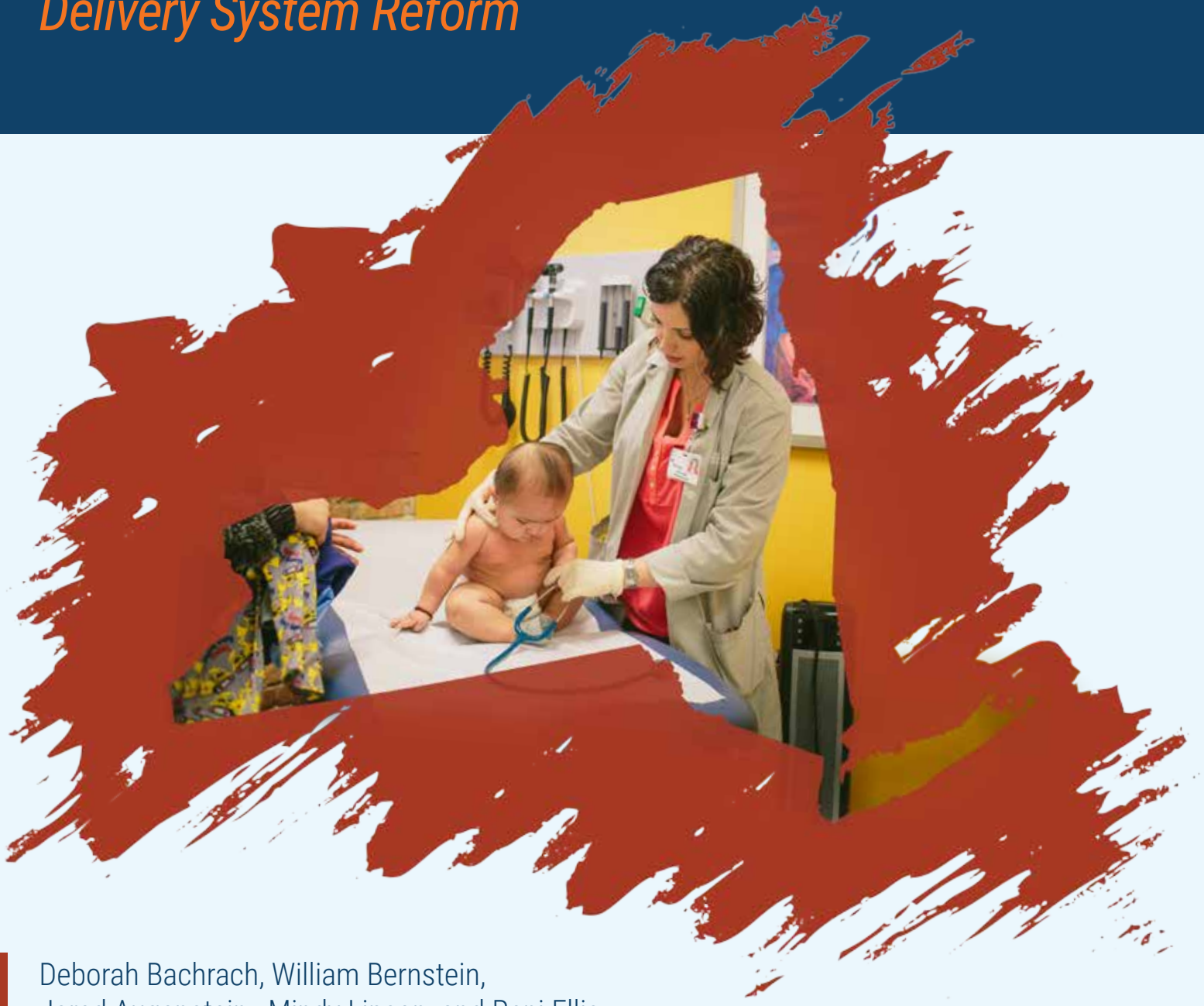
Implementing New York's DSRIP Program

Implications for Medicaid Payment and Delivery System Reform



Deborah Bachrach, William Bernstein,
Jared Augenstein, Mindy Lipson, and Reni Ellis

April 2016

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APRIL 2016

ABSTRACT

Medicaid is the largest health care payer in virtually every state. States are increasingly leveraging that position to drive payment and delivery system reform efforts. One powerful tool to enable transformation is Medicaid's Delivery System Reform Incentive Payment (DSRIP) program. New York is implementing the largest and most ambitious program to date, a five-year, $8.25 billion effort aimed at improving the way care is paid for and delivered to Medicaid beneficiaries and ultimately all state residents. Through stakeholder interviews, this report examines New York's experience implementing its DSRIP waiver, focusing on emerging issues in areas such as governance, data-sharing and analytics, social determinants of health, and value-based payments. The Centers for Medicare and Medicaid Services and other states can use New York's early experiences to inform their efforts in designing, planning for, and implementing Medicaid-led transformation efforts.

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

At a Glance

What is it?

An $8.25 billion Medicaid-funded program designed **to reduce avoidable hospital use by 25% in five years** by changing the way health care is paid for and delivered.

How will that goal be met?

The state hopes that within five years programs will make at least 80% of Medicaid managed care payments to health care providers **based on the value of care rather than the number or type of services delivered.**

Will the changes be sustainable?

Across the state, Medicaid providers and community-based organizations have formed integrated delivery networks or Performing Provider Systems. **Twenty-five of these networks are launching projects to improve health outcomes for their patient populations,** enhance disease management programs for chronic conditions, and reform the way providers are paid.

Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform

INTRODUCTION

With the implementation of the Affordable Care Act, Medicaid has become the largest insurer in the United States, covering almost 25 percent of all Americans.[1] State Medicaid agencies are leveraging Medicaid's purchasing power to drive reform of the delivery system to benefit Medicaid patients and ultimately all patients. One powerful tool available to states is the Delivery System Reform Incentive Payment (DSRIP) program authorized under Section 1115 of the Social Security Act (i.e., the law that authorizes Medicaid). To secure DSRIP funds, states must articulate a clear vision and plan for reforming their payment and delivery models, integrating care across providers and settings, and advancing the "Triple Aim" of better care, better health, and reduced costs.

In April 2014, the Centers for Medicare and Medicaid Services (CMS) approved New York's $8 billion Medicaid Redesign Team waiver amendment. Of the waiver funds, $6.42 billion are designated for DSRIP (Exhibit 1).[2] Aside from this, CMS and the state have allocated an additional $1.83 billion to DSRIP, bringing total DSRIP funds to $8.25 billion.[3] In addition, the state is funding a $1.5 billion Capital Restructuring Financing Program to "help strengthen and promote access to essential health services."[4] Seven other states (Alabama, California, Kansas, Massachusetts, New Hampshire, New Jersey, and Texas) also are implementing DSRIP initiatives. Additional states are in negotiations with CMS regarding approval of a DSRIP waiver or have expressed interest in pursuing a DSRIP program. The design and planning of these new programs will be shaped by the experiences of the early implementers.

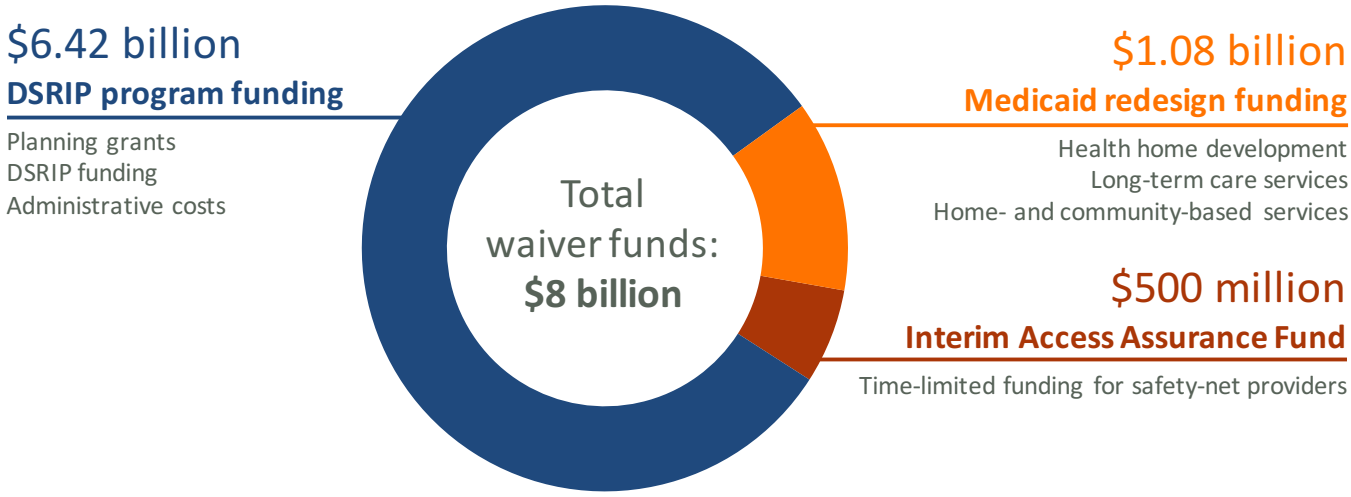
New York's DSRIP began in April 2014 and will continue through March 31, 2020 (Exhibit 2). The goal of New York's DSRIP is to "reduce avoidable hospital use by 25 percent through transforming the New York State health care system into a financially viable, high performing system."[5] At the outset, New York required Medicaid providers and community-based organizations to form integrated delivery networks, referred to as Performing Provider Systems (PPSs) as a condition of receiving DSRIP funding. Today, 25 PPSs are implementing a range of projects to build care management and population health management infrastructure, enhance disease management programs for targeted chronic conditions, and improve population health. Payment reform is a central component of the New York DSRIP. To ensure that its investments in delivery reforms are sustained in the long term, New York is requiring that by the end of the five-year DSRIP waiver at least 80 percent of payments between Medicaid managed care plans and providers use value-based methodologies.

CMS officials have been clear that New York's waiver is the new baseline for states pursuing DSRIP initiatives (Exhibit 3). This fact, combined with the magnitude of change contemplated in New York, has grabbed the attention of Medicaid stakeholders across the country.

> "It is of compelling public importance that the state conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.
>
> New York Governor Andrew Cuomo

Exhibit 1

Distribution of New York's 1115 Waiver Funds

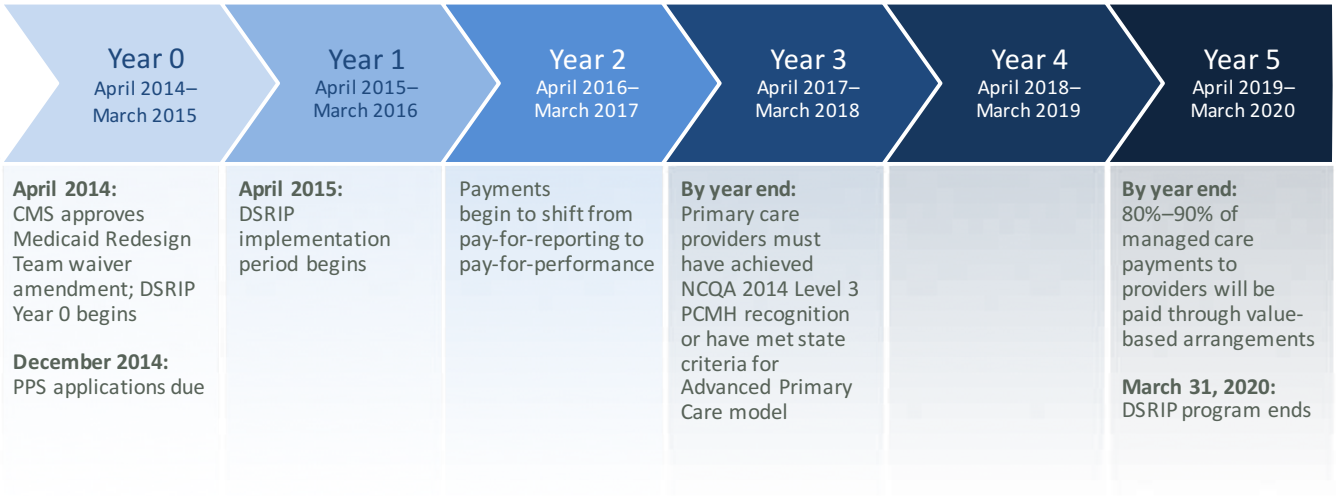


Note: The federal Centers for Medicare and Medicaid Services and the state allocated an additional $1.83 billion to DSRIP, bringing total DSRIP funds to $8.25 billion. The state also is funding a $1.5 billion Capital Restructuring Financing Program for DSRIP.

Sources: Centers for Medicare and Medicaid Services, New York Partnership Plan Special Terms and Conditions, March 31, 2016; New York State Department of Health, Final DSRIP Valuation Overview, June 2015; and New York State Department of Health, Capital Restructuring Financing Program, April 2015.

Exhibit 2

Key DSRIP Dates



Sources: New York State Department of Health, DSRIP Timelines, Jan. 2016; and New York State Department of Health, DSRIP Frequently Asked Questions (FAQs), Aug. 2015.

Exhibit 3

New York's DSRIP: The Basics

DSRIP feature	The New York approach
Goals and timeline	New York's DSRIP initiative aims to "reduce avoidable hospital use by 25% through transforming the New York State health care system into a financially viable, high-performing system."[a] New York's DSRIP began in April 2014 with a planning year and will continue through March 31, 2020. Throughout DSRIP, Performing Provider Systems (PPSs) must meet major milestones. For example, by the end of year 3 of implementation, all participating primary care providers must achieve either NCQA 2014 Level 3 patient-centered medical home recognition or the state's Advanced Primary Care model criteria.
Organization	New York organized its DSRIP initiative by selecting lead entities through an application process to create PPSs, which are networks of providers and community-based organizations (CBOs) led by a safety-net provider, most frequently a hospital. PPS participating organizations work together, under the lead entity, to implement DSRIP projects, including initiatives to clinically and financially integrate systems of care.
Governance	PPSs must have formalized governance structures to oversee the planning and implementation of DSRIP projects, including program planning, patient engagement strategies, administration of funds flow, design and use of information technology, and reporting to the state.
Care model(s)	PPSs were required to select between five and 11 clinical projects to implement from a menu of 44 projects curated by the state, in consultation with CMS. The range of projects addresses system transformation, clinical improvement, and population health. Projects are based in hospital, primary care, behavioral health, skilled nursing, and other home- and community-based settings.
Data-sharing and analytics	New York has committed to building the Medicaid Analytics Performance Portal, which houses performance dashboards. The portal will act as a data warehouse and serve as an electronic care planning tool. The state also has committed to sharing Medicaid claims information with PPSs and has required that PPSs ensure that DSRIP-eligible providers be connected to a qualified regional health information organization to promote clinical data-sharing and access to data for treatment purposes.
Measurement and accountability	New York has imposed a rigorous accountability structure on PPSs. PPSs are responsible for reporting to the state a robust set of process metrics and are accountable for meeting performance metrics, such as reductions in potentially avoidable emergency room visits, potentially avoidable readmissions, and Healthcare Effectiveness Data and Information Set (HEDIS) metrics. The state reports quarterly to CMS, and if milestones are not achieved, CMS will reduce New York's total DSRIP funding.
Funds flow	Each PPS has a maximum valuation, defined as the maximum amount of funding it can receive over the five years of DSRIP, based on factors designed to assess the scope and complexity of the PPSs' undertakings. DSRIP funding flows from the state to PPS lead entities, which are then responsible for distributing the funds to PPS partners, subject to approval by PPS governing bodies. DSRIP payments to PPSs are distinct from the state's capitation payments to managed care plans. All funds that flow to PPS participating organizations must be reported to the state on a quarterly basis. No more than 5 percent of total PPS funding may flow from a PPS to non-safety-net providers and CBOs.
Value-based payment arrangements and sustainability	New York has issued a value-based payment roadmap, which outlines a five-year plan for achieving comprehensive payment reform, including a shift to 80 percent to 90 percent value-based payments through Medicaid managed care plans by the end of DSRIP.

[a] New York State Department of Health, New York State Delivery System Reform Incentive Payment Program Project Toolkit, Oct. 2014.

This report examines New York's experience implementing its DSRIP waiver to identify emerging issues enabling or impeding Medicaid transformation. Findings are informed by two rounds of interviews: the first with federal and state officials and thought leaders from national health care organizations, and the second with New York stakeholders involved in on-the-ground implementation efforts, including leaders from provider entities, health care trade organizations, and health plans. (See Appendix A for a full list of individuals interviewed.)

This report focuses on five areas that have broad implications for stakeholders pursuing Medicaid-driven delivery system reform, with or without a DSRIP waiver: organization, governance and market transformation; care model and social determinants of health; data-sharing and analytics; measurement and accountability; and value-based payment (VBP) arrangements and sustainability. Across each of these topics, we describe the New York approach, assess the early successes and challenges, and identify how New York's experiences can influence new state payment and delivery system reform initiatives.

In New York, DSRIP is one of a series of efforts to transform the delivery system. New York is also implementing a $99.9 million Center for Medicare and Medicaid Innovation State Innovation Models grant, a statewide Medicaid Redesign initiative, and a Medicaid Health Home program.

ORGANIZATION, GOVERNANCE, AND MARKET TRANSFORMATION

Why It Matters

One issue facing states is determining the entities to be entrusted with and held accountable for achieving the quality and cost-saving goals associated with Medicaid transformation. To implement a DSRIP program, a state must define "lead entities," which are the entities eligible to lead the transformation and receive and distribute funds. While states establish the overarching rules, the lead entities responsible for project implementation and dispensing the DSRIP funds play a central role in shaping transformation, including bringing together provider organizations and community-based organizations (CBOs), establishing the parameters of these new partnerships, and setting priorities. Examining the opportunities and challenges faced by DSRIP lead entities can provide insight into the type of collaborative partnerships that can result in Medicaid redesign efforts that support high-performing health care systems.

The New York Approach

In New York, lead entities were defined as major public hospitals and other safety-net providers. CMS and New York policymakers viewed hospital leadership as pivotal to DSRIP's success, given the size and complexity of the undertaking and the central role of hospitals in New York's Medicaid delivery system. As one state official summed

Many observers noted that the complexity of the application process and the number of economic and programmatic requirements placed on applicants created significant hurdles to serving as a lead entity. Observers also noted the state sought to pair together stronger institutions with weaker ones, and to compel, where possible, market consolidation in the PPSs as a means of promoting the development of stronger and more integrated systems of care.

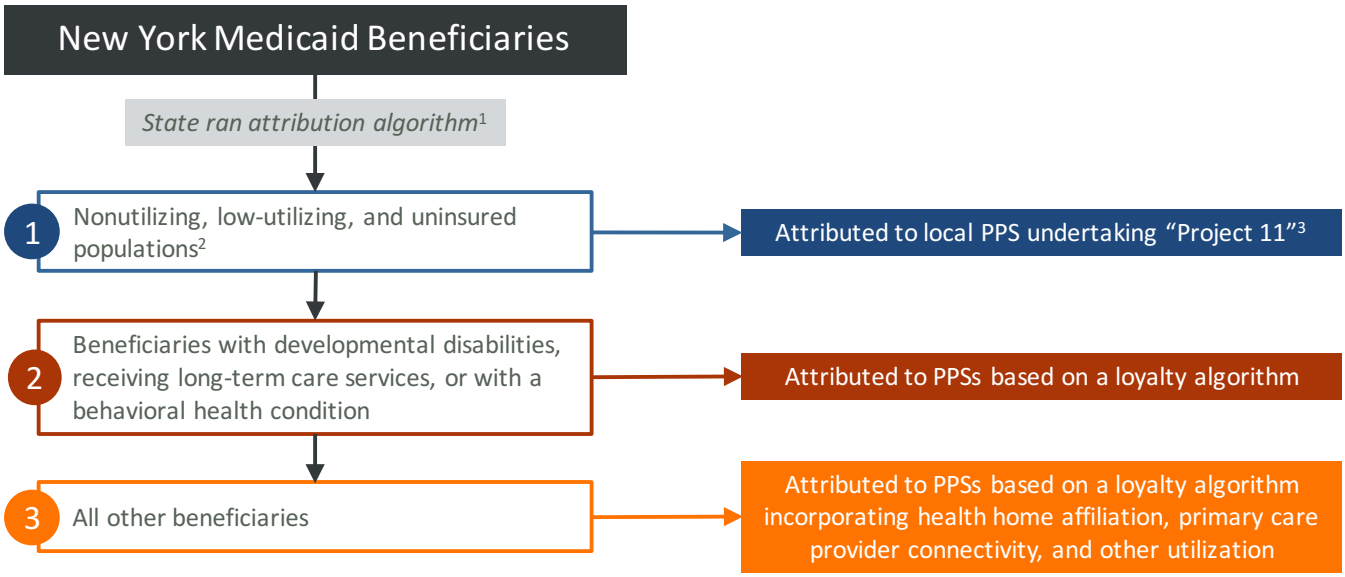
up: to conduct the amount of transformational work required by DSRIP, organizations serving as lead entities must have financial strength, leadership ability, and access to resources. In the New York health care system, the institutions with the strongest platforms to lead complex change initiatives tend to be hospitals.

As part of the DSRIP application process, lead entity applicants were required to demonstrate financial viability, which involved passing several stress tests, and the ability to build a PPS by bringing together providers and CBOs to implement DSRIP projects and develop a partnership to enter into valued-based contracting arrangements with Medicaid managed care plans. Initially, 88 organizations submitted letters of intent to be a lead entity. The state facilitated a process to consolidate these organizations into fewer PPSs, and 25 organizations received final approval to serve as a lead entity: 23 hospitals, one physician group (in partnership with a hospital), and one federally qualified health center (FQHC).[6]

The state developed an attribution methodology to ensure that each Medicaid beneficiary was assigned to only one PPS, using geography, utilization data, and patient loyalty trends (Exhibit 4). In forming their PPSs, the lead entities were mindful of the state's intention to allocate DSRIP funds based on the number of lives attributed to each PPS. They sought to develop broad provider networks generating the largest possible number of attributed lives. (See Appendix B for attribution and valuation by PPS.) PPSs are composed of diverse sets of provider organizations and CBOs. PPS partner networks range from several hundred to over 5,000 partners.[7] Because of differences in health care markets across state regions, PPSs vary in their position. In some regions, a sole PPS encompasses a large group of competing provider organizations and CBOs. In others, providers and CBOs have signed up with multiple PPSs, resulting in overlapping PPS networks. (See Appendix C for the geographic distribution of PPSs.)

Exhibit 4

Performing Provider System Attribution Methodology



Note: This exhibit describes the process for attribution for valuation, which is "the highest possible financial allocation a PPS can receive for their plan over the duration of their participation in the DSRIP program." The state distinguishes between attribution for valuation and attribution for the purpose of performance.

[1] If a PPS is the only one in a county, its attribution includes all beneficiaries receiving a plurality of services in that county.

[2] Nonutilizing members are defined as enrolled in Medicaid but have not used services in a given year. Low-utilizing members are defined as utilizing three or fewer services per year and having no relationship with their primary care provider or care manager.

[3] Project 11 is an optional DSRIP project targeted primarily toward public hospitals. The goal of Project 11 is to increase patient self-management and access to coverage through linking the uninsured population to insurance coverage and those who are non- or low-utilizers to their primary care providers.

Sources: New York State Department of Health, DSRIP Frequently Asked Questions (FAQs), Aug. 2015; and New York State Department of Health, DSRIP Update: New Project, Attribution & Valuation, Aug. 2014.

Providers and CBOs that signed up with multiple PPSs are wrestling with competing priorities from different lead entities and duplicative reporting requirements.

Governance structures vary by PPS. As the fiduciary to the state, each lead entity has ultimate authority over how funds are spent and for reporting to the state. A multistakeholder committee structure oversees the development and approval of key decisions. Some lead entities also have created separately incorporated, wholly owned subsidiaries to house the PPS's population health capabilities, such as IT, analytics, and care management. How well the PPS governance structure carries out key DSRIP tasks will be a critical indicator of the initiative's success. PPS governance structures will approve how money is spent and, more important, will decide what sort of contractual obligations are placed on participant organizations in a PPS as a condition of receiving funds. As of early 2016, newly established PPS governing entities are just beginning to make these kinds of decisions.

Early Observations and Lessons Learned

1 *DSRIP Is a Change Agent for Medicaid Providers*

The New York DSRIP program is clearly enabling change to the Medicaid delivery system, even if the extent of this change is not yet known. Some stakeholders referred to DSRIP as "priming the pump" or as "a down payment on transformation." DSRIP has stimulated planning for the integration of services that have traditionally been siloed; investment in hot spotting populations requiring the greatest supports; reengineering of care management processes; and development of IT and analytics infrastructure to measure and improve performance over time. While these enterprises are still in early development, it is expected that they will result in greater clinical and financial integration of provider-led efforts to improve the delivery of health care services.

> "DSRIP has galvanized the industry to think about advancing a population health infrastructure and accelerating the shift from fee-for-service to population health management. It is making the investment necessary to make this transition effective. It has served as both a catalyst and an accelerant.
>
> PPS leader

2 *Long-Term Role of PPSs Is Uncertain*

There is no consensus as to how PPSs will evolve and fit into the New York landscape post-DSRIP. Their evolution will provide important insights as to what it takes for any delivery system transformation effort, however it is organized or labeled, to succeed. Several commentators noted that transformation is occurring at a far faster pace in communities that are using DSRIP to accelerate preexisting collaborative efforts to clinically and financially integrate care into organized delivery systems, as opposed to where DSRIP served as a wake-up call. Laying the foundation for providers' transformation to integrated delivery networks is a lengthy process. The DSRIP timetables are challenging for those without preexisting efforts under way.

The prevailing view is that most DSRIP PPSs will not survive long term in their current forms, but are transitional vehicles that may give rise to other entities, such as clinically integrated networks or accountable care organizations (ACOs). From this perspective, the partnerships that emerge post-DSRIP will principally be determined by broader market strategies being pursued by large provider organizations, including the merger and consolidation activity that has become a staple of the New York marketplace. Many of the partnerships spawned by DSRIP were motivated by a desire to access DSRIP funds, rather than a more deeply considered decision to pursue joint

contracting and collaborative care delivery strategies. In addition, the definition of a safety-net hospital to qualify under DSRIP is broad, and for many PPS hospitals, Medicaid is not their leading line of business.[8] For PPSs that are pursuing a joint contracting strategy, a major issue is how the roles and responsibilities of the PPSs complement or overlap with managed care plans' roles and responsibilities such as network management, data analytics, and care management. As one observer said, "At this point, nobody has articulated a good conceptual framework for how plans and PPSs will coexist in the future state."

3 *PPS Governance Will Evolve Based on Marketplace Realities*

Lead entities are taking different approaches to defining the scope and nature of obligations placed on participating providers. Many PPSs are still in an early stage of defining their network strategies. But the most mature PPSs view DSRIP as a way to provide monies to build population health infrastructure—care management programs, connected health IT capabilities, data analytics, and clinical protocols—that will support clinically and financially integrated networks capable of entering into at-risk, value-based payer contracts.

What seems to be emerging as a truth in New York—and an important lesson for other states pursuing delivery system transformation—is that though government can fuel change, it cannot legislate its outcome. Some of the "forced marriages" in PPS networks triggered by the DSRIP process will need to be rationalized and adjusted based on trust and common interests that develop between willing collaborators. Absent such evolution, the partnerships will inevitably dissolve. From a state perspective, it is expected that the governance and organizational structures developed at the start of the DSRIP process will stimulate a transformational process where new, more tightly integrated structures evolve over time as the market matures. Time will tell whether this vision is realized.

CARE MODEL AND SOCIAL DETERMINANTS OF HEALTH

Why It Matters

Delivery system transformation requires providers to fundamentally change their approach to meeting the health needs of the patients and communities they serve. At the heart of the transformation agenda is a shift away from focusing exclusively on treating the sick to working proactively to keep a community healthy. The work to date makes clear that transformation is complex and requires a shift from inpatient to outpatient care, the development of clinically integrated provider networks, changes in the health care workforce, implementation of team-based care models, and partnerships between providers and social services organizations.

The New York Approach

Having concluded that prior DSRIP programs in California and Texas provided lead entities with too much flexibility, CMS required New York to adopt a more focused approach. While the Texas DSRIP gave birth to over 1,500 projects, New York required PPSs to select from a menu of 44 projects or models of care delivery. (See Appendix D for a full list of projects.) The state believed that fewer projects enhanced the likelihood of meeting DSRIP goals, allowed for evaluation of discrete clinical programs, and facilitated state oversight over PPS care model development.

New York's 44 projects fall into three areas: 1) building care management and population health management infrastructure, including programs that improve care coordination and transitional care, connect care occurring in multiple settings, and more systematically engage with patients; 2) clinical programs, focusing on areas such as home-based asthma interventions, primary care and behavioral health integration, cardiovascular care, diabetes

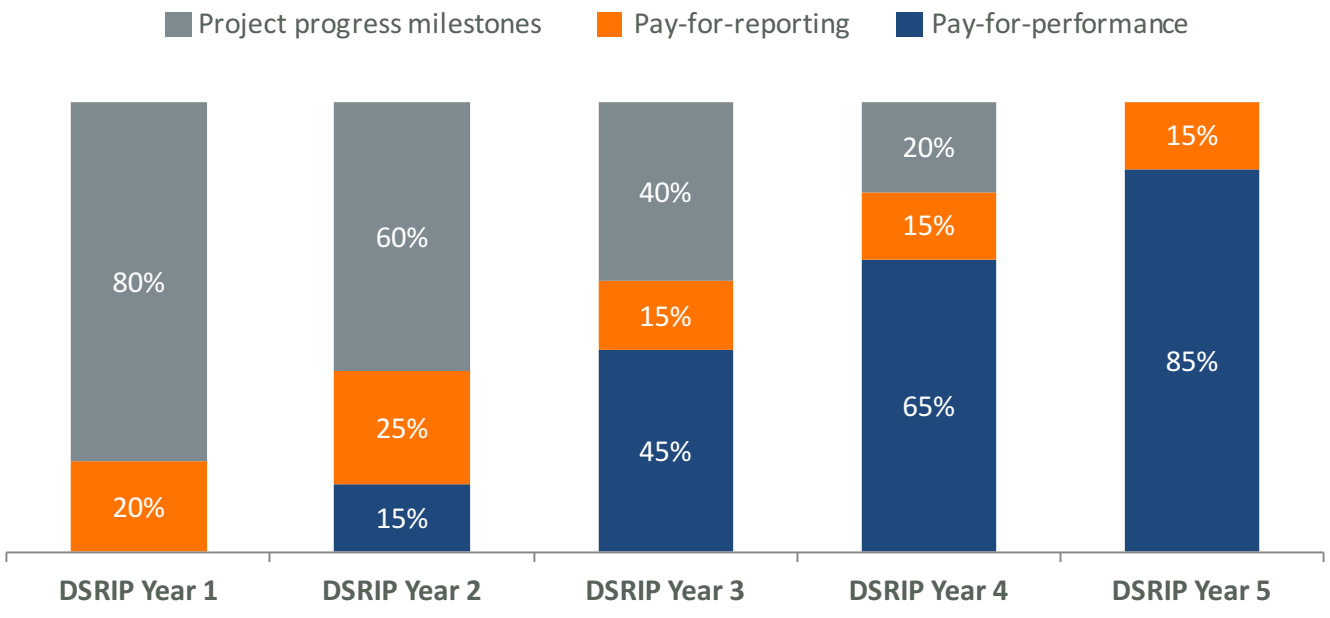
care, palliative care, and renal care; and 3) population health projects geared toward chronic disease, HIV, maternal and infant health, and mental health and substance abuse prevention. For each project, the state prescribed a general approach and process and outcomes metrics, but allowed PPSs the flexibility to customize their particular care models.

To ensure that projects are implemented according to the state's vision, New York requires each PPS to achieve "project progress milestones,"—process metrics that assess whether a PPS is adhering to DSRIP requirements. Examples include establishing a governance structure and implementing clinical projects according to state guidelines. The project progress milestones are distinct from pay-for-reporting and pay-for-performance metrics. Pay-for-reporting and pay-for-performance metrics include select Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. By the end of DSRIP, 85 percent of PPS funding will be based on pay-for-performance (Exhibit 5).

New York's approach emphasizes the impact that delivery system transformation will have on the health care workforce. As part of their applications for funding, PPSs were required to articulate a workforce strategy that would "identify all workforce implications" of DSRIP and "present a plan for how workers will be trained and deployed to meet patient needs in the new delivery system."[9] PPSs are held accountable for meeting milestones related to the hiring, retraining, and redeployment of members of the health care workforce and adhering to a workforce strategy budget.

Exhibit 5

Shift from Pay-for-Reporting to Pay-for-Performance



Note: As part of a December 2015 waiver amendment request to the federal Centers for Medicare and Medicaid Services, New York is seeking to slightly modify these percentages.

Source: New York State Department of Health, Attachment I–NY DSRIP Program Funding and Mechanics Protocol, April 2014.

Early Observations and Lessons Learned

1 *DSRIP Is Generating Investment in Community-Based Care Initiatives*

There is no question that as a result of the New York DSRIP, PPSs are investing in community-based care initiatives that would not otherwise be funded. As one PPS leader remarked, "DSRIP has catalyzed the transition [from hospital to community-based care] and provided a financial base to cement the transition." Investments include: technical assistance to primary care partners to achieve 2014 Level 3 patient-centered medical home (PCMH) recognition; embedded care management services in primary care settings; expansion of community-based asthma programs; and colocation of behavioral health and primary care services.

> "DSRIP is local. It's about identifying and meeting local needs and investing in infrastructure to meet those needs.
>
> PPS leader

2 *Sustainability of PPS Investments in New Care Models Is Unclear*

While PPSs envision that their investments in primary care, care management, and population health management will endure post-DSRIP through value-based payment arrangements, it is unclear how this will work. Stakeholders noted that PPSs have only minimally engaged managed care organizations (MCOs) in their clinical planning efforts, and as a result, may not be aware of duplication between their planned investments and services provided by MCOs. In addition, New York is implementing a health home program to provide care management services to Medicaid beneficiaries with HIV/AIDS, serious mental illness, or multiple chronic conditions.[10] PPSs are still clarifying the role of health homes in DSRIP and are trying to determine how health homes fit into their care management strategies. As DSRIP progresses, the state, PPSs, and MCOs will need to work together to identify ways to sustain successful programs.

3 *Lack of Focus on Social Determinants of Health*

While PPSs are making substantial investments into strengthening primary care and care management infrastructures, many stakeholders are concerned PPSs are not making similar investments in interventions addressing the social determinants of health. They note that individuals with significant unmet social needs are often driving inappropriate utilization and high costs. Without sufficiently targeting the social determinants of health, many PPSs are missing an opportunity to reduce costs and improve outcomes.

Stakeholders cited a number of reasons for the limited focus on patients' unmet social needs, starting with the dominance of hospitals in the governance and leadership of PPSs. State timelines required that DSRIP networks be created quickly. As a result, PPS lead entities incorporated as many organizations as possible into their networks without thoughtfully considering each partner's role. More fundamentally, there is a large cultural divide between most hospitals and CBOs. Several stakeholders noted that there was not sufficient attention paid to the fact that clinical and CBO communities have little experience working together and they have very different business models, in terms of funding sources, level of accountability, and reporting capabilities.

Finally, although PPSs express interest in addressing social determinants of health as part of their care models, stakeholders noted there is a mismatch between the perceived need and the dollars available to fund these interventions. New York's waiver permits only 5 percent of PPS funds to be flowed directly to non-safety-net providers. This category includes clinical providers that do not meet the state's definition of a safety-net provider and nonclinical social support services. As a result, PPSs have had to develop workarounds to flow funds to CBOs that do not provide Medicaid-reimbursable services.

DATA-SHARING AND ANALYTICS

Why It Matters

The successful implementation of new care models and value-based payment structures requires that providers have access to clinical, administrative and financial data that allows targeted identification of at-risk patients and better coordination of care. To create delivery system transformation, states must address a number of significant issues that influence providers' ability to gain access to, analyze, and use data. Key issues include whether and how to share Medicaid claims information, the requirements that providers use electronic health records, the requirements placed on plans for timely and accurate claims reporting, and requirements for providers to exchange information electronically.

The New York Approach

New York is taking several approaches to ensure that clinical and claims data are available and used to improve care delivery. First, New York has committed to building the Medicaid Analytics Performance Portal (MAPP) with "the goal of building a 360-degree view of a patient that is not constrained by organizational barriers."[11] MAPP houses performance dashboards, will act as a data warehouse, and will serve as an electronic care planning tool for the health home population.[12]

New York also has committed to share Medicaid claims information with PPSs. Claims data were supposed to be distributed at the start of the DSRIP implementation period, but distribution was delayed to ensure requirements were put in place to protect the privacy and security of health information. The state is providing Medicaid patients with a right to opt out of having their Medicaid data shared with the PPS and has also imposed significant security requirements on how PPSs store and distribute data that are shared once the opt-out process is complete. It is expected that claims data for patients who do not opt out will be shared with PPSs in the second quarter of 2016. Some PPSs are working with health plans to directly access plans' claims feeds, which typically have a shorter lag time than those provided by the state. These arrangements will provide better data to PPSs that are able to establish these relationships, but may result in inconsistent access to claims data for providers across the state.

The state is using DSRIP as a lever to promote clinical data exchange among providers. One of the performance requirements for DSRIP is that eligible providers in a PPS be connected to a regional health information organization (RHIO) that is part of the State Health Information Network of New York (SHIN–NY) by the end of March 2018. In doing so, the state has a goal of promoting SHIN–NY, a statewide health information exchange that has received substantial state investment over the past decade. Under state law, accessing clinical information through the SHIN–NY requires patient consent, a requirement that is more burdensome than federal legal requirements as set forth in the Health Insurance Portability and Accountability Act (HIPAA).

Early Observations and Lessons Learned

1 *Access to Data Is Critical*

Under DSRIP, the state has recognized the importance of timely access to claims and clinical data to allow providers to better identify at-risk patients and improve coordination of care. Provider stakeholders note that this goal is critical to success, but that privacy requirements under state law impede their access to essential data. One suggestion is to conform state law to federal HIPAA requirements, thereby allowing access to information without consent for purposes of treatment, payment, and operations. The state Value-Based Payment Workgroup's Regulatory Impact Subcommittee recommends that a new workgroup convene to "address . . . privacy law issues on a scenario by scenario basis."[13]

2 *Analytic Approaches in Early Stage of Development*

Stakeholders are skeptical as to whether the state's MAPP tool or the benefits of information exchange through the SHIN–NY will help them achieve their DSRIP performance objectives because of issues of timing and utility. Most stakeholders are taking a wait-and-see attitude, while investing significantly in their own IT and population health capabilities. PPSs' investments in IT and population health are in an early stage of development. Their ultimate form will have a real impact on providers' ability to implement more effective care coordination programs.

MEASUREMENT AND ACCOUNTABILITY

Why It Matters

Any state undertaking large-scale delivery system reform must have clear short- and long-term goals and the capacity to assess performance against those goals. States that are designing DSRIP initiatives must determine how to ensure accountability without imposing overly burdensome requirements that impede implementation.

The New York Approach

New York's DSRIP program has an accountability structure with multiple levels, with substantial reporting requirements. Organizations participating in DSRIP must report to their PPS, the PPS must report to the state, and the state must report to CMS. Many PPSs require participating organizations to report on how they use their DSRIP funds. In most cases, PPS contracts with participating organizations make receipt of funds contingent upon some form of proof of performance. In addition, the state Office of the Medicaid Inspector General has indicated that recipients should expect to be subject to state audits.[14] PPSs have very detailed quarterly reporting obligations to the state on project progress milestones, as well as annual reporting obligations to the state on process and performance measures. Overall, the New York DSRIP involves hundreds of metrics, creating a substantial reporting burden for each PPS.

The state is required to report to CMS on a quarterly basis; the terms and conditions governing the relationship between the state and CMS are highly specific. The state's performance is measured according to four types of milestones: delivery system improvement metrics, performance on DSRIP project and populationwide goals,

Medicaid spending growth targets, and goals related to transition from fee-for-service payments to value-based payment arrangements. By the final year of DSRIP, $175.6 million of approximately $1 billion in expected DSRIP expenditures are at risk if the state does not achieve certain milestones.[15]

Early Observations and Lessons Learned

1 *Complex Reporting Requirements May Stifle Implementation Efforts*

While it is broadly acknowledged that it is crucial for DSRIP programs to have rigorous accountability structures, the complexity of New York's reporting requirements and associated metrics could hinder implementation efforts. For example, under New York's waiver, each PPS is accountable for between approximately 100 and 330 process and outcome metrics, depending on project selection.[16] Provider stakeholders observed that the number of process metrics that PPSs are required to report creates a heavy administrative burden for PPSs, taking focus and time away from project implementation.

VALUE-BASED PAYMENT ARRANGEMENTS AND SUSTAINABILITY

Why It Matters

Value-based payment (VBP) reforms are a key ingredient to motivating and sustaining provider-led initiatives to improve health care service delivery. But it is difficult for states to balance the substantial investment necessary to enable providers to change their business models with the need to control overall Medicaid spending. Achieving value is further complicated by the need to determine how available dollars, along with risk and responsibility for administrative and medical spending, should be distributed among providers and payers. States undertaking Medicaid delivery system reform must simultaneously pursue the development and implementation of new care models, payment reforms that align provider and payer incentives, and state budget goals.

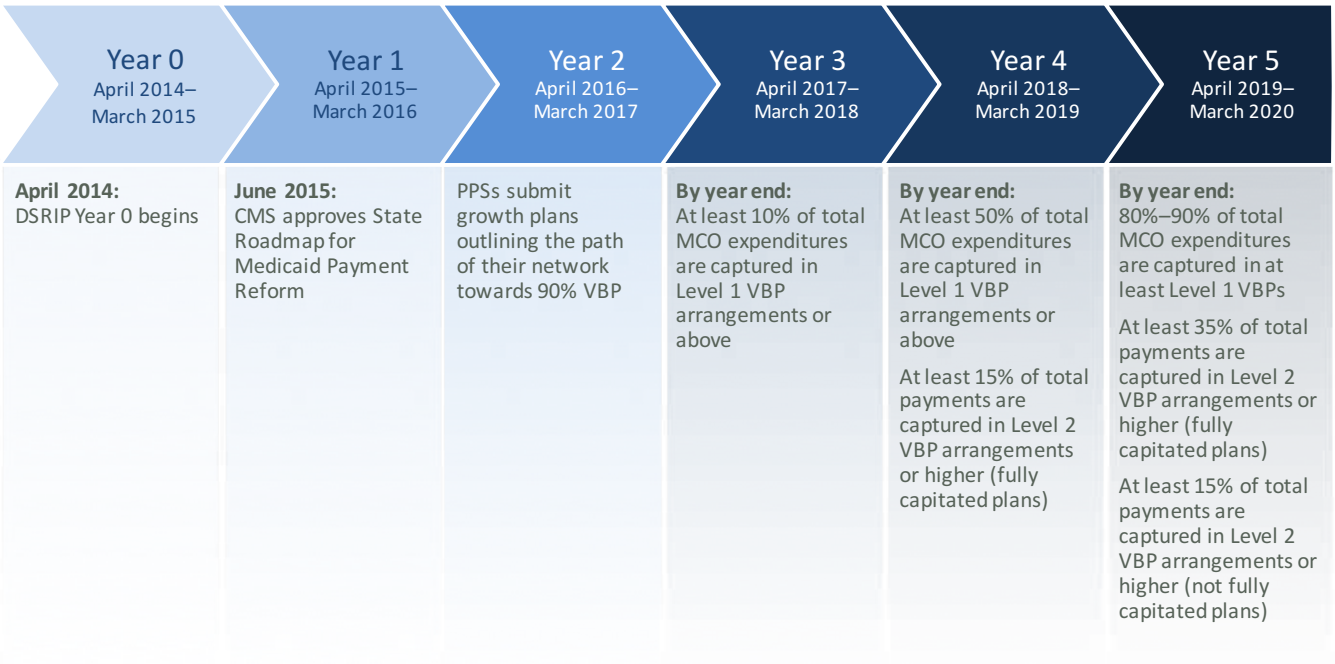
> "[DSRIP is] not about launching 10 or 11 projects, not about ticking boxes to hit particular requirements, not about moving the needle on performance measures. It's about a fundamental restructuring towards a system that really rewards value. It's beginning to sink in with folks that that's really the endgame here, and what they should be working towards.
>
> State government official

The New York Approach

As part of its DSRIP initiative, New York developed and received CMS approval of a "VBP roadmap," which outlines a five-year plan for comprehensive payment reform in New York Medicaid (Exhibit 6). The VBP roadmap provides options for MCO and provider contracting structures to share the savings expected to be generated through the implementation of new clinical models and population health management capabilities. The state expects that a significant percent of Medicaid beneficiaries will be in managed care plans by the end of 2018.[17] As such, these new contract models are the linchpin to the sustainability of DSRIP programs. The VBP roadmap is robust and will likely serve as a blueprint for other states contemplating DSRIP waivers.

Exhibit 6

Key Value-Based Payment Dates in DSRIP Timeline



Note: MCO = managed care organization.

Source: New York State Department of Health, A Path Toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform Annual Update, March 2016.

The VBP roadmap requires that 80 percent to 90 percent of managed care payments to providers use VBP methodologies by the end of the five-year DSRIP waiver. The state anticipates MCOs will contract with provider entities through four types of arrangements:

- **Total care for the general population:** The provider is accountable for the cost and quality of all services received by its attributed population with the exception of special needs populations.
- **Total care for special needs populations:** Providers serving special needs populations, such as people living with HIV/AIDS or developmental disabilities, are held accountable for the cost and quality of care delivered to their attributed members.
- **Integrated primary care:** PCMHs or practices meeting the state's Advanced Primary Care criteria are accountable for a specified set of primary care, care coordination, and population health management services.[18]
- **Bundles of care:** New York is permitting bundles for maternity care and chronic care. The provider is accountable for the costs and quality of services across the care continuum for maternity care and specified chronic conditions, such as asthma, diabetes, and osteoarthritis.[19]

New York views its approach to VBP as aligned with Medicare reforms, including the shift to Next Generation ACOs, the Bundled Payments for Care Improvement Initiative, and Comprehensive Care for Joint Replacement Payment Model. Across the four types of VBP arrangements, the state has defined four approaches, each corresponding to a higher level of risk for provider (Exhibit 7).

Exhibit 7

Value-Based Payment Level Requirements

VBP options	Level 0 VBP[a]	Level 1 VBP	Level 2 VBP	Level 3 VBP[b]
Total care for general population	Fee-for-service (FFS) with bonus and/or withhold based on quality scores	FFS with upside-only shared savings (when quality scores are sufficient)	FFS with risk-sharing (upside and downside)	Global capitation (with quality-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (when quality scores are sufficient)	FFS with risk-sharing-based on subpopulation capitation (upside and downside)	PMPM capitated payment for total care for subpopulation (with quality-based component)
Integrated primary care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared-savings based on total cost of care (when quality scores are sufficient)	FFS (plus PMPM subsidy) with risk-sharing based on total cost of care (upside and downside)	PMPM capitated payment for primary care services (with quality-based component)
Bundles of care	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (when quality scores are sufficient)	FFS with risk-sharing based on bundle of care (upside and downside)	Prospective bundled payment (with quality-based component)

Note: PMPM = per member per month.
[a] Level 0 is a baseline, and managed care payments at this level will not count toward 80%–90% VBP.
[b] Level 3 feasible only after experience at other levels.
Source: New York State Department of Health, A Path Toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform Annual Update, March 2016.

Early Observations and Lessons Learned

1 *Ultimate Relationship Between PPSs and MCOs Is Unclear*

The state has established a general framework governing contractual relationships between MCOs and providers, but defers to MCOs and providers to determine the precise form of those relationships within established guardrails. It is unclear whether providers and payers will be able to agree on how to best allocate roles, responsibilities, and the flow of funds, without increased state intervention. This issue is especially important to resolve, as many PPSs are investing significantly in population health infrastructure, the costs of which can be supported only if ultimately paid for through restructured arrangements with MCOs. Some states like Minnesota have imposed specific downstream contracting requirements on health plans, including requirements covering required ACO contracting, patient attribution methodologies, and shared savings or loss calculations.[20] New York has largely left these details to the MCOs and providers to negotiate.

> “We’re in a race to get to value-based reimbursement before other funding streams run out.
>
> PPS leader

2 VBP Requirements May Incentivize Provider Consolidation

It is also unclear whether providers who joined a PPS to participate in DSRIP also will be willing to participate with the same group of providers in joint managed care contracting arrangements after DSRIP ends. If these providers are willing to participate in joint contracting arrangements, it would require accepting risk as a group of disparate providers that may not have access to each other's performance data. It also may require providers to subject themselves to new governance arrangements that have authority over network participation rules and the distribution of funds. Market participants are just beginning to realize how complex an issue this is for each PPS participating provider, especially because many DSRIP participating providers already have MCO contracts in place and will need to evaluate how their current arrangements would compare to any proposed new arrangement.

Many stakeholders expect DSRIP to lead to the creation of provider-governed risk-bearing entities, although significant issues exist as to the ultimate form of those entities, the rules governing network participation, and the governance structures of such entities. CMS and other states contemplating Medicaid delivery system transformation will be keen observers of this dynamic, watching to see if the benefits of more highly coordinated, provider-led delivery systems will outweigh the costs of consolidation. Many MCOs fear that too much provider consolidation could increase providers' power in negotiating prices, a point echoed in an April 2015 letter issued by the Federal Trade Commission (FTC). "FTC staff is concerned that combining the DSRIP program with [Certificate of Public Advantage][21] regulations will encourage health care providers to share competitively sensitive information and engage in joint negotiations with payers in ways that will not yield efficiencies or benefit consumers," the letter stated.[22]

> "What we'd be interested in purchasing is a functioning integrated delivery system that really works—where there is innovation, where providers get electronic notifications seamlessly, and where there are emergency room diversion programs, hospital-to-home-transition programs, and innovative ways to reach people in the community.
>
> Managed care plan executive

3 Will Social Services Be Supported in VBP Relationships?

While the VBP roadmap envisions that contracts for integrated primary care will include "clear alignments with community-based, home, and social service agencies" it is unclear if and how these services will be supported in practice.[23] Social services typically are not reimbursed in fee-for-service relationships with insurers nor are their costs built into the rates paid to MCOs by the state. In addition, insurance payments typically are not included in the revenue streams of social service organizations. While provider entities taking on risk will want their members to receive social service interventions with demonstrable value, the role these providers will play in funding those interventions has yet to be determined. The Social Determinants of Health and CBO Subcommittee of the state's VBP Workgroup addressed this issue in its February 2016 recommendations: "Providers/provider networks and MCOs should invest in, and the state should provide financial incentives for, ameliorating [social determinants of health] at the community level employing a community participatory process."[24] In relation to payment for social service interventions, one hospital executive noted, "there is magical thinking that if you move to VBP, everything will be taken care of."

3 *Payment Levels Matter*

One issue raised by PPS and managed care executives is that shifting payment from fee-for-service to VBP arrangements will not solve an underlying economic issue of low reimbursement. To the extent that a bundled or global capitation payment is developed based on historical fee-for-service rates that may themselves be too low, the bundle will be insufficient to cover required clinical services, much less investments in care coordination or social services that are envisioned.

> “You can’t sustain a program on nothing. Post-DSRIP, there is going to be some continuing need for support for transformation, and we don’t want the system to stop transforming.
>
> Trade association leader

CONCLUSION

Changing how the state pays for services and how providers deliver care is at the heart of New York’s efforts to redesign Medicaid. Given the enormity and complexity of this effort, it is hardly surprising that it is a messy process and there is a diversity of perspectives on what is and is not working, as well as what requires re-envisioning. This stage of the process brings to mind President Theodore Roosevelt’s observation that absent great effort, both valiant and flawed, there is never “high achievement.” Extraordinary resources—financial and human—are being devoted in an effort to dramatically improve New York’s health care delivery system. The results will resonate beyond Medicaid and New York, to be watched and studied by all.

NOTES

[1] J. Paradise, *Medicaid Moving Forward* (Kaiser Family Foundation, March 2015).

[2] Centers for Medicare and Medicaid Services, New York Partnership Plan Special Terms and Conditions, March 31, 2016.

[3] New York State Department of Health, Final DSRIP Valuation Overview, June 2015.

[4] New York State Department of Health, Capital Restructuring Financing Program, April 2015.

[5] New York State Department of Health, New York State Delivery System Reform Incentive Payment Program Project Toolkit, Oct. 2014.

[6] New York State Department of Health, DSRIP Performing Provider Systems (PPS), Jan. 2016.

[7] New York State Department of Health, Performing Provider System Network Lists, July 2015.

[8] Only state-designated safety-net providers were eligible to serve as lead entities. To be classified as a safety-net provider, a hospital had to meet one of the following criteria: 1) be a public hospital, critical access hospital, or sole community hospital; 2) serve at least 35 percent Medicaid, uninsured, or dual-eligible patients in their outpatient business and at least 30 percent Medicaid, uninsured, or dual-eligible patients in their inpatient business; or 3) serve at least 30 percent of all Medicaid, uninsured, or dual-eligible patients in their service region. Non-hospital-based providers were classified as safety-net providers if 35 percent of their business was composed of Medicaid, uninsured, or dual-eligible patients. Centers for Medicare and Medicaid Services, New York Partnership Plan Special Terms and Conditions, March 31, 2016.

[9] Centers for Medicare and Medicaid Services, New York Partnership Plan Special Terms and Conditions, March 31, 2016.

[10] New York State Department of Health, Eligibility Criteria for Health Home Services: Chronic Conditions, Sept. 23, 2014.

[11] G. Allen and P. Roohan, Letter to PPS and RHIO Executives, RE: Integrating clinical information from the State Health Information Network of New York (SHIN-NY) with Medicaid claims data, July 21, 2015.

[12] New York State Department of Health, MAPP 101 Webinar, June 2015.

[13] New York State Department of Health VBP Regulatory Impact Subcommittee, Meeting #6 Minutes, Dec. 7, 2015.

[14] Office of the Medicaid Inspector General, New York State Department of Health, Frequently Asked Questions by Performing Provider System (PPS) Leads Relative to Compliance Programs, July 15, 2015.

[15] Centers for Medicare and Medicaid Services, New York Partnership Plan Special Terms and Conditions, March 31, 2016. In December 2015, New York submitted a waiver amendment request to CMS that would increase the maximum amount of funds at risk to $200 million in the fifth year of DSRIP.

[16] New York State Department of Health, DSRIP Measure Specification and Reporting Manual, Feb. 25, 2016; and New York State Department of Health, DSRIP Domain 1 Project Requirements, Milestones, and Metrics, March 20, 2015.

[17] New York State Department of Health, Care Management for All, July 24, 2014.

[18] New York created the Advanced Primary Care model as part of the New York State Health Innovation Plan. The state defines advanced primary care as "an integrated care delivery and payment model that ties together a service delivery model and reimbursement to promote improved health and health care outcomes that are financially sustainable." New York State Department of Health, New York State's Advanced Primary Care Model Frequently Asked Questions, Dec. 2015.

[19] New York State Department of Health, A Path Toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform Annual Update, March 2016.

[20] Minnesota Department of Human Services, Contract for Medical Assistance and MinnesotaCare Medical Care Services: 2016 Families and Children Contract, Jan. 1, 2016.

[21] As defined by New York, "a COPA is a document issued by the Department of Health (Department) signifying the approval of a Cooperative Agreement or planning process, subject to certain conditions being satisfied. Parties that have received a COPA are provided state action immunity under federal antitrust laws and immunity from private claims under state antitrust laws and may negotiate, enter into, and conduct business pursuant to, a Cooperative Agreement or a planning process covered by a duly issued Certificate of Public Advantage."

[22] U.S. Federal Trade Commission, Letter to Center for Health Care Policy and Resource Development, Office of Primary Care and Health Systems Management, RE: Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1, April 22, 2015.

[23] New York State Department of Health, A Path Toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform Annual Update, March 2016.

[24] New York State Department of Health, Value-Based Payment: Subcommittee Recommendation Report, Feb. 2016.

Appendix A

Thought Leaders and Stakeholders Interviewed

National thought leaders

Lindsey Browning, Senior Policy Analyst, National Association of Medicaid Directors
Sophia Chang, Vice President of Programs, California Health Care Foundation
Beth Feldpush, Senior Vice President of Policy and Advocacy, America's Essential Hospitals
Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services
Heather Howard, Program Director, State Health Reform Assistance Network, Robert Wood Johnson Foundation
Frederick Isasi, Division Director, Health Division, National Governor's Association Center for Best Practices
Kathleen Nolan, Managing Principal, Health Management Associates *(Director, State Policy and Programs, National Association of Medicaid Directors at time of interview)*
Chris Perrone, Director, Improving Access, California Health Care Foundation
Trish Riley, Executive Director, National Academy for State Health Policy
Matt Salo, Executive Director, National Association of Medicaid Directors
Bruce Siegel, President and CEO, America's Essential Hospitals
Hemi Tewarson, Program Director, Health Division, National Governors Association Center for Best Practices

New York stakeholders

Gregory Allen, Director, Division of Program Development and Management, Office of Health Insurance Programs, New York State Department of Health
Gary Belkin, Executive Deputy Commissioner for Mental Health, New York City Department of Health and Mental Hygiene
Marc Berg, Principal, Health Care Strategy and Transformation, KPMG LLP USA
Deb Blanchard, Director of Patient-Centered Medical Homes, Finger Lakes PPS
Peggy Chan, Director, DSRIP, New York State Department of Health
Andrea Cohen, Senior Vice President for Program, United Hospital Fund
David Cohen, CEO, Central Services Organization, Community Care of Brooklyn; Executive Vice President, Clinical Affairs & Affiliations at Maimonides Medical Center
Donna Colonna, CEO, Services for the UnderServed
Carla D'Angelo, Senior Vice President of Strategic Business Development, Monroe Plan for Medical Care
Diane Ferran, Senior Director, Clinical Quality Improvement Program, Community Health Care Association of New York State
Arthur Gianelli, President, Mount Sinai St. Luke's; President, Mount Sinai PPS Board of Managers
Dennis Graziano, President/CEO, Monroe Plan for Medical Care
Val Grey, Executive Vice President, Healthcare Association of New York State
Beverly Grossman, Senior Policy Director, Community Health Care Association of New York State
Jason Helgerson, Medicaid Director, New York State
Harold Iselin, Managing Shareholder, Greenberg Traurig, LLP
Christina Jenkins, President and CEO, OneCity Health
Deborah King, Executive Director, 1199 SEIU Training and Employment Funds
Jeffrey Kraut, Senior Vice President, Strategy and Business Informatics, Northwell Health
Pamela Mattel, COO, Acacia Network
Ann Monroe, President, Health Foundation for Western & Central New York
Lisa Perry, Vice President, Quality and Technology Initiatives, Community Health Care Association of New York State
John Rugge, CEO, Hudson Headwaters Health Network
Chad Shearer, Director, Medicaid Institute, United Hospital Fund
Kathleen Shure, Senior Vice President, Health Economics, Finance, and Managed Care, Greater New York Hospital Assn.
Carol Tegas, Executive Director of the Finger Lakes PPS
Pat Wang, CEO, HealthFirst
Dennis Whalen, President, Healthcare Association of New York State
Grace Wong, Vice President and CFO of Medicaid Strategy, Northwell Health

Appendix B

Attribution and Valuation by Performing Provider System

Performing Provider System *PPS lead entity or entities*	Number of attributed Medicaid members[a]	Maximum valuation[b]	Safety net or public lead entity?
Adirondack Health Institute PPS *Adirondack Health Institute*	143,640	$186,715,496	Safety net
Advocate Community Providers *AW Medical Office, PC; New York Community Preferred Partners; Northwell Health*	312,623	$700,038,844	Safety net
Albany Medical Center Hospital PPS *Albany Medical Center*	107,781	$141,430,547	Safety net
Alliance for Better Health Care *Ellis Hospital*	193,150	$250,232,844	Safety net
Bronx Partners for Healthy Communities *SBH Health System*	159,201	$384,271,362	Safety net
Bronx-Lebanon Hospital Center PPS *Bronx-Lebanon Hospital Center*	70,861	$153,930,779	Safety net
Brooklyn Bridges *NYU Lutheran Medical Center*	74,326	$127,740,537	Safety net
Care Compass Network *United Health Services Hospitals*	186,101	$224,540,274	Safety net
Central New York Care Collaborative *Auburn Community Hospital; Faxton St. Luke's Healthcare; St. Joseph's Hospital Health Care; SUNY Upstate University Hospital*	262,144	$323,029,955	Public
Community Care of Brooklyn *Maimonides Medical Center*	212,586	$489,039,450	Safety net
Community Partners of Western NY *Sisters of Charity Hospital*	43,375	$92,253,402	Safety net
Finger Lakes PPS *Rochester Regional Health System; UR Medicine*	413,289	$565,448,177	Safety net
Hudson Valley Collaborative *Montefiore Medical Center*	105,752	$249,071,149	Safety net
Leatherstocking Collaborative Health Partners PPS *Bassett Medical Center*	62,043	$71,839,379	Safety net
Millennium Collaborative Care *Erie County Medical Center*	309,457	$243,019,729	Public
Mount Sinai PPS *Mount Sinai Health System*	136,370	$389,900,648	Safety net
Nassau Queens PPS *Nassau University Medical Center, in alliance with Northwell Health and Catholic Health Services of Long Island*	1,030,400	$535,396,603	Public
New York-Presbysterian/Queens PPS *New York-Presbyterian/Queens*	12,962	$31,776,993	Safety net
New York-Presbyterian PPS *New York-Presbyterian Hospital*	47,293	$97,712,825	Safety net
North Country Initiative *Samaritan Medical Center*	61,994	$78,062,822	Safety net

Performing Provider System *PPS lead entity or entities*	Number of attributed Medicaid members[a]	Maximum valuation[b]	Safety net or public lead entity?
OneCity Health *NYC Health + Hospitals*	2,760,602	$1,215,165,724	Public
Refuah Community Health Collaborative *Refuah Health Center*	26,804	$45,634,589	Safety net
Staten Island PPS *Richmond University Medical Center; Staten Island University*	180,268	$217,087,986	Safety net
Suffolk Care Collaborative *SUNY at Stony Brook University Hospital*	437,896	$298,562,084	Public
WMCHealth PPS *Westchester Medical Center*	573,393	$273,923,615	Public

[a] This column reflects each PPS's attribution for valuation, which is the "number of Medicaid and uninsured lives for use in the calculation of potential performance awards as part of the DSRIP valuation process." New York State Department of Health, Bringing The Pieces Together: Attribution for Performance, Provider Counts by Service Type & Speed & Scale Templates, Dec. 2014.

[b] The state defines maximum valuation for a PPS as "the highest possible financial allocation a PPS can receive for their plan over the duration of their participation in the DSRIP program." New York State Department of Health, DSRIP Frequently Asked Questions (FAQs), Aug. 2015.

Source: New York State Department of Health, DSRIP Performing Provider Systems by County, Jan. 2016.

Appendix C

Performing Provider System by County

County	Performing Provider System (PPS lead entity or entities)
Upstate	***10 PPSs***
Albany	Albany Medical Center Hospital PPS (Albany Medical Center) Alliance for Better Health Care (Ellis Hospital)
Allegany	Finger Lakes PPS (Rochester Regional Health System/UR Medicine) Millennium Collaborative Care (Erie County Medical Center)
Broome	Care Compass Network (United Health Services Hospitals)
Cattaraugus	Millennium Collaborative Care (Erie County Medical Center)
Cayuga	Central New York Care Collaborative (Auburn Community Hospital/Faxton St. Luke's Healthcare/ St. Joseph's Hospital Health Care/SUNY Upstate University Hospital) Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Chautauqua	Community Partners of Western New York (Sisters of Charity Hospital) Millennium Collaborative Care (Erie County Medical Center)
Chemung	Care Compass Network (United Health Services Hospitals) Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Chenango	Care Compass Network (United Health Services Hospitals)
Clinton	Adirondack Health Institute PPS (Adirondack Health Institute)
Columbia	Albany Medical Center Hospital PPS (Albany Medical Center)
Cortland	Care Compass Network (United Health Services Hospitals)
Delaware	Care Compass Network (United Health Services Hospitals) Leatherstocking Collaborative Health Partners PPS (Bassett Medical Center)
Erie	Community Partners of Western New York (Sisters of Charity Hospital) Millennium Collaborative Care (Erie County Medical Center)
Essex	Adirondack Health Institute PPS (Adirondack Health Institute)
Franklin	Adirondack Health Institute PPS (Adirondack Health Institute)
Fulton	Adirondack Health Institute PPS (Adirondack Health Institute) Alliance for Better Health Care (Ellis Hospital)
Genesee	Finger Lakes PPS (Rochester Regional Health System/UR Medicine) Millennium Collaborative Care (Erie County Medical Center)
Greene	Albany Medical Center Hospital PPS (Albany Medical Center)
Hamilton	Adirondack Health Institute PPS (Adirondack Health Institute)
Herkimer	Leatherstocking Collaborative Health Partners PPS (Bassett Medical Center)
Jefferson	North Country Initiative (Samaritan Medical Center)
Lewis	Central New York Care Collaborative (Auburn Community Hospital/Faxton St. Luke's Healthcare/ St. Joseph's Hospital Health Care/SUNY Upstate University Hospital) North County Initiative (Samaritan Medical Center)
Livingston	Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Madison	Central New York Care Collaborative (Auburn Community Hospital/Faxton St. Luke's Healthcare/ St. Joseph's Hospital Health Care/SUNY Upstate University Hospital) Leatherstocking Collaborative Health Partners PPS (Bassett Medical Center)
Monroe	Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Montgomery	Alliance for Better Health Care (Ellis Hospital)
Niagara	Community Partners of Western New York (Sisters of Charity Hospital) Millennium Collaborative Care (Erie County Medical Center)

County	Performing Provider System (PPS lead entity or entities)
Oneida	Central New York Care Collaborative (Auburn Community Hospital/Faxton St. Luke's Healthcare/ St. Joseph's Hospital Health Care/SUNY Upstate University Hospital)
Onondaga	Central New York Care Collaborative (Auburn Community Hospital/Faxton St. Luke's Healthcare/ St. Joseph's Hospital Health Care/SUNY Upstate University Hospital)
Ontario	Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Orleans	Finger Lakes PPS (Rochester Regional Health System/UR Medicine) Millennium Collaborative Care (Erie County Medical Center)
Oswego	Central New York Care Collaborative (Auburn Community Hospital/Faxton St. Luke's Healthcare/ St. Joseph's Hospital Health Care/SUNY Upstate University Hospital)
Otsego	Leatherstocking Collaborative Health Partners PPS (Bassett Medical Center)
Rensselaer	Alliance for Better Health Care (Ellis Hospital)
St. Lawrence	Adirondack Health Institute PPS (Adirondack Health Institute) North County Initiative (Samaritan Medical Center)
Saratoga	Adirondack Health Institute PPS (Adirondack Health Institute) Albany Medical Center Hospital PPS (Albany Medical Center) Alliance for Better Health Care (Ellis Hospital)
Schenectady	Alliance for Better Health Care (Ellis Hospital)
Schoharie	Leatherstocking Collaborative Health Partners PPS (Bassett Medical Center)
Schuyler	Care Compass Network (United Health Services Hospitals)
Seneca	Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Steuben	Care Compass Network (United Health Services Hospitals) Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Tioga	Care Compass Network (United Health Services Hospitals)
Tompkins	Care Compass Network (United Health Services Hospitals)
Warren	Adirondack Health Institute PPS (Adirondack Health Institute) Albany Medical Center Hospital PPS (Albany Medical Center)
Washington	Adirondack Health Institute PPS (Adirondack Health Institute)
Wayne	Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Wyoming	Finger Lakes PPS (Rochester Regional Health System/UR Medicine) Millennium Collaborative Care (Erie County Medical Center)
Yates	Finger Lakes PPS (Rochester Regional Health System/UR Medicine)
Hudson Valley	***3 PPSs***
Dutchess	Hudson Valley Cooperative (Montefiore Medical Center) WMCHealth PPS (Westchester Medical Center)
Orange	Hudson Valley Cooperative (Montefiore Medical Center) Refuah Community Health Collaborative (Refuah Health Center) WMCHealth PPS (Westchester Medical Center)
Putnam	Hudson Valley Cooperative (Montefiore Medical Center) WMCHealth PPS (Westchester Medical Center)
Rockland	Hudson Valley Cooperative (Montefiore Medical Center) Refuah Community Health Collaborative (Refuah Health Center) WMCHealth PPS (Westchester Medical Center)
Sullivan	Hudson Valley Cooperative (Montefiore Medical Center) WMCHealth PPS (Westchester Medical Center)
Ulster	Hudson Valley Cooperative (Montefiore Medical Center) WMCHealth PPS (Westchester Medical Center)
Westchester	Hudson Valley Cooperative (Montefiore Medical Center) WMCHealth PPS (Westchester Medical Center)

County	Performing Provider System (PPS lead entity or entities)
Long Island	***2 PPSs***
Nassau	Nassau Queens PPS (Nassau University Medical Center, in alliance with Northwell Health and Catholic Health Services of Long Island)
Suffolk	Suffolk Care Collaborative (State University of New York at Stony Brook University Hospital)
New York City	***11 PPSs***
Bronx	Advocate Community Providers (AW Medical Office, PC/New York Community Preferred Partners/ Northwell Health) Bronx-Lebanon Hospital Center PPS (Bronx-Lebanon Hospital Center) Bronx Partners for Healthy Communities (SBH Health System) OneCity Health (NYC Health + Hospitals)
Kings	Advocate Community Providers (AW Medical Office, PC/New York Community Preferred Partners/ Northwell Health) Brooklyn Bridges (NYU Lutheran Medical Center) Community Care of Brooklyn (Maimonides Medical Center) Mount Sinai PPS (Mount Sinai Health System) OneCity Health (NYC Health + Hospitals)
New York	Advocate Community Providers (AW Medical Office, PC/New York Community Preferred Partners/ Northwell Health) New York-Presbyterian PPS (New York-Presbyterian Hospital) Mount Sinai PPS (Mount Sinai Health System) OneCity Health (NYC Health + Hospitals)
Queens	Advocate Community Providers (AW Medical Office, PC/New York Community Preferred Partners/ Northwell Health) Community Care of Brooklyn (Maimonides Medical Center) Mount Sinai PPS (Mount Sinai Health System) Nassau Queens PPS (Nassau University Medical Center, in alliance with Northwell Health and Catholic Health Services of Long Island) New York-Presbyterian/Queens PPS (New York-Presbyterian/Queens) OneCity Health (NYC Health + Hospitals)
Richmond	Staten Island PPS (Richmond University Medical Center/Staten Island University)

Source: New York State Department of Health, DSRIP Performing Provider Systems by County, Jan. 2016.

Appendix D

Performing Provider System Project Menu

Project number	Project name
	Domain 2. System transformation projects
A.	Create integrated delivery systems
2.a.i	Create integrated delivery systems that are focused on evidence-based medicine and population health management
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care models (as developed under the NYS Health Innovation Plan (SHIP))
2.a.iii	Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for health homes through access to high quality primary care and support services
2.a.iv	Create a medical village using existing hospital infrastructure
2.a.v	Create a medical village/alternative housing using existing nursing home infrastructure
B.	Implementation of care coordination and transitional care programs
2.b.i	Ambulatory intensive care units
2.b.ii	Development of co-located primary care services in the emergency department (ED)
2.b.iii	Emergency department care triage for at-risk populations
2.b.iv	Care transitions intervention model to reduce 30-day readmissions for chronic health conditions
2.b.v	Care transitions intervention for skilled nursing facility (SNF) residents
2.b.vi	Transitional supportive housing services
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
2.b.viii	Hospital-home care collaboration solutions
2.b.ix	Implementation of observational programs in hospitals
C.	Connecting settings
2.c.i	Development of community-based health navigation services
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services
D.	Utilizing patient activation to expand access to community-based care for special populations
2.d.i	Implementation of patient activation activities to engage, educate, and integrate the uninsured and low/nonutilizing Medicaid populations into community-based care
	Domain 3. Clinical improvement projects
A.	Behavioral health
3.a.i	Integration of primary care and behavioral health services
3.a.ii	Behavioral health community crisis stabilization services
3.a.iii	Implementation of evidence-based medication adherence programs (MAPs) in community-based sites for behavioral health medication compliance
3.a.iv	Development of withdrawal management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
3.a.v	Behavioral Interventions Paradigm (BIP) in nursing homes
B.	Cardiovascular health–implementation of Million Hearts Campaign
3.b.i	Evidence-based strategies for disease management in high-risk/affected populations (adult only)
3.b.ii	Implementation of evidence-based strategies in the community to address chronic disease–primary and secondary prevention projects (adult only)

Project number	Project name
C.	Diabetes care
3.c.i	Evidence-based strategies for disease management in high-risk/affected populations (adults only)
3.c.ii	Implementation of evidence-based strategies to address chronic disease–primary and secondary prevention projects (adults only)
D.	Asthma
3.d.i	Development of evidence-based medication adherence programs (MAPs) in community settings–asthma medication
3.d.ii	Expansion of asthma home-based self-management program
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management
E.	HIV/AIDS
3.e.i	Comprehensive strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations–development of a Center of Excellence for Management of HIV/AIDS
F.	Perinatal care
3.f.i	Increase support programs for maternal and child health (including high risk pregnancies), for example, the Nurse-Family Partnership
G.	Palliative care
3.g.i	Integration of palliative care into the patient-centered medical home model
3.g.ii	Integration of palliative care into nursing homes
H.	Renal care
3.h.i	Specialized medical home for chronic renal failure
	Domain 4. Populationwide projects: New York's prevention agenda
A.	Promote mental health and prevent substance abuse
4.a.i	Promote mental, emotional, and behavioral (MEB) well-being in communities
4.a.ii	Prevent substance abuse and other mental/emotional/behavioral disorders
4.a.iii	Strengthen mental health and substance abuse infrastructure across systems
B.	Prevent chronic diseases
4.b.i	Promote tobacco use cessation, especially among low-socioeconomic-status populations and those with poor mental health
4.b.ii	Increase access to high-quality chronic disease preventive care and management in both clinical and community settings (note: this project targets chronic diseases that are not included in domain 3, such as cancer)
C.	Prevent HIV and sexually transmitted diseases
4.c.i	Decrease HIV morbidity
4.c.ii	Increase early access to, and retention in, HIV care
4.c.iii	Decrease STD morbidity
4.c.iv	Decrease HIV and STD disparities
D.	Promote the health of women, infants, and children
4.d.i	Reduce premature births

Source: New York State Department of Health, Delivery System Reform Incentive Payment Program Project Toolkit, Oct. 2014.

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