I. DSRIP Program

A. Overview

The largest allocation of MRT Waiver funding is to the DSRIP program. DSRIP funds a variety of projects and reform initiatives from a "menu" of eligible delivery system improvement projects and related reporting metrics. However, each project has a common goal—to encourage collaboration among New York's key health care stakeholders to decrease avoidable hospital readmissions by 25% over the term of the MRT Waiver.

B. Eligible Providers

DSRIP funding is available only to so-called Performing Provider Systems that consist of specific types of "safety net" or "vital access" providers. Given this eligibility standard, the definitions of safety net and vital access providers are critically important to a provider's ability to participate in, and receive funding for, an approved DSRIP project.

1) **Safety Net Providers**

   a) **Hospitals:** To qualify, an Article 28-licensed hospital must either (a) be a public hospital, a federally designated Critical Access Hospital or Sole Community Hospital; (b) have a certain percentage of its inpatient and outpatient volume comprise Medicaid, uninsured or dual-eligible individuals; or (c) serve at least 30% of all Medicaid, uninsured and dual-eligible members in a designated community.

   b) **Non-Hospital Providers:** A non-hospital-based provider must have at least 35% of its primary patient volume associated with Medicaid, uninsured or dual-eligible individuals who are not part of a state-designated Health Home. This category likely encompasses most providers of services to individuals with behavioral or mental health diagnoses, substance abuse disorders and intellectual and developmental disabilities, as well as freestanding clinics, nursing homes and home health providers. Inclusion of these types of non-hospital providers is essential to applying for certain projects eligible for DSRIP funding.

      Note that if an otherwise eligible non-hospital provider is already participating as a provider in a state-designated Health Home, that provider does not qualify under this definition. Accordingly, if a non-hospital provider has joined a Health Home and does not independently meet another eligibility category, then that Health Home must represent the provider in DSRIP projects or else the provider risks being deemed "non-qualifying."

2) **Vital Access Providers:** If a provider does not meet the safety net definition, it may still participate in the DSRIP program under the vital access provider exception. This exception allows participation by providers that may not otherwise qualify, but nonetheless serve key Medicaid populations. Confusingly, the definition of "vital access provider" under the MRT Waiver is not directly linked to providers previously eligible for funding under the existing Value Access Provider ("VAP") grant program, as financial viability is not a definitional element. Rather, to meet the definition of vital access provider under the MRT Waiver, a provider must show that (a) there are other providers willing to partner with it to apply for a DSRIP project in a particular community; (b) it is an Article 28-licensed hospital uniquely qualified to serve a community; or (c) it is already a state-designated Health Home or group of Health Homes.

Failure of a provider to fall within one of these categories does not mean that participation in a DSRIP project is precluded, but that the non-qualifying provider cannot receive more than 5% of funding from any DSRIP project.

C. Performing Provider Systems

The MRT Waiver *requires* that providers collaborate in applying for DSRIP project-based funding. The mechanism for fostering such collaboration is the creation of coalitions named Performing Provider Systems. Each Performing Provider System must have an attributed Medicaid beneficiary population of at least 5,000 to participate in DSRIP programs. Under the terms of the MRT Waiver, Performing Provider Systems are required to build systems to share data, implement DSRIP project objectives and report project performance and milestones.

Other than requiring designation of a "lead coalition provider" and that a clear business relationship exist between the component providers (*e.g.*, a joint budget and funding distribution plan), the MRT Waiver provides little guidance on how such coalitions should be structured and operated. Accordingly, providers who seek to apply for DSRIP funding should consider several important legal and practical gatekeeping considerations when forming or joining a Performing Provider System, which may include:

- **Use of a Formal Legal Entity:** Providers should consider whether becoming a Performing Provider System will require formation of a new legal entity, repurposing an existing legal entity or collaboration through an incorporated association. Such legal entities or associations should be sufficiently flexible in admitting new qualifying component providers to ensure that attributed beneficiary counts are met and to fill gaps in fulfilling the stated objectives of DSRIP project plans.
- **Repurposing or Leveraging Existing Coalitions:** If collaboration through a legal entity is desired, providers should consider whether existing coalitions formed for other health reform purposes, such as IPAs for managed care contracting or a state-designated Health Home, can be converted into a Performing Provider System. If such existing entities can be leveraged, providers should consider whether modifications to any corporate governance or operational documents are necessary to achieve DSRIP project objectives. Conversely, qualifying providers should consider whether a Performing Provider System should be formed in a way that can be leveraged for other health reform purposes down the road, such as clinical integration activities or risk sharing with managed care plans.
- **Agreements:** Other than the data agreement specified by the MRT Waiver, component providers of a Performing Provider System should consider whether other agreements, such as participating provider, shared services and membership agreements, will be necessary to bind component providers to accomplish DSRIP project objectives and to ensure component provider accountability.
- **Risk Management:** The MRT Waiver and related guidance materials stress the importance of the lead coalition provider, which will bear ultimate responsibility for meeting the stated objectives of different DSRIP projects. Performing Provider Systems should consider what risk mitigation strategies are necessary to protect existing, unrelated assets or operations of a lead coalition provider if DSRIP project objectives are not met.
- **Capital Contributions:** While start-up funding is available to Performing Provider Systems during the project development phase, it is likely that additional capital contributions will be needed to organize a coalition and complete the DSRIP application. Performing Provider Systems should consider how to structure such capital contributions, whether as membership contributions, dues,

subventions, loans or otherwise, based on the expectation of whether such start-up funding will be returned or repaid through a distribution plan after a Performing Provider System receives DSRIP funding.

- **Distribution Plan:** Similar to ACOs, providers should consider how to draft and implement a distribution plan so that component providers of a Performing Provider System are compensated equitably based on contribution of attributed beneficiaries, start-up capital or other factors. The design of a distribution plan should be structured to comply with federal and state fraud and abuse laws as well as federal and state tax-exempt requirements.
- **Exclusivity:** While provider exclusivity is not a requirement for participating in a Performing Provider System, Medicaid beneficiaries can be attributed to only a single Performing Provider System for DSRIP projects. As a practical matter, in structuring a Performing Provider System, applicants should consider whether exclusivity of provider participation will promote a DSRIP project's success by "locking in" provider commitments and solidifying the attributed beneficiary count for that provider.

D. DSRIP Project Planning/Domains

Once a qualifying provider joins a Performing Provider System, the Performing Provider System must select at least five projects from across four distinct "domains": (1) Overall Project Progress; (2) System Transformation; (3) Clinical Improvement; and (4) Population-Wide Strategy Implementation. Each project plan must have clearly defined process measures, outcome measures, measures of success relevant to provider type and population, and financial sustainability metrics.

1) *Domain 1 - Overall Project Progress:* This domain category provides funding for investments by Performing Provider Systems in technology, tools and human resources that strengthen the ability of the Performing Provider System to meet its DSRIP goals. Performing Provider Systems are not required to choose a project from this domain.

2) *Domain 2 - System Transformation:* The System Transformation domain has three subcategories, including support for creation of integrated delivery systems, implementation of care coordination and transitional care programs and connecting systems. For example, two projects included in the integrated delivery systems subcategory are creating a medical village using existing hospital infrastructure and creating a medical village or alternative nursing home using an existing nursing home. All Performing Provider Systems must select at least two, but no more than four, projects from this domain. At least one of these projects must relate to creating an integrated delivery system, and another must be chosen from one of the other two subcategories.

3) *Domain 3 - Clinical Improvement*: Projects in this domain focus on improved care and outcomes for patients with certain high-priority diseases. The Performing Provider System must choose at least one project that focuses on behavioral health, and at least one other project that is related to cardiovascular health, diabetes care, asthma or HIV/AIDS. For example, a Performing Provider System may choose to implement a project that uses DSRIP funds to expand an asthma home-based self-management program or to develop a Center of Excellence for management of HIV/AIDS. The requirement to choose a behavioral health project ensures that component providers that specialize in these treatment modalities, such as Article 31-licensed mental health clinics or Article 32-licensed substance abuse treatment programs, will be an essential partner in most Performing Provider Systems.

4) *Domain 4 - Population-Wide Strategy Implementation*: The projects in this domain complement and strengthen the projects in the Clinical Improvement domain. All Performing Provider Systems must select at least one, but no more than four, of these projects from four designated priority areas: mental health and substance abuse; chronic disease; HIV/AIDS; and women, infants and children. For example, a Performing Provider System may use DSRIP funds for a program designed to promote mental, emotional and behavioral well-being in communities, or to reduce premature births.

E. Comparison to Other Health Reform Initiatives

The overall objectives to be achieved by the DSRIP component of the MRT Waiver are not new. At its core, the DSRIP program is intended to lower Medicaid costs and improve patient care through better coordination and management of care among different types of providers within defined geographic areas. Specifically, the objectives of the DSRIP program align substantially with those care coordination objectives of the Medicare Shared Savings Program ("MSSP") and the development of state-approved Health Homes. Providers should consider the interplay between these reform initiatives and DSRIP if such providers plan to participate in both.

1. The Relationship between ACOs and the DSRIP Program

Under the MSSP, CMS implemented an application system through which providers form integrated networks (called ACOs) to deliver care to Medicare beneficiaries and, subject to cost and quality benchmarks, share in any savings that the ACO achieves for attributed Medicare beneficiaries. The primary hypothesis of the MSSP is that if providers coordinate care and share accountability for outcomes, then higher quality and lower cost care will result. Since the adoption of the MSSP, insurance companies and other health care organizations also have entered into broad contractual relationships, sometimes called commercial ACOs or risk sharing or coordinated care arrangements.

Similar to ACOs, for a Performing Provider System participating in the DSRIP program to be successful, the organization needs robust care coordination, data sharing and analytics among providers, and quality monitoring/feedback mechanisms designed to provide real-time feedback to providers. Ideally, providers in existing Medicare and commercial ACOs could leverage their relevant experience when pursuing DSRIP projects, such as how to achieve attributed beneficiary counts and how to allocate funding to providers through a distribution plan in a way that complies with applicable legal requirements. However, providers who participate in ACOs should be aware of several differences between existing Medicare and commercial shared savings programs on the one hand, and the DSRIP program on the other, including:

- **Different timing of payment mechanisms:** Under the MSSP and typical commercial ACO arrangements, participating providers tend to be paid at otherwise-applicable fee-for-service or global payment rates, notwithstanding the ACO arrangement. The ACO, usually at least six months following the end of a year, then may receive shared savings payments based on quality metrics, cost metrics or both. However, under the DSRIP program, participating providers receive money prior to implementing health care reform initiatives and then throughout the year for meeting certain milestones and targets set by the state.
- **Selection of component providers:** Where ACOs have been focused on primary care and other providers who are in the best position to coordinate care and achieve cost savings, Performing Provider Systems must select DSRIP projects that require the involvement and input of all different types of licensed providers to improve care and lower cost within a specific geographic region,

including hospitals, clinics, behavioral and mental health providers and other community-based providers of Medicaid-funded services. Accordingly, certain DSRIP projects may require the involvement of providers that may not be necessary to the success of an ACO.

Notwithstanding these differences, providers who are experienced members of ACOs are likely to have a leg up in implementing DSRIP programs and in understanding how to address practical and operational issues concerning provider collaboration.

2. The Relationship between Health Homes and the DSRIP Program

Health Homes are a care management service model for New York Medicaid recipients with chronic conditions. Health Homes unite providers, health plans and community-based organizations to allow all of a recipient's caregivers to communicate with one another. Typically, a single patient's care is coordinated through a "care manager" who ensures that the patient has access to all services needed to stay healthy. Health Homes receive a per-member, per-month ("PMPM") care management fee that is adjusted based on region, case mix and patient functional status.

Much like the Performing Provider Systems envisioned by the MRT Waiver, Health Homes are coalitions of providers organized for the purposes of lowering cost and improving quality through better care coordination and data sharing. While the stated objectives of DSRIP projects are in many cases more specific and prescriptive than traditional Health Home activities, the MRT Waiver recognizes that Health Homes will, in many cases, serve as turnkey Performing Provider Systems that are experienced in the types of activities envisioned by many of the DSRIP projects. Moreover, the eligibility criteria encourage non-hospital providers in existing Health Homes to leverage these efforts for DSRIP program participation. Specifically, the definition of "safety net" providers requires non-hospital providers participating in Health Homes to join a Performing Provider System through their Health Home if they wish to participate.