIP. However, non-safety net providers are eligible to receive, in aggregate, DSRIP payments totaling no more than 5 percent of a project's total valuation. Please contact your local PPS for possible participation.

4. Q: How is the 5% limit on non-safety net provider performance payments applied? (Revised 8/28/2015)

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

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

A: If a private doctor does not meet the DSRIP safety net provider qualifications, they can still participate in a DSRIP PPS either as a non-qualifying provider (subject to the 5% earnings limit) or they could have applied to be part of the PPS through meeting the DSRIP Vital Access Provider (VAP) Exception criteria. (see Page 6, What was the DSRIP VAP Exception and how does it pertain to DSRIP safety-net eligibility?)

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

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

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

DSRIP Eligibility Appeals

1. Q: Based on the safety net list on the DSRIP website, my organization was listed, but did not meet the qualifications to be a safety net provider in the DSRIP program. Can my organization appeal if we feel there was an error in the data used to determine eligibility? (Revised 8/28/2015)

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

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

The second and final DSRIP safety net appeal process is closed. Providers who are not included on the eligible provider lists above, and believe they had met the safety net definition had the opportunity to appeal their safety net provider status. These appeals were due August 27, 2014. Late appeals were not accepted. Please note that the safety net appeals process was NOT for entities who were looking to pursue the DSRIP Vital Access Provider (VAP) Exception process, which closed October 24, 2014.

A final posting of Safety Net lists and VAP Exceptions has been finalized and posted on the DSRIP website: https://www.health.ny.gov/health_care/medicaid/redesign/dsrrip/safety_net_definition.htm

2. Q: What was the DSRIP VAP Exception and how does it pertain to DSRIP safety-net eligibility? (Revised 8/28/2015)

A: Under the DSRIP Vital Access Provider (VAP) Exception, the state considered exceptions (to the safety net definition) on a case-by-case basis if it is deemed in the best interest of Medicaid members and made clear that the provider system in question provides essential benefits within the larger system. The list of approved VAP Exceptions are on the DSRIP website. The application period for VAP Exception is closed and no new providers will be added to the list at this time. Those providers that received a DSRIP VAP Exception will be viewed as a qualifying safety net providers in regards to the DSRIP program and will be eligible to share in safety net portion ($\geq 95\%$) of performance payments allotted to a PPS.

There were three reasons under which DOH and CMS would grant a VAP Exception in the DSRIP Program:

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

*The Department submitted a draft list to CMS of those State Designated Health Homes and Network Care Management Agencies (CMAs) that had been previously approved as safety net providers, as well as those that were pending approval by CMS. The list of State Designated Health Homes and CMAs is posted to the Safety Net section of the DSRIP website. Initially, you did not need to submit a VAP Exception form if:

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

If your Health Home organization did not appear on the draft Health Home list pending CMS approval, or on another approved safety net provider list, but your organization believed that it should qualify as a Health Home, you were asked to complete the VAP Exception form.

3. Q: How do I apply for a Vital Access Provider Exception? (Revised 8/28/2015)

A: The Vital Access Provider Exception process is now closed. The form to apply for a VAP Exception was posted on the DSRIP website in late September 2014. VAP Exception applications were due by October 24, 2014 and made public on the DSRIP website immediately for a 30-day comment period. CMS approval of exceptions were posted to the website in February 2015.

Performing Provider Systems (PPS)

1. Q: What is a Performing Provider System? (Revised 8/28/2015)

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

2. Q: Can a provider still join a PPS at this point in time? If yes, can you still participate in the financial incentive payment? (New 8/28/2015)

A: At this time, the PPS provider networks are closed. However, in the near future PPS networks will reopen for the addition of new partners for performance purposes only. At DSRIP midpoint, providers may be added for valuation. We recommend reaching out to the PPSs in your region regarding participation. A list of PPS contact information can be found on the DSRIP website at:

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

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

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

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

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

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

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

However, providers who are considering joining multiple PPS should understand that there can be some drawbacks. Firstly, the attribution an organization brings to a PPS will diminish with each additional PPS the provider/organization joins. For example, if a clinic joins two PPS in the same county, the clinic’s attributed members will most likely be split between the two PPS networks it is partnered with. This could

harm the clinic's performance payment negotiations with each PPS, because the clinic will bring fewer lives to each PPS. Additionally, the clinic may see that there are greater administrative and reporting demands placed on the entity as it has to be responsive to two PPS.

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

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

6. Q: Are providers encouraged to work together? If so, what types of providers can collaborate as partners? (Revised 8/28/2015)

A: It is a requirement that eligible providers within a region/service area work together on a DSRIP project. Significant community collaboration by Medicaid and non-Medicaid providers is a key theme of DSRIP and is necessary in order to meet the performance aims of DSRIP.

Within a PPS there should be a wide variety of providers including hospitals, clinics, primary care physicians, specialists, home care, SNF, Health Homes, and behavioral health providers. Also, community based organizations such as housing providers should be key participants so that the PPS will have resources in the community and be able to address the social determinants of health.

7. Q: Will there be collaboration between PPSs? (Revised 8/28/2015)

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

Also, from DY1-DY5, PPSs will be required to take part in DSRIP Learning Symposiums. These learning collaboratives will take place in person no less than once a year and will foster an environment of mutual assistance. PPSs will be encouraged to share best practices and challenges, and receive assistance and guidance from other PPS counterparts on how to best implement and meet the objectives of their DSRIP Project Plans. This will be particularly important as, starting in DSRIP DY3, CMS will be evaluating summative statewide performance on DSRIP benchmarks. There will be performance payment reductions across the board to all PPSs if those statewide benchmarks are not met.

8. Q: Are there any signed attestations required to confirm DSRIP Partnership? (Revised 8/28/2015)

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

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

9. Q: What is the DSRIP Network Tool? (Revised 8/28/2015)

A: The DSRIP Network Tool is an electronic tool housed in New York's Medicaid Analytics Performance Portal (MAPP), a web-based portal accessed through the Health Commerce System (HCS). The Network Tool is the means by which PPS entities updated/replaced their list of partner organizations during the DSRIP planning process. Providers were **required** to update their partner organization list, using this tool, by September 29, 2014, so that the state could begin the process of running *initial attribution*. PPSs could continue to edit their partner organization lists via the Network Tool until December 1, 2014 when the tool was closed for the state to run *attribution for valuation*. The network for valuation is locked and closed for changes.

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

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

10. Q. Can you explain why there are some providers listed on the performance list that are not on the valuation list? (New 8/28/2015)

A: Each PPS has two partner network lists in the MAPP System: a valuation network and a performance network. Networks for valuation were closed December 1, 2014 and were used to attribute members for purposes of calculating valuation. Valuation networks were locked and will not be changed – it is basically a snapshot of the PPS on that date.

However, as the DSRIP program goes forward, PPS will need to change their networks and add providers as they expand services or need a specific type of provider to meet their objectives. Hence, a performance network can change during the course of the DSRIP program. Providers cannot be removed, but can be added; the performance network should be larger than the valuation network. This is why you will see some providers on the performance network, but not on the valuation network. The performance network is used to set baselines and then to measure performance on a quarterly basis.

11. Q: How is a partner defined for the network list? (Revised 8/28/2015)

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

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

12. Q: What is required for the network partnership agreements? (Revised 8/28/2015)

A: All PPS Leads were required to have signed partnership agreements from each partner in their files by the time they submitted their final partner list via the Network Tool. Partnership agreements must relate to the DSRIP program and connect the entities together for DSRIP attribution and program purposes. The state is not providing a standardized template, but issued the following guidance:

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

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

13. Q: What happens if a partner drops out of the DSRIP process due to financial issues? (Revised 8/28/2015)

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

Additionally, PPS governance plans must address how it proposes to manage lower performing / financially distressed members within the PPS network. This plan must include progressive sanctions prior to any action to remove a member from the performing provider system. Unless the partner organization closes or there is some other extreme circumstance, PPSs will not be able to alter their partner lists for valuation purposes. A PPS may add partners at a state-chosen time, but no more than once a year.

14. Q: Can you remove partners after finalizing your partner list? (Revised 8/28/2015)

A: PPS networks were submitted via the DSRIP Network Tool for the purposes of calculating attribution for valuation and later, attribution for performance.

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

15. Q: Can you add partners after finalizing your partner list? (New 8/28/2015)

A: Once a year, the state will open performance networks and PPSs may add partners. Please note, additional partners will be for performance purposes only.

16. Q: What provider types qualify to be lead applicants in a DSRIP Performing Provider System? (Revised 8/28/2015)

A: Any qualifying DSRIP safety net provider can be a lead applicant, regardless of provider type. However, in the DSRIP Project Plan, the lead applicant will be assessed on its ability to fulfill the role as

the lead entity within the Performing Provider System. Qualifications that could allow an entity to fulfill the role as the lead applicant may include, but are not limited to:

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

It should be noted that while all PPS entities, as a whole, undergo a financial evaluation to ensure the entity's ability to complete the program, lead organizations underwent a more intensive, individual financial assessment to ensure fiscal stability for the PPS through the DSRIP program. Furthermore, the new governing structures ("NewCos"), rather than individual safety net providers, can serve as leads for Performing Provider Systems in the DSRIP program.

17. Q: Within a PPS network, how much autonomy does a PPS have in distributing funds?
(Revised 8/28/2015)

A: A PPS has the autonomy to allocate performance funds how it best sees fit, as long as at least 95% of performance payments go to safety net qualified partners and no more than 5% go to non-qualifying safety net partners. However, PPS funds allocation must be described in the DSRIP Budget & Flow of Funds section of the Project Plan Application and include a description of how DSRIP performance payments will be distributed amongst providers, and how the distribution of funds is consistent with the governance structure and DSRIP goals.

After DSRIP payments are received from the PPS Lead, Partners are not restricted from making payments to other in-network or out-of-network providers (e.g., contracts for DSRIP-supportive services). Once a performance payment is properly received, the DSRIP program does not impose any additional restrictions on these funds.

The PPS Lead must establish a budget and funding distribution plan, (at the level of detail set forth in the DSRIP Project Plan Application and Award Letter and the DSRIP Implementation Plan) that specifies how DSRIP funds received will be distributed among the participating providers in the PPS to incentivize providers to reach DSRIP performance goals. The PPS Lead in its budget plan will need to provide a distribution methodology taking into account five different categories:

- Project implementation costs
- Costs for delivery of services not reimbursed or under-reimbursed by Medicaid
- Provider performance payments
- Compensate revenue loss
- Other for administrative and other costs not included in previous categories

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

A: Yes, in instances where a DSRIP PPS can show that a potential collaboration between providers will benefit the community, there will be an opportunity for the state to provide protections for a PPS. This protection will come in the form of a Certificate of Public Advantage (COPA), which will be granted if it appears that the benefits of a collaboration between PPS partners will outweigh any disadvantages attributable to their anticompetitive effects and will be subject to active state supervision. COPA regulations are explicated in Article 29-F of New York's Public Health Law.

More information on COPA in relation to DSRIP is available at:

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

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

A: Yes. The state will be delivering provider-specific Medicaid information through a DSRIP portal, Medicaid Analytics and Performance Portal (MAPP).

Minimally, a Data Exchange Application and Agreement (DEAA) will need to be executed with the state for data available in the portal and any data sharing outside of the portal. Additionally, PPS are required to have established Health Commerce System (HCS) accounts to access the DSRIP portal (MAPP).

New Governing Structures (“NewCo”) (New 8/28/2015)

1. Q: Can a NewCo receive DSRIP award money directly from DOH? (New 8/28/2015)

A: Only PPS Lead entities will receive DSRIP award money directly from DOH.

For a NewCo to receive DSRIP award money directly from DOH, the NewCo would have to qualify as a PPS Lead entity, including being registered as a Medicaid provider, and either satisfying the requirements to be a Safety Net Provider or having been granted a Vital Access Provider (VAP) Exception.

Where there is a public hospital in a NewCo with multiple members, DSRIP payments will be made to the public hospital entity in order to enable Intergovernmental transfer (IGT) funding. The NewCo Lead will receive its DSRIP payments from the public hospital partner.

2. Q: If a NewCo cannot receive DSRIP award money directly from DOH, can the NewCo function as the PPS Lead entity? (New 8/28/2015)

A: The NewCo has to be approved by DOH and CMS to be a PPS Lead entity per the requirements previously stated. If it is not approved, then it cannot serve as PPS Lead entity or receive funds directly.

3. Q: Can a NewCo be used to create multiple Lead entities for a single PPS? (New 8/28/2015)

A: No. Only one legal entity can receive DSRIP award money, and that entity is the Lead entity.

Project Advisory Committee

1. Q: What is the Project Advisory Committee? (Revised 8/28/2015)

A: Each emerging Performing Provider System (PPS) was required to form a Project Advisory Committee (PAC). The PAC advises Performing Provider Systems on all elements of their DSRIP Project Plans and should include representation from each of the PPS partners as well as workers and/or relevant unions. The PACs were a requirement for the DSRIP Design Grant application and are expected to be in place over the duration of the DSRIP program.

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

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

PAC meetings/conference calls serve as forums to share and review proposals as well as discuss ideas

that will affect the PPS and its workforce. PACs may choose to form sub-committees around various issues or projects, but sub-committees should attempt to maintain their representativeness of the PAC stakeholders. PACs should meet no less than once a month during the DSRIP planning phase and no less than once a quarter during the implementation and oversight phases.

Community Needs Assessment

1. Q: Can you provide information about conducting and using a Community Needs Assessment? (Revised 8/28/2015)

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

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

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

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

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

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

3. Q. Will there be guidance with respect to continual updates to the community needs assessment conducted for the program? (New 8/28/2015)

A: The goal of DSRIP is continuous quality improvement with use of rapid cycle improvement methodology. The basis for the projects chosen for DSRIP were needs identified through the initial community needs assessment (CNA). As the CNA is intimately tied to the process of continuous quality improvement, the PPS should identify if those needs have been met/improved/not met through an updated community needs assessment.

Domains, Strategies & Projects

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

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

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

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

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

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

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

A: Yes. DSRIP project plans include a minimum of 5 and no more than 10 projects for valuation purposes. However, if a PPS is eligible to pursue Project 2.d.i. the Project Plan may include 11 projects. At least two (and no more than four) system transformation projects (unless Project 2.d.i is included in which up to five system transformation projects can be involved) in (Domain 2), at least two (and no more than four) clinical improvement projects (Domain 3), and at least one (and no more than two) population-wide project(s) (Domain 4) must be included in the PPS’ Project Plan.

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

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

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

3. Q: For PPS picking 10 projects, is there any opportunity to pick more from Domains 2 and 3 instead of Domain 4? (Revised 8/28/2015)

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

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

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

be needed most, the project's metrics will be measured based upon the entire PPS population attributed to that project.

5. Q: Can a Performing Provider System's DSRIP funds be used to supplant other, existing programs?

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

6. Q: What types of primary care providers may be utilized to provide primary care in the Behavioral Health (BH) setting for 3.a.i.? NPs, PAs, tele-psychiatry, other? (New 8/28/2015)

A: The only types of "primary care providers" that may be utilized to provide primary care services within the BH site for 3.a.i are participating PCPs, NPs, and physician assistants working closely with a PCP. Tele-psychiatry by its nature is psychiatry and not primary care services. Tele-psychiatry could be utilized potentially in the third model, IMPACT, when there are insufficient psychiatrists to provide the onsite services.

7. Q: Are pediatric members, who meet the definition of "actively engaged" for a project able to count towards committed numbers each year? (New 8/28/2015)

A: The basis for the actively engaged population is based on a subset of the total attributed population associated with the PPS, which includes all Medicaid beneficiaries (adults and children).

8. Q: How will "actively engaged" patients be tracked? For example, for Project 3.f.i, how will the Scheduled Delivery Forms be submitted? (New 8/28/2015)

A: All guidance to date concerning Active Engagement is provided in the following document:

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

9. Q: For Project 3.c.i, the definition of "actively engaged" is "The number of participating patients with at least one hemoglobin A1c test within previous Demonstration Year". Since this actively engaged definition would include a Medicaid claim for the HgA1C, will the IA expect the PPS to show claims data for a patient to count as actively engaged? Or, given the lag in claims data, is the PPS's own tracking system sufficient? (New 8/28/2015)

A: For the attributed patients the PPS can run a report that demonstrates the number of patients that have had an HgA1C in the last year. The Independent Assessor recognizes that data provided through Salient will only reflect paid claims. The PPS can demonstrate HgA1C services by producing reports from its own reporting tool.

10. Q: For project 2.b.v, the "actively engaged" definition is "the number of participating patients with a care transition plan developed prior to discharge". What are the criteria that define

participating patients here, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders? (New 8/28/2015)

A: The definition of “actively engaged” for project 2.b.v. includes Medicaid nursing home patients with recent hospital discharges who are at risk for re-hospitalization, with a care transition plan developed prior to discharge, and who are not readmitted within that 30-day period.

11. Q: Are Article 28 clinics that offer primary care and are in DSRIP required to become Patient Centered Medical Homes? (New 8/28/2015)

A: Clinics that offer primary care and are involved in certain DSRIP projects must meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care models by the end of DSRIP Year 3. Please refer to the DSRIP Project Toolkit for additional information:

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

Project 2.d.i. (“Project 11” or “The 11th Project”)

1. Q: What is Project 2.d.i, or the “11th project?”

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

2. Q: Can any PPS select to pursue the 11th project? (Revised 8/28/2015)

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

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

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

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

Metrics & Milestones

1. Q: What are the implications of changing target dates for project milestones? (New 8/28/2015)

A: The PPS has the option to change the target dates of a step/milestone only if that milestone is not attached to an achievement value. The steps/milestones for which the Independent Assessor set minimum target dates cannot be changed and cannot exceed what the Independent Assessor has put into the plan.

2. Q: If all of a PPS's projects are live by the end of year 2 and all providers have met all of the requirements, will the PPS no longer get the 7th achievement value for remaining years?

A: Correct. For the remaining years, the PPS no longer gets that 7th achievement value (i.e., back to 6 total).

3. Q. What constitutes a completed quarterly progress report for workforce process measures and milestones? (New 8/28/2015)

A: PPSs will need to provide updates on milestone progress and workforce process measures for quarterly progress reports. Submission of both is what constitutes a completed quarterly progress report. However, it is the reporting and measuring of the workforce process measures that drive achievement values/payments, as opposed to the milestone updates.

4. Q: When will the state be releasing the data to allow the PPS to see what performance targets are? (New 8/28/2015)

A: All statewide performance goals have been included in the DSRIP Measure Specification and Reporting Manual published April 2, 2015; no changes have been made to statewide performance targets.

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

In some cases, measures are defaulted to maximum performance targets and may be updated following finalization of Measurement Year 1 data (expected February 2016). DOH is currently evaluating measures which are high-performance eligible and are currently defaulted to maximum values in the Measure Specification and Reporting Manual.

5. Q: Some of the metrics are based on 3M proprietary software (PPV, PPR). Will the PPS have access to the proprietary software or data output that is used for some of the metrics?

A: The potentially preventable events (PPV and PPR) are calculated annually using the 3M proprietary logic. The latest annual results will be made available to the PPSs with information about observed and expected events to provide PPSs with information about improvement opportunities. Ongoing PPV and PPR results will not be available throughout the measurement year. Ongoing monitoring for readmissions and ED visits may be done using the events without the logic. Proxy PQI and PDI results for the PPSs will be available with the other quality measures which will be made available to the PPSs in MAPP, but will not be the same file that is used for calculation of PPS results for payment.

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

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

7. Q: There are multiple projects around redirecting patients from ED to more appropriate urgent care or BH services. How does is the metric for 25% reduction in avoidable hospital use and PPV determined? (New 8/28/2015)

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

8. Q: The specific metrics for Domain 4 are divided into groups (a, b, c, d). As there are multiple projects in each group (b1, b2, etc.), do all the group b metrics count for any group b project?

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

As noted, these are pay for reporting, but, in fact, the state is the one responsible for reporting. The state will continue to monitor the Prevention Agenda as it always has, and all metrics from Domain 4 will be reported by the state for the PPSs. A PPS does not need to report metrics.

Also note, the Prevention Agenda includes all New York State residents and projects in this area should be inclusive of the total population. What the PPS will be monitored for in Domain 4 is how the PPS meets the milestones for the implementation of its chosen project(s), including number of sites, impact on full population, etc.

Attribution

1. Q: What is DSRIP Member Attribution?

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

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

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

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

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

3. Q: Are there any changes to attribution guidelines based on Project 2.d.i.? (Revised 8/28/2015)

A: No. Portions of the uninsured individuals in a given region may be attributed to a PPS in a given region based on their approval to undertake Project 2.d.i. Three PPS “types” will be referred to for attribution of uninsured individuals (UI), non-utilizing (NU) and low-utilizing (LU) members which are as follows:

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

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

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

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

5. Q: If there is only one PPS in a region, does the geography trump the loyalty aspect of the attribution algorithm? In other words, even if patients in that geography are frequenting another PPS further away, will they still be attributed to the one PPS? (Revised 8/28/2015)

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

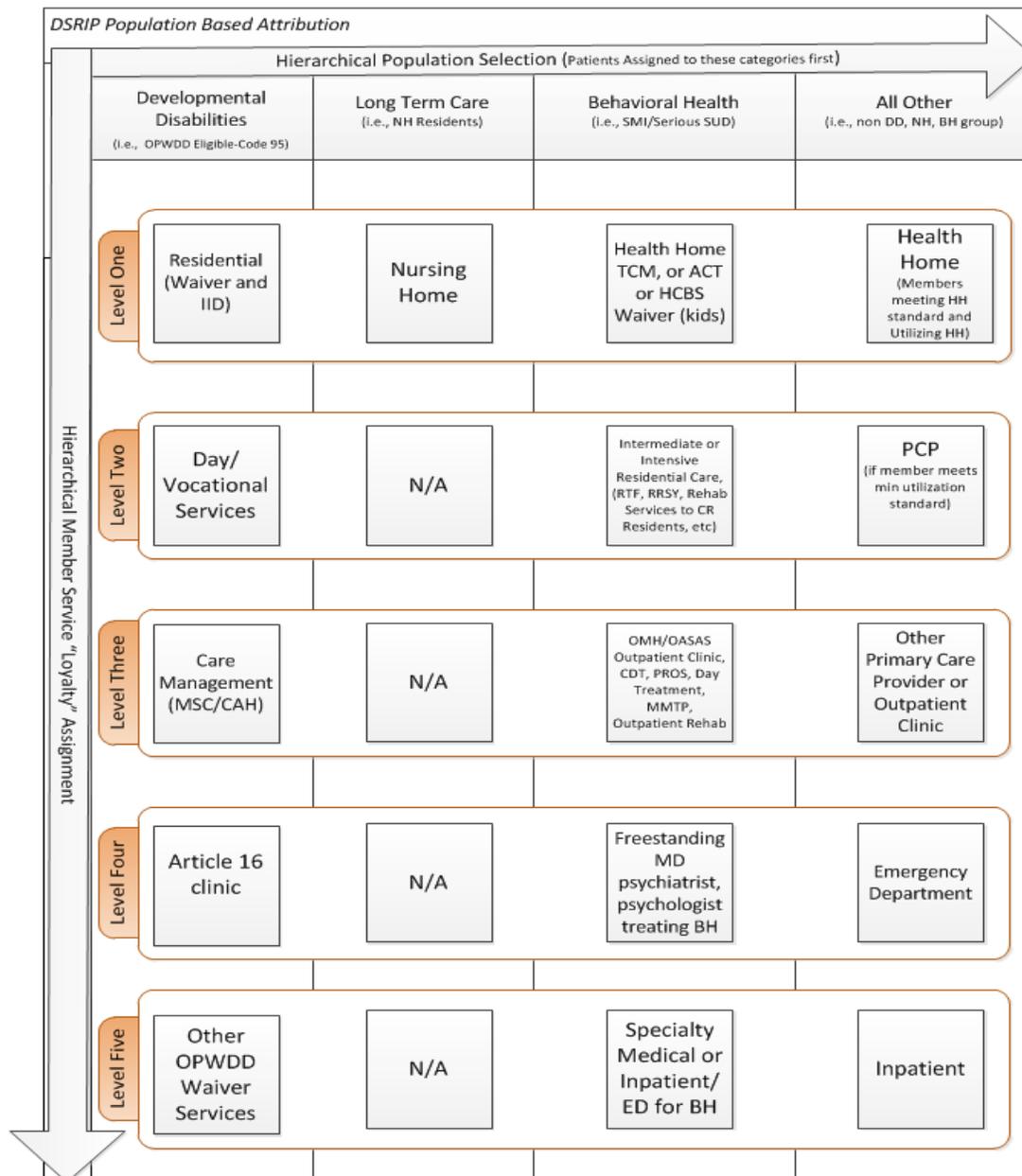
6. Q: How are members attributed when there is more than one PPS in a defined region? (Revised 8/28/2015)

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

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

A: Recipient loyalty is assigned based on a patient’s claim and encounter data to a specific provider in a PPS network based on a hierarchy of the population categories and their specific attribution logic. A patient is attributed to a category (DD, LTC, BH, All Other) based upon the hierarchy of population categories. A patient is attributed to the first category they have a claim in based on the category

hierarchy logic. Once attributed to a population category, the patient will then be assigned to a specific population subcategory. Patients are assigned to a specific subcategory based on a subcategory hierarchy logic (similar to the process that matched patients to a category). A patient is attributed to the first subcategory category they have a claim in (based on the subcategory hierarchy logic). The DSRIP loyalty logic hierarchy flow chart proceeds. If the patient has claims in the same category bucket that is tied to a provider(s) in two different PPS, the tie-break logic will be used to assign the patient.



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

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

Tie-break level 1:

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

Tie-break level 2:

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

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

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

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

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

10. Q: What is the DSRIP measurement population?

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

11. Q: If attribution valuation is a part of the PPS application approval done in DSRIP Year 0, what happens if a PPS greatly expands during the DSRIP program? (Revised 8/28/2015)

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

Project Plan & Support Team

1. Q: Do we need to submit a DSRIP Project Plan application? If so, when is it due? (Revised 8/28/2015)

A: Yes, submission of a formal DSRIP Project Plan was the final step in the DSRIP application process. Performing Provider Systems needed to submit their Project Plans to the state by December 22, 2014. This application process is now closed. The Final DSRIP Project Plan Application was submitted electronically through the DSRIP/Health Home Portal.

2. Q: What needs to be contained in the DSRIP Project Plan? (Revised 8/28/2015)

A. The DSRIP Project Plan provided rationale for project selection including target population, strategies, specific milestones, goals, how project will change the system, how stakeholders are engaged in the process; description of project activities including outcome metrics; and justification of the project funding, including a detailed project specific budget.

Finalized versions of the DSRIP Project Plan application and Review Tool were made available on November 14, 2014. These documents indicated precisely what needed to be included in the DSRIP Project Plan, as well as how the Project Plans would be evaluated and scored.

3. Q: Was there help available to assist providers with completing the DSRIP Project Plan application? (Revised 8/28/2015)

A: New York hired a contractor, KPMG, to serve as the DSRIP Support Team (DST). The role of the DST was to help Performing Provider Systems with technical assistance in developing their DSRIP Project Plan. In addition, the state allocated a portion of the DSRIP funding to assist Performing Provider Systems with their DSRIP Project Plan development in the form of DSRIP Project Design Grants. Project Design Grant awards were made on August 6, 2014 to 42 of the Emerging PPS. Some PPSs merged and there were ultimately 25 PPSs that submitted Project Plan applications on December 22, 2014. More information on these awards can be found here:

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

Funding from these design grants was used to prepare the DSRIP Project Plan application for participation in DSRIP. Recipients of these awards were expected to submit a DSRIP Project Plan application.

4. Q: Could a group of providers come together and submit a DSRIP Project Plan even if they did not apply for the Project Design Grant? (Revised 8/28/2015)

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

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

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

5. Q: Were there any signed Attestations required for the DSRIP Project Plan? (Revised 8/28/2015)

A: Yes. Project Plan Application Attestation: The lead PPS partner submitted an attestation statement documenting that the information provided in the Project Plan application was accurate at the time of submission and that the PPS, if accepted into the DSRIP program, would 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 also provided a description of the IGT source identified for the project and attest that this IGT derives from local, public funds.

6. Q: What type of clinical information was required in the DSRIP Project Plan application, if any? (Revised 8/28/2015)

A: Since DSRIP is about system transformation, it is important for performing provider systems to identify the most critical structural and clinical issues in their service area that affect their performance as a system. In essence, the Performing Provider System needs more information than just clinical information to develop a successful application.

Performing Provider Systems needed to complete a current community health assessment including population demographics, types and numbers of medical, behavioral health and community service providers and services, cost profile, designation as Health Professional Shortage Area, mortality and morbidity statistics, and health disparities. Refer to the Community Needs Assessment Guidance and associated webinars for additional specifics (link below). The state assisted Performing Provider Systems by providing a significant amount of this information through the DSRIP Performance Data site (link below, respectively). Providers should not rely on community needs assessments required for hospitals as these will not provide the breadth of information required in DSRIP.

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

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

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

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

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

8. Q: What qualifies as capital under the budget section of the DSRIP Project Plan application? (Revised 8/28/2015)

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

Project Plan Assessment

1. Q: What is the role of the Independent Assessor? (Revised 8/28/2015)

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

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

2. Q: Has the Independent Assessor been selected? (Revised 8/28/2015)

A: The state announced the award of DSRIP Independent Assessor procurement to Public Consulting Group (PCG) Inc.

3. Q: How were the submitted DSRIP Project Plan applications reviewed and evaluated for selection? (Revised 8/28/2015)

A: The state developed a standardized application review tool that the DSRIP Independent Assessor used to review DSRIP Project Plans and to ensure compliance with all terms, conditions and protocols agreed to between CMS and the state. The application and review tool (which included a project scoring guide) were made available for public comment for a 30-day period on September 29, 2014; the application was revised based upon public comments received. The application and review tool was approved by CMS in November, 2014 and finalized versions were posted to the DSRIP site on December 3, 2014. The review tool defined the relevant factors, assigned weights to each factor, and included a scoring for each factor. Each factor addressed the anticipated impact of the project on the Medicaid and uninsured populations consistent with the overall purpose of the DSRIP program.

After DSRIP Project Plans were submitted by Performing Provider Systems on or before December 22, 2014, the Independent Assessor conducted an initial screen to ensure that they met the minimum submission requirements. The Independent Assessor notified the Performing Provider System in writing of any initial questions or concerns identified with the provider’s submitted DSRIP Project Plan and provided a 14-day period for Performing Provider Systems to address these concerns. All submitted DSRIP Project Plans were posted for a 30-day public comment period.

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

The Independent Assessor then forwarded the panel's recommendations to the New York State Commissioner of Health regarding approvals, denials, or recommended changes to Project Plans. The Commissioner then had the opportunity to accept or reject the panel's recommendations. Any deviations from the Independent Assessor's recommendations needed to be explained to, and approved by, CMS, which maintain its own monitoring process of these reviews.

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

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

Also, if a DSRIP PPS has not successfully met its milestones, modifications may be allowed with the approval of the state and CMS. Based on the information contained in the Performing Provider System's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation.

DSRIP Project Valuation

1. Q: What is DSRIP Project Valuation? (Revised 8/28/2015)

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

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

2. Q: What is a Project Index Score? (Revised 8/28/2015)

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

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

3. Q: Can the State provide a calculation example for a DSRIP Project Plan Valuation? (Revised 8/28/2015)

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

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

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

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

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

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

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

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

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

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

DSRIP Reporting & Payments

1. Q: How will PPSs be assessed with regards to pay for reporting measures, and what are they required to report on? *(Revised 8/28/2015)*

A: In cases where the measure type is Pay for Reporting (P4R), Performing Provider Systems can earn incentive payment for successfully reporting the measures the PPS is responsible for reporting to NYS DOH within the timeframes for each Measurement Year (MY). Some of these measures are claims-based, while others will require medical records review and chart abstraction. Measures which are DOH responsibility for reporting will be credited to the PPS in P4R situations based upon Medicaid claims and other population health measures. All Domain 4 measures are P4R for the entire DSRIP Project period and it is expected that PPS will earn all AVs in Domain 4 due to limited PPS responsibility in measure reporting. Domain 2 and 3 measures that are P4R during the initial project years convert to P4P over the course of the DSRIP initiative. The details on the P4R measures can be found in the DSRIP Measurement and Reporting Manual, as well as in Attachment J in the official CMS waiver documents.

2. Q: Can you please clarify how Domain 4 projects will be evaluated against their requirements? Do all requirements have to be met for all collaborators for Domain 4 projects? What are PPSs reporting on in Domain 4? *(New 8/28/2015)*

A: Domain 4 is meant to enhance community collaboration regarding population health. DOH entities already have active initiatives aligned with Domain 4 projects, so PPS should look to join in these efforts. Domain 4 requirements are all self-reported per milestones communicated in the PPS application. Similar to the Domain 2 and 3 projects, PPSs will be expected to update progress at a project-wide level via Quarterly Reports in MAPP.

The Domain 4 Reference Guide has been released to PPSs. The "Reference Guide for DSRIP Domain 4 Projects Implementation Planning" was created by the NYS DOH Office of Public Health (OPH) and Office of Health Insurance Programs (OHIP). This document is part of the ongoing series of webinars and documents intended to help guide PPS through their project planning and implementation process. The purpose is to provide considerations on evidence-based project activities, milestones and metrics, and resources that PPS may choose to incorporate into their implementation planning efforts for DSRIP projects within Domain 4.

3. Q: Can a PPS budget be modified in future reporting periods? *(New 8/28/2015)*

A: Budget projections for each DSRIP year need to be finalized within the DY1 Q1 Quarterly Report submission. Changes will only be allowed under extenuating circumstances; however, PPSs will have the opportunity in the reporting structure to explain variations.

4. Q What Domain 1 Achievement Values is the PPS held accountable to in DY1? *(New 8/28/2015)*

A: DY1 Q2 is based on 6 AVs that come from the Governance, Workforce, Cultural Competency/Health Literacy, Financial Sustainability/Quarterly Progress Reports/Project Budget & Flow of Funds and Patient Engagement Speed measures. DY1 Q4 will include these same AVs. The AV for workforce prior to the updates will be based on organizational updates and work plan steps.

5. Q: Will PPSs be required to submit lists of participating providers for each project? (New 8/28/2015)

A: PPSs will be required to identify the network providers that will be participating in each project as part of the October quarterly reporting process (due October 31, 2015). The number of total providers listed in each category must match the scale and speed table commitments from the PPS's DSRIP application.

6. Q: For tracking patient engagement, will the Independent Assessor (IA) audit the PPS or the specific provider? (New 8/28/2015)

A: PPSs are required to submit supporting evidence that demonstrates active engagement based on application commitments. The IA reserves the right to audit any evidence of achievement towards active engagement commitments.

7. Q: How will "actively engaged" be tracked and reported? (New 8/28/2015)

A: It is the PPS's responsibility to track actively engaged patients. The Independent Assessor can audit actively engaged patients as part of program oversight.

8. Q: Will a PPS receive any extra financial benefit if they accelerate their timeline for Domain 1 AVs and achieve the AV sooner? (New 8/28/2015)

A: PPSs were rewarded for aggressive commitments to project speed and scale in the scoring of the application and the valuation process. There is no additional financial performance award for Domain 1.

9. Q: If project speed is met early, how is the AV determined and what is the impact on PPS payments? (New 8/28/2015)

A: The PPS becomes eligible for the high performance fund, and that AV becomes non-applicable for all periods after the measure was met.

10. Q: How are PPSs held accountable to the quarterly reports for those that do not drive payment, since the payoff is associated with every other report (at six month intervals)? (New 8/28/2015)

A: How the PPS fares on the reports that drive payment will be the determining numbers for payments. The quarterly reports that do not drive payments directly will be evaluated by the Independent Assessor for completeness. The Independent Assessor has indicated that unsatisfactory quarterly reports (also in non-payment times) may still have an effect on performance payments, depending on the severity of the assessed gaps.

11. Q: In what quarter will PPSs report on major system change requirements that are required to take no more than the first two years? (New 8/28/2015)

A: PPSs will report on this for DY2 Q4, which is the quarter ending March 30th, 2017.

12. Q: For the workforce milestone that requires documentation of a compensation and benefit analysis report, signed off by PPS workforce governance body, subsequent quarterly reports will require an update on the implementation of your workforce transition roadmap, including updates on compensation and benefits. What is required in these updates, and will the PPS

have to do this update every quarter or is it sufficient if, once the analysis is complete, they then they just report on progress? (New 8/28/2015)

A: The PPS needs to be sensitive to changes and able to accommodate for changes in their analysis when necessary. If none of the starting premises is altered, then it is unlikely that the analysis has to be updated, and an update on progress will likely suffice.

13. Q: Will providers be required to submit data and/or progress reports? If so, how often and will it be required to be submitted in a secured manner? (Revised 8/28/2015)

A: Providers will be required to submit progress reports quarterly. The reports will be submitted using the standardized reporting form in MAPP approved by the state and CMS.

14. Q: How will the State evaluate the providers' DSRIP project data after it is collected and submitted? (Revised 8/28/2015)

A: Upon the approval of each DSRIP Project Plan, project specific metric baselines will be identified. In addition, the target high performance goal for each metric will be established. From those baselines, PPSs will have to reach the pre-defined goal/benchmark targets in given metrics. Some metrics will be met based upon reporting specific data; some metrics will be met based upon actual progress to a predefined goal. This predefined goal will generally be closing the gap between current PPS performance and the statewide goal. More information on these targets and calculations can be found in the DSRIP Measure Specification and Reporting Manual, available on the DSRIP website.

15. Q: Are DSRIP payments tied to the performance of the Performing Provider System? (Revised 8/28/2015)

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

16. Q: What is the difference between a Process Milestone and an Outcome Milestone?

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

17. Q: What are the criteria for achieving incentive payments? (Revised 8/28/2015)

A: At least two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form in MAPP approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The Performing Provider System shall have available for review by the state or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones.

Incentive payments will be calculated based upon the progress of process milestones/metrics and outcome milestones/metrics. The value of each type of metric type is noted below. As the projects progress, less payment will be allocated to process milestones/metrics and more will be allocated to

outcome milestones/metrics. Some payments will be based on submitting required reporting only (Pay for Reporting) and others will be based on attaining specific outcome targets (Pay for Performance). Please note that the DSRIP performance payment distribution (highlighted in the chart below) for the duration of the DSRIP program is based on the overall application value, not the valuation of individual projects.

Metric/Milestone Domains 2	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%	48%	70%	91%
	P4R	20%	40%	12%	10%	9%

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

Metric/Milestone Domain 3	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%
Clinical Improvement Milestones (Domain 3)	P4P	0%	24%	50%	69%	87.5%
	P4R	20%	16%	10%	11%	12.5%

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

Metric/Milestone Domain4	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%
Population health Outcome Milestones (Domain 4)	P4R	20%	40%	60%	80%	100%

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

18. Q: How does the State's High Performance Fund work? (Revised 8/28/2015)

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

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

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

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

19. Q: Will the State provide tools, baseline/benchmark data, and progress & feedback report educational materials to providers? (Revised 8/28/2015)

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

- As noted earlier, the state awarded DSRIP Project Design Grants to assist PPSs in planning their projects.
- The state deployed a DSRIP Support Team, KPMG, throughout the state to help emerging PPSs in their planning efforts.
- The state is developing a number of data resources for the Performing Provider Systems. Initially, these data resources were static data books. More recently, the state unveiled its web-based performance dashboards with drillable data on member counts by region and baseline performance data.
- The state launched a performance portal that allows PPSs access to current metrics based upon data in the Medicaid Data Warehouse and supported by the analytical capabilities of Salient® software.
- The state will support regular learning collaboratives throughout the duration of the DSRIP program. The Learning Symposiums, which will be a required activity for all Performing Provider Systems, will be organized either geographically, by the goals of DSRIP, or by the specific DSRIP projects. The 1st of these meetings will be held in Westchester County on September 17th & 18th, 2015.

20. Q: What are the intergovernmental transfer (IGT) risks for public providers?

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

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

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

22. Q: What is the role of Managed Care Organizations in DSRIP? (Revised 8/28/2015)

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

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

In the future state, meaning the NYS health system after the DSRIP program, managed care companies will pay PPSs directly for a portion of the care on a PMPM basis for the people whose care the PPS is responsible for maintaining. This future state would be a true value and performance based health care system where silos across the health system have been broken down and where shared accountability exists at the provider level. The MCO payments to PPS would include not only traditional health care

providers, but other non-traditional providers that impact health outcomes (like supportive housing providers).

The Department's Value-based Payment roadmap was approved by CMS July 22, 2015:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/vbp_reform.htm

IT Communications & Investments

1. Q: Is the State working with and/or endorsing specific external IT vendors? (New 8/28/2015)

A: The state is not working with any external vendors at this time. There will be data feeds of member files and claims data initially. The PPS will need to take those files and feed them into their software and work with their own software vendor to meet their needs. In the latter part of the year, the same data will be available in MAPP and the PPS can work with their own IT vendor regarding how to pull the data to populate their own system for the PPS to use.

2. Q: When will Quarterly Reports go live in the MAPP tool? (New 8/28/2015)

A: MAPP Quarterly Reports were scheduled to go live on July 1, 2015; Q1 reports were initially due July 31, 2015, but was pushed back to August 7th to address technical issues with MAPP. For consistency, formatting has been kept as close as possible to the June Implementation Plan, and training documentation and webinars were made available to the public.

3. Q: What are the State's expectations around the implementation of EHR or other IT platforms being integrated into CBOs? Will interoperability and real time notification be expected at these locations? (New 8/28/2015)

A: Connectivity between providers is a key component to the DSRIP program, as it will better serve the population. It is expected that, where needed, the PPS will support CBOs to connect to the integrated network of care.

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

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

5. Q: Does the state offer support for IT investments that are needed to help achieve real-time secure data sharing and clinically integrated network formation? (Revised 8/28/2015)

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

Workforce Strategy

1. Q: Is there a plan for care management agencies to grow to meet the demand for care management under DSRIP? (Revised 8/28/2015)

A: Yes. There is a plan for care management agencies to grow to meet demand under DSRIP program. The overarching DSRIP goal of a 25% reduction in avoidable hospital use (emergency department and admissions) will result in the transformation of the existing health care system - potentially impacting thousands of employees. This system transformation will create significant new and exciting employment opportunities for appropriately prepared workers. PPS Project Plans must identify all impacts on their workforce that are anticipated as a result of the implementation of their chosen projects, as well as a workforce plan for repurposing jobs that will free up as we lower avoidable hospitalization.

One clear area to repurpose those jobs will be to care management. Training and outreach for care management will be needed. The state is working with health homes to have them staff up for the demands of DSRIP, HARPs, and the community transition activities related to Olmstead.

Health Home Infrastructure

1. Q: Previous communication from the state indicated that significant funding was planned to enhance the existing health home infrastructure. What is the current status and plans for infrastructure build out? (Revised 8/28/2015)

A: \$190.6M is available under the MRT waiver to fund health home infrastructure (i.e., member engagement, staff training/retraining, HIT implementation and joint governance/start up).

These funds will be distributed through an add-on to the health home care management fee. Before the state can implement the add-on, it must receive approval from CMS for an amendment to the Medicaid State Plan. The state is actively working with CMS on this state plan.

Additional DSRIP Funds (New 8/28/2015)

1. Q: Will performance standards be the same for the High Performance Fund and the Safety Net Equity Fund? (New 8/28/2015)

A: No. The High Performance fund is based on a percentage of exceeding project metrics and benchmarks. The Safety Net Equity fund is intended to address inequity for Non-Public, Safety Net PPSs with lower performance PMPMs due to the attribution for valuation logic.

2. Q: Will the Safety Net Guarantee payments be equally spread across the 5 years or be held to the same percentages as the project revenue spread over the 5 years? (New 8/28/2015)

A: The payments will be equally spread across the 5 years.

Data Sharing and Security (New 8/28/2015)

- 1. Q: Can the Department provide examples of allowable secure transmission mechanisms that would allow PPSs to share PHI with downstream providers, including smaller providers? (New 8/28/2015)**

A: PHI cannot be shared with any downstream providers until the Security Assessment Affidavit is completed, previous data has been destroyed or returned with DEAA Attachment C finalized, and the opt-out process has completed. Any downstream providers receiving PHI from the PPS Lead Entity (PPS Lead) need to have Business Associate Agreements in place. The provider agreements may be specific to the PPS project selection.

- 2. Q: Assuming encrypted files could be transferred, would every recipient downstream provider need to meet the same “local server” requirements? (New 8/28/2015)**

A: After the Security Assessment process is completed and the Affidavit approved by the Department, and following opt-out, your downstream providers may receive encrypted files with the same protections required of the Lead on their own local servers. Currently, before the Security Assessment, data destruction and opt-out process is finalized, no PPS Lead may transfer encrypted files to downstream partners. The PPS Lead and any downstream providers receiving data are expected to be compliant with the applicable NYS policies and standards, which are provided in the following link:

<https://www.its.ny.gov/eiso/policies/security>

- 3. Q: What does the Department mean by “remotely sharing PHI data with respect to the Lead Entity?” (New 8/28/2015)**

A: Remote sharing refers to not being in the same physical location on the same physical network. The server used needs to be physically cabled to the workstation containing PHI data. This excludes the use of WiFi.

- 4. Q: Are PPSs outsourced I.T. systems or any other PPS vendor with whom significant PPS I.T. assesses reside considered “downstream partners” and cannot receive PHI? (New 8/28/2015)**

A: Yes. According to the DEAA Addendum they are considered downstream partners.

- 5. Q: CMS through the MSSP program allows dissemination of data to partners such as vendors who are remotely hosted (cloud service) if they are certified with a Data Use Agreement, are there options such as this offered in terms of data sharing within DSRIP? (New 8/28/2015)**

A: Until the Security Assessment, data destruction and opt-out process have completed, no remotely hosted vendors are permitted to access the data, including cloud providers. After opt-out has completed, the Security Assessment Affidavit will still need to be completed on those partners using a cloud service.

- 6. Q: Should the PPS Lead chose as the data storage center consider designating a secure server for the process of receiving PHI? (New 8/28/2015)**

A: Yes. A secure server is necessary to store PHI data. The server must be located in a secure data center, on a secure network and access to the server must be protected with least-privileged access controls. The server should also encrypt data at rest.

7. Q: Can a RHIO named on the PPS DEAA download the files on behalf of a PPS? (New 8/28/2015)

A: They are still considered a subcontractor to the PPS Lead Entity, so the same data sharing restrictions apply as they would to any other PPS non-lead entity.

Data Sharing for New Corporation (NewCo) (New 8/28/2015)

8. Q: Is a NewCo required to store data at one of the co-lead locations, or can the NewCo set up a secure server to store data compliant with all policies and laws? (New 8/28/2015)

A: The NewCo PPS is subject to the same restrictions as non-NewCo PPS. Before the Security Assessment Affidavit is completed and approved, the PHI data must be stored at rest at a co-lead location on a secure server. The data cannot be stored on a remotely hosted server. Follow the guidance in the DEAA Addendum and Security Assessment Affidavit.

9. Q: Can the Department offer guidance to those NewCos that may consist of multiple partners, which are considered equally contributing to the composition of the NewCo. (New 8/28/2015)

A: The Department is actively working on creating an Amendment to the DEAA to acknowledge the multiple founding entities of the NewCo and recognize them as co-lead partners. However, access to data will remain restricted prior to the completion of the Security Assessment Affidavit and opt-out process. More information on NewCos and data sharing will be released shortly, and in the interim NewCo PPSs should follow the same procedures that have been outlined in the DEAA and DEAA Addendum.

Opt-Out Process (New 8/28/2015)

10. Q: What is the opt-out process? (New 8/28/2015)

A: The opt-out process refers to the DSRIP consent process where unless the Medicaid member formally opts-out of DSRIP data sharing, they are considered participating in data sharing. To “opt-out” means electing NOT to permit the sharing of PHI and other Medicaid data held by the Department to the PPS and its partners. DSRIP Performance measures will include opt-out members in the numerators and denominators, but drill-down information to these members will not be available. Members can opt-in or out of data sharing at any time.

11. Q: What is the status of those Medicaid beneficiaries who do not respond to the opt-out? (New 8/28/2015)

A: Medicaid beneficiaries are considered opted-in to PPS data-sharing unless they call the Medicaid Call Center to opt-out or return the opt-out form.

12. Q: How will the PPSs be notified of Medicaid members who do not want their data shared? (New 8/28/2015)

A: There will be no official notice. Those members who have selected to opt-out of DSRIP data sharing will not be refreshed in subsequent releases of the Member Roster files.

13. Q: Can the Department share the letter with the PPSs to educate their beneficiaries? (New 8/28/2015)

A: Yes. The letter will be shared with the PPSs after it has been finalized. The Department is working towards finalizing the opt-out letter mailing out in August.

Claims Data (New 8/28/2015)

14. Q: If we are to get claims data for all attributed patients, does that mean the PPS Lead will know which patients are attributed to the PPS? How will new Medicaid members be reflected? (New 8/28/2015)

A: Member rosters and claims data received by a PPS will reflect that PPS' attributed lives. The PPS receives all Medicaid claims for members within their PPS. If a member is not eligible for Medicaid on the day the extract is run the members won't be included in that claims file.

15. Q: What patient information is included in the claims? (New 8/28/2015)

A: MAPP will provide both a Member roster and a claims extract file to the PPS. The Member roster will provide a list of members attributed to the PPS and for each member include the member's name, birthday, member's county code, member address, member contact number, member's Medicaid identification number and gender. The claims extract file will provide a list of claims for the attributed members and will include the following PHI info on the member: member's name, birthday, member's county code, member's Medicaid identification number and gender.

16. Q: How will this claims data affect the data in Salient? Will there be PHI in Salient data? (New 8/28/2015)

A: The Department intends to provide PHI through Salient Interactive Miner (SIM) and Salient Performance Dashboards to the PPS' for authorized users. Salient is working with the Department to determine the requirements necessary for PHI views in SIM and develop a timeline for access. SIM and Performance Dashboards will not expose member level data for members who have opted-out. PPS users will still have the ability to view performance measures at the PPS (summary) level that include members who have opted out. No drill down to opted out members will occur.

Medicaid Analytics Performance Portal (MAPP) & 2-Factor Authentication (2FA) (New 8/28/2015)

17. Q: Are there any other ID's that will be accepted in lieu of a NYS DMV issued identification? (New 8/28/2015)

A: Currently, other means of identification will not be accepted to access MAPP when a 2FA login is deployed. This is because 2FA is tied to the NYS DMV vetting database. The Department is working to build both a PHI and a non-PHI view, however a timeline has not been released for this future development.

18. Q: Will the Department expand MAPP user slots per PPS? (New 8/28/2015)

A: Not at this time. The Department expanded the MAPP user slots available to each PPS in the recent past (June 4, 2015). If a PPS requires an update to understand their current MAPP users they may request this information via the DSRIP email address: dsrip@health.ny.gov

19. Q: Will MAPP permit exports of the list of patient data including PHI for leads and partners in the fall after 2FA is added? (New 8/28/2015)

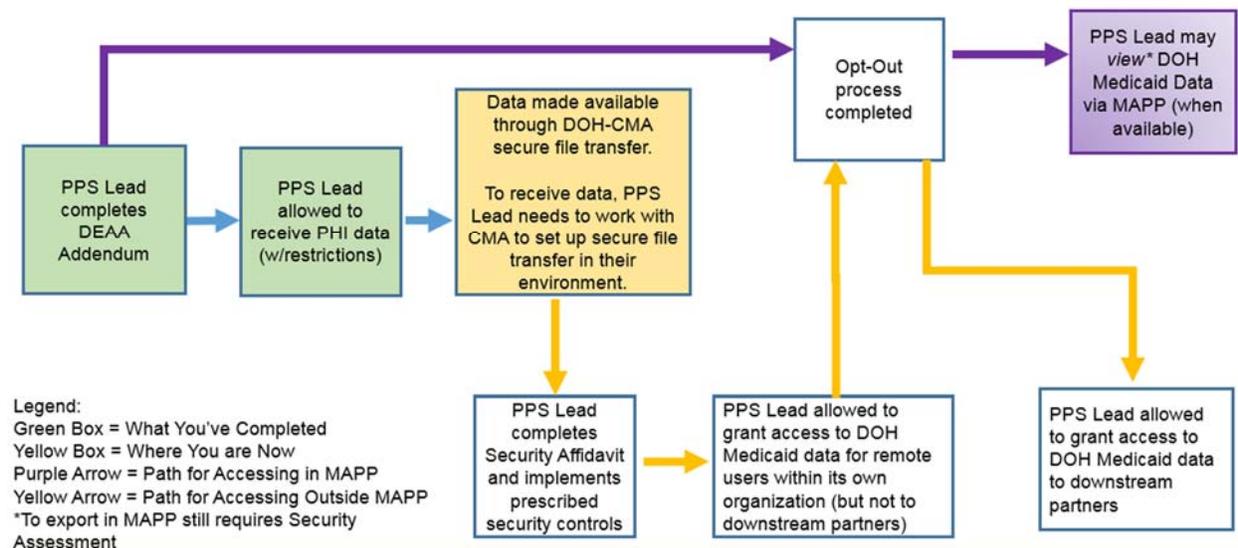
A: Yes. MAPP will have the capability to allow exports of PHI data from MAPP for **authorized** users and also allow view only access to patient data based on our Performance Module dashboards. Any MAPP user who requests export ability of PHI in MAPP will be considered a point of access within your PPS requiring execution of the Security Assessment procedure and Affidavit, and proceeds the opt-out process. PPSs granting view-only access to patient data within MAPP will not be required to complete a Security Assessment for those MAPP users approved for this access by their Gatekeepers.

Other Topics (New 8/28/2015)

20. Q: How do the definitions here apply to modern bulk or virtual storage pools such as NAS/SAN disk arrays? Is the use of commercial or certified secure deletion programs an allowable “Purge” option? (New 8/28/2015)

A: Should a NAS/SAN disk array be shared with other servers, the host server should implement an encrypting file system on its NAS/SAN volume, to protect the data at rest, wherever it may reside in the array. NYS standards at the following link address methods and tools to securely erase sensitive data, such as PHI: <https://www.its.ny.gov/eiso/policies/security>

Process Flow for Release of DOH Medicaid Data



Appendix: Archive of out-of-date questions (*new 8/28/2015*)

Interim Access Assurance Fund (IAAF)

1. Q: What is IAAF?

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

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

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

3. Q: Who qualified to receive IAAF funding?

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

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

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

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

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

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

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

7. Q. How does IAAF funding affect a PPS’s applicant status?

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

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

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

Performing Provider Systems

1. Q: As a partnering provider, what happens if the emerging PPS I choose to join did not receive approval to operate a PPS? Am I going to be left out of DSRIP? (Revised 8/28/2015)

A: The State has worked proactively to provide planning resources to PPS so that they had a thorough understanding of what was expected in, as well as the means to create, a thorough/approvable Project Plan Application. These resources included, but were not limited to, the state's launch of a DSRIP Support Team in addition to planning funds via DSRIP Design Grants. Furthermore, the State published a draft of the applicant scoring tool in September 2014, so applicants could see the metrics which their application will be scored against.

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

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

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

Project Advisory Committee

1. Q: How should Project Advisory Committee representatives chosen?

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

1. Organizational representatives:
 - a. Emerging PPS partners with more than 50 employees are required to have an organizational (managerial) representative participate in the PAC.
 - b. Emerging PPS partners with less than 50 employees have the option of selecting an organizational (managerial) representative to participate in the PAC.
2. Worker representatives:
 - a. Partner organizations that are not unionized and have over 50 employees must develop a process to elect a worker (non-managerial employee) representative to participate in the PAC.

- b. For non-unionized partner organizations with less than 50 employees, the employees have the option of electing a worker (non-managerial employee) representative to participate in the PAC if they so choose.

3. Union Representatives:

- a. Partner organizations that are unionized and have over 50 employees must designate a union representative to participate in the PAC. If a particular union represents workers from multiple emerging PPS partners, one representative from that union is sufficient to satisfy PAC requirements.
- b. For unionized partner organizations with less than 50 employees, the union has the option of designating a union representative to participate in the PAC if they so choose.

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

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

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

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

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

Suggested Structure:

- i. To maintain a manageable and effective PAC, the State recommends alternative PAC structures be divided into a smaller Governing Committee that will work in conjunction with unrestricted sub-committees.
- ii. Governing and sub-committee members should be selected from within the larger pool of representatives that would have been generated based on the standard PAC formation process.
- iii. The Governing Committee should:
 - a. consist of no more than 25 members
 - b. represent key partners proportional to the number of Medicaid patients they serve
 - c. represent key labor organizations proportional to the number of workers represented
 - d. be regionally representative
 - e. include subject-matter experts
- iv. Sub-committees may be organized according to scope of care, project domains, or other method which achieves adequate stakeholder representation, partner collaboration, and comprehensive oversight of DSRIP initiatives.
- v. The PPS must explicate how the Governing and sub-committees will collaborate within the PAC structure.

Further Considerations:

- i. When forming an alternative PAC structure, the PPS should consider the following:
 - a. The PAC should include sufficient representation from partners who serve the greatest proportion of the Medicaid population.

- b. The PAC should include sufficient representation from all safety net providers.
- c. The PAC should include sufficient representation from Behavioral Health partner organizations to suitably align with DSRIP goals.
- d. The PAC should be demographically and geographically representative of the community served by the PPS.
- e. The PAC should facilitate engagement with frontline staff and non-partner stakeholders (e.g., community members).
- f. There should be occupational diversity within the PAC (e.g., include both administrators and practitioners).

Letter of Intent & Project Design Grant

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

A: The letters of intent served two main purposes:

1. To help entities interested in participating in DSRIP to become aware of one another. Every letter of intent (including their list of their partners) has been posted online and categorized by region: https://www.health.ny.gov/health_care/medicaid/redesign/dsrp_loi_received/

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

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

2. Q: Is there funding available to help with 'start-up' activities?

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

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

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

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

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

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

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

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

Project Plan & Support Team

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

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

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

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