spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

DSRIP Extension Draft Proposal Summary

OVERVIEW

On September 17th, the New York State Department of Health (DOH) released a draft proposal describing an amendment to the 1115 Medicaid Redesign Team (MRT) waiver that would extend the Delivery System Reform Incentive Payment (DSRIP) for a total of four years. DSRIP Year 5 is currently scheduled to end in March 2020. In the draft, DOH proposes to request that the Centers for Medicare & Medicaid Services (CMS) approve an additional federal investment of $8 billion over a four-year time period, consisting of a one-year extension through March 2021 followed by a three-year renewal period through March 2024. This $8 billion would be invested in four program areas:

- DSRIP Performance ($5 billion);
- Workforce Development ($1 billion);
- Social Determinants of Health ($1.5 billion); and
- A second Interim Access Assurance Fund ($500 million).

The renewed DSRIP program would focus on sustaining and expanding "promising practices" identified during the first DSRIP period. It would offer more time and funding to integrate such practices into value-based payment (VBP) contracts. New DSRIP funds would flow to collaborations called Value-Driving Entities (VDEs), which will expand on the Performing Provider System (PPS) concept to include managed care organizations (MCOs), community-based organizations (CBOs), and Qualified Entities (i.e., health information exchanges). Each VDE's single overarching goal would be to create VBP contracts that fully fund and support DSRIP promising practices and other high-need projects by the end of the renewal period in 2024, which would effectively be DSRIP Year 9 (DY 9).

Other notable alterations to DSRIP under the proposed renewal include:

- Alignment with federal priority initiatives, including projects in the following areas:
  - Substance Use Disorder (SUD) Care and the Opioid Crisis;
  - Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED);
  - Social Determinants of Health; and
  - Primary Care Improvement and Alternative Payment Models;
- A narrower set of high-value projects and associated performance measures, aligned with federal priorities such as the CMS Meaningful Measures Framework; and
- Implementation of three new priority areas for DSRIP outcomes:
  - Reducing maternal mortality;
  - Children's population health; and
  - Long-term care reform.

The amendment proposal is available here. The State is accepting comments through November 4th.

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FUNDING

The amendment requests a total of $8 billion in federal funds over four years (see table below). The State would provide matching funds, although only the federal funding would represent new funding if the matching funds would again be generated through intergovernmental transfers. The State proposes that, as with the original DSRIP program, these investments would be supported by the reinvestment of savings achieved through other 1115 waiver programs (e.g., mandatory managed care) to achieve budget neutrality, but has not provided a detailed budget neutrality calculation as called for under recent CMS statements.

Program (Federal $ Millions)	Year 1	Year 2	Year 3	Year 4	Total
DSRIP Performance	$2,750	$1,250	$500	$500	**$5,000**
Workforce Development	$500	$250	$125	$125	**$1,000**
Social Determinants of Health	$250	$500	$375	$375	**$1,500**
Interim Access Assurance Fund	$500	$0	$0	$0	**$500**
Total	**$4,000**	**$2,000**	**$1,000**	**$1,000**	**$8,000**

VALUE-DRIVING ENTITIES

The State intends to expand on the PPS concept by creating a second generation of DSRIP funding entities called Value-Driving Entities (VDEs). VDEs will be collaborations of PPS, MCOs, providers, and CBOs, integrated with QEs to enhance data exchange capabilities. A VDE may be based on an existing PPS, but will be required to incorporate MCOs in the region into its management and operational structures. It would also, ideally, similarly incorporate CBO governance participation. VDEs will also build on existing VBP structures, such as accountable care organizations (ACOs), independent practice associations (IPAs), and Behavioral Health Care Collaboratives (BHCCs).

Each VDE's goal will be to make a set of DSRIP promising practices and other high-need projects ready to be fully supported by VBP contracts by the end of the renewal period in March 2024. Like the first-generation PPSs, VDEs will operate with a specific attributed population within a certain geographic region/market. However, they will have more structural flexibility, being able to modify existing PPS structures or to propose new teams from a subset of its partners (providers, CBOs, MCOs, and QEs).

The State has not committed to approving each existing PPS to become or form a VDE. Instead, it will specifically approve VDEs based on the following criteria:

- History of performance improvement;
- Strength of partnerships with MCOs, CBOs, and providers;
- Governance structure that includes MCOs, CBOs, and providers; and
- Potential to sustain DSRIP promising practices under VBP arrangements by the end of DY 9.

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CONTINUED INVESTMENTS AND IMPROVEMENTS

Workforce

VDEs will be encouraged to continue the work of current DSRIP initiatives that support the expansion of the non-traditional, non-clinical workforce, including community health workers, peers, and patient navigators. During the extension period, all VDE partners will need to assess intervention costs and savings of workforce-related activities for purposes of future VBP. Portions of VBP bonus payments could be based on integrating non-traditional workforce into higher level VBP arrangements.

Social Determinants of Health

The State is encouraging the development of new network groups, known as Social Determinant of Health Networks (SDHNs), that will contract with plans to deliver socially focused interventions to individuals with complex needs. Each network will operate in a State-designated region and will be selected through a competitive procurement process.

Eligible lead applicants of SDHNs will be VDEs/PPSs that serve Medicaid members with complex health and social needs, including families with children experiencing, or at risk of, significant and multiple adverse childhood experiences. Lead applicants will:

- Formally organize a network of CBOs that will collectively use evidence-based SDH interventions to coordinate and address housing, nutrition, transportation, interpersonal safety, and toxic stress;
- Coordinate a regional referral network with multiple CBOs and health systems;
- Create a single point of contracting for VBP SDH arrangements; and
- Assess Medicaid members for key State-selected SDH issues and make appropriate referrals based on need.

Substance Use Disorder and Opioid Crisis

The extension phase will continue to build on best practices implemented in the current demonstration, such as broad screening for OUD/SUD in primary care practices, Medication-Assisted Treatment (MAT), care transition services from hospitals to community, and the use of peers. VDEs will partner with regional Centers for Treatment Innovations (COTIs) that target underserved areas and help to expand access to telehealth practices, linkages to MAT, and peer outreach and engagement within the local community.

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ADDITIONAL HIGH PRIORITY AREAS

The State has additionally identified other priority areas for VDEs to address the needs of high-cost, high-need populations.

Reducing Maternal Mortality

Under the extension, communities with high maternal mortality and low birthweight deliveries will be encouraged to adopt VBP contracts that includes a maternity bundle that integrates practices from beyond DSRIP, such as the Centering Pregnancy model.

Children's Population Health

The proposed renewal would seek to create a new focus on children's services by extending DSRIP promising practices that primarily served the adult population. Promising practices would be adapted for children's services in the following areas, among others:

- Chronic care management;
- Behavioral health integration;
- Pediatric-focused patient-centered medical homes;
- Expansion of transitional care teams and care management services in collaboration with Health Homes serving Children;
- Integration of community health workers into provider teams;
- Use of telemedicine for residential populations for ED triage; and
- Expansion of crisis stabilization programs.

Long-Term Care Reform

The State recognizes the need to address shifting demographic patterns that will increase the need for long-term care (LTC) services in New York. It intends to further explore the combination of (1) care bundles and other VBP options and (2) new and expanded managed care models for long-term services. VDEs will participate in this by continuing existing PPS collaborations focused on the LTC workforce that identify system reforms needed to support an aging population, including subsidies and stipends for participating in aide certification and nursing programs, loan forgiveness programs for nursing graduates, and subsidies for childcare for LPNs and aides.

Also, VDEs would target specific high-need populations for activities meeting a limited set of state-defined criteria designed to move towards VBP. The State anticipates that matched Medicare and Medicaid data will be available during the renewal period, which can be used to identify the population and opportunities for improvement and identification of measures to be integrated into the performance measure set for the VDEs, weighted by the size of the defined high-need population in comparison to the whole of the attributed population.

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PERFORMANCE MEASUREMENT

The extension will seek to align and narrow the set of quality measures that VDEs will need to report and on which they will be responsible for performance. The State will seek to closely collaborate with CMS to select initial measure specifications that:

- Appropriately measure performance on DSRIP promising practices;
- Align with the CMS Meaningful Measures Framework, CMS core measure sets, and other federal and state measures already in use;
- Focus on areas with existing poor performance and/or broad performance disparities;
- Demonstrate clinical relevance, reliability, validity, and feasibility as performance measures for both the purposes of the amendment request and as VBP measures at the provider level;
- Allow for universal application for VDE performance payment; and
- Allow for widescale adoption of all or most of the measures in VBP arrangements.

These measures will be reviewed by the existing VBP Clinical Advisory Groups and be used to determine performance payments. Under the amendment, performance payment will be based on demonstrating improvement across the entirety of the measure set rather than specific measures for individual projects. A bonus payment program will reward ongoing high performance and VDEs that take on increased risk and enter into higher-level VBP contracts with MCOs using aligned amendment and VBP measures. The VBP portion of the bonus payment could include additional elements of overall utilization decreases and/or resulting cost savings.

Additional measures may also be considered for reporting purposes only in order to track MCO, CBO, and QE engagement.

The State aims to incentivize VDEs that develop advanced payment models (APMs) that meet to-be-defined criteria for adopting best practices in areas such as additional system transformation, data usage, and sharing, continuous performance improvement, network and service rationalization, and regional population health improvement.

INTERM ACCESS ASSURANCE FUND 2.0

During the initial year of the DSRIP program, an Interim Access Assurance Fund (IAAF) was used to authorize payments to financially distressed safety net providers participating in DSRIP and experiencing revenue losses due to success of DSRIP initiatives in reducing inpatient and emergency department utilization. The proposed renewal would create a second round of the Interim Access Assurance Fund (IAAF), offering another $500 million to financially distressed hospitals. This funding would provide supplemental payments able to exceed limitations on hospital funding such as the Upper Payment Limit (UPL), DSH limitations, or state plan payments. IAAF payments will be limited to providers that service significant numbers of Medicaid beneficiaries and that face financial hardship in the form of financial losses or low margins, as determined by the State.

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EVALUATION

DSRIP has contracted with an Independent Evaluator (IE), the State University of Albany. The IE submitted the Interim Evaluation Report on August 2nd and the final summative report is due on June 30, 2021. The current waiver amendment's evaluation parameters will be reviewed with CMS to determine the best approach for evaluating the extension.

Timeline

Comments may be sent through November 4th by email to 1115waivers@health.ny.gov or by mail to the following address:

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Avenue
12th Floor, Suite 1208
Albany, NY 12210