New York State's $8 Billion Medicaid 1115 Waiver Amendment to Improve Access, Quality and Efficiency in the State's Health Care Delivery System

I. Overview

On April 14, 2014, Governor Cuomo announced that New York had finalized the terms and conditions of a Medicaid 1115 waiver amendment agreement (the "MRT Waiver") with the Centers for Medicare and Medicaid Services ("CMS"). The waiver amendment enables the state to reinvest over a five-year period $8 billion of the approximately $17.1 billion in federal savings generated by Medicaid Redesign Team ("MRT") reforms. The reinvestment will allow for comprehensive reform primarily through the Delivery System Reform Incentive Payment ("DSRIP") program.

The DSRIP program is not unique to New York. It has been approved in several other states—including Texas, New Jersey, Pennsylvania and Kansas—as an alternative to more traditional waiver-funded supplemental payment programs. Program details vary by state, but generally provide federal and local funding for projects that further the "triple aims" of better care for individuals, better population health and lower cost through improvement and innovation. Participating providers receive funding to design and implement certain projects from a pre-approved "menu" provided as part of the MRT Waiver and are eligible for incentive payments if the programs meet or exceed certain performance metrics.

Similar to DSRIP programs already approved by CMS in other states, the New York State DSRIP program approved through the MRT Waiver utilizes a rewards-based payment structure. This structure is designed to promote community-level collaborations and system reform with the overall goal of a 25% reduction in avoidable hospital utilization over the five-year reinvestment period.

II. The Components of the MRT Waiver Amendment

New York submitted the MRT Waiver amendment proposal to CMS in August 2012, requesting to reinvest $10 billion in MRT-generated federal savings. CMS deemed several innovative strategies initially proposed by the state "unfundable" under federal rules, including those for rental subsidies and health information technology. After much back and forth, New York and CMS negotiated several structural changes to the original proposal, which enabled New York to reinvest $8 billion in federal savings for the following funding opportunities:

- **$6.42 Billion for the DSRIP Program**. The primary focus of the MRT Waiver is a rewards-based program that provides significant funding to eligible providers through planning grants, provider incentive payments and payments to fund administrative costs and related workforce transformation costs associated with innovative reform projects. The DSRIP program shares many features with existing federal and state reform initiatives and grant opportunities, but is unique in that it encourages meaningful collaboration among providers within a geographic area. For more information on the DSRIP program, please click here.

- **$500 Million for Interim Access Assurance Fund ("IAAF")**. This time-limited funding will ensure that Medicaid safety net hospitals remain financially viable as they prepare for, commit to and participate fully in the DSRIP program transformation process. For more information on IAAF, please click here.

- **$1.08 Billion for other Medicaid Redesign Purposes**. Unrelated to the DSRIP program, this "other" funding provided by the MRT Waiver will support ongoing state Medicaid reform initiatives, including: (i) Health Home sustainability; (ii) investments in workforce for Medicaid Long-Term Care plans ("MLTCs"); and (iii) the transition of individuals with mental health and substance abuse diagnoses into Medicaid managed care plans. For more information on waiver funding for these other Medicaid redesign purposes, please click here.

III. The Importance of Strategic Planning

The expansive funding opportunities available through the MRT Waiver, and specifically the DSRIP program, must be carefully reviewed by providers, as each project carries unique eligibility and application criteria. In most cases, the DSRIP program will require new or expanded collaborative efforts with other eligible providers through coalitions called "Performing Provider Systems." As providers analyze their eligibility and desire to apply for DSRIP funding, it is important to recognize that the DSRIP program does not supplant, but mostly supplements, existing Medicare and Medicaid reform efforts. Accordingly, providers should not lose sight of other ongoing Medicare and Medicaid reform initiatives, such as the transition of virtually all Medicaid beneficiaries into "care management" through managed care plans and state-designated Health Homes, which present opportunities for collaboration regarding planned changes in service delivery.

Providers seeking to access MRT Waiver funding through the DSRIP program will need to contemplate whether to create new or leverage existing collaborative platforms, such as a Health Home, independent practice association ("IPA") or Accountable Care Organization ("ACO"). In describing the components of the MRT Waiver, this summary presents key legal and practical issues for consideration to enable providers to appropriately develop new, or expand upon existing, collaborative initiatives.

IV. Links and Resources

For more information about the MRT Waiver, please click here.

For more information about the DSRIP program, please click here.

Note that New York is seeking comments on DSRIP documents as follows:

- Special Terms and Conditions ("STCs")
- Program Funding and Mechanics Protocol (Attachment I)
- Strategies and Metrics Menu (Attachment J)

If you have any questions about the DSRIP program or New York health care reform, please contact your usual Ropes & Gray attorney.

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.

II. Accessing the Interim Access Assurance Fund

A. Overview

Up to $500 million in funding is available to help support certain hospitals and to preserve key health care services as these hospitals begin developing and implementing DSRIP projects. These funds are intended to sustain qualifying hospitals until April 1, 2015, when DSRIP funding becomes available for their selected projects.

Unlike the DSRIP funds made available through the MRT Waiver, IAAF funding does not need to be devoted to a specific project. Like existing VAP funding, IAAF operates as a grant that is intended to supplement existing payments to essential hospitals experiencing financial hardship. While providers already receiving VAP awards are not expressly precluded from also receiving additional funding through IAAF, the MRT Waiver requires the New York State Department of Health ("DOH") to ensure that there is no duplication of payment for purposes covered by other grant programs. As a result, it remains to be seen if and how DOH will consider existing VAP awards in providing additional funding under IAAF.

B. Eligible Hospitals

Unlike VAP funding made available to hospitals, nursing homes, diagnostic and treatment centers and home care providers, IAAF is available only to hospitals. Further, eligible hospitals are subdivided into two "pools"

of IAAF funds: (1) "safety net hospitals" for which $250 million in IAAF funding is available; and (2) "large public hospitals" for which the remaining $250 million in IAAF funding is available. While other types of providers are encouraged to participate in the DSRIP, IAAF funding is not available to them.

Safety Net Hospitals: All public hospitals and federally designated Critical Access or Sole Community Provider Hospitals are categorically eligible to apply for IAAF funding as safety net hospitals. For a private hospital to qualify as a safety net hospital for the purpose of receiving IAAF funding, it must meet one of the following requirements:

1) Have Medicaid, uninsured or Medicaid dual-eligible patients comprise (a) at least 25% of all outpatient visits and (b) at least 30% of all inpatient charges; or

2) Provide services to at least 30% of the Medicaid, uninsured or Medicaid dual-eligible population residing in the target county.

Furthermore, the safety net hospital must have available resources of fewer than 15 days' cash and equivalents and have exhausted all efforts to monetize unneeded assets and obtain resources from corporate parents and other affiliated entities.

Large Public Hospitals: Unlike the means testing required under the definition of safety net hospitals, the waiver specifically names the "large" five hospital systems that operate public hospitals as public benefit corporations: Erie County Medical Center, Health and Hospitals Corporation, SUNY Medical Centers, Nassau University Medical Center and Westchester Medical Center. These appear to be the only five hospitals and hospital systems that qualify for this portion of IAAF funding.

C. Application Process

Any safety net or public hospital looking to take advantage of IAAF funding must apply by May 30, 2014. As part of the application, to be released in its final form on May 16, 2014, the provider must answer a brief questionnaire that identifies how the applicant qualifies for funding, and provide the following documentation: (1) a project narrative that justifies the funding request; (2) the latest fully audited financial statements; (3) the latest internal balance sheet; (4) an income statement and a statement of cash flow; (5) 2013 breakdown of utilization; (6) a monthly budget for the period April 1, 2014 – March 31, 2015; and (7) monthly utilization projections for the period April 1, 2014 – March 31, 2015.

D. Use of IAAF Funds

An approved provider will receive funds on a monthly basis to help support personnel costs, supplies, utilities, administrative services, communications and recordkeeping. These funds cannot be used for capital projects, consultants or repayment of existing debt obligations. The funding will be provided as a Medicaid rate adjustment, but the actual amount received will depend on reported revenue and expenses for the prior month, projected cash needs for the current and coming month, and progress toward achieving certain goals agreed upon with DOH. Funding will be available through March 31, 2015.

III. Other Medicaid Redesign Purposes

Given the MRT Waiver's focus on DSRIP, it is easy to lose sight of other important features of the MRT Waiver that are featured less prominently, but provide critical funding to ongoing MRT health reform initiatives. These features include (1) a rate add-on for Health Homes and (2) funding for managed care activities to expand coverage for individuals with behavioral or mental health diagnoses.

A. Health Home Rate Add-On

The DSRIP component of the MRT Waiver emphasizes the importance of Health Homes through its definitions of "safety net" and "vital access" providers, which make Health Homes a preferred vehicle for DSRIP project participation. The MRT Waiver also commits additional funding to Health Homes, likely in response to the perceived insufficiency of the current Health Homes rates to meet the costs of care coordination and related support activities. To help Health Homes cover costs and to support their financial sustainability, $190.6 million of the MRT Waiver is dedicated to this financial relief, which will be paid through an increase to the PMPM fee for each beneficiary assigned to the Health Home.

B. Managed Care Programming

The MRT Waiver provides a total of $890.9 million in funding for certain types of "managed care programming" activities. This funding is divided into two components:

- **Behavioral Health Services:** Support for the key MRT initiative to move certain fee-for-service populations and services into managed care as part of New York State's goal of having virtually all Medicaid beneficiaries served in care management by April 2018. As part of this initiative, referred to as "Care Management for All," New York State plans to transition populations with mental health and substance abuse diagnoses into specialized Medicaid managed care plans called Health and Recovery Plans ("HARPs"), which will be responsible for furnishing a benefit package inclusive of both general Medicaid State Plan services and Home and Community Based services, such as rehabilitation, habilitation, crisis intervention, employment support and other services. While implementation of HARPs will be pursuant to a separate 1115 waiver submitted by New York State to CMS on December 31, 2013, the MRT Waiver provides a "down payment" of $645.9 million to managed care plans seeking to achieve HARP-readiness.
- **Long-Term Care Workforce Strategy:** The more than 40 Managed Long-Term Care plans ("MLTCs"), which serve chronically ill or disabled Medicaid beneficiaries, will receive $245 million in Long-Term Care Workforce Strategy funds. MLTCs must use these funds to invest in programs that attract, recruit and retrain long-term care professionals. MLTCs also need to develop strategies that place long-term care workers in underserved communities and train workers to care for individuals who will seek coverage under the Affordable Care Act. To receive funds, each MLTC must submit a retraining, recruitment and retention plan annually for state approval, and then achieve its stated workforce strategy.