New York’s Pathway to Achieving the Triple Aim
Better Care, Better Health, Lower Costs

Reducing Avoidable Hospital Use through Delivery System Reform

New York’s Medicaid Redesign Team Waiver Amendment
Delivery System Reform Incentive Payment (DSRIP) Plan
# TABLE OF CONTENTS

I. Transforming the Health Care Safety Net and Reducing Avoidable Hospital Use in New York State.................................................................3
   A. DSRIP Purpose/Background..................................................................3
   B. MRT Implementation to Date.................................................................4
   C. MRT DSRIP – The Needs Case.............................................................6

II. DSRIP Goals and Performance Metrics..................................................9

III. DSRIP Focus Areas and Programs.........................................................10

IV. DSRIP Eligible Providers........................................................................13

V. DSRIP Project Plan Submission Requirements .......................................14

VI. DSRIP Project Review and Approval Process .........................................17

VII. DSRIP Project Timetable.......................................................................20

VIII. DSRIP Performance Management and Monitoring..............................21
   A. DSRIP Performance Management......................................................21
   B. DSRIP Learning Collaboratives.........................................................22
   C. Data Collection..................................................................................23
   D. Managed Care Plans and DSRIP Project Performance.....................25

IX. Disbursement of DSRIP Funds...............................................................26
   A. Project Valuation..............................................................................27
   B. Performance Payment Methodology..................................................28

X. DSRIP Further Improvements Post-Waiver............................................32
APPENDICES

A. DSRIP Programs List ........................................................................................................................................33

B. DSRIP Program Descriptions..........................................................................................................................34

C. Medicaid Redesign Team and Waiver Amendment Stakeholder Engagement ..............................................83
MRT DSRIP:  
PATHWAY TO ACHIEVING THE TRIPLE AIM  
_Transforming the Health Care Safety Net and Reducing Avoidable Hospital Use in NYS_

**DSRIP Purpose**

New York seeks a five year waiver amendment to fundamentally restructure the New York State health care delivery system by building on progress already underway from the state’s Medicaid Redesign Team (MRT). As a central component of MRT going forward, the MRT DSRIP plan proposed in this document will reinvest federal savings already produced by MRT initiatives into a series of critically needed performance capacities and delivery system reforms to further achieve the Triple Aim. The ultimate goal of this plan is to reduce avoidable hospital use by 25%.

**Background**

In January 2011, New York State began a historic march toward fundamentally reforming its Medicaid program. After years of political in-fighting and policy drift, Governor Cuomo changed the game by asking a diverse set of stakeholders to develop a plan to fundamentally restructure the nation’s largest Medicaid program.

Governor Cuomo’s Medicaid Redesign Team accomplished its mission. It developed a historic multi-year action plan that now has New York’s Medicaid program on a path toward achieving the Triple Aim: _better care, better health and lower costs_. At the heart of the plan lies the notion that you can achieve the Triple Aim by ensuring that all Medicaid members access the most appropriate care in the most appropriate setting. This in turn is achieved by effectively managing care with special emphasis on the populations that are poorest served by the current “siloed” health care delivery system. These are the individuals who tend to fall between system cracks, utilize services inefficiently or not at all, experience diminishing quality of life and drive overall Medicaid costs. MRT is about fundamentally changing, for the better, the health care experience for these individuals which in turn will make the program affordable for state and federal taxpayers.

The MRT understood there is no single “silver bullet” solution to achieving the Triple Aim in New York Medicaid. Rather the plan includes more than 200 different initiatives that, in aggregate represent the most sweeping overhaul of New York’s Medicaid program in state history. Virtually no part of the program remains unaffected.
While the plan is broad and comprehensive, it does rely heavily on five core strategies. These strategies are:

- **Care Management for All:** All Medicaid members will be enrolled into comprehensive, fully integrated managed care plans. Those plans will continue to be held accountable for providing high quality of care, as well as for fundamentally changing the incentives in health care delivery by using payment reform to reward value over volume.

- **Global Spending Cap:** State share Medicaid spending is now capped and is allowed to rise annually at the rate of medical inflation. This innovation has fundamentally changed how the program is managed and has brought tremendous transparency to the nation’s largest Medicaid program.

- **Health Homes:** Traditional managed care is not enough for many high needs Medicaid members. Health Homes go beyond the federal requirements and in New York are sophisticated multi-disciplinary networks of providers tasked with managing the care of high need individuals. Health Homes will, over time, evolve beyond care management and navigation to become Accountable Care Organizations (ACOs) specially built for high needs Medicaid members.

- **High Quality Primary Care for All:** The goal is that all Medicaid members will utilize high quality primary care. This is achieved by providing incentive payments to providers to become NCQA accredited, and eventually to go above and beyond those standards to address other issues, such as behavioral health integration through a more advance primary care model.

- **Address the Social Determinants of Health:** Many Medicaid members face life challenges that prevent them from managing their own health. Unless these challenges are addressed head-on improved health and lower costs will never be achieved. Under MRT, New York is a national leader in addressing social determinants of health such as the lack of affordable housing and health disparities through innovative solutions like the MRT Supportive Housing Program.

**MRT Implementation to Date**

New York is now almost three years into MRT plan implementation. No longer is the focus solely on what will happen, but rather on what is happening. The early results are impressive. For the first time in over a decade year-on-year Medicaid spending was reduced while maintaining eligibility rules despite growing numbers enrolling in the program during the recent economic downturn. In only its first full year of operation (CY2012), total spending was reduced by $4.6 billion, which has led to over $2 billion in savings for federal taxpayers. During this time New York Medicaid added 217,000 members in CY 2012, a 4.35 percent increase in enrollment.
In addition to cost containment success, important programs targeting quality improvement were successfully launched. One million additional Medicaid members are now utilizing NCQA accredited primary care providers and Health Homes are now available in almost every county in the state and are already delivering results. Over 121,000 members are receiving health homes services. Data from early Health Home enrollees suggest that the program is driving down both inpatient utilization and ER use. New York is truly on the move when it comes to reshaping its Medicaid program.
MRT DSRIP – The Needs Case

MRT has been a success, but there is much more left to do. Despite decreasing costs and improvements in care, there are fundamental structural problems facing New York’s safety net providers that put even basic health care access at risk in certain communities. If these underlying challenges are not addressed not only will it impact the ability to achieve New York’s MRT goals, but also the implementation of the Affordable Care Act (ACA) could be a disaster as existing access problems will be exacerbated for one million New Yorkers receiving health insurance for the first time.

At its core, New York’s safety net problem is an over reliance on institutional services (inpatient care, emergency room services and nursing home care) and under-reliance on community based services. This structural imbalance began during Medicaid’s early history and despite efforts such as the F-SHRP 1115 waiver and hospital/nursing home payment reform the system remains unbalanced.

The over reliance on institutional services has had a direct impact on quality in Medicaid. A 2009 Commonwealth Fund study found that New York ranked near the bottom when it came to avoidable hospital use. This outcome could be reversed if strategic investments are made with a special focus on re-balancing the delivery system to reduce avoidable hospital use.
In addition to quality impacts, state and federal taxpayers are harmed because of avoidable hospital use. A recent study found that in 2011, New York Medicaid spent almost $1.2 billion in avoidable inpatient utilization. In particular, the analysis found that up to 16% of all Medicaid hospital admissions could be avoided if systems of care around the state provided the right care in the right setting. In addition, the analysis found that nearly 60% of ER visits were avoidable which in turn added $230 million in unnecessary Medicaid costs to taxpayer burden.

When you consider that this analysis did not include costs to Medicare for dually-eligible Medicaid members, or the “down-stream” costs for things such as rehabilitation services, it isn’t a stretch to say that this kind of inefficiency could exceed $2 billion per year. If New York can find a way to reduce these avoidable services by 25% health care spending could be lowered by $500 million per year. If these avoidable services are cut in half savings to taxpayers could reach $1 billion per year. There is a clear fiscal case to be made that transformation is needed and that the focus must be on reducing avoidable hospital use.

**Total Number and Cost of Potentially Avoidable Hospitalizations for Medicaid (2011)**

<table>
<thead>
<tr>
<th></th>
<th>FFS Medicaid</th>
<th>Cost in Millions of Dollars</th>
<th>Percentage of Total Admissions</th>
<th>Managed Care</th>
<th>Cost in Millions of Dollars</th>
<th>Percentage of Total Medicaid Admissions</th>
<th>Total Cost of care in Millions of Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYC</td>
<td>60,009</td>
<td>$560</td>
<td>9%</td>
<td>35,728</td>
<td>$270</td>
<td>17%</td>
<td>$  830</td>
</tr>
<tr>
<td>Rest of state</td>
<td>29,226</td>
<td>$204</td>
<td>6.5%</td>
<td>19,208</td>
<td>$139</td>
<td>15%</td>
<td>$  344</td>
</tr>
<tr>
<td>Statewide</td>
<td>89,235</td>
<td>$765</td>
<td>8.25%</td>
<td>54,936</td>
<td>$409</td>
<td>16%</td>
<td>$1,174</td>
</tr>
</tbody>
</table>
In New York, delivery system rebalancing and reductions in avoidable hospital use will not occur smoothly on their own. In fact, quality improvement efforts launched by MRT further de-stabilize essential safety net providers at a time when they are already fragile. Under our Health Homes strategy, NCQA accredited primary care providers and/or high quality managed care ensures people use the most cost effective health care options and stay out of hospitals. Yet, this reduces revenue to safety net institutions which further destabilizes these providers. In some communities, such as Brooklyn, this problem has the potential to create “health care deserts” where hundreds of thousands of people will no longer have access to even the most basic services.

To ensure a smooth transition to a rebalanced delivery system that achieves the Triple Aim, New York needs to make targeted reinvestments. Thanks to the MRT, billions of dollars are being saved. New York is asking that a portion of the savings accruing to the federal government ($2 billion annually) be reinvested into the delivery system to both transform the system as well as to achieve the health policy objective of reduced avoidable hospital use. These goals are aligned with both the MRT action plan and the Affordable Care Act. In addition, a more efficient health care delivery system will generate even greater savings to state and federal taxpayers over time.

**MRT DSRIP – Reforming the Health Care Safety Net and Achieving the Triple Aim**

New York proposes a DSRIP plan specifically designed to both rebalance the delivery system as well as radically reduce avoidable hospital use. The state’s DSRIP plan will rely on 25 programs which will target a wide array of providers across the state. While each program will have its own success measures all programs will directly contribute to a state wide quality improvement goal. The statewide goal is to reduce avoidable hospitalizations and emergency department use by 25 percent over the next five years. Achieving this goal will mean 91,000 fewer inpatient days and 1,050,000 fewer emergency department visits over the five year program. Based on current performance nationwide, this will bring New York from almost dead last on this measure nationally to the top quartile of performance.

To achieve this ambitious goal, a total of $7.317 billion over five years will need to be reinvested. This reinvestment will be made out of federal savings generated by MRT reforms. The programs funded under the effort will assist safety net institutions by allowing them to both downsize unneeded inpatient capacity as well as transform delivery to provide the right mix of services necessary in the communities in which they serve. In addition, the programs will help community-based providers expand and provide additional, vital services so that lower cost alternatives to inpatient care and emergency room services are available statewide. Additionally, DSRIP will incentivize collaboration across previously siloed providers to reduce system fragmentation. By working together care delivery will be more appropriate, timely and coordinated.

At the end of the waiver period New York will have a high performing and financially sustainable health care safety net. The system will rely less on institutional care and will offer a wider-array of high quality community based options such as primary care and behavioral health services.
In addition, thanks to other MRT initiatives, all Medicaid members will have access to high quality primary care, high needs members will utilize Health Homes and more generally, providers will be reimbursed based on the value of the care they provide to improving patient health thanks to robust payment reform that is already underway and will be further advanced during the waiver period.

Through the combined impact of DSRIP, MRT and ACA implementation, New York seeks to be the national leader in advancing health care reform. DSRIP is an essential strategy in a long-term plan to achieve the Triple Aim of better health, better care and lower costs. New York is prepared to lead and serve as a national example for what a Medicaid waiver can do to fundamentally change health care delivery in ways that improve the health of millions of Medicaid members.

II. DSRIP Goals and Performance Metrics

New York’s DSRIP plan is focused on reducing avoidable hospital use. While there are multiple avoidable hospital use measures New York proposes to build off existing performance metrics used in its Medicaid managed care program as well as the New York State Health Innovation Plan (under development). Specifically, New York proposes to the use the four following nationally recognized measures for avoidable hospital use:

- **Potentially Preventable Emergency Room Visits (PPVs):** are a set of measures that identify emergency room visits that could have been avoided with adequate ambulatory care.

- **Potentially Preventable Readmissions (PPRs):** are a set of measures for readmissions to a hospital that follows a prior discharge from a hospital and that is clinically-related to the prior hospital admission.

- **Prevention Quality Indicators – Adult (PQIs):** are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions.” These are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs are population-based and can be adjusted for covariates for comparison purposes.

- **Prevention Quality Indicators – Pediatric (PDIs):** are a set of measures that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problems that pediatric patients experience as a result of exposure to the healthcare system and that may be amenable to prevention by changes at the system or provider level. Similarly the PDIs are population based and can be also be adjusted for covariates for evaluation.

In sum, these measures reflect a comprehensive view of avoidable hospital use. The baseline for evaluation will be actual 2011 Medicaid results. Performance will focus on all Medicaid members, including the dually-eligible population, which meet the criteria for inclusion for each measure. The five-year goal is to reduce each measure by 25%. The state expects to be at least 50% of the way to the 25% reduction mark by the waiver’s third year.
While reduced avoidable hospital use is the central goal of New York’s plan, the state has other DSRIP aspirations. The state’s original waiver amendment clearly established stabilizing the health care safety net as a key objective and it remains a focus. This additional goal is completely consistent with efforts to reduce avoidable hospital use because without a stable and efficient health care safety net, Medicaid members will not have access to vital health care services necessary to keep them out of the hospital.

As stated earlier, New York needs more community-based providers capable of managing patient needs. The state also needs financially viable and high quality hospitals and nursing homes because those institutions will be needed well into the future. The state will track the financial viability of every provider that participates in the DSRIP plan. Each provider’s DSRIP project will include the goal that by waiver’s end they will emerge financially stable if not sooner. This approach to measuring financial viability is already a hallmark of the state’s Vital Access Provider Program (VAP) which is already helping, on a very limited basis, financially challenged providers modify their business models in ways to both ensure financial viability and improve patient outcomes.

In order to both reduce avoidable hospital use by 25% and to ensure safety net sustainability, true transformation is required. DSRIP is the vehicle for financing that transformation. Without DSRIP avoidable hospital use will continue to plague New York which in turn will mean higher Medicaid costs and a lower quality of life for members.

### III. DSRIP Focus Areas and Programs

New York’s DSRIP program plan includes 25 programs which are divided into three focus areas. As mentioned, a wide array of safety net providers will be encouraged to participate (either alone or preferably in community-wide collaborations) in this statewide plan designed to reduce avoidable hospital use by 25% over five years. The proposed programs (see Appendix A for a list and Appendix B for detailed descriptions of each) were developed through stakeholder engagement and as a result of a needs assessment.

The proposed programs also tie back very closely to the goals of the state’s original MRT waiver amendment request. The state went through a detailed stakeholder engagement process to develop that original request and while CMS has stated that it is not approvable in its original form the integrity of that engagement process must be maintained. In addition, the structural problems identified in the original waiver amendment submission continue to face the state and are highly correlated with avoidable hospital use which lies at the heart of the DSRIP plan.

<table>
<thead>
<tr>
<th>MEASURE DESCRIPTION</th>
<th>2011 Baseline rate</th>
<th>Cumulative Change</th>
<th>2018 Goal</th>
<th>Events Reduced From 2014 to 2018, N</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPV rate per 100 Eligible ER Visits</td>
<td>59.57</td>
<td>14.89</td>
<td>44.68</td>
<td>1,053,701</td>
</tr>
<tr>
<td>PPR rate per 100 At Risk Admissions</td>
<td>6.79</td>
<td>1.70</td>
<td>5.09</td>
<td>31,740</td>
</tr>
<tr>
<td>Adult PQI rate per 100,000 member months</td>
<td>187.71</td>
<td>46.93</td>
<td>140.78</td>
<td>53,572</td>
</tr>
<tr>
<td>Pediatric PDI rate per 100,000 member months</td>
<td>35.48</td>
<td>8.87</td>
<td>26.61</td>
<td>5,761</td>
</tr>
</tbody>
</table>
The three focus areas are:

- **Hospital Transition, Public Hospital Innovation, Primary Care Expansion and Vital Access Providers (VAP):** These programs focus on improving quality of care in acute and behavioral health provider networks. Programs in this area will both transform safety net hospitals as well as expand the capacity and quality of community based providers. Programs will also integrate care more effectively and ensure better patient navigation which is essential for complex Medicaid patients that frequently use hospitals ineffectively.

- **Long Term Care Transformation:** Ineffective long term care is a major driver of avoidable hospital use. In the Commonwealth study cited above NYS was 49th in home care generated hospital admissions and 34th in nursing home generated hospital admissions nationally. When nursing homes fail to adequately manage patients pressure ulcers occur and patients are hospitalized. This doesn’t need to happen. Programs in this area will allow both institutional and non-institutional long term care providers to pursue evidence-based strategies to reduce avoidable hospital use. This portion of the program is especially important as the long term care sector transitions into managed care where they will face a far different set of financial incentives and performance expectations. It is also essential because nursing homes are explicitly excluded from the Balancing Incentive Program which New York is also pursuing.

- **Public Health Innovation:** Thanks to the MRT, New York Medicaid now embraces public health approaches to achieving the Triple Aim. Unfortunately, many of these approaches, while evidence-based, are not traditional Medicaid “fundable”. DSRIP is a vehicle for implementing some of these strategies such as the Nurse-Family Partnership program which was the most strongly supported waiver program during the stakeholder engagement process. While this program operates on very limited basis in certain counties it has shown tremendous result in keeping moms and babies well by keeping them out of the hospital. Published medical research of the longitudinal effect of enrollment in this program show early effects of reduced preterm births, increased birth weight, reduction in maternal smoking, and continued medical and social benefits resulting in savings of over $23,000 per case, including a 56% reduction in emergency department visits for accidents/poisonings. The CDC has supported the value of the Nurse-Family Partnership as the most rigorously evaluated program that promotes all aspects of good prenatal and early childhood health, resulting in lasting positive effects for those participating.

The 25 programs contained within each of these three focus areas constitute a “menu” from which eligible safety net providers will be able to choose. Each program will have clearly defined outcome measures that relate specifically to the statewide goal to reduce avoidable hospital use. In addition, each program will have additional measures of success which are relevant to provider type and population impacted. In addition, each program will include financial sustainability metrics that will ensure that all participating providers are financially viable long after the waiver ends.

The state will strongly encourage providers to work together, across traditional health care silos, to develop single proposals. These collaborative proposals can either relate to a single DSRIP program or multiple programs. The state feels strongly that transformation is most impactful when providers work together and that the goal of reduced avoidable hospitalizations is best achieved if hospitals, nursing homes, clinics, behavioral health providers, primary care providers and other stakeholders are all working together in common cause. Proposals that reflect this collaborative approach will receive greater consideration and DSRIP funding.
Participating providers will be required to select at least one of the CMS approved programs for implementation. The selected program(s) must be:

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

The state will develop a data book as a resource tool for providers as they determine which programs to pursue and how to develop a detailed proposal that can win state approval. The data book will contain data on PPV, PPR, PQI and PDI as well as other information on Medicaid members that is helpful in tailoring implementation to the unique needs of each community.

Once the provider has selected a program and has submitted a proposal to the state for consideration their particular initiative will be called a “project”. As a result, multiple projects will be launched throughout the state, and will work toward the shared goal of reducing avoidable hospitalizations. Projects that implement the same programs will be held to the same standards and will use the same metrics for that program.
For each state-approved selected program, the provider’s project will be required to submit a detailed activities list that will address each project phase. The list will also contain a clear description of project milestones as well as a timeline. If providers deviate from their state-approved plans, without prior approval, future funding will be withdrawn. The state will monitor implementation of each project and will report publicly, on a quarterly basis, each project’s progress. Under MRT, New York has shown an unprecedented commitment to transparency, and that tradition will continue under DSRIP.

Lastly, the state and all participating providers will be committed to rapid, life-cycle improvement. If projects are not on path to achieve stated goals, immediate action will be taken to course correct. The state will be open to further project tailoring in order to ensure each project is properly structured to achieve the desired outcomes. In addition, providers will be expected to continuously monitor their results and take whatever steps are necessary in order to modify project implementation and ensure project success.

IV. DSRIP Eligible Providers

In order to reduce avoidable hospital use by 25%, New York’s DSRIP plan will need to involve multiple provider types. In addition, the program must be statewide and encourage regional collaboration whenever possible to ensure all parties are “rowing in the same direction.” Specifically, the state will be classifying DSRIP eligible providers into two distinct categories: Major Public General Hospitals and Safety Net Providers.

**Major Public General Hospitals** are defined as those general hospitals owned or operated by the State University of New York; those general hospitals operated by the New York City Health and Hospitals Corporation; and those general hospitals operated by public benefit corporations in the counties of Erie, Nassau and Westchester Counties. The non-federal share of DSRIP payments to these hospitals will be funded through the use of intergovernmental transfers (IGTs) from the participating hospitals or their sponsoring governmental entity that comport with federal requirements.

**Safety Net Providers** will include hospitals (other than Major Public General Hospitals), nursing homes, clinics including Federally Qualified Health Centers, behavioral health providers, and home care agencies. Eligible providers will be defined by specific criteria that are currently under development and may vary across different regions of the state. These criteria will include but not be limited to:

- Prevalence of pre-determined chronic diseases among Medicaid beneficiaries living in each provider’s service area, and payer mix, defined as each provider’s number or percentage of services rendered to Medicaid beneficiaries, Medicare beneficiaries, and uninsured/self-pay individuals;
- Medicaid beneficiaries as a proportion of the total population in each provider’s service area; and
- The location of the provider in a Medically Underserved Area or Health Professional Shortage Area designated by the federal Health Resources Services Agency or provides services to populations in areas that are geographically isolated.
Another factor that may be considered includes each provider’s financial condition, losses from treating Medicare and Medicaid beneficiaries, and level of uncompensated care—all net of disproportionate share hospital payments and other such subsidies.

The non-federal share of DSRIP payments to safety net providers will be funded through the use of IGTs made by the Major Public General Hospitals or their sponsoring governmental entity that comport with federal requirements.

V: DSRIP Project Plan Submission Requirements

Each eligible provider(s), wishing to participate in DSRIP, will submit a completed application to the state by the specified deadline. This completed submission will include the following documents in the provided format:

A. DSRIP Face Sheet

This face sheet will list the documents included within the package and include the applicant’s name and a brief (no more than 300 word) summary of the submitted project.

B. Project Application

It is expected that the transformational nature of the activities to be undertaken in these projects will require a strict adherence to disciplined project management. This document must provide evidence that the involved organizations have a clear understanding of the needs of the service area, that the program will address these needs in a significant manner, that the provider understands the three metric sets that will need to be monitored and the methodology that will be used to do such, and that the provider has internal and/or external resources that will be available for project management and the required rapid cycle improvements inherently needed in these projects.

The application should include the following components:

1) Provider Demographics including:
   a) Name, Address, Senior level person responsible for the DSRIP project and to whom all correspondence should be addressed
   b) Definition of service area.
   c) Identification as public hospital or safety net provider with documentation supporting that identification
   d) Current patient population including demographic information, payer mix.

2) Identification of Provider Overarching Goal: The provider will need to identify the focus of this program, either Potentially Avoidable Admissions and/or Potentially Preventable Readmissions. It is expected that each project undertaken through DSRIP will be relevant to the state goal of reducing avoidable/preventable admissions to a hospital including emergency department. The provider will need to provide objective data evidence that this is a relevant goal for the provider and its service area. If the provider overall has already reached the state-wide goal for the provider goal, the provider must briefly document why this goal is still relevant.
3) **Identification of Provider Programs to meet identified goal** including brief rationale for program choice. Further information will be provided in the detailed assessment provided in (4) and must include the four stages previously outlined.

4) **Performance Assessment**
   a) Current status of the community (population demographics, types and numbers of providers and services, cost profile, designation as Health Professional Shortage Area, mortality and morbidity statistics)
   b) Evidence of regional planning including names of additional partners involved in the proposed project.
   c) Detailed analysis of issues causing poor performance in the project area. These must include assessment of patient co-morbidities, patient characteristics, social system support, system capacity for primary care and disease management, and institutional issues such as finances, fragmentation of services, competition, and assessment of regional planning issues.
   d) Evidence of public input into the project. This should include evidence of collaboration with local departments of public health, public stakeholders and consumers. In addition, the provider will need to document how there will be ongoing engagement with the community stakeholders, including active participation in any regional health planning activities currently underway in their community.

5) **Work Plan Development**: In this section the provider will provide an initial high level work plan using the four life cycle stages identified in Section IV.
   - Infrastructure Development,
   - Project Design and Management,
   - Quality Improvements and
   - Avoidable Hospitalization Improvements.

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

6) **Establishment of Milestones and Metrics**: A section of the work plan must provide documentation of the monitoring strategy for the identified program including significant milestones and associated metrics. Three classes of metrics will be monitored for these programs:
   - Process metrics related to milestone attainment,
   - Outcome metrics related to expected outcomes of the programs, and
   - Preventable Hospitalization Metrics for the overall objective of DSRIP.
Process metrics will be established by the providers with the approval of the state. These will be utilized to document time line progression on the provider’s project. The provider will be responsible for supplying documentation to the state regarding extent of attainment of these goals.

In order to ensure movement to the goals of the state to meet the Triple Aim, the state will establish outcome metrics to be used for each of the projects approved for DSRIP. The metrics will be generally based upon nationally vetted metrics such as used by NCQA/QARR and the Quality Forum.

The providers, working with the state, must establish the baseline metric values and the agreed upon measurement process including frequency of measurement, the periodicity of which will not be greater than one year. The state will develop a data book to assist providers in calculating these metrics. However, where hybrid data is required to obtain a valid measure, the provider will be responsible for any medical record review. It is expected that provider will be compared to other like providers who are currently not involved in the DSRIP process to ensure progress to the goal is specific to the activities of the provider and not a general trend of improvement that all providers are experiencing.

The third class of metrics will measure the incremental change in preventable hospital usage. The state will work with providers to calculate this metric for Medicaid members in the provider’s service area, first as a baseline measure and then subsequent annual recalculations to ensure movement to the state’s goal.

7) **Expectation of Sustainability:** Providers are asked to explain how the outcomes of this project will be sustained at the end of DSRIP and how gains can be continued after the conclusion of the project period. This should include a financial forecast of expected savings related to the implementation.

C. **Signed Attestations:**

1) The provider will submit a description of any initiatives that the provider is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiative currently in place. The provider will, by signature, attest that the submitted DSRIP project is not a duplication of a project from these other funded projects and does not duplicate the deliverables required by the former project(s). It should be noted if this program is built on one of these other projects or represents an enhancement of such a project that may be permissible.

2) The provider will submit an attestation statement documenting that the information provided in this document is accurate at the time of submission and that the provider, if accepted into the DSRIP, will cooperate fully with the state in the implementation and monitoring of this project and participate in the required learning collaboratives related to this program.
VI. DSRIP Project Review and Planning Process

New York will establish a timeline for submission and review of submitted DSRIP project applications that will align with CMS approval of the submitted New York State DSRIP plan. The timeline will include the following steps:

1. Eligible providers, either public providers or safety net providers, will be required to submit a completed application by a specific deadline. A second round of applications may be accepted if the state decides such action is needed to achieve DSRIP objectives and/or to balance the distribution of funds by focus area, sector and provider. No further applications will be allowed to be submitted after state imposed deadlines, although revisions may be submitted with the permission of the state. It is expected that eligible providers would have worked with the state in developing their application, in particular with regard to milestones and metrics.

2. The state will initiate a preliminary review of all applications to ensure they are complete and meet the baseline requirements of this program. As part of the development of the review timeline, the state will develop an initial checklist to be utilized for this review and that will be available for review by CMS.

New York will at a minimum document the following:

- The submitted project must be in the required format and must contain all of the required elements as noted in the DSRIP Project Submission Requirements section of this document.
- The submitted project must consist of one or more programs from the DSRIP Program Menu that represent a reasonable approach to addressing avoidable hospitalizations for that provider.
- The submitted project must include a high level project plan that includes benchmarks, milestones and metrics including baseline and goal.
- The description of the project must be coherent and comprehensive and be a logical approach for that provider/community to address avoidable hospitalizations.
- The project selection must be appropriate to address unmet needs within that provider’s service area and be supported by regional planning initiatives currently in place in that area. The project must reasonably be shown to meet the Triple Aim for better care for individuals, better health for the population, and lower costs through improvements.
- The goals of the project should be based upon evidence based interventions and measurable by nationally recognized metrics which are aligned with the state-required measures.
- The providers will participate in a learning collaborative to be established by the state.
• The amount and distribution of funds is included that is consistent with state requirements and consistent with the project milestones.

• The provider has attested that this project is independent of any other institutional projects supported by federal funding.

• In support of this critical review component, the state is developing a file of all currently HHS funded grant programs including CMMI grants to institutions, Hospital Medical Home Demonstration Program, New York State Healthcare Innovation Plan, Medicaid Incentives for the Prevention of Chronic Disease and the ADK Multi-Payer Medical Home Demonstration to ensure DSRIP proposed programs are not duplicative.

• The project milestones and metrics are consistent with the overall goals of the DSRIP plan.

3. After completion of the preliminary review, the provider will be notified by the state of any deficiencies in the submission. The provider will have 20 business days to submit a revised version addressing all of the state’s concerns.

4. Either an original submission (if deemed complete) or a revised submission (addressing deficiencies) will then undergo a final review for approval of the project. The final review panel will consist of employees from appropriate New York State agencies with specific expertise in quality improvement and outside non-conflicted independent entities with expertise in health care policy and research.

5. The final review panel will use a standardized review tool (to be developed) that will provide an objective score for each project. The review tool will be published prior to the project submission date to assist providers in developing their submission. The panel will undergo training with the tool including assessing inter-rater reliability. A passing score will be established. A passing score will represent a project that is consistent with state DSRIP goals, is consistent with the unmet needs of the provider’s community and region, represents evidenced based practice, has goals that represent transformational progress, and for which the provider has shown reasonable expectation of success.

6. Providers will be notified of the outcome of the review. Providers who have projects accepted will be required to submit an expanded project plan to the state within 30 days. Approval of that project plan will be required for the project to be initiated.
**Off-Menu Projects:** If the provider chooses to submit an “off-menu” or unique project that is not part of the pre-defined programs as specified in this document the provider will be required to develop the project’s defined objective, high level implementation methodology, anticipated outcomes, and program specific metrics. The provider’s analysis must present justification for the off-menu program, showing that the provider reviewed the menu programs and found that the proposed program could not be accommodated within any of the model programs and that the provider should implement the proposed off-menu program instead of a menu program.

With this justification, the provider must show, using internal and external data, that the new project is beyond those in the program list, that it would achieve the Triple Aim, that it is responsive to local data and community needs, and that it addresses an area of poor performance and/or health care disparity that is important to the Medicaid and/or uninsured population. The provider must explain why this off-menu project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).

Off-menu projects must be focused on an area or condition in which there is demonstrable need for improvement, be outpatient focused, and have clearly identified improvement objectives that can be measured using nationally endorsed (primarily outcome) metrics (such as those endorsed by the National Quality Forum (NQF) or National Committee for Quality Assurance (NCQA)). A reasonable explanation must be established that the project will result in measurable improvements in the patient population’s clinical outcomes and result in reducing avoidable hospital admissions.

Review of off-menu projects will follow the same format noted above.
VII. DSRIP Project Timetable

The following events represent the DSRIP review timeline. Unless otherwise specified, denoted dates throughout the document refer to calendar days and any specified date that falls on a weekend or holiday is due the prior business day.

<table>
<thead>
<tr>
<th>DSRIP Project Timetable</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider DSRIP project application review and approval steps</td>
<td></td>
</tr>
<tr>
<td>Target approval date by CMS of the NYS DSRIP Program submitted to CMS</td>
<td>January 1, 2014</td>
</tr>
<tr>
<td>Target approval date by CMS of the NYS DSRIP Funding and Mechanics Protocol submitted to</td>
<td>February 15, 2014</td>
</tr>
<tr>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>Provider DSRIP project application must be submitted to New York State Department of</td>
<td>April 4, 2014</td>
</tr>
<tr>
<td>Health (NYSDOH) if project is a unique focus area or “off-menu” from pre-defined list</td>
<td></td>
</tr>
<tr>
<td>Provider DSRIP Project application submitted to NYSDOH</td>
<td>April 25, 2014</td>
</tr>
<tr>
<td>NYSDOH completes review and approves Provider DSRIP Plans</td>
<td>May 15, 2014</td>
</tr>
<tr>
<td>Funds Allocated to Approved Projects</td>
<td>June 1, 2014</td>
</tr>
<tr>
<td>Standardized reporting form and databook</td>
<td></td>
</tr>
<tr>
<td>Toolkit is updated with the standardized reporting form and databook</td>
<td>June 13, 2014</td>
</tr>
<tr>
<td>Claims-based (i.e. MMIS) metric baseline results calculated and provided to Providers</td>
<td>July 11, 2014</td>
</tr>
<tr>
<td>Provider submits attestation of verification for claims-based measure results used in</td>
<td>August 8, 2014</td>
</tr>
<tr>
<td>calculating the New York Low Income baseline dataset</td>
<td></td>
</tr>
<tr>
<td>New York Low Income Improvement Target Goals and Baseline Performance Thresholds</td>
<td>August 29, 2014</td>
</tr>
<tr>
<td>established</td>
<td></td>
</tr>
</tbody>
</table>
VIII. DSRIP Performance Management and Assessment

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

- Ongoing provider-level evaluations will occur on a regular basis, as described below, and seek to provide timely and actionable feedback on the initiative’s progress, in terms of infrastructure changes, implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, performance on objective attainment and overall progress towards achieving a health care system based on the Triple Aim, and progress toward achieving the primary goal of DSRIP, to reduce preventable hospitalizations.

- Learning collaboratives will be implemented to seek peer-to-peer (provider-to-provider) input on program level development of action plans, implementation approaches and program assessment. New York will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results).

- On a quarterly basis, the state will publish on its website project-by-project status updates which will show each project’s success and relative to pre-approved milestones.

- A mid-point assessment (end of the third year) will be completed by an independent evaluator to provide broader learning both within the state and within the national landscape. Part of the midpoint assessment will examine issues overlapping with ongoing provider-level evaluations, and part of this effort will examine questions overlapping with the final evaluation.

- A final statewide evaluation of DSRIP will be completed by the independent evaluator describing the changes in quality and access outcomes as a result of DSRIP activities.

A. Performance Management

The state will identify a DSRIP plan manager who will be responsible for management of required reporting from each of the participating providers.

Each provider participating in the program will submit its detailed project plan to the state. This project plan will be the basis for monitoring of program progression, milestones, and metric results. Each provider, once the program has been initiated, will submit at least quarterly reports, documenting progress on the project plan.
The state will review and analyze the submissions to document:

- The level of progress the provider is making toward project plan milestones.
- The specific activities of the program which appear to be driving the desired measurable change.
- Identified implementation challenges related to program implementation and goal attainment.
- Identification of adjustments in the implementation that may be required.

For the last two bullets, in situations where there has not been expected progress, the provider will submit a barrier analysis and plan in the model of “Plan, Do, Check, Act” to address the identified barriers limiting progress. The barrier analysis should include provider specific data where applicable and other objective findings to support the analysis. Subsequent reporting to the state will need to address the previously identified issues and progress to resolution. Any changes to the project plan as a result of this barrier analysis will need to be approved by the state. If issues persist, another cycle of barrier analysis and planning will be required until a resolution is achieved or until it is evident that no solution is possible and that component of the program will be terminated.

The DSRIP plan manager will utilize submitted reports to prepare quarterly summary reports to identify common barriers and best practices which will be reviewed within the state and with participating providers. These summary reports will also provide material for the Learning Collaborative. In addition, the state will establish a website specific to the DSRIP plan on which relevant data including progress to goal will be posted for public review.

**B. DSRIP Learning Collaborative**

In order to achieve and sustain success at responding to community needs, providers and communities will need to apply best practices in continuous quality improvement. Most notably, learning collaboratives are essential to the success of high quality health systems that have achieved the highest level of performance. New York providers will be required to participate in statewide learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar programs. These learning collaboratives are an important opportunity for DSRIP providers to share learning, experiences, and best practices acquired from the DSRIP plan across the state.

The New York State Department of Health is the appropriate agent to convene providers for shared learning by connecting providers who are working on similar programs. Based on programs ultimately chosen by providers, the state will connect providers on an ongoing basis to share best practices, breakthrough ideas, challenges and solutions. This will allow providers to learn from each other’s challenges and develop shared solutions that can accelerate the spread of breakthrough ideas across New York.

The Learning Collaborative will be managed by New York State through both virtual and in-person collaboration that builds relationships as well as facilitates program analysis and measurement.
The Learning Collaborative will be designed to promote and/or perform the following:

- Sharing of DSRIP project development including data, challenges, and proposed solutions based on the hospitals’ quarterly progress reports;
- Collaborating based on shared ability and experience;
- Identification of best practices;
- Provide updates on DSRIP projects and outcomes;
- Track and produce a "Frequently Asked Questions" document; and,
- Encourage the principles of continuous quality improvement cycles

In addition to the state-wide collaborative, collaboratives will also be developed based on the number and type of projects submitted by providers. Depending on the collaborative, its size and needs, a number of tools can be leveraged, such as, but not limited to:

- An online, web-based tool to effectively manage the collection and the dissemination of information related to DSRIP, and,
- Regular in-person or virtual meetings to increase the rate and disbursement of learning.

These tools will allow providers to deliver data in ways that can be: 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models. It will be the responsibility of each DSRIP provider to ensure effective diffusion of learning amongst providers who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Check-Act (PDCA) cycles that have been implemented throughout the demonstration. It is anticipated that participating providers will also use DSRIP as an opportunity to enhance understanding within their own organizations on these principles on which the health care system of the future will be based.

**C. Data Collection**

The evaluation of DSRIP projects will rely on the measurement of four classes of metrics: project process metrics, avoidable hospitalization metrics, project specific outcome metrics and provider financial viability metrics. The state has extensive resources including highly skilled staff that will be engaged to ensure that all necessary data is collected in timely fashion and effectively analyzed.

Once data is collected at the project level it will be “rolled up” to the program levels. In addition, each program will be evaluated in terms of its effectiveness in helping achieve the statewide performance metrics for reduced avoidable hospital use.
The state will collect data from providers often as is practical in order to ensure that project impact is being viewed in as “real time” a fashion as possible. Collecting and analyzing data in this fashion will allow for rapid, life-cycle improvement which is an essential element of the DSRIP plan. In addition, all these metrics will be used to calculate provider payments. A detailed description of how provider payments will be calculated is provided in Section IX.

**Project Process Metrics** – Each provider will be responsible for its own process metrics based upon specifications agreed upon by the state. The state will audit any and all results as deemed necessary. Process metrics will be established for all identified project milestones that are contained in the state approved project work plans.

**Avoidable Hospitalization Metrics** – Each participating provider will be expected to contribute the state’s effort to reduce avoidable hospital utilization. Certain projects will target certain subsets of avoidable hospitalizations, which will mean that measures applied will vary by project. Baseline performance will be set either on a provider basis or based on performance in the provider’s service area. A challenge with certain projects will be to determine what exact impact a particular project has on community-wide rates of avoidable hospital use. While this is a challenge the state will expect providers to work with other stakeholders in their communities to ensure that their projects are capable of “moving the needle” in terms of avoidable hospital use. Projects that cannot prove an ability to improve outcomes in this key DSRIP area will not be funded.

**Project Specific Outcome Metrics** – Many of the projects envisioned under DSRIP will also contribute to achieving other statewide health care and public health metrics. While reducing avoidable hospital use is paramount the state seeks to measure the broader impact of DSRIP by requiring all participating providers to work toward other important goals. These additional metrics are “project specific” because they may be unique to the project. The state will report out these metrics and they will be used to calculate payment. Using project specific metrics will allow the state to tailor this transformation to the specialized needs of each community in the exceptionally large and diverse Empire State.

**Financial Viability Metrics** – As has been stated, New York’s health care safety net is extremely fragile. A key goal of the DSRIP plan is to help stabilize as well as transform the safety net so that it can continue to provide high quality, community appropriate, services well after the waiver is over. The state will require all participating providers to address how they will either achieve or maintain financial viability in their project proposals. In addition, metrics will be tracked to ensure each provider is achieving the goal of financial sustainability. It does the state no good to invest DSRIP resources in providers that have not taken steps to either remain financial viable on their own or as part of their transformation are prepared to join with other providers in ways that lead to both financial solvency as well as improved performance for Medicaid members.
D. Managed Care Plans and DSRIP Project Performance

As mentioned above a core strategy of MRT is care management for all and the leveraging of full benefit managed care enrollment to improve accountability and quality. Managed care plans will assist the department and DSRIP providers in advancing DSRIP objectives through active patient management some of which has already begun as plans work closely with health home networks on high needs patients. To further facilitate this partnership between plans, DSRIP providers and health homes, the Department is already in the process of implementing a provider/plan data portal that will allow access to appropriately permissioned patient and provider specific data in the Medicaid Data Warehouse. Role based access to this portal will allow providers and their partnering health plans access to current Medicaid claims and encounters data and eventually real time EMR and care management data provided through connectivity with local regional health organizations (RHIOs). Faster access to more real time clinical and managed care data will be particularly relevant to this project and is also the rationale for using state-measured health plans metrics or Quality Assurance Reporting Requirements (QARR) as a major data source for this project. In addition, providers and their partnering health plans will have access to the analytical capabilities of 3M and Salient suite of performance tools through the portal. This will allow DSRIP providers and the health plans to partner with the state to measure case mix adjusted avoidable hospitalization metrics at the local level using standardized definitions and eventually with more real time updates.
IX: DSRIP Program Valuation and Disbursement of Funds

DSRIP funds will be distributed in a manner that assures both state and CMS policy and performance objectives are achieved. Using a four step distribution method the state will assure that resources are targeted to providers and projects that are adding the most measurable value in the statewide DSRIP plan effort including reductions in avoidable hospitalizations, increases in quality and improvements to the financial stability of the system.

Allocation Method

New York proposes to distribute DSRIP funds using a simple four step process illustrated in the Distribution of DSRIP Funds diagram below. This process is as described below:

Step 1: **State Allocation**: NYS would receive a total statewide allocation, as agreed to by CMS.

Step 2 **Public/Non Public Allocation**: The state allocation would then be broken into two pools one for public hospital projects and one for non-public safety net provider projects.

Step 3 **Project Allocation**: After submission by eligible providers, each approved project would then be valued using standardized four point scoring system that measures 1) potential impact on avoidable hospitalizations and quality improvement, 2) potential for cost reduction, 3) number of Medicaid members impacted and 4) degree to which project is supported by evidence.

Step 4 **Performance Allocation**: Each approved project allocation would then be distributed based on metrics achieved in four performance areas including 1) process, 2) outcome, 3) financial viability and 4) avoidable hospitalization. Process oriented payments will phase down in each year and outcome and avoidable hospitalization payments phase up.

The diagram on the following page explains the allocation method.
**Project Allocation Method**

An index will be used to create a value score for each project after submission and approval. The value score will be translated into an allocation percentage across the pool of funds for public hospitals and separately for the pool of funds for safety net providers. The project index factors are below:

**Project Value Index:**

- Alignment with Avoidable Hospitalization and Quality Objectives (Score 1 (lowest) – 5 (highest))
- Potential Cost Savings (Score 1-5)
- Number of Medicaid Members Impacted (Score 1-5)
- Robustness of evidence base (Score 1-3)

Scores will be totaled for each project then weighted based on rank within the funds pool. Funding will be allocated to each project based on the project relative weight that has been derived from the total index value. The highest scoring project will receive the highest allocation and the lowest value will receive the lowest value allocation. All other program values will be proportional to the relative position between the highest value project and lowest value project. Projects have to be acceptable to the State review team in order to be scored.

While final projects will not be scored until received and approved, the state will provide an interim score for each of the 25 programs to enable providers to have some sense of what the final values may be as they develop local project proposals. This will assist providers and their community partners with developing a menu of programs in their final project submission that includes programs the state has identified to be of higher value and therefore likely to have higher associated performance payment opportunity.
DSRIP Performance Pool

New York intends to establish a DSRIP Performance Pool (DPP) to incentivize and reward high performing providers who exceed quality improvement goals. The goal is to keep providers working hard - even after they have reached milestones - to improve beyond targets and to put more resources into high functioning and high quality projects and providers. Continuous performance is hereby rewarded throughout the project life cycle. All DSRIP participating providers shall be eligible for DPP reward payments based on performance. The DPP shall be funded by the following sources:

- Unclaimed DSRIP funds remaining after the first or second stage allocation process described above.
- Unclaimed DSRIP funds from providers who do not achieve metrics established in their DSRIP plans within the allotted timeframe.

These funds shall be redirected into the DPP to participating providers who have achieved performance improvement beyond the stated metric in their DSRIP project plan. New York shall establish a process to distribute DPP funds with a tiered methodology that rewards higher performing providers.

- Higher performing participating providers whose performance is within 5% of their stated metric shall receive Tier 1 level reward payments.
- Higher performing participating providers whose performance is within 10% of their stated metric shall receive Tier 2 level reward payments.
- Higher performing participating providers whose performance is above 10% of their stated metric shall receive Tier 3 level reward payments.

DPP payments shall be adjusted based on Medicaid and indigent population size served by the project being implemented by the provider.

Performance Based Payment Process

DSRIP payments for each participating provider are contingent on the provider meeting program and project metrics and milestones defined in the approved state’s DSRIP plan and consistent with the valuation process. In order to receive funding relating to any metric, the provider must submit all required reporting, as outlined in the DSRIP funding and mechanics protocol using the format and process agreed upon by the state and CMS.

The New York DSRIP Funding and Mechanics Protocol (to be developed) will:

- Provide guidelines requiring providers to develop projects, which shall include consistent with included guidance, timelines and deadlines for the meeting of metrics associated with the programs/projects and activities undertaken to ensure timely performance;
- Provide minimum standards for the process by which providers seek public input in the development of their projects and provides that providers must include documentation of public input in their projects;
- Specify a state review process, including non-conflicted external peer reviewers, and criteria to evaluate each provider’s project and develop its recommendation for approval;

- Specify a process for obtaining CMS approval for program or projects that do not appear on the list included in this DSRIP plan;

- Describe, and specify the role and function, of a standardized, provider-specific application to be submitted to the state (consistent with guidance from the DSRIP project submission requirements included herein), and renewed on an annual basis for the utilization of DSRIP funds that outlines the provider’s project, as well as any databooks or reports that providers may be required to submit to report baseline information or substantiate progress;

- Specify that providers must submit periodic reports to the state using a standardized reporting form to document their progress (as measured by the specific metrics required/applicable to the project that the providers have chosen), and qualify to receive DSRIP payments if the specified performance levels were achieved;

- Specify a review process and timeline to evaluate provider progress on its project metrics in which the state must certify that a provider has met its approved metrics as a condition for the release of associated DSRIP funds to the provider;

- Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating provider may be eligible to receive and a formula for determining the incentive payment amounts associated with the specific activities and metrics, such that the amount of incentive payment is commensurate with the value and level of effort required;

- Describes a process for how dollars in each annual stage will move from more process oriented measures to objective improvement measures. New York is considering the following in developing final guidance.

<table>
<thead>
<tr>
<th>Table III. DSRIP FUNDING DISTRIBUTION STAGES</th>
<th>DY2</th>
<th>DY3</th>
<th>DY4</th>
<th>DY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Project Process Metrics</td>
<td>70%</td>
<td>60%</td>
<td>30%</td>
<td>5%</td>
</tr>
<tr>
<td>(Includes Infrastructure and Project Design and Management)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Project Specific Outcome Metrics</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>(Includes quality improvement chronic disease management and population health)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Provider Financial Viability Metrics</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>(if applicable, if not applicable to a given provider this percentage will get moved equally to the other three categories)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Avoidable Hospitalizations</td>
<td>5%</td>
<td>10%</td>
<td>30%</td>
<td>55%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
- Include a yearly application process that allows for potential project modification and an identification of circumstances under which a project modification may be considered; and

- Include a DSRIP performance pool that allows a portion of DSRIP dollars not paid due to poorer performance to be redistributed to very high performing programs/projects and providers.

**Payment Based on Achievement of Milestone and Milestone Bundles**

(This section will likely move to DSRIP Project Funding Mechanics Document once finalized.)

A milestone bundle is a state-selected or state-approved compilation of milestones and related metrics associated with a program/project in a given time period. A milestone may have more than one metric associated with it. Two or more metrics associated with a milestone shall be assigned equal weighted value for the purpose of calculating incentive payments. A milestone bundle is a pre-selected compilation of reporting measures/milestones within a given stage or project.

**Basis for Calculating Incentive Payments**

Incentive payments are calculated separately for each project. The amount of the incentive funding paid to a provider will be based on the amount of progress made within each specific milestone bundle. For each milestone within the bundle, the provider will include in the required DSRIP provider report the progress made in completing each metric associated with the milestone. Progress for a given metric will be categorized as fully achieved or not achieved. Based on the progress reported, each milestone will be categorized as follows to determine the total achievement value for the milestone bundle:

- Full achievement (achievement value = 1)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .5)
- At least 25 percent achievement (achievement value = .25)
- Less than 25 percent achievement (achievement value = 0)

The achievement values for each milestone in the bundle will be summed together to determine the total achievement value for the milestone bundle. The provider is then eligible to receive an amount of incentive funding for that milestone bundle determined by multiplying the total amount of funding related to that bundle by the result of dividing the reported achievement value by the total possible achievement value. If a provider has previously reported progress in a bundle and received partial funding, only the additional amount it is eligible for will be disbursed. The state may determine milestones that qualify for partial achievement. (See example below of disbursement calculation.)
**Example of Disbursement Calculation:**

A project is valued at $30 million and has five milestones, which make up the milestone bundle. Under the payment formula, the five milestones represent a maximum achievement value of 5. The provider reports the following progress at 6 months:

**Milestone 1:** 100 percent achievement (achievement value = 1)
- Metric 1: Fully achieved
- Metric 2: Fully achieved

**Milestone 2:** 76.7 percent achievement (Achievement value = .75)
- Metric 1: Fully achieved
- Metric 2: Fully achieved
- Metric 3: Not Achieved
- Metric 4: Fully Achieved

**Milestone 3:** 100 percent achievement (Achievement value = 1)
- Metric 1: Achieved

**Milestone 4:** 50 percent achievement (Achievement value = .5)
- Metric 1: Fully Achieved
- Metric 2: Not Achieved

**Milestone 5:** 80 percent achievement (Achievement value = 1)
- Metric 1: Fully achieved
- Metric 2: Fully Achieved
- Metric 3: Fully Achieved
- Metric 4: Fully Achieved
- Metric 5: Not Achieved

Total achievement value at 6 months = 4.25

Disbursement at 6 months = $30M x (4.25/5) = $25.5 million

DSRIP Performance Pool Amount = $30M – $25.5M = $4.5M x .75 = $3.375 million
Section X - DSRIP – Further Improvements Post-Waiver

New York is committed to ensuring that the significant improvements achieved as a result of the MRT DSRIP plan are not only maintained but enhanced. The state’s five year goal is a 25% reduction in avoidable hospital use. While meaningful and achievable during the waiver period, the state has grander ambitions. In fact, the ten year goal for the reform launched through DSRIP is a 50% reduction in avoidable hospital use.

To ensure that DSRIP gains are maintained and enhanced, key policy design elements will be built into each DSRIP project. These design elements will ensure that participating providers build on their success in the post-waiver years. Below is a list of key policy design elements that will help achieve the ten year goal to cut New York’s avoidable hospitalization rate in half:

- Each approved project plan will need to include a clear description of how the provider will maintain gains achieved through the waiver investments and how future gains will be achieved post-waiver.

- Projects will be structured to prevent funding “cliffs”. This will be achieved by having funding peak mid-waiver and phase down in waiver years 4 and 5.

- Projects that fail to show early success will be terminated or modified with funding re-allocated to more successful projects. This continuous life-cycle improvement approach will ensure that waiver funds are spent wisely and gains grow over time. This enhanced accountability will also send a clear message to participating providers that success is essential.

In addition to DSRIP, it is important to note that this initiative is not being done in isolation. The DSRIP plan is explicitly designed to reinforce other, permanent strategies that have the exact same goal: reduce avoidable hospital use. Built directly into key MRT initiatives such as “Care Management for All” and Health Homes are program objectives wholly consistent with DSRIP. The state’s existing performance metrics for these initiatives are already completely consistent with DSRIP metrics and hence will be “rowing in the same direction” with waiver-participating providers.

Sustainability is not actually a DSRIP goal. Actually, the state would see the inability to clearly build upon waiver achieved gains as a major disappointment. The ultimate future state envisioned in New York is a health care delivery system in which avoidable hospital use is a problem of the past. The state stands ready to ensure that collectively - CMS, the state and the New York Medicaid stakeholder community - works together to achieve the ultimate goal of reducing avoidable hospital use by half in ten years.
# Appendix A. DSRIP Programs List

<table>
<thead>
<tr>
<th>PROGRAM NUMBERS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus Area #1: Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion</strong></td>
<td></td>
</tr>
<tr>
<td>1.01</td>
<td>Implementation of evidence based best practices for disease management in medical practice (Cardiovascular Disease/Diabetes/Renal to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.02</td>
<td>Implementation of care coordination and transitional care programs for hospitals to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.03</td>
<td>Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.04</td>
<td>Expand access to primary care and support services (based on assessment) to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.05</td>
<td>Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services as a means to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.06</td>
<td>Increase certification of primary care practitioners with PCMH certification to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.07</td>
<td>Integration of behavioral health into primary care setting to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.08</td>
<td>Development of community-based health navigation services to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.09</td>
<td>Increase access to specialty care (including mental health) to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.10</td>
<td>Development of co-located of primary care services in ED to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.11</td>
<td>Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.12</td>
<td>Create a bed buy-back program for hospitals to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.13</td>
<td>Implementation of observational programs in hospitals to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.14</td>
<td>Expansion of palliative care program to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.15</td>
<td>Development of evidence-based medication adherence programs in hospitals to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>1.16</td>
<td>Development of ambulatory detox capabilities within communities to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td><strong>Focus Area #2: Long Term Care Transformation</strong></td>
<td></td>
</tr>
<tr>
<td>2.01</td>
<td>Development of inpatient transfer avoidance program for SNF to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>2.02</td>
<td>Expand pressure ulcer prevention program to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>2.03</td>
<td>Implement medication error prevention program to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>2.04</td>
<td>Create a bed buy-back program for nursing homes to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td><strong>Focus Area #3: Public Health Innovation</strong></td>
<td></td>
</tr>
<tr>
<td>3.01</td>
<td>Increase support programs for maternal &amp; child health (including high risk pregnancies) to reduce avoidable hospital use (Example: Nurse-Family Partnership)</td>
</tr>
<tr>
<td>3.02</td>
<td>Implementation of programs to reduce healthcare acquired infections to decrease avoidable hospitalizations</td>
</tr>
<tr>
<td>3.03</td>
<td>Development of community-based strategies to improve cancer screening to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>3.04</td>
<td>Expansion of asthma home-based self-management program/evidence based medicine guidelines for asthma management to reduce avoidable hospitalizations</td>
</tr>
<tr>
<td>3.05</td>
<td>Expansion of home visits to prevent childhood lead poisoning to reduce avoidable hospitalizations</td>
</tr>
</tbody>
</table>
Appendix B:
DSRIP Program Descriptions
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.01

**Program Title:** Implementation of evidence-based best practices for disease management in medical practice (Cardiovascular Disease/Diabetes/Renal) to reduce avoidable hospitalizations

**Program Objective:** To increase community and ambulatory care use of evidence based strategies to improve management of specific chronic diseases. These strategies are focused on improving practitioner population management, patient self-efficacy and confidence in self-management, and engagement of the at-risk population in disease prevention strategies.

**Program Methodology:**

*Implementation of evidence based strategies for disease management in high risk populations.*

Practices/clinics will build on the current DOH strategies focused on EHR implementation and PCMHs to enhance use of patient registries including recall strategies, implement patient stratification models and develop care coordination teams including use of nursing staff, pharmacy, and community workers to address health literacy issues, and patient self-efficacy and confidence in self-management. Evidence based disease management will be implemented in a culturally appropriate format to encourage patient compliance. Additional actions may include “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.

*Implementation of evidence based strategies in the community to address chronic disease primary and secondary prevention strategies.*

Providers will develop or partner with community resources to develop a community appropriate wellness center model such as the YMCA model. Providers will identify patients at high risk for onset of hypertension or diabetes and refer them to the wellness center. Providers will collaborate with the wellness center to monitor progress and make ongoing recommendations. Focus will be on lifestyle modification including diet, tobacco use, exercise and medication compliance and will provide recommendations consistent with community resources.
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. **Process Metrics (to be established with provider and may include):**
   - Patient count engaged in wellness center compared to number referred
   - Length of stay within program
   - Patient satisfaction with program
   - Assessment of patient knowledge of preventive measures

2. **Avoidable Hospitalization Metrics:**
   - PPVs
   - PPRs
   - PQIs

3. **Project Specific Outcome Metrics:**
   - Medical Assistance with Smoking Cessation (CAHPS)
   - Flu Shots for Adults Ages 50 -64 (CAHPS)
   - Adult BMI Assessment (HEDIS)
   - Aspirin Discussion and Use (CAHPS)
   - Alcohol screening (SBIRT) (NYS)
   - Cholesterol Management for Patients with Cardiovascular Conditions (HEDIS)
   - Comprehensive Diabetes Care (HEDIS)
   - Controlling High Blood Pressure (HEDIS)

4. **Financial Viability Metrics: Specific to Provider**
Focus Area: Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

Program Number: 1.02

Program Title: Implementation of care coordination and transitional care programs for hospitals to reduce avoidable hospitalizations

Program Objective: To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of health condition, improve provider to provider communication, and provide supportive assistance to transitioning members in the least restrictive environment.

Program Methodology:

A. ED Care Triage for At-Risk Populations:
   - The participating facilities will establish linkages to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
   - For patients presenting with minor illnesses, once required triage is performed validating a less urgent need, patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider with whom they can establish a care relationship.
   - In a collaborative model with first responders working with established protocols and under supervision of ED practitioners, patients calling for ambulance services for non-acute disorders could be transported to alternate care sites such as urgent care centers to receive more appropriate level of care.

B. Care Transitions Intervention Model to Reduce 30 day Readmissions for Chronic Health Conditions-Cardiac/Renal/ Diabetes/Psychiatry:
   - Participating hospitals, generally partnering with a home care service or other appropriate community services, will focus on pre-discharge patient education, care record transition to receiving practitioner, and patient community support for a 30 day transition period post hospitalization to ensure patient understanding of self-care and receipt of follow-up care.
New York State DSRIP Program Descriptions

C. Care Transitions Intervention Model to Reduce 30 day Readmission for Chronic Health Conditions for SNF Residents:
• In a model similar to B., participating hospitals will partner with a SNF to perform the same basic three services, ensuring SNF staff and practitioner are accurately informed regarding patient care needs including current medications, rehabilitation services and follow-up medical care.

D. Transitional Supportive Housing:
• Participating hospitals would partner with community housing providers and, if appropriate, home care services, to develop transitional housing for high risk patients who, due to their medical or behavioral health condition, have difficulty transitioning safely from a hospital when the acute medical needs are fully met. Such housing would provide short term care management to allow transition to a longer term care management program or PCMH and would allow additional time to support rehabilitation, stabilization of medical condition, and patient confidence in self-management.
New York State DSRIP Program Descriptions

Project Specific Metrics:

1. Process Metrics (to be established with provider and may include):
   - Patient count agreeing to receive service
   - Patients seen within 48 hours prior to hospital discharge
   - Care records documented received with 24 hours after discharge by primary care provider
   - SNF – timely transmission of transition record
   - Compliance with follow-up outpatient appointments
   - Patient satisfaction

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs
   - PQIs
   - PDIs

3. Project Specific Outcome Metrics:
   - Follow-up after hospitalization for mental illness (HEDIS)
   - Persistence of Beta-blocker treatment after a Heart Attack (HEDIS)
   - Cholesterol Management for Patients with Cardiovascular conditions (HEDIS)
   - Pharmacotherapy Management of COPD Exacerbation (HEDIS)

4. Diabetes Comprehensive Care (HEDIS)

Financial Viability Metrics: Specific to the Provider
**New York State DSRIP Program Descriptions**

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP)/ Primary Care Expansion

**Program Number:** 1.03

**Program Title:** Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management to reduce avoidable hospitalizations

**Program Objective:** Develop an integrated clinical management program incorporating medical, mental health, social service organizations as well as payers to transform current service delivery model from hospital based to community. Integrated program may be of several structures including joint governance or based upon memorandums of understanding. It is anticipated that potential models will include payment for performance; inpatient restructuring and bed reduction, enhancement of community based services, and will be based upon a community and regional assessment of need.

**Program Methodology:**

- Complete a regional/service area assessment of health care needs including current resources, needed resources, excess bed capacity, and community partner resources.

- Based upon the assessment, develop and implement a comprehensive strategy and action plan for acute care bed reduction, development of ambulatory/community based health care needs, and community partnership development including with primary care services, behavioral health services, social services including social support services, Health Homes and local governmental units (health, SPOA, social services).

- Develop governance strategy for integrated delivery system such as joint governance, memorandums of understanding.

- Develop process improvement strategy such as Lean to ensure efficiency within the delivery system and reduction of redundancies.

- Support EHR linkage to the local health information exchange/RHIO/SHIN-NY including supporting notifications/secure messaging.
New York State DSRIP Program Descriptions

Project Specific Metrics:

1. Process Metrics (to be established with provider and may include):
   - Patient Satisfaction Survey (Press Ganey, CAHPS)
   - Bed Occupancy Rate
   - Percentage of available providers participating in IDS
   - Service adequacy (wait times for services – ED)

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcome Metrics (partial list/as appropriate to population):
   - Adolescent Preventive Care Measures (NCQA)
   - Adult BMI Assessment (NCQA)
   - Annual Monitoring for Patients on Persistent Medications (NCQA)
   - Appropriate Treatment for Children with Pharyngitis; with Upper Respiratory Infection (NCQA)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (NCQA)
   - Breast Cancer Screening (NCQA)
   - Cervical Cancer Screening (NCQA)
   - Chlamydia Screening in Women (NCQA)
   - Cholesterol Management for Patients with Cardiovascular Conditions (NCQA)
   - Comprehensive Diabetes Care (NCQA)
   - Use of imaging Studies in Low Back Pain (NCQA)
   - Use of Spirometry Testing in the Assessment and Diagnosis of COPD (NCQA)
   - Adult Access to Preventive/Ambulatory Care (NCQA)
   - Children’s Access to PCP (NCQA)
   - Well Child Visits (two measures) (NCQA)
   - Adolescent Well-Care Visits (NCQA)
   - Ambulatory Care (NCQA)

4. Financial Feasibility Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.04

**Program Title:** Expand access to primary care and support services (based on assessment) to reduce avoidable hospitalizations

**Program Objective:** To expand access to primary care services in the community and develop integrated care teams (physicians and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers) to meet the individual needs of patients, particularly those whom are high risk, who otherwise do not qualify for care management services

**Program Methodology:**

- Provider will do a community needs assessment where necessary to identify service area sections without sufficient primary care services.

- Provider will develop primary care capacity in identified shortage areas based upon the community assessment. This may include not only community based services, but also focused services in congregate living sites such as assisted living facilities.

- Primary care site will provide linkages with needed services to include behavioral health providers, pharmacists, nurse educators and care managers that are necessary to meet patient needs in that community. It is expected the provider will work with local government units such as SPOAs and public health where appropriate.

- Using EHR registries and other community data, at risk patients will be identified who do not already have access to care management services and engaged with the care management team for development of a comprehensive care management plan to reduce patient’s risk factors.

- Evidence based practice guidelines will be implemented to address risk factor reduction (smoking cessation/immunization/substance abuse identification and referral to treatment/depression screening/etc) as well as disease management guidelines (Diabetes/Cardiovascular Disease/Asthma)
New York State DSRIP Program Descriptions

- Instant messaging and alerts programs will be implemented to ensure timely sharing of critical patient information.
- A dashboard of outcome metrics will be established to monitor the care provision.
- All participating providers must already be a NCQA accredited PCMH or commit to achieving these standards

**Project Specific Metrics:**

1. Process Metrics (to be established with provider and may include):
   - Assessment of service adequacy including provider engagement/reduction in unmet services
   - Patients eligible for care management and engaged in care management
   - Patient satisfaction with service
   - Time to next third appointment (IHI)

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcome Metrics (partial list/will be specific to community focus)
   - Adolescent Preventive Care Measures (NCQA)
   - Adult BMI Assessment (NCQA)
   - Annual Monitoring for Patients on Persistent Medications (NCQA)
   - Appropriate Treatment for Children with Pharyngitis; with Upper Respiratory Infection (NCQA)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (NCQA)
   - Breast Cancer Screening (NCQA)
   - Cervical Cancer Screening (NCQA)
   - Chlamydia Screening in Women (NCQA)
   - Cholesterol Management for Patients with Cardiovascular Conditions (NCQA)
   - Comprehensive Diabetes Care (NCQA)
   - Use of imaging Studies in Low Back Pain (NCQA)
   - Use of Spirometry Testing in the Assessment and Diagnosis of COPD (NCQA)

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.05

**Program Title:** Expand Usage of Telemedicine in Underserved Areas to Provide Access to Otherwise Scarce Services as a Means to Reduce Avoidable Hospitalizations

**Program Objective:** Create access to services otherwise not accessible due to patient characteristics, travel distance or specialty scarcity. Services can be supplied in the patient home for patient to MD/practitioner management or in the primary care office for enhanced specialty access. This electronic communication encompasses the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment and support direct active communication that is not delayed or stored.

Telemedicine projects could address the patient issues such home based telemedicine for chronic disease management and/or specialty scarcity such as telemedicine specialty services for AIDS/HIV, Adult Psychiatry or Child Psychiatry.

**Program Methodology:**

Providers implementing this project will need to provide clear definition of the following:

- how telemedicine services will reduce available hospital use
- telemedicine service to be supplied (such as access to HIV specialty services),
- equipment specs and rationale for equipment choice,
- service area for implementation,
- service agreements in place for provision of the telemedicine service such as specialty service, participating primary care networks and nurse triage monitoring,
- standard protocols for the service (such as patient eligibility, appointment availability, medical record protocols).
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with the provider and may include):
   - Percentage of Primary care providers participating
   - Specialty network developed
   - Lead time for appointment scheduling
   - Number of patient appointments scheduled and completed
   - Patient/practitioner satisfaction with service

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs
   - PQIs
   - PDIs

3. Project Specific Outcome Metrics
   - Improved compliance with disease specific metrics particularly to service delivered - HIV/AIDS Comprehensive Care (NYS)
   - Diabetes Monitoring for People with Diabetes and Schizophrenia (HEDIS)
   - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (HEDIS)
   - Follow-up Care for Children Prescribed ADHD Medication (HEDIS)
   - Persistence of Beta-Blocker Treatment After a Heart Attack (HEDIS)
   - Cholesterol Management for Patients with Cardiovascular Conditions (HEDIS)
   - Controlling High Blood Pressure (HEDIS)

4. Financial Viability Metrics
   - Specific to Provider
New York State DSRIP Program Descriptions

Focus Area: Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

Program Number: 1.06

Program Title: Increase Certification of Primary Care Practitioners with PCMH certification to reduce avoidable hospitalizations

Program Objective: To transform all safety net providers in primary care practices to Level Three Patient Centered Medical Homes (PCMHs). This Program will address those providers who were not otherwise eligible for support in this practice advancement as well as those programs with multiple sites which wish to undergo a rapid transformation.

Program Methodology:

- Identification of a physician champion with knowledge of PCMH implementation who can assist with meeting all components of the NCQA requirements including skills of population management through EHR and process improvement methods.
- Identification of care coordinators at each primary care site who are responsible for care connectivity and engagement of other staff in PCMH process as well as care managers who provide care coordination for higher risk patients not otherwise involved in care management.
- Implementation of necessary HIT functionality including EHR, HIE connectivity, e-prescribing, instant messaging, ER alerts
- Staff training on care model including evidence based preventive and chronic disease management
- Implementation of open access scheduling
- Development of process and outcome quality process to monitor practice and ensure efficiency and quality of service
- Monitoring of financial status
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider and may include):
   - Progress to meeting NCQA Level Three standards
   - Time to next third appointment (IHI)
   - Patient satisfaction
   - Care management record transmission efficiency

2. Avoidable Hospitalization Suite
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcome Metrics (partial list/will be specific to community focus)
   - Adolescent Preventive Care Measures (NCQA)
   - Adult BMI Assessment (NCQA)
   - Annual Monitoring for Patients on Persistent Medications (NCQA)
   - Appropriate Treatment for Children with Pharyngitis; with Upper Respiratory Infection (NCQA)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (NCQA)
   - Breast Cancer Screening (NCQA)
   - Cervical Cancer Screening (NCQA)
   - Chlamydia Screening in Women (NCQA)
   - Cholesterol Management for Patients with Cardiovascular Conditions (NCQA)
   - Comprehensive Diabetes Care (NCQA)
   - Use of imaging Studies in Low Back Pain (NCQA)
   - Use of Spirometry Testing in the Assessment and Diagnosis of COPD (NCQA)
   - Access and use of Services Suite (HEDIS)

4. Financial Viability Metrics Specific to Provider
New York State DSRIP Program Descriptions

<table>
<thead>
<tr>
<th>Focus Area:</th>
<th>Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Number:</td>
<td>1.07</td>
</tr>
<tr>
<td>Program Title:</td>
<td>Integration of Behavioral Health into Primary Care Setting to Reduce Avoidable Hospital Use</td>
</tr>
<tr>
<td>Program Objective:</td>
<td>Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services. This may be achieved by integration of behavioral health specialists into primary care clinics using the collaborative care model and supporting the PCMH model, or integration of primary care services into established behavioral health sites such as clinics, Crisis Centers. When onsite coordination is not feasible, to incorporate behavioral health specialists into primary care coordination teams.</td>
</tr>
<tr>
<td>Program Methodology:</td>
<td>IMPACT Model:</td>
</tr>
<tr>
<td></td>
<td>a. This is an integration project based on the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model. The IMPACT model, which originates from the University of Washington in Seattle, integrates depression treatment into primary care and improves physical and social functioning, while cutting the overall cost of providing care. Several community-based primary care providers in New York have experience implementing the IMPACT model. Based on the IMPACT model, this project directs primary care providers to collaborate with LCSWs or community health workers to improve overall patient care by executing an internal referral system and mastering two-way communication between service providers. This integration project provides for several treatment options, including medication, group therapy, or individualized therapy; as well as early access to on-site mental counseling, mental health referrals, and psychiatric care. Integration projects such as these can help to reduce avoidable hospital admissions across New York State, and support hospital objectives as well.</td>
</tr>
</tbody>
</table>
New York State DSRIP Program Descriptions

b. Integration of behavioral health services into PCMH

- Provider will work with community, facility and LGU (SPOA) resources to identify behavioral health providers in the community and interest in developing collaborative care model with PCMH. This will include a community assessment of most efficient care delivery plan.

- With interested community and facility providers, provider will develop structure for integration including governance, MOUs, and financial feasibility.

- PCMH and behavioral health providers will collaborate on evidence based standards of care including medication management and care engagement process.

- Preventive care screenings including depression screening and SBIRT will be implemented for all patients to identify unmet needs.

- A quality process and outcome program will be implemented to ensure integration is efficient and appropriate outcome metrics are met.

c. Integration of primary care services into behavioral health sites.

- It is anticipated that C. will follow essentially the same process for implementation as B. except that clinic licensure issues will need to be addressed with the appropriate state agencies.
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider and may include):
   - Percent of patients enrolled in IMPACT program
   - Percent of patients screened with validated tools for clinical depression/substance abuse by primary care provider
   - Provider satisfaction with model implementation and care delivery
   - Patient satisfaction
   - Percent of patients with an optimal/reduced PHQ-9 score

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcome Metrics
   - Follow-up after hospitalization for Mental Illness (NCQA)
   - Antidepressant Medication Management (NCQA)
   - Adherence to Antipsychotic Medications for People with Schizophrenia (NCQA)
   - Diabetes Monitoring for People with Diabetes and Schizophrenia (NCQA)
   - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (NCQA)
   - Follow-up care for children prescribed ADHD medications (NCQA)
   - SBIRT Screening (State specific)

4. Financial Viability Metrics:
   - Specific to Provider
# New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.08

**Program Title:** Development of Community Based Health Navigation Services to Reduce Avoidable Hospital Use

**Program Objective:**
Hire community resource “navigators” person available face to face, telephonically or through on line services who can assist patients to access health care services efficiently. The community resource is not necessarily a licensed health care provider, but a person who has been trained and resourced to understand the community care system and how to access including assisting patients with appointments.

**Program Methodology:**

- The need for this program will be identified through a regional or service area needs assessment. Need may be based on identified language, cultural or health literacy barriers to understanding the health care delivery system, particularly as it transforms and old patterns of care are expected to change.

- Where need is identified, a collaborating program oversight group of medical and behavioral health practitioners and providers and community nursing and social support services will need to develop a community care resource guide to assist the community resource person and ensure compliance with protocols.

- Resourcing for the community resource person will need to be established and could include placement in an ED waiting area, community health center, community meeting center, etc. Telephonic and IT resources including a chat line will need additional resourcing to increase community access to the service.

- Wide marketing of the resource in the community will need to occur.

- Utilization measures will need to be developed, collected and reported on to the program oversight committee.
Project Specific Metrics:

1. Process Metrics (to be established with provider and may include):
   - Service utilization
   - Patient satisfaction with service
   - Monitoring of complaints
   - Provider satisfaction with service

2. Avoidable Hospitalization Suite:
   a. PPVs (3M)

3. Project Specific Outcome Metrics:
   - Adult Access to Preventive/Ambulatory Care (HEDIS)
   - USE OF SERVICES – Well Child Visit Suite (HEDIS)
   - Adolescent Well Care Visits

4. Financial Viability Metrics:
   - Specific to the Provider
New York State DSRIP Program Descriptions

Focus Area: Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

Program Number: 1.09

Program Title: Increase Access to Specialty Care (Including Mental Health) to reduce Avoidable Hospitalizations

Program Objective: To increase access to scarce specialty services for complex patient care through innovative care models

Program Methodology:

A. Create ambulatory ICUs for Patients with Multiple Co-Morbidities/Non-physician interventions for Stable Patients with Chronic Care Needs.

An ambulatory ICU, the term for multi-provider team based visits for patients with complex medical, behavioral, and social morbidities, and community based non-physician care for stable patients in need of chronic disease monitoring combined allow efficient use of complex services by allocating levels of service only as needed. This model is based upon the NUKA team based care program endorsed by the Institute for Healthcare Improvement.

Program development requires:

- Identification of need for complex specialty services by community
- Development of specialty services network to participate in the ambulatory ICU
- Identification of primary care physicians/practitioners interested in ambulatory ICU
- Identification of eligible population of patients through EHR patient registries and community referrals
- Co-locating care managers and social support services on site in ambulatory ICU clinic
- Development of EHR and HIE connectivity, notifications and secure messaging to ensure complete access to all patient medical information, patient portal to support communication and self-management skills.
- Team based review of care planning
New York State DSRIP Program Descriptions

B. Specialized Medical Homes for Chronic Renal Failure/Specialized Stage 4 Renal Failure Program

Management of renal failure requires close monitoring, anticipatory guidance and education for the patient, and proactive interventions for ports in anticipation of need for dialysis. African American patients with renal failure, particularly, are more likely to progress in an aggressive decline in renal function due to certain genetic predispositions and require close and aggressive monitoring. A medical home for chronic renal failure would ensure primary care, specialty care, nursing, dialysis, nutritional education services and social supports would be coordinated to optimally manage declining renal function and support improved quality of life for these patients.

Program development requires:

- Identification of nephrologist champion supportive of the new model of care
- Identification of primary care physicians/practitioners interested in shared care of their complex renal patients
- Identification of support services including dialysis co-located at clinic site for efficiency
- Development of EHR with care planning enhancements for team based records of clinic visits; HIE connectivity for collection of laboratory and other clinical testing; patient portal for self-management and communication with care team

C. Development of Behavioral Health Crisis Stabilization Services for Community Access

Routine emergency departments and community behavioral health providers are unable to readily find resources for the acutely psychotic or otherwise unstable behavioral health patient. The Behavioral Health Crisis Stabilization Service provides a single source of specialty expert care management for these complex patients within the hospital campus for observation monitoring in a safe location and ready access to inpatient psychiatric stabilization if short term monitoring does not resolve the crisis. A mobile crisis team extension of this service will assist with moving patients safely from the community to the services and do community follow-up after stabilization to ensure continued wellness.
New York State DSRIP Program Descriptions

Program development requires:

- Access to hospital with specialty psychiatric services and crisis oriented psychiatric service
- Observation unit within hospital outpatient for up to 48 hours of monitoring to attempt stabilization
- Development of mobile crisis team with appropriate management skills utilizing evidence based protocols developed by medical staff
- EHR and HIE connectivity to allow alerts and secure messaging and to obtain current medical records for the patient.
- Concurrence of community of psychiatrists and behavioral health providers to support central triage service based upon community assessment of need

**Project Specific Metrics:**

1. Process metrics:
   - To be established with provider dependent upon program developed

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcomes Metrics (will be driven by program):
   - Comprehensive Diabetes Management (NCQA)
   - Cholesterol Management for Patients with Cardiovascular Conditions (NCQA)
   - Controlling High Blood Pressure (NCQA)
   - Persistence of Beta Blocker Treatment after a Heart Attack (NCQA)
   - Pharmacotherapy Management of COPD Exacerbation (NCQA)
   - Flu shots for Adults Ages 50 – 64 (NCQA)
   - Annual Monitoring for Patients on Persistent Medications (NCQA)
   - Adherence to Antipsychotic Medications for People with Schizophrenia (NCQA)
   - Antidepressant Medication Management (NCQA)
   - Follow-up after Hospitalization for Mental Illness (NCQA)

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.10

**Program Title:** Development of Co-located Primary Care Services in Emergency Department to Reduce Avoidable Hospitalizations

**Program Objective:** To improve access to primary care services as a PCMH model co-located/adjacent to community emergency services

**Program Methodology:**

Patients in certain communities are accustomed to and comfortable with seeking their health care services in the hospital setting, frequently leading to over use of emergency room services while missing preventive health care services. This model allows a facility to have a co-located primary care PCMH adjacent to the ED. The PCMH practice, consistent with the model, will have extended hours and open access scheduling. This will allow patients presenting to the ED who are triaged and do not require emergency services to be redirected to the PCMH, beginning the process of engaging patients in comprehensive primary care.

- Based upon a community assessment of need for primary care services, analysis of service type provided by community ED, and zip code analysis of ED patients seeking non-acute services to ensure appropriate location of the co-located primary care, a provider can seek to recruit or relocate a PCMH into the same facility as the community ED.

- Practitioners in the ED and the PCMH will develop care management protocols for triage and referral to ensure compliance with EMTALA standards.

- EHR with HIE connectivity including secure messaging and alerts will be needed to ensure communication of medical records between the two services.

- As part of the PCMH model, care coordinator will assist patients in understanding use of the health system, increasing confidence in self-management of common conditions, and increasing knowledge on appropriate care for common conditions based upon EMB guidelines.
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospital Suite:
   - PPVs (3M)

3. Project Specific Outcomes Metrics
   - Use of appropriate Medications for Asthma (NCQA)
   - Use of Imaging Studies for Low Back Pain (NCQA)
   - Appropriate Testing for Children with Pharyngitis (NCQA)
   - Appropriate Treatment for Children with Upper Respiratory Infections NCQA)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis(NCQA)

4. Financial Feasibility Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.11

**Program Title:** Comprehensive Strategy to Decrease HIV/AIDS Transmission to Reduce Avoidable Hospitalizations

**Program Objective:** To reduce transmission of HIV and, therefore, new cases by improving identification of those currently infected with HIV, improving access to effective viral suppressive therapy and implementing evidence based prevention and disease management strategies

**Program Methodology:**

A. Harm Reduction Program for IV Drug Users

- Established AIDS Institute Syringe Exchange Programs will develop harm reduction counseling services for active users that target high risk activities and serve as a bridge for entry into drug treatment and other health and social services. Programs participating will develop integration/coordination with Health Home and Health Plan services and develop co-located mental health and medical services.

B. HIV Services Transformation – Center of Excellence Management of HIV

- **Model 1 – Early Access to and Retention in HIV and HCV Care – scatter model**

  Patients at risk for or already diagnosed with HIV or HCV will receive evidenced based care at their usual primary care location in this model. Primary care practitioners will have received training in current management of these diseases and will have access to specialty expertise for complex cases. Coordination of care including behavioral health and social services at the primary care site will support retention of the patient in care and improved management of the disease.

- **Model 2 – Center of Excellence Management of HIV**

  Patients with HIV will receive all services for the management of their disease in one site where access to primary care, specialty care, dental care, mental health service, dietary services as well as prevention services including PREP, testing, high risk prenatal care, Suboxone treatment will be provided to improve access to needed care, manage viral loads and reduce risk of continued viral transmission. “One stop shopping” will improve patient experience and ensure care is comprehensive. Management of care will utilize multidisciplinary staff linked with EHR enhanced with care management tools.
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with the provider):

2. Avoidable Hospital Suite:
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcomes Metrics:
   - HIV/AIDS Comprehensive Care (NYS specific)
   - Colorectal Cancer Screening (NCQA)
   - Medical Assistance with Smoking Cessation (CAHPS)
   - Cervical Cancer Screening (NCQA)
   - Chlamydia Screening (NCQA)

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP)/ Primary Care Expansion

**Program Number:** 1.12

**Program Title:** Create a Bed Buy-Back program for Hospitals to Reduce Avoidable Hospitalizations

**Program Objective:**

Today, with advances in medical technology and methods of delivery, health care systems face the central issue of how and where to provide effective and efficient care. The role of the hospital in our evolving health care system is changing, with an emphasis on outpatient diagnosis and treatment as well as alternatives to long-term hospital care, leading to reductions in numbers of hospital beds that are needed. Today, hospitals are no longer seen as the “big-box” dominating the delivery of health care services.

For instance, during the 2011 Brooklyn Medicaid Redesign Work Group, the committee found that the borough had 15 hospitals with nearly 6,400 licensed beds. However, almost 30 percent of those beds are vacant on an average day and more than 15 percent of adult medical-surgical admissions could be prevented with appropriate primary care. High rates of avoidable emergency department use and preventable hospitalizations, moreover, suggested that Brooklyn residents were not accessing care in the most effective and efficient setting.

Hence, a hospital cannot, and should not, provide all of the health care that a community needs, but rather, should be a part of a highly effective, integrated health delivery system. There needs to be an understanding that access to hospital care is not the benchmark against which to judge the health status of a community. Access to high quality primary care and community-based specialty care is a critical component of an effective system of care.

To achieve this state, hospitals must undergo delivery and service reconfiguration to promote clinical integration and reduce its reliance on in-patient revenue. As more services are delivered in outpatient settings, New York State envisions the bed buy-back program as a way to allow hospitals to reduce their inpatient bed capacity, while expanding other services in the continuum of care that meets the needs of the community they serve. Additionally, facilities with high rates of readmissions would be encouraged to apply, so that we could reduce the capacity of poorer-performing hospitals and realigning those resources to provide, more effective and efficient out-patient services.

One example of a hospital bed buy-back program could be to transition an old hospital into stand-alone emergency departments and/or spaces occupied by local service organizations and specialized clinics with extended hours and staffing. This reconfiguration, sometimes referred to as a “medical village,” would allow for the space to be utilized as the center of a coordinated health network. These new integrated centers would result in a health system that includes organizations with: fully integrated provider networks responsible for community health outcomes; a primary focus on quality and service outcomes; enhancement of primary and preventative health care services; as well easier integration of and more incentive to utilize health information technology resources.
New York State DSRIP Program Descriptions

Program Methodology:

Providers undertaking this project will need a clear definition of the following:

- How the bed buy-back program will promote better service and outcomes (service volume, occupancy stats, discharge and or visit data, etc.).
- Proposal must provide clear objectives for the use of the funds being requested
- Specific activities funded through program must be stated.
- The proposal must provide a defined timeline for accomplishing the project’s activities/goals
- Financial section with a detailed operating budget by cost category including personnel costs, FTE data, OTPS and additional capital costs must be included.
- Any Closure Plan should outline how this will be accomplished with a clear timeline for implementing closure and the effect on employees (including severance and other closure costs not covered by other assets of funds, costs related to job relocation, retraining efforts, transitioning of staff to alternate service areas in facility, etc.).

Program Metrics:

1. Project Process Metrics (Performance):
   Detail in measurable terms the program objectives to be achieved (e.g., improved patient outcomes, reduced inpatient stays and PQI related admits, increased access to/utilization of ambulatory care services, improved occupancy rates).

2. Avoidable Hospitalization Metrics:
   - PPVs
   - PPRs
   - PQIs
   - PDIs
   - PSI (AHRQ)
   - IQI (AHRQ)

3. Project Specific Outcome Metrics:
   - Specific to the Provider and Project

4. Financial Viability Metrics:
   Detail in measurable terms the financial objectives to be achieved (e.g., improved financial metrics documented by operating margins, net profit margins, debt to capital coverage, days cash on hands, improved fund balances, and current rations greater than 1:1).
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.13

**Program Title:** Implementation of Observation Programs in Hospitals to Reduce Avoidable Hospitalizations

**Program Objective:** To reduce inpatient admissions by creation of dedicated observation units for patients presenting to ED whose need for inpatient services is not clearly defined or who need limited extended services for stabilization and discharge.

**Program Methodology:**

- Providers will create a clinical and financial model supporting the need for unit to include number of beds, staffing requirements, services definition, and admission, discharge, and inpatient transfer protocols.
- Appropriately sized and staffed units will be established in close proximity to ED services.
- Care coordination services will be established to ensure safe community discharge.
- Communication will require EHR with HIE/RHIO connectivity and ability to send alerts/secure messaging will be established to ensure community physicians are aware of short stay patient and are able to accept transfer with continuity back to the community
- Quality assurance program will be established to ensure unit is meeting service and quality outcome goals.

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):
   - Clinical Record Transmission to Community provider within 24 hrs.
   - Percentage of patients admitted to unit who were discharged to home

2. Avoidable Hospital Suite:
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)

3. Project Specific Outcome Metrics:
   - TBD

4. Financial Viability Metrics:
   - Specific to Provider
### New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.14

**Program Title:** Expansion of Palliative Care Programs to Reduce Avoidable Hospitalizations

**Program Objective:** To increase access to palliative care programs for end of life planning, which will in turn, reduce the need for hospital care in end of life situations

**Program Methodology:**

a. **Conversation Ready** - Implementation of IHI “Conversation Ready” project model or similar project by partnering care coordinators with community based and faith based partners to facilitate End of Life planning in a socially/belief system compatible manner to increase patients acceptance of program.

b. **Integration of Palliative Care Services into the PCMH model** – Partnerships with community and provider resources including Hospice will be created to bring a full range of palliative care supports and services into the primary care setting to enable conversations regarding patients’ desires for end of life management within a known environment, during active treatment and before a health crisis. Program may include development of Hospice services to support increased interest in accessing that service.

c. **Integration of Palliative Care Services into Nursing Homes** – Similar to B. above, but additionally providing on site management of pain and symptoms and supporting the end of life goals of residents with advance, life-limiting conditions.

**Project Specific Metrics:**

1. **Process Metrics (to be established with provider and may include):**
   - Percentage of patients presenting treatment option and accepted
   - Patient satisfaction including culture sensitivity of program

2. **Avoidable Hospitalization Suite:**
   - PPVs (3M)
   - PPRs (3M)
   - PQIs (AHRQ)
   - PSI (AHRQ)
   - IQI (AHRQ)

3. **Project Specific Outcome Metrics:** TBD

4. **Financial Viability Metrics:**
   - Specific to Provider
**New York State DSRIP Program Descriptions**

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.15

**Program Title:** Development of Evidence-Based Medication Adherence Programs in Hospitals to Reduce Avoidable Hospitalizations

**Program Objective:** To implement an evidence-based clinical treatment and care management program focusing on improved medication adherence in high utilizing patients with severe and persistent mental illness.

**Program Methodology:**

The program is based upon two successful pilots in Europe, the protocols of which are being modified to meet the needs of patients in a large urban environment. Program is based upon shared decision-making and behavior modification to effect sustained change. Program is an enhancement to the Fund for Public Health NY Medication Adherence Project. Care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists are trained in motivational interviewing techniques and engage in patients in structured conversations about medication compliance.

**Project Specific Metrics:**

1. **Process Metrics (to be established with provider and may include):**
   - Percentage of patients offered participation who agree to participate
   - Inter-rater reliability of technique
   - Patient satisfaction
   - Provider Satisfaction

2. **Avoidable Hospitalization Suite:**
   - PPVs
   - PPRs (3M)
   - PQRs (AHRQ)

3. **Project Specific Outcome Measures**
   - Adherence to Antipsychotic Medications for People with Schizophrenia
   - Antidepressant Medication Management
   - Asthma Medication Ratio (HEDIS)
   - Annual Monitoring for Patients on Persistent Medications

4. **Financial Viability Metric:**
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Hospital Transition / Public Hospital Innovation / Vital Access Provider (VAP) / Primary Care Expansion

**Program Number:** 1.16

**Program Title:** Development of Ambulatory Detox Capabilities within Communities to Reduce Avoidable Hospitalizations

**Program Objective:** To develop ambulatory detoxification program within the community that provides medical supervision and allows rapid transfer of stabilized patient to community addiction services.

**Program Methodology:**

The majority of patients seeking inpatient detoxification services do not require the intensive monitoring and medication management available in the inpatient setting. These patients can be monitored in an outpatient program until stability is assured and be rapidly integrated to a co-located outpatient treatment program. Such programs can address alcohol and opioid dependency. Steps to establish a program includes:

- Assessment of community need for program to ensure location and services are coincident.
- Referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.
- Addressing licensure status of ambulatory detoxification
- Identification/recruitment of an ASAM certified medical director with training and privileges for use of Suboxone
- Identification of community providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy. These may include practices with collocated behavioral health services.
- Development of ambulatory detoxification protocols and staff training.
New York State DSRIP Program Descriptions

Project Specific Metrics:

1. Process Metrics (to be established with provider):

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs (3M)
   - PQIs (AHRQ)

3. Project Specific Outcomes:
   - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)
   - Transfer to Continuing care after discharge from detox/rehab (NYS Specific Measure/PSYCKES)

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Long Term Care Transformation  

**Program Number:** 2.01  

**Program Title:** Development of Inpatient Transfer Avoidance program for SNF to Reduce Avoidable Hospitalizations  

**Project Objective:** To reduce transfer of patients from a SNF facility to an acute care hospital by early intervention strategies to stabilize patients before crisis levels occur.

**Project Methodology:**

A. *Behavioral Interventions Paradigm in Nursing Homes (BIPNH)*

The BIPH model uses SNF skilled nurse practitioners and psychiatric social workers to provide early assessment, reassessment, intervention and care coordination for at-risk residents to reduce the risk of crisis requiring transfer to a higher level of care. Model requires:

- Augmenting the skills of the clinical professionals in behavioral health issues.
- Enabling the non-clinical staff to effectively interact with a behavioral population.
- Assigning a NP with Behavioral Health Training as a coordinator of care.
- Implementing a Behavior Management Interdisciplinary Team Approach to care.
- Implementing a medication reduction and reconciliation program.
- Increasing the availability of psychiatric and psychological services via telehealth and urgent prescribers.
- Holistic Psychological Interventions.
- Providing enhanced recreational services.
- Developing Crisis Intervention Strategies via development of an algorithm for staff intervention and utilizing sitter services.
- Improving documentation and communication re: patient status.
- Modifying the facility environment.
New York State DSRIP Program Descriptions

B. Implementation of the Interact Program

The nursing homes will implement the evidence-based Interact program developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare and Medicaid Services (CMS). The current version of the INTERACT Program was developed by the Interact interdisciplinary team under the leadership of Dr. Ouslander, MD with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by the Commonwealth Fund. There is significant potential to further increase the impact of INTERACT by integrating INTERACT II tools into nursing home health information technology through a standalone or integrated clinical decision support system.

The program is composed of the following components:

- Leadership education
- Facility champion
- Nursing home staff education
- Coaching to facilitate and support implementation
- Measurement of outcomes
- INTERACT 3.0 Toolkit

The program includes staff training, enhanced communication between the SNF and acute care hospitals, quality assessment/root cause analysis of transfer to identify interventions; and patient and family education and empowerment.

C. Hospital-Home Care Collaboration Solutions

Similar models can be applied to the patients who are being managed with home care services.

This program can consist of the following components:

- Rapid Response Teams (hospital/home care) to facilitate patients’ discharges to home including assurance services are in place
- Home care staff with knowledge and skills to identify and respond to patient risks for readmission and to support EBM chronic care management
- Integration of primary care, pharmacy and other services into the model to enhance coordination of care and medication management
- Utilization of telehealth/telemedicine
- Utilization of interoperable EHR to enhance communication, avoid medication errors and duplicative services
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospital Suite
   - PPVs
   - PPRs (3M)
   - PQIs (AHRQ)

3. Project Specific Outcome Metrics: TBD

4. Financial Viability Metrics:
   - Specific to the Provider
New York State DSRIP Program Descriptions

**Focus Area:** Long Term Care Transformation

**Program Number:** 2.02

**Program Title:** Expand Pressure Ulcer Prevention program to Reduce Avoidable Hospitalizations

**Program Objective:** The objective of this program is to expand the NYS Gold STAMP Program reduce avoidable pressure ulcers in nursing home and home care patients.

**Program Methodology:**

Pressure ulcers are one of the five most common problems experienced by patients in healthcare facilities and are both high cost and high volume adverse events, the majority of which can be prevented. In 2006, the mean cost of treating a patient with the primary diagnosis of pressure ulcers in a hospital was $1200/day and about 54% of hospitalized patients with a primary or secondary diagnosis of pressure ulcers were discharged to a skilled nursing facility. In a study published in 2008, skilled nursing facility residents’, with Stage II pressure ulcers, median healing time was 46 days.

This program will follow the implementation strategies of the successful NYS Gold STAMP Program. The New York State Department of Health and other professional and provider organizations across the continuum of health care, have partnered together and developed a quality improvement program to reduce the incidence of facility acquired pressure ulcers and ultimately improve care to patients and residents living with pressure ulcers.

The Gold STAMP Program has created educational tools to assist and support health care providers with the challenge of reducing pressure ulcers. These resources include an organizational self-assessment tool, and a resource guide aimed to help providers with strategic instructional information that will improve communication and reduce pressure ulcers within their setting and across the continuum. Since its implementation, the New York State Gold STAMP Program has had great success in reducing the occurrence and duration of pressure ulcers in patient at facilities using the program’s practices. The program also has a significant return on investment for providers.

http://www.health.ny.gov/professionals/nursing_home_administrator/gold_stamp/
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospitalization Suite:
   - PPVs
   - PPRs (3M)
   - PQIs (AHRQ)
   - PSI-03 (AHRQ)

3. Project Specific Metrics:
   - SNF State mandated reporting on Pressure Ulcers
   - Home Care state quality reporting

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

Focus Area: Long Term Care Transformation

Program Number: 2.03

Program Title: Implement medication error prevention program to reduce avoidable hospitalizations

Program Objective: To reduce the incidence of medication errors

Program Methodology:

To implement this program, the following steps should minimally be followed:

- Development of Root Cause Analysis Task Force to identify causes of medication errors within the organization
- EHR capability with HIE connectivity and e-prescribing capability to reduce errors in fill and ensure transferred patients have accurate lists of patient medications including most updated list of medications with adverse effects.
- On site or telemedicine access to pharmacy services, preferably from major referring hospital to ensure best understanding of facility prescribing practices and reduction in medication errors with transfer.
- Single unit dosing is preferred
- Patient verification process to ensure correct dose to correct patient, e.g., ID bar code scan technology.
- On-going staff training on medication compliance and new pharmaceuticals

Project Specific Metrics:

1. Process Metrics (to be established with provider):

2. Avoidable Hospitalizations Suite:
   - PPVs
   - PPRs (3M)
   - PQIs (AHRQ)

3. Project Specific Outcome Metrics:
   - TBD utilizing required SNF and HC reporting

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Category:**  
Long-Term Care Transformation

**Program Number:**  
2.04

**Program Title:**  
Create a Bed buy-back program for nursing homes to reduce avoidable hospitalizations

**Program Objective:**

Over the past decade, there has been significant growth in long term care needs. Over the same period, however, there have been major shifts within the long term care system itself. Emphases on outpatient diagnosis, treatment as well as alternatives to institutional care are leading to reductions in numbers of nursing home beds that are needed.

While it is widely assumed that an aging population would increase the need for in-patient and institutional care, this assumption may not be justified. Although aging has led to increased health care utilization, the increase is largely attributable to growing numbers of people with chronic conditions, for which acute care is ineffective, while alternatives, like community based care and supports, are more appropriate.

New York is committed to providing home and community based services that promote independence, safety and dignity. Hence, nursing homes must undergo a delivery and service reconfiguration to deliver the most meaningful services to its patient population. As more services are delivered in outpatient settings, New York State envisions the bed buy-back program as a way to allow nursing homes to reduce their bed capacity, while expanding other services in the continuum of care that meets the needs of the community they serve, including assisted living and transitional housing. Additionally, facilities with high rates of avoidable hospitalizations would be encouraged to apply, so that we could reduce the capacity of poorer-performing nursing homes and realigning those resources to provide, more effective and efficient out-patient long term care services.

These revamped facilities would result in a long-term care system that includes organizations focused on community based supports with a primary focus not only on quality, but also focus on supports and service, while enhancing primary and preventative health care services. resources. Additionally, due to advances in medicine, many health care services that were once the exclusive domain of in-patient facilities can now be delivered as effectively, and often, more efficiently in an outpatient setting or at home. By reducing beds, long term care facilities can utilize this freed space to expand their service model by becoming a low cost provider of services that had once only been provided in a hospital setting.

Furthermore, the New York Medicaid program is in the midst of a sweeping transformation moving many of its beneficiaries to managed care programs and to community based service settings for many of its high need/high cost populations. As the Medicaid program evolves to more appropriately address the needs of its beneficiaries, it is essential that the health care providers in New York have the support to realign their business to meet the better service those within their community. Hence, the bed buy-back program is essential to make New York’s health system transformation a reality.
New York State DSRIP Program Descriptions

**Program Methodology:**

Providers undertaking this project will need a clear definition of the following:

- How the bed buy-back program will promote better service and outcomes (service volume, occupancy stats, etc.).
- Proposal must provide clear objectives for the use of the funds being requested
- Specific activities funded through program must be stated.
- The proposal must provide a defined timeline for accomplishing the project’s activities/goals
- Financial section with a detailed operating budget by cost category including personnel costs, FTE data, OTPS and additional capital costs must be included.
- Any Closure Plan should outline how this will be accomplished with a clear timeline for implementing closure and the effect on employees (including severance and other closure costs not covered by other assets of funds, costs related to job relocation, retraining efforts, transitioning of staff to alternate service areas in facility, etc.).

**Program Metrics:**

1. **Project Process Metrics (Performance):** Detail in measurable terms the program objectives to be achieved (e.g., improved patient outcomes, reduced PQI related admits, increased access to/utilization of ambulatory care services, improved occupancy rates).

2. **Avoidable Hospitalization Metrics:**
   - PPVs
   - PPRs
   - PQIs

3. **Project Specific Outcome Metrics:**
   - Specific to the Provider and Project

4. **Financial Viability Metrics:** Detail in measurable terms the financial objectives to be achieved (e.g., improved financial metrics documented by operating margins, net profit margins, debt to capital coverage, days cash on hands, improved fund balances, and current rations greater than 1:1).
New York State DSRIP Program Descriptions

**Focus Area:** Public Health Innovation

**Program Number:** 3.01

**Program Title:** Increase support programs for maternal & child health (including high risk pregnancies) to reduce avoidable hospital use (Example: Nurse-Family Partnership)

**Program Objective:** To reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the two years of life

**Program Methodology:**

A. Implementation of Nurse-Family Partnership program model for pregnant teenaged girls.

http://www.nursefamilypartnership.org/

B. Where accessibility to complex high risk pregnancy care is poor, a regional medical center capable of managing high risk pregnancies and infants (NICU services) will form multi-disciplinary care teams with clinical and social expertise who will co-manage care of the high risk mother and infant with the local obstetrical and pediatric providers. Services will be available during the pregnancy and first year after birth. A core program component will be utilization of EHRs and HIE/RHIO to ensure real time data sharing and analytic capabilities and implementation of uniform clinical protocols based upon evidence based guidelines.

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospitalizations Suite:
   - PPVs
   - PPRs (3M)
   - PQIs
   - PDIs (AHRQ)
   - PSI (AHRQ)
   - IQI (AHRQ)

3. Project Specific Outcome Metrics: (TBD)
   - NYS-Specific Prenatal Care Measures
   - Childhood Immunization Status
   - Lead Screening in Children

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

Focus Area: Public Health Innovation

Program Number: 3.02

Program Title: Implementation of programs to reduce healthcare acquired infections to decrease avoidable hospitalizations

Program Objective: To implement infection control management within the hospital setting to reduce healthcare related infection and to reduce incidence of antibiotic resistance

Program Methodology:

A. Facility-wide Hand Hygiene Program

- Implement an institute wide hand hygiene and infection control training program with support from high level executives
- Identify a physician and nurse champion
- Ensure environment supports hand washing regimen before and after each patient encounter and other infection control methods
- Employ random “secret shopper” methods to catch staff doing well and reward, and catch staff that need remedial education
- Establish a quality evaluation committee that monitors infections and staff compliance and publish dashboard on intranet

B. Antibiotic Stewardship Program

- Identify a physician/Infectious Disease (ID) specialist and a pharmacist champion who will lead the program.
- Ensure antibiograms are performed by the laboratory and the results are transmitted to the medical record, preferably through the EHR, and require physician/practitioner sign-off.
- Ensure pharmacists become part of patient rounds in each ward of the hospital and are otherwise available to physicians for consultation.
- Ensure availability to ID specialist for physician consultation and when physician orders antibiotic not supported by antibiogram.
- Perform quality reporting on program on hospital intranet, to Nursing, Physician and Pharmacy staff.
New York State DSRIP Program Descriptions

C. Sepsis Detection and Management Program

- Facilities undertaking this project will develop multidisciplinary teams consisting of Nursing, Intensivists, Infectious Disease Specialists, and Pharmacists that will:
  - Create guidelines supported by EBM for the identification of at risk patients, early sepsis and sepsis management
  - Consult on each identified sepsis case and perform a root cause analyses to determine factors that recognized early would have prevented the sepsis
  - Ensure antibiograms are done in the clinical laboratory and prescribers adhere to these results (Antibiotic Stewardship Program)
  - Provide reports to Nursing, Physician staff and Administration on progress in reducing sepsis

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospital Suite:
   - PPRs (3M)
   - PSI (AHRQ) Sepsis

3. Project Specific Outcome Metrics:
   - TBD from required hospital reporting

4. Financial Viability Metrics Specific to Provider:
New York State DSRIP Program Descriptions

**Focus Area:** Public Health Innovation

**Program Number:** 3.03

**Program Title:** Development of community-based strategies to improve cancer screening to reduce avoidable hospitalizations

**Program Objective:** To implement a community strategy to improve cancer screening and early detection particularly among disparate populations. Cancer is more frequently diagnosed at a later stage in these populations, leading to the need for more aggressive therapies, often in the hospital setting, as well as more frequent hospitalizations for complications of therapies and metastatic disease. Early curative treatment can often be done in the outpatient setting.

**Demographic Incidence Rates**

- Incidence rates of late-stage colorectal cancer increased with age and were highest among black men and women.
- Incidence rates of late-stage breast cancer were highest among women aged 70–79 years and black women.
- Incidence rates of late-stage cervical cancer were highest among women aged 50–79 years and Hispanic women.

(http://www.cdc.gov/cancer/breast/what_cdc_is_doing/tests_article.htm)

**Project Methodology:**

- With community partners including social organizations, faith based organizations and community health care providers, perform a community assessment of need for cancer screening.
- Identify strategies to address social, cultural, language and health literacy barriers to cancer screening services, and implement strategies.
- Enlist community champions who support the program and are interested in marketing.
- Create screening fairs in community centric locations such as mobile mammography at a hair salon or church.
- Address cost of services (covered preventive service)
- Create/obtain appropriate brochures to address the common concerns regarding cancer screening.
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospital Suite:
   - PPVs (3M)
   - PQIs (AHRQ)

3. Project Specific Outcome Metrics:
   - Colorectal Cancer Screening (NCQA)
   - Breast Cancer Screening (NCQA)
   - Cervical Cancer Screening (NCQA)

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Public Health Innovation

**Program Number:** 3.04

**Program Title:** Expansion of asthma home-based self-management program/evidence-based medicine guidelines for asthma management to reduce avoidable hospitalizations

**Program Objective:** To ensure implementation of asthma self-management skills including monitoring, medication use and medical follow-up to reduce avoidable ED and hospital care. Special focus will be on children where asthma is a major driver of avoidable hospital use.

**Program Methodology:**

A. Implementation of Home-based Self-Management Program

Providers will partner with home care services to develop a home-based self-management program that will address:

- Home environmental assessment and abatement
- Asthma self-management with peak flow evaluation and asthma care plan
- Appropriate use of medication including controller and rescue inhalers and rescue oral corticosteroids; need for nebulizer
- Myths and truths of asthma and asthma management
- Periodic follow-up particularly if ED or hospital visit occurs to assist family with root cause analyzing what happened and how to avoid future events.

Programs will be built from recommendations of evidence based guidelines for management of asthma.

Home care services will ensure communication and coordination with primary care providers and specialty providers to ensure continuity and coordination of care.

B. Primary care practitioners collaborating specialists and community based asthma research center organization to support asthma management program. In rural communities, pulmonary specialty services may be difficult to access for primary care practitioners and their patients.

This program leverages regional medical center expertise to:

- Increase access to pulmonary specialists
- Educate community providers on best practices and guideline compliance
New York State DSRIP Program Descriptions

**Project Specific Metrics:**

1. Process Metrics (to be established with provider):

2. Avoidable Hospital Suite:
   - PDIs (AHRQ)
   - PPVs (3M)

3. Project Specific Outcome Metrics:
   - Appropriate Asthma Medications 3 or more controller dispensing events (NCQA)
   - Asthma Medication Ratio (NCQA)

4. Financial Viability Metrics:
   - Specific to Provider
New York State DSRIP Program Descriptions

**Focus Area:** Public Health Innovation

**Program Number:** 3.05

**Program Title:** Expansion of home visits to prevent childhood lead poisoning to reduce avoidable hospitalizations

**Program Objective:** To reduce number of children with elevated level of lead

**Project Methodology:**

- Providers will partner with home care agencies and public health resources to develop protocols for assisting parents/caretakers whose children are found to have elevated lead levels.
- Children identified with elevated lead levels will be monitored and treated as needed.
- Parents/caretakers will be advised of need for monitoring/treatment of lead level and for home evaluation and abatement.
- Trained nursing staff and public health staff will arrange a home visit to discuss concerns related to lead poisoning and assess the need for abatement services.
- Team will assist with any landlord issues, abatement issues or need for relocation.
- Team will continue working with parent until lead levels have become normal and home is safe.

**Project Specific Metrics:**

1. Process Metrics (to be established with provider)

2. Available Hospital Suite:
   - PDIs (AHRQ)

3. Project Specific Outcome Metrics
   - Lead Screening in Children (NCQA)

4. Financial Viability Metrics Specific to Provider
Appendix C:
Medicaid Redesign Team and Waiver Amendment
Stakeholder Engagement

Medicaid Redesign Stakeholder Engagement

This DSRIP plan is designed around feedback from extensive stakeholder engagement which has already occurred. Governor Cuomo created the MRT in January 2011 with the goal being to engage stakeholders in a meaningful way. This MRT process serves as a national model on how to move stakeholders beyond the common political rancor to real dialogue that generates creative, thoughtful reform. Thanks to the MRT and the process it created, New York State is now unified in its overall approach to Medicaid reform.

New York continued its commitment to engaging stakeholders and the greater public in ACA implementation and in developing the MRT Waiver Amendment, which now takes the form of the DSRIP plan. New York used a similar approach to engage stakeholders around key ACA provisions such as the health insurance exchange and continued the MRT tradition of rigorously engaging the public; ensuring transparency, while finalizing the 1115 Medicaid waiver amendment.

The goals of New York’s DSRIP program align as closely as possible with the original goals of New York’s MRT Waiver Amendment submitted in August 2012. The stakeholder engagement process for developing the MRT Waiver Amendment was carefully thought-out to ensure that all interested parties would be able to participate and share ideas for consideration.

A website for all waiver amendment materials was created and includes links to: the waiver summary paper; the full public notice; an application with a sufficient level of detail to provide the public with an opportunity to review and provide meaningful input; and information on related public engagement opportunities, including public hearings and webinars. More information is available at:


An online survey tool was created and made available for several weeks to receive public input. New York also used an electronic e-mail listserv, which distributes information to more than 2,000 subscribers, along with various social media tools to notify interested members of the public of the availability of these items and any additional updates on the waiver amendment website. New York will also include a link to the relevant page on the CMS website regarding the State’s waiver amendment application.

New York utilized stakeholder engagement strategies that were successfully deployed during the MRT process and also introduced new methods for determining public preferences for how and where New York should invest waiver resources.
Public Forums and Webinars

Public forums were held throughout the state to provide information on the MRT waiver amendment and to seek public feedback. Hearings took place in Buffalo, Syracuse, Albany and the Bronx between June 12, 2012 and June 20, 2012.

At the MRT Waiver Amendment Public Forums, the state’s Medicaid Director gave a presentation on the MRT waiver amendment and proposed areas of reinvestment. Members of the public had the opportunity to speak for two minutes to allow for as many comments as possible. Interested citizens, Medicaid members, representatives from associations, providers and community-based organizations were all represented at the forums. More than 400 people attended the forums, and more than 100 spoke and provided their thoughts and ideas. Comments were recorded as members of the public spoke, and were reviewed with relevant state staff working on each of the reinvestment areas. Attendees were also able to submit written comments, which were disseminated to staff working on specific reinvestment sections of the MRT waiver amendment.

Major themes in the comments heard at public forums included support for:

- Financial assistance for safety net providers throughout the state, including funding to support planning initiatives and provide technical assistance to interested providers and parties to develop proposals to be funded with waiver dollars;

- Reinvestment into primary care programs, including support for expansion of Patient Centered Medical Homes, addressing primary care shortages in both urban and rural areas, ensuring primary care providers have access to funding to support their full range of services; recognizing the need for expanded access to dental services and support for dental providers, and support for Doctors Across New York, which encourages providers to practice in underserved areas;

- Public health initiatives, especially to expand successful programs like Nurse Family Partnership;

- Expanding supportive housing and using supportive housing to assist in addressing employment, peer support and access to community-based services; and

- Workforce training, including examining scope of practice issues, expanding the community-based workforce and developing key competencies in the move to care management, expanding peer support programs, training providers from doctors to nurses to aides to community workers; and focusing on the need for cultural, disability, and LGBT competency.

General support was also expressed for other areas of reinvestment including new care models, regional planning, quality measurement, Health Home expansion and transition planning. Other suggestions and comments referenced a desire for continued transparency throughout the waiver amendment process, addressing health disparities in each of the reinvestment areas, and maintaining the ability of Medicaid members to have choices. Comments that were taken were shared with staff leads of the reinvestment areas and incorporated into the development of the waiver amendment application.
In addition to the public forums, three topic-specific webinars were held to seek additional feedback. The webinars focused on specific technical aspects of individual waiver amendment components and offered an opportunity for questions and feedback. The webinars were organized in a way to align related reinvestment strategies. Members of the public were able to sign up and view the webinar online, or dial-in and connect via conference call if they did not have computer access. Information on the public forums and topic-specific webinars was posted to the MRT Waiver web site and announced through the MRT listserv. More than four hundred people participated in the webinars. Archived versions were posted to the MRT Waiver web site.

**Tribal Consultation**

The state also provided notice and consulted with tribes in accordance with its federally approved tribal consultation process. The changes sought in the waiver amendment are expected to have minimal impact on tribal nations. A letter and relevant materials were mailed to tribal representatives and Indian Health contacts on June 6, 2012 announcing of the State’s intent to seek a waiver amendment.

An additional letter was sent on June 28, 2012, to schedule a conference call to consult with tribal nations on the waiver amendment. A conference call was held on July 17, 2012 to provide an overview of the waiver amendment and seek feedback. One nation participated in the call, and requested more opportunities to provide comment on the Medicaid program in general, to which the state committed.

**Medicaid Member Focus Groups**

The views of Medicaid members too often go unheard when it comes to Medicaid reform. New York worked with providers and community-based organizations to form member focus groups to help gather their important perspective on the waiver amendment. Three member focus groups were held in mid-July in New York City, Binghamton and Queensbury, and a total of 23 Medicaid members participated. A diverse group of members participated from various Medicaid programs. The focus groups provided an opportunity for the Medicaid Director to interact directly with Medicaid members and hear their concerns and issues with the Medicaid program, including what they like most about the Medicaid program, and where reinvestment dollars could help.