m. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for parents and caretaker relatives with incomes above 133 percent of the FPL through 150 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible but who are parents or caretaker relatives of individuals under the age of 21; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is above 133 percent of the FPL through 150 percent of the FPL. Federal financial participation for the premium assistance portion of QHP subsidies for citizens and eligible qualified aliens will be provided through the Designated State Health Programs pursuant to this STC. Authority to claim federal matching for this program will end on December 31, 2014.

n. The state may claim as allowable expenditures under the demonstration, the payments made through its state-funded program to provide FHPlus benefits to parents and caretaker relatives with incomes up to and including 150 percent of the FPL who are no longer eligible under the demonstration. Authority to claim federal matching for this program will end on December 31, 2014.

13. Designated State Health Programs (DSHP) Claiming Process.

a. Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 12 of this section. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHPs listed in STC 12 of this section, they shall not be used as a source of non-federal share.

d. The administrative costs associated with DSHPs in STC 12 of this section and any others subsequently added by amendment to the demonstration shall not be included in any way as demonstration and/or other Medicaid expenditures.

e. Any changes to the DSHPs listed in STC 12 of this section shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

VIII. DELIVERY SYSTEM REFORM PROGRAM DESCRIPTION AND OBJECTIVES

1. Medicaid Redesign Team (MRT)

a. BACKGROUND

The purpose of this demonstration amendment is to describe a structure under which the federal government will provide up to $8 billion in new federal funds for all Medicaid Redesign Team (MRT) activities including delivery system reform in the waiver, managed care programming and state plan amendment (SPA) activities. The purpose of one component of MRT, the

Delivery System Reform Incentive Payment (DSRIP) program, is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving care, improving health and reducing costs. Up to $6.42 billion of the new MRT funding is available for DSRIP payments to providers. An additional $500 million in temporary, time limited, funding is available from an Interim Access Assurance Fund (IAAF) for payments to providers to protect against degradation of current access to key health care services in the near term. And, up to $1.08 billion in federal funding for non-DSRIP Medicaid Redesign purposes, with specific uses of that funding still to be discussed and finalized.

Only initial funding of this structure is authorized in 2014; continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.

The DSRIP program is focused on the following goals: (1) safety net system transformation at both the system and state level; (2) accountability for reducing avoidable hospital use and improvements in other health and public health measures at both the system and state level; and (3) efforts to ensure sustainability of delivery system transformation through leveraging managed care payment reform.

i. **Safety Net System Transformation.** The DSRIP funds provider incentive payments to reward safety net providers when they undertake projects designed to transform the systems of care that support Medicaid beneficiaries and low income uninsured by addressing three key elements, which must be reflected in all DSRIP projects proposed by safety net providers participating in DSRIP (referred to as "Performing Provider Systems"). DSRIP projects will be designed to meet and be responsive to community needs while ensuring overall transformation objectives are met. As such, all projects must include the following elements, whose core components and associated outcome measures are further described in the DSRIP Strategies Menu and Metrics (Attachment J):

   A. **Element 1: Appropriate Infrastructure.** The DSRIP will further the evolution of infrastructure and care processes to meet the needs of their communities in a more appropriate, effective and responsive fashion to meet key functional goals. This will include changes in the workforce. Infrastructure evolution must support the broader goals of DSRIP, and key outcomes reflect the kinds of infrastructure to be supported under DSRIP. Appropriate infrastructure should ensure access to care, particularly to outpatient resources as well as effective care integration. In support of linking settings, the transforming infrastructure should place more emphasis on outpatient settings. Also, critical services such as care coordination may need to be expanded to meet the broad needs of the population served.

Indicators related to this objective are included in the System Transformation Milestones (Domain 2) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Because many of these indicators are difficult to benchmark, the state will be

accountable for ensuring that these indicators are moving overall in the right directions across all systems as part of the statewide accountability described in STC 14 (f) of this section.

B. Element 2: Integration across settings. The DSRIP will further the transformation of patient care systems to create strong links between different settings in which care is provided, including inpatient and outpatient settings, institutional and community based settings, and importantly behavioral and physical health providers. The goal will be to coordinate and provide care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while also managing total cost of care. The DSRIP will fund projects that include new and expanded care coordination programs, other evidence based, data driven interventions and programs focused on key health and cost drivers and opportunities for providers to share information and learn from each other.

Key outcomes to be measured are expected to reflect this ongoing transformation. Integration across settings will create alignments between providers. The DSRIP will include restructuring payments to better reward providers for improved outcomes and lower costs.

Indicators related to this objective are included in the Clinical Improvement Milestones (Domain 3) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J). Each system will be accountable for these indicators, and in addition, because the state should also work to support this goal, the state will also be accountable for statewide performance on these outcomes as described in STC 14(g) of this section.

C. Element 3: Assuming responsibility for a defined population. The DSRIP projects will be designed in ways that promote integrated systems assuming responsibility for the overall health needs of a population of Medicaid beneficiaries and low income uninsured people, not simply responding to the patients that arrive at the doors of a hospital. The state will approve a defined population for each DSRIP project based on geographic and member service loyalty factors, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I). Safety net providers may propose to develop integrated systems that target the individuals served by a set of aligned community-based providers, or more ambitious systems to tackle accountability for an entire geographic population. Patient and beneficiary engagement through tools including community needs assessment and responsiveness to public health needs will be an important element of all DSRIP projects.

Each indicator used to determine DSRIP awards should reflect a population, rather than the patients enrolled in a particular intervention. In addition, DSRIP performing provider systems will be required to report on progress on priorities related to the Prevention Agenda as included in the Population-wide Strategy

Implementation Milestones (Domain 4) described in more detail in DSRIP Strategies Menu and Metrics (Attachment J).

D. Element 4: Procedures to reduce avoidable hospital use: guidepost for statewide reform. New York has identified a statewide goal of reducing avoidable hospital use and improving outcomes in other key health and public health measures. Effectively reducing avoidable hospital use requires alignment of outpatient and inpatient settings, requires systems that can take responsibility for a population, and requires investments in key infrastructure--and so this is a guidepost that can ensure that these transformations are aligned with our shared goals of better health, and better care at lower cost.

Consistent with the fact that this is an integral guidepost to system transformation, key improvement outcomes for avoidable hospital use and improvements in other health and public health measures will be included for each project, and the state will be held accountable for these measures as part of the statewide accountability described in STC 14 (f) of this section.

E. Element 5: State managed care contracting reforms to establish and promote DSRIP objectives. The state must also ensure that its managed care payment systems recognize, encourage and reward positive system transformation. To fully accomplish DSRIP goals and ensure sustainability of the initiatives supported by this demonstration, as a condition of receiving DSRIP project funding, the state shall develop and execute payment arrangements and accountability mechanisms with its managed care contractors. These payment and accountability changes, described further in STC 39 of this section, must be reflected in the state's approved state plan and managed care contracts, and are funded through the approved state plan (without separate DSRIP funding). These changes are a condition for overall DSRIP project funding to be released.

This goal will also be monitored as part of the statewide accountability test described in STC 14(f) of this section and will be tracked not at a DSRIP project level, but at the state level. The state must ensure state payments to managed care plans reflect and promote the establishment and continuation of integrated service delivery systems and procedures to reduce avoidable hospital use and ensure improvements in other health and public health measures.

ii. State and Provider Accountability. Overall DSRIP project funding is available up to the amounts specified in the special terms and conditions. Such funding is subject to the Performing Provider System meeting ongoing milestones established pursuant to this demonstration, and the state meeting overall state milestones as described in the STCs and DSRIP Program Funding and Mechanics Protocol (Attachment I). In addition, statewide achievement of performance goals and targets must be achieved and maintained for full access to the funding level as specified in the STCs. Specific reductions from statewide funds are taken from the state starting in Year 3 accordance with STC 14 (h) of this section if these targets are not achieved.

Individual projects are awarded based on the merit of the proposal itself, its support of the overall DSRIP goals, and the projected breadth and depth of the impact on Medicaid beneficiaries. Public transparency, a process that allows for community input, and independent expert evaluation are critical to the approval and funding levels for each project.

It should be noted that federal funding for DSRIP activities is limited in any phase of the demonstration period to the amounts set forth in this demonstration authority, subject to all of the reductions based on milestones, even if the state expenditures exceed the amount for which federal funding is available.

b. Interim Access Assurance Fund (IAAF). Temporary, time limited, funding is available from an IAAF to protect against degradation of current access to key health care services in the near term. The IAAF is available to provide supplemental payments that exceed upper payment limits, DSH limitations, or state plan payments, to ensure that current trusted and viable Medicaid safety net providers, according to criteria established by the state consistent with these STCs, can fully participate in the DSRIP, transformation without unproductive disruption. The IAAF is authorized as a separate funding structure from the DSRIP program to support the ultimate achievement of DSRIP goals. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself. In addition, a separate fund is authorized to make DSRIP project design grants to providers. The IAAF and the design grant funds are both part of the overall DSRIP total funding.

i. Interim Access Assurance Fund. To protect against degradation of current access to key health care services, limit unproductive disruption, and avoid gaps in the health delivery system, New York is authorized to make payments for the financial support of selected Medicaid providers.

A. Limit on FFP. New York may expend up to $500 million in FFP for Interim Access Assurance payments for the period from the date of approval of the IAAF expenditure authority until December 31, 2014. Contingent upon renewal of the demonstration, the authority could be extended until March 31, 2015. To the extent available funds are not expended in this time-limited IAAF, they are available for the DSRIP program itself.

B. Funding. The non-federal share of IAAF payments may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any IAAF payments must remain with the provider receiving the payment to be used for health care related purposes, and may not be transferred back to any unit of government, directly or indirectly, or redirected for other purposes. The IAAF payments received by providers cannot be used for the non-federal share of any expenditures claimed under a federally-supported grant.

ii. Interim Access Assurance Fund Requirements.

A. The state will make all decisions regarding the distribution of IAAF payments to ensure that sufficient numbers and types of providers are available to Medicaid beneficiaries in the geographic area to provide access to care for Medicaid and uninsured individuals while the state embarks on its transformation path. The IAAF payments shall be limited to providers that serve significant numbers of Medicaid individuals, and that the state determines have financial hardship in the form of financial losses or low margins. In determining the qualifications of a safety net provider for this program and the level of funding to be made available, the state will take into consideration both whether the funding is necessary (based on current financial and other information on community need and services) to provide access to Medicaid and uninsured individuals. The state will also seek to ensure that IAAF payments supplement but do not replace other funding sources.

B. Before issuing any payments to providers, the state must post on its Website a list of qualifications that providers must meet to receive payments under this section, provide an opportunity for public comment for at least 14 days, and consider such comments. On the day the proposed qualifications list is posted, the state must provide to CMS the URL where the list can be found. The state must take the public comments into account when qualifying providers and distributing funds from this account.

C. Following the end of the public comment period in (ii), the state will initiate an open application period of at least 14 days duration for providers to submit applications.

D. If a provider otherwise meeting the qualifications of this section is also receiving funds through the state's vital access program, or any other supplemental payment program for which the federal government provides matching funds, or Medicaid disproportionate share hospital payments, the state must assure CMS of non-duplication. As part of the reporting requirements described in (iii) below, the state assures that the payment information for the IAAF will be maintained, as the reporting information is subject to CMS audit. A provider may receive both funding through this special fund and a planning grant as part of the DSRIP program.

iii. Reporting.

A. Within 10 days of initiating payments under this section to a provider, the state must submit a report to CMS that states the total amount of the payment or payments, the amount of FFP that the state will claim, the source of the non-Federal share of the payments, and documentation of the needs and purposes of the funds to assure CMS of non-duplication. The state should document all other Medicaid payments (e.g. base, supplemental, VAP, DSH) the provider receives to demonstrate that existing payments are not sufficient to meet financial needs of

the providers.

B. In each quarterly progress report, the state will include a summary of all payments under this section made during the preceding quarter, including all information required in (A), and attach copies all reports submitted under (A) for payments made during the quarter.

C. When reporting payments under this section on the CMS-64, the state must include in Form CMS-64 Narrative a table that lists all payments by date, provider, and amount (broken down by source), and a reference to the quarterly progress report(s) where the payments and all of their required supporting documentation is presented.

iv. IAAF payments. The IAAF payments are not direct reimbursement for expenditures or payments for services. Payments from the IAAF are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the state plan.

c. Delivery System Reform Incentive Payment (DSRIP) Fund. The terms and conditions in Section c apply to the State's exercise of Expenditure Authority 9: Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Fund. These requirements are further elaborated by Attachment I, "NY DSRIP Program Funding and Mechanics Protocol," Attachment J "NY DSRIP Strategies Menu and Metrics," and Attachment K "DSRIP Operational Protocol." For purposes of this section, the DSRIP program will have its own demonstration years (DY) and any reference to DY is in reference to the DSRIP portion of the Partnership Plan demonstration and not the entire Partnership Plan demonstration. DSRIP funding for demonstration year DY 1 through DY 5 is contingent on renewal of the demonstration no later than December 31, 2014 and the revision of Attachments I, J and K based on the pre-implementation activities described in this section.

As described further below, DSRIP funding is available to *Performing Provider Systems* that consist of *safety net providers* whose *project plans* are approved and funded through the process described in these STCs and who meet particular *milestones* described in their approved DSRIP *project plans*. DSRIP project plans are based on the evidenced-based *projects* specified in the DSRIP Strategies Menu and Metrics (Attachment J) and are further developed by Performing Provider Systems to be directly responsive to the needs and characteristics of the low-income communities that they serve and to achieve the transformation objectives furthered by this demonstration.

2. Safety Net Definition: The definition of safety net provider for hospitals will be based on the environment in which the performing provider system operates. Below is the safety net definition:

a. A hospital must meet the following criteria to participate in a performing provider system:

i. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital, or

ii. Must pass two tests:
A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.
B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals; or

iii. Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.

b. Non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume in their primary lines of business and must be associated with Medicaid, uninsured and Dual Eligible individuals.

c. Vital Access Provider Exception: The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval. Three allowed reasons for granting an exception are:

i. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.

ii. Any hospital is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use.

iii. Any state-designated health home or group of health homes.

d. Non-qualifying providers can participate in Performing Providers Systems. However, non-qualifying providers are eligible to receive DSRIP payments totaling no more than 5 percent of a project's total valuation. CMS can approve payments above this amount if it is deemed in the best interest of Medicaid members attributed to the Performing Provider System.

3. Performing Provider Systems. The safety net providers that are funded to participate in a DSRIP project are called "Performing Provider Systems." Performing Provider Systems that complete project milestones and measures as specified in Attachment J, "DSRIP Strategies

Menu and Metrics", are the only entities that are eligible to receive DSRIP incentive payments.

4. **Two DSRIP Pools**. Performing Provider Systems will be able to apply for funding from one of two DSRIP pools: Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund.

   a. The Public Hospital Transformation Fund will be open to applicants led by a major public hospital system. The public hospital systems allowed to participate in this pool include:

   i. Health and Hospitals Corporation of New York City
   ii. State University of New York Medical Centers
   iii. Nassau University Medical Center
   iv. Westchester County Medical Center
   v. Erie County Medical Center

   b. The Safety Net Performance Provider System Transformation Fund would be available to all other DSRIP eligible providers.

   c. Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool. The valuation framework is described in STC 9 of this section and will be further specified in the Program Funding and Mechanics Protocol.

   d. There is also a Performance Pool within the two DSRIP pools, as described in the Program Funding and Mechanics Protocol (Attachment I).

5. **Coalitions and Attributed Population**. Major public general hospitals and other safety net providers are strongly required to form coalitions that apply collectively as a single Performing Provider System. Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System. Coalitions are subject to the following conditions in addition to the requirements specified in the Program Funding and Mechanics Protocol:

   a. Coalitions must designate a lead coalition provider who will be held responsible under the DSRIP for ensuring that the coalition meets all requirements of Performing Provider Systems, including reporting to the state and CMS.

   b. Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1)

and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.

c. Each Performing Providers System must, in the aggregate, identify a proposed population for DSRIP. The proposed population will be aligned with the population attribution methodology specified in the Program Funding and Mechanics Protocol. The attribution methodology will assure non-duplication of members between DSRIP Performing Providers Systems.

d. Each coalition must have a data agreement in place to share and manage data on system-wide performance.

6. **Objectives**. Performing Provider Systems will design and implement projects that aim to achieve each of the following objectives or sub-parts of objectives, which are elaborated further in the DSRIP Strategies Menu and Metrics (Attachment J). To put in the context of the overall three objectives below, each performing provider system is responsible for project activity that addresses the first two objectives, for a defined population as specified in the third objective.

   a. The creation of appropriate infrastructure and care processes based on community need, in order to promote efficiency of operations and support prevention and early intervention.

   b. The integration of settings through the cooperation of inpatient and outpatient, institutional and community based providers, in coordinating and providing care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while managing total cost of care.

   c. Population health management as described in the attribution section of the Program Funding and Mechanics Protocol.

7. **Project Milestones.** Progress towards achieving the goals specified above will be assessed by specific milestones for each project, which are measured by particular metrics that are further defined in the DSRIP Strategies Menu and Metrics (Attachment J). These milestones are organized into the following domains:

   a. *Project progress milestones (Domain 1).* Investments in technology, tools, and human resources that will strengthen the ability of the Performing Provider Systems to serve target populations and pursue DSRIP project goals. Performance in this domain is measured by a common set of project progress milestones, which will include milestones related to the monitoring of project spending and post-DSRIP sustainability. This includes at least semi-annual reports on project progress specific to the performing provider system's DSRIP project and its Medicaid and uninsured patient population.

b. *System transformation milestones (Domain 2).* As described further in the Project Menu, this includes outcomes that reflect the four subparts of the goal on system transformation, including measures of inpatient/ outpatient balance, increased primary care/community-based services utilization, and rates of global capitation, partial capitation and bundled payment of providers by Medicaid managed care plans, and measures for patient engagement.

c. *Clinical improvement milestones (Domain 3):* As described further in the Project Menu, this domain includes metrics that reflect improved quality of care for Medicaid beneficiaries; including the goal of reducing avoidable hospital use and improvements in other health and public health measures. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over a baseline, using a valid, standardized method. Systems that are already high performers on these metrics, with the exception of avoidable hospitalization metrics, before initiation of projects must either explore alternative projects or align with lower performing providers such that the system as a whole has adequate room for improvement (as defined in DSRIP Program Funding and Mechanics Protocol (Attachment I).

d. *Population-wide Strategy Implementation Milestones (Domain 4).* DSRIP Performing Provider Systems will be responsible for reporting on progress on strategies they have chosen related to the Prevention Agenda as identified in DSRIP Strategies Menu and Metrics (Attachment J) for relevant populations as identified in DSRIP Program Funding and Mechanics Protocol (Attachment I) and as approved in their project plan.

8. DSRIP Project Plan Performing Provider Systems must develop a DSRIP project plan that is based on one or more of the projects specified in the DSRIP Strategies Menu and Metrics (Attachment J) and complies with all requirements specified in the DSRIP Program Funding and Mechanics Protocol. Performing Provider Systems should develop DSRIP project plans, while leveraging community needs, including allowing community engagement during planning, to sufficiently address the delivery system transformation achievement that is expected from their projects. DSRIP project plans will be provided in a structured format developed by the state and approved by CMS and must be tracked by the state over the duration and close out of the program. DSRIP project plans must be approved by the state and may be subject to additional review by CMS, DSRIP project plans must include the following elements:

a. *Rationale for Project Selection.*

i. Each DSRIP project plan must identify the target populations, program(s), and specific milestones for the proposed project, which must be chosen from the options described in the approved DSRIP Strategies Menu and Metrics.

ii. Goals of the project plan should be aligned with each of the objectives as described in STC 6 of this section.

iii. Milestones should be organized as described above in STC 7 of this section reflecting

the three overall goals and subparts for each goal as necessary.

iv. The project plan must describe the need being addressed and the starting point (including baseline data consistent with the agreement between CMS and the state) of the performing provider system related to the project. The starting point of the project plan must be after April 1, 2015.

v. Based on the starting point the performing provider system must describe its 5-year expected outcome for each of the domains described in STC 7 of this section. Supporting evidence for the potential for the interventions to achieve these changes should be provided in support of this 5 year projection for achievement in the goals of this DSRIP.

vi. The DSRIP Project Plan shall include a description of the processes used by the Performing Provider System to engage and reach out to stakeholders, including a plan for ongoing engagement with the public, based on the process described in the Operational Protocol (Attachment K).

vii. Performing Provider Systems must demonstrate how the project will transform the delivery system for the target population and do so in a manner that is aligned with the central goals of DSRIP, and in a manner that will be sustainable after DY5. The projects must implement new, or significantly enhance existing health care initiatives; to this end, providers must identify the CMS and HHS funded delivery system reform initiatives in which they currently participate or in which they have participated in the previous five years, and explain how their proposed DSRIP activities are not duplicative of activities that are already or have recently been funded.

viii. The plan must include an approach to rapid cycle evaluation that informs the system in a timely fashion of its progress, how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

ix. The plan must contain a comprehensive workforce strategy. This strategy will identify all workforce implications – including employment levels, wages and benefits, and distribution of skills – and present a plan for how workers will be trained and deployed to meet patient needs in the new delivery system. Applicants will need to include workers and their representatives in the planning and implementation of their workforce strategy.

b. *Description of Project Activities.*

i. Each project must feature strategies from all domains described in STC 7 of this section and the DSRIP Strategies Menu and Metrics.

ii. For each domain of a project, there must be at least one associated outcome metric that must be reported in all years, years 1 through 5. The initially submitted DSRIP project plan must include baseline data on all measures, should demonstrate the ability to provide valid data and provide benchmarks for each measure. Baseline measurements should be based on the most recently available baseline data, as agreed to by CMS and the state.

c. *Justification of Project Funding.*

i. The DSRIP project plan shall include a detailed project specific budget as provided for in DSRIP Program Funding and Mechanics Protocol (Attachment I) and a description of the performing provider system or provider coalition's overall approach to valuing the project. Project valuations will be subject to a standardized analysis by the state as described below and further specified in the Program Funding and Mechanics Protocol.

ii. DSRIP project plans shall include any information necessary to describe and detail mechanisms for the state to properly receive intergovernmental transfer payments (as applicable and further described in the program funding and mechanics protocol).

9. Project Valuation. DSRIP payments are earned for meeting the performance milestones (as specified in each approved DSRIP project plan). The value of funding for each milestone and for DSRIP projects overall should be proportionate to and its potential benefit to the health and health care of Medicaid beneficiaries and low income uninsured individuals, as further explained in the Program Funding and Mechanics Protocol (Attachment I).

a. *Maximum project valuation*. As described further in the Program Funding and Mechanics Protocol, a maximum valuation for each project on the project menu shall be calculated based on the following valuation components as specified in the Program Funding and Mechanics Protocol (Attachment I).

i. Index score of transformation potential. The state will use a standardized index to score each project on the project menu, based on its anticipated delivery system transformation. This index will include factors of anticipated transformation, such as potential for achieving the goals of DSRIP outlined in STC 6 of this section, expected cost savings, potential to reduce preventable events, capacity of the project to directly affect Medicaid and uninsured beneficiaries and robustness of evidence base. The index scoring process is described in the DSRIP Program and Funding and Mechanics Protocol and will be available for public comment in accordance with STC 10 of this section.

ii. Valuation benchmark. The project index score will be multiplied by a valuation benchmark in combination with the components below for all DSRIP projects in order to determine the maximum valuation for the project, as specified in the Program Funding and Mechanics Protocol (Attachment I). The valuation benchmark should be externally justified based on evidence for the value and scope of similar system

transformations and delivery system reforms, and may not be based on the total statewide limit on DSRIP funding described in STC 14 of this section. By no later than 15 days after the public comment period for initial DSRIP applications, the state will establish a state-wide valuation benchmark based on its assessment of the cost of similar delivery reforms. This value will be expressed in a per member per month (PMPM) format and may not exceed $15 PMPM, calculated multiplying paragraphs (iii)(B) and (C) below.

iii. DSRIP Project Plan Application Score. Based on the Performing Provider System's application, each project plan will receive a score based on the following:

A. The fidelity to the project description, and likelihood of achieving improvement by using that project.
B. Number of beneficiaries attributed to each performing provider's project plan.
C. Number of DSRIP months that will be paid for under the DSRIP project plan.

b. *Progress milestones and outcome milestones.* A DSRIP project's total valuation will be distributed across the milestones described in the DSRIP project plan, according to the specifications described in the Program Funding and Mechanics Protocol (Attachment I). An increasing proportion of DSRIP funding will be allocated to performance on outcome milestones each year, as described in DSRIP Program Funding and Mechanics Protocol (Attachment I).

c. *Performance based payments*. Performing Provider Systems may not receive payment for metrics achieved prior to the baseline period set by CMS and the State in accordance with these STCs and the funding and mechanics protocol and achievement of all milestones is subject to audit by CMS, the state, and the state's independent assessor described in STC 10 of this section. The state shall also monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring reporting required under STC 12 of this section. In addition to meeting performance milestones, the state and performing providers must comply with the financial and reporting requirements for DSRIP payments specified in STC 13 of this section and any additional requirements specified in the Program Funding and Mechanics Protocol (Attachment I).

10. Pre-implementation activities. In order to authorize DSRIP funding for DY 1 to 5, the state must meet the following implementation milestones according to the timeline outlined in these STCs and must successfully renew the demonstration according to the process outlined in STC 8 in Section III. Failure to complete these requirements will result in a state penalty, as described in paragraph (vi) below.

a. *Project Design Grants*. During calendar year 2014, the state may provide allotted amounts to providers for DSRIP Design Grants from a designated Design Grant Fund. These grants will enable providers to develop specific and comprehensive DSRIP Project Plans. New York may expend up to $100 million in FFP for the grant payments from the

Design Grant Fund. Unspent funds will be carried over to DSRIP. DSRIP Project Design Grant payments count against the total amounts allowed for DSRIP under the demonstration.

i. Submitting a proposal for a DSRIP Project Design Grant. Providers and coalitions must submit a DSRIP design proposal as an application for a design. The state will review proposals and award design grants at any time during the pre-implementation activities.

ii. Use of Design Grant Funds. The providers and coalitions that receive DSRIP project design grants must use their grant funds to prepare a DSRIP project plan to prepare the provider's application for a DSRIP award. Providers and coalitions that receive DSRIP project design grants must submit a DSRIP application.

b. *Public comment period.* The state must engage the public and all affected stakeholders (including community stakeholders, Medicaid beneficiaries, physician groups, hospitals, and health plans) by publishing the development of the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J), including all relevant background material, and providing a public comment period that will be no less than 30 days that includes submission of comments through electronic means as well as public meetings across the State.

c. *Allowable changes to DSRIP protocols.* The state must post the public comments received and any technical modifications the state makes to the DSRIP Program Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics (Attachments I and J). Only changes to the protocol and menu that are related to the public comments will be allowed and incorporated into final protocols for DY 1 to DY 5. The state will submit the final protocols and menu and CMS will review and take action on the changes (ie. approve, deny or request further information or modification) no later than 30 days after the state's submission.

d. *Baseline data on DSRIP measures.* The state must use existing data accumulated prior to implementation to identify performance goals for performing providers. The state must identify high performance levels for all anticipated measures in order to ensure that providers select projects that can have the most meaningful impact on the Medicaid population, and may not select projects for which they are already high performers, with the exception of projects specifically focused on avoidable hospitalization.

e. *Procurement of entities to assist in the administration and evaluation of DSRIP.* The state will identify independent entities with expertise in delivery system improvement, including an independent assessor, an independent evaluator and any other an administrative costs. The independent entities will work in cooperation with one another to do the following:

i. Independent Assessor: Conduct a transparent review of all proposed DSRIP project plans and make project approval recommendations to the state.

ii. Independent Evaluator: Assist with the continuous quality improvement activities.

iii. Administrative Costs: Administrative costs the state incurs associated with the management of DSRIP reports and other data.

A. The state must describe the functions of each independent entity and their relationship with the state as part of its Operational Protocol (Attachment K)

B. The state may elect to require IGTs to be used to fund the non-federal share of the administrative activities, as permitted under the state plan.

C. Spending on the independent entities and other administrative cost associated within the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund.

f. *Submit evaluation plan*. The state must submit an evaluation plan for DSRIP consistent with the requirements of STC 19 of this section no later than 120 days after award of the DSRIP program and must identify an independent evaluator. The evaluation plan, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 21 of this section, is subject to CMS approval.

g. *Update comprehensive quality strategy*. The state must update its comprehensive quality strategy, defined in Section VI, to ensure the investment in DSRIP programs will complement and be supported by the state's managed care quality activities and other quality improvements in the state, including the state's Medicaid Redesign Team and Health Homes initiatives.

h. *DSRIP Operational Protocol.* The state shall submit for CMS approval a draft operational protocol for approving, overseeing, and evaluating DSRIP project grants no later than 90 days after the award of the Demonstration. The protocol is subject to CMS approval. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days. This protocol will become an appendix to Attachment K of these STCs.

i. The Operational Protocol, including required baseline and ongoing data reporting, independent assessor protocols, performing provider requirements, and monitoring/evaluation criteria shall align with the CMS approved evaluation design and the monitoring requirements in STC 34 of this section.

ii. The state shall make the necessary arrangements to assure that the data needed from the Performing Provider Systems, and data needed from other sources, are available as required by the CMS approved monitoring protocol.

iii. The Operational Protocol and reports shall be posted on the state Medicaid website within 30 days of CMS approval.

i. *CMS Oversight of Pre-implementation Activities*. CMS reserves the right to provide oversight over the state's pre-implementation activities in order to document late submissions and missed deliverables without notice of a delay from the state. Notice of delay from of any deliverable must be received by CMS no less than 10 days before the due date of the deliverable. As part of CMS' review of the state's deliverables, CMS will assess completeness based on listed deliverable requirements in the STCs.

11. DSRIP proposal and project plan review. In accordance with the schedule outlined in these STCs and the process described further in the Program Funding and Mechanics Protocol (Attachment I), the state and the assigned independent assessor must review and approve DSRIP project plans in order to authorize DSRIP funding for DY 1, DY 2, and DY 3 and must conduct ongoing reviews of DSRIP project plans as part of a mid-point assessment in order to authorize DSRIP funding for DY 4 and DY 5. The state is responsible for conducting these reviews for compliance with approved protocols. CMS reserves the right to review projects in which the state did not accept the finding of the independent assessor or other outlier projects, as specified in the Program Funding and Mechanics Protocol (Attachment I).

a. *Review tool.* The state will develop a standardized review tool that the independent assessor will use to review DSRIP project plans and ensure compliance with these STCs and associated protocols. The review tool will be available for public comment for a 30 day period according to the timeframe specified in the Program Funding and Mechanics Protocol (Attachment I). The review tool will define the relevant factors, assign weights to each factor, and include a scoring for each factor. Each factor will address the anticipated impact of the project on the Medicaid and uninsured populations consistent with the overall purpose of the DSRIP program.

b. *Role of the Independent assessor*. An independent assessor will review project proposals using the state's review tool and consider anticipated project performance. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to project plans to make them approvable. This entity (or another entity identified by the state) will also assist with the mid-point assessment and any other ongoing reviews of DSRIP project plan.

c. *Public comment.* Project proposals will be public documents and subject to public comment. The public will have no less than30 days from the date of project posting to submit comments for specific project proposals, according to the process described in the Operational Protocol (Attachment K). After the comment period for the projects closes, a method for which the public can continue to comment must remain available, to obtain feedback on the ongoing implementation of the projects. The state must periodically compile comments received over the life of the demonstration and ensure that responses to comments are provided and released for public view.

d. *Mid-point assessment.* During DY 3, the state's independent assessor shall assess project performance to determine whether DSRIP project plans merit continued funding and

provide recommendations to the state. If the state decides to discontinue specific projects, the project funds may be made available for expanding successful project plans in DY 4 and DY 5, as described in the Program Funding and Mechanics Protocol (Attachment I).

12. Monitoring. With the assistance of the independent assessor, the state will be actively involved in ongoing monitoring of DSRIP projects, including but not limited to the following activities.

a. *Review of milestone achievement.* At least two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The Performing Provider System shall have available for review by New York or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to Performing Provider Systems for achievement of DSRIP milestones.

b. *Quarterly DSRIP Operational Protocol Report.* The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

c. *Learning collaboratives*. With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be a required activity for all Performing Provider Systems, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects as described in the DSRIP Strategies Menu and Metrics (Attachment J). Learning collaboratives are forums for Performing Provider Systems to share best practices and get assistance with implementing their DSRIP projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help providers share ideas and simple data over time (which should not need to be developed from scratch). In addition, the collaboratives should be supported by individuals (regional "innovator agents") with training in quality improvement who can travel from site to site in the network to rapidly answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

d. *Rapid cycle evaluation.* In addition to the comprehensive evaluation of DSRIP described

in STC 22 of this section, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.

e. *Additional progress milestones for at risk projects.* Based on the information contained in the Performing Provider System's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment, described in STC 11 of this section.

f. *Annual discussion and site visits*. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned. The state, the independent assessor, and CMS will conduct annual site visits of a subset of Performing Providers to ensure continued compliance with DSRIP requirements.

g. *Application, review, oversight, and monitoring database.* The state will ensure that there is a well maintained and structured database, containing as data elements all parts and aspects of Performing Provider Systems' DSRIP project plans including the elements discussed in paragraph 8; independent assessor, state, and CMS review comments and scores; project planning, process, improvement, outcome, and population health milestones, with indicators of their required timing, incentive payment valuation, and whether or not they were achieved; and any other data elements required for the oversight of DSRIP. Along with the database, the state will develop software applications that will support:

i. Electronic submission of project plans by Performing Provider Systems;

ii. Public comment on project plans;

iii. Review of project plans by the independent assessor, state, and other independent participants in project plan review and scoring;

iv. Electronic submission by Performing Provider Systems of their performance data;

v. Generation of reports, containing (at a minimum) the elements in STC 36 of this section, that can be submitted to CMS to document and support amounts claimed for DSRIP payments on the CMS-64;

vi. Summaries of DSRIP project plans submissions, scoring, approval/denial, milestone

achievement, and payments that can be accessed by the public;

vii. Database queries, and export all or a portion of the data to Excel, SAS, or other software platforms; and

viii. On-line access rights for CMS.

13. Financial Requirements applying to DSRIP payments generally.

a. The non-Federal share of Fund payments to providers may be funded by state general revenue funds, and transfers from units of local government consistent with federal law. Any DSRIP payment must remain with the provider specified in the DSRIP project plan, and may not be transferred back to any unit of government, including public hospitals, either directly or indirectly. In the case of coalitions that are performing DSRIP projects collectively, the DSRIP funding will flow to the participating providers and/or the coalition coordinating entity according to the methodology specified in the DSRIP project plan but may not be transferred between coalition providers.

b. The state must inform CMS of the funding of all DSRIP payments to providers through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter, as required under STC 36 of this section. This report must identify the funding sources associated with each type of payment received by each provider. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. The state will ensure that any lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of Medicaid services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

d. The state may not claim FFP for DSRIP Payments until both the state and CMS have concluded that the performing providers have met the performance indicated for each payment. Performing providers' reports must contain sufficient data and documentation to allow the state and CMS to determine if the performing provider has fully met the specified metric, and performing providers must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved DSRIP project plan.

e. Each quarter the State makes DSRIP Payments or IAAF payments and claims FFP, appropriate supporting documentation will be made available for CMS to determine the appropriate amount of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for

payments will also identify all other funds transferred to such fund making the payment. This documentation should be used to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

f. DSRIP Payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP Fund are intended to support and reward performing providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Fund are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.

14. Limits on Federal Financial Participation.

a. Use of FFP. The state will receive up to a total of $8 billion FFP to support MRT activities: $6.92 billion for DSRIP, $500 million of which will be for the IAAF, and the remaining amount to be allocated by the state for remaining MRT activities (with no more than $1.08 billion for such other activities).

b. MRT Cap. The State can claim FFP for MRT expenditures in each DSRIP Year up to the limits shown in the table below. Each DSRIP Project Plan must specify the DSRIP Year to which each milestone pertains; all incentive payments associated with meeting the milestone must count against the annual limit for the DSRIP Year identified. The state or its contractor shall monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring and reporting required under STC 35 of this section.

c. One-year DSRIP funding carry-over. If a performing provider system does not fully achieve a metric in Domains 2, 3 or 4 that was specified in its approved DSRIP project plan for completion in a particular DSRIP year, the performing provider system must report on the missed metrics in the given DSRIP year. Performing Provider Systems that do not meet annual milestones for a given metric will not be eligible to receive incentive payments for the missed metrics in that given DSRIP year. Any funding that would have been allocated to the performing provider system during that DSRIP year will be placed in the performance pool fund to be redistributed to Performing Provider Systems that have exceeded their set performance benchmarks for that DSRIP year. When a performing provider system does not meet its DSRIP year performance metrics, the missed metrics milestone will be recalibrated based on the procedures in DSRIP Program Funding and Mechanics Protocol (Attachment I) for the next DSRIP year and the performing provider system will be eligible to receive payments from the DSRIP payment pool for that next year if it reaches the recalibrated milestone in that next DSRIP year.

d. Fund Allocations According to MRT Demonstration Year

($ millions)

	Year-0	Year-1	Year-2	Year-3	Year-4	Year-5	Total
Sources of Funding							
Public Hospital IGT Transfers (Supports DSRIP IGT Funding for Public Performing Provider Transformation Fund, Safety Net Performance Provider System Transformation Fund, DSRIP, State Plan and Managed Care Services)	$512.0	$878.1	$933.0	$1,481.8	$1,317.1	$878.1	$6,000.0
State Appropriated Funds	$188.0	$345.4	$476.6	$467.8	$343.5	$178.7	$2,000.0
Total Sources of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**
Uses of Funding							
DSRIP Expenditures	$620.0	$1,007.8	$1,070.7	$1,700.6	$1,511.6	$1,007.8	$6,918.5
Interim Access Assurance Fund (IAAF)	$500.0	$0.0	$0.0	$0.0	$0.0	$0.0	$500.0
Planning Payments	$70.0	$0.0	$0.0	$0.0	$0.0	$0.0	$70.0
Performance Payments	$0.0	$957.8	$1,020.7	$1,650.6	$1,461.6	$957.8	$6,048.5
Administration	$50.0	$50.0	$50.0	$50.0	$50.0	$50.0	$300.0
Health Homes	$80.0	$66.7	$43.9	$0.0	$0.0	$0.0	$190.6
MC Programming	$0.0	$149.0	$294.9	$249.0	$149.0	$49.0	$890.9
Health Workforce MLTC Strategy	$0.0	$49.0	$49.0	$49.0	$49.0	$49.0	$245.0
1915i Services	$0.0	$100.0	$245.9	$200.0	$100.0	$0.0	$645.9
Total Uses of Funding	**$700.0**	**$1,223.5**	**$1,409.5**	**$1,949.6**	**$1,660.6**	**$1,056.8**	**$8,000.0**

**Includes costs associated with State based planning in Year-0.*
**New York State may spend up to 5% of annual costs on Administration.*

e. Notwithstanding the limits in STC 1.a and 14.a, to the extent that the state elects to limit supplemental payments to an institutional provider class otherwise authorized under its state plan in any state fiscal year during which the DSRIP demonstration is in effect, an amount equal to the federal share of the amount not paid to such providers, up to $600 million may be added to the overall MRT and DSRIP limits on federal funding. This election will be available only to the extent that the state does not increase the authorized levels of such supplemental payments, or initiate new supplemental payments, during the authorized demonstration period. The state must develop and use a tracking spreadsheet (following a format approved by CMS) to ensure that the amounts of the DSRIP increase

do not exceed the amount of authorized but unpaid supplemental payments.

f. Statewide accountability. Beginning in DSRIP Year 3, the limits on DSHP funding and on total DSRIP payments described in paragraph (a) above may be reduced based on statewide performance, according to the process described in the Program Funding and Mechanics Protocol.

g. Statewide performance will be assessed on a pass or fail basis, for a set of 4 milestones.

i. Statewide performance on universal set of delivery system improvement metrics (as defined in Attachment J). Metrics for delivery system reform will be determined at a statewide level. Each metric will be calculated to reflect the performance of the entire state. Each of these statewide metrics will be assigned a direction for improving and worsening. This milestone will be considered passed in any given year if more metrics in these domains are improving on a statewide level than are worsening, as compared to the prior year as well as compared to initial baseline performance.

ii. A composite measure of success of projects statewide on project-specific and population wide quality metrics. This test is intended to reflect the success of every project in achieving the goals that have been assigned to each project, including pay for reporting for certain outcome measures as specified in DSRIP Strategies Menu and Metrics (Attachment J). As described in DSRIP Program Funding and Mechanics Protocol (Attachment I), each metric that determines project level incentive payments for each project will be determined at the project level to be meeting the improvement standards. This statewide milestone will be considered passed in any given year if the number of metrics for each project that trigger award as the improvement standards in DSRIP Program Funding and Mechanics Protocol (Attachment I) are greater than the number of metrics for each project that fail to trigger an award as per the improvement standard in DSRIP Program Funding and Mechanics Protocol (Attachment I).

iii. Growth in statewide total Medicaid spending, including MRT spending, that is at or below the target trend rate (Measure applies in DY4 and DY5). The per member per month (PMPM) amounts will be adjusted to exclude growth in federal funding associated with the Affordable Care Act. The state will not be penalized if it uses these higher FMAP rates generated by the Affordable Care Act to reinvest in its Medicaid program.

Growth in statewide total inpatient and emergency room spending that is at or below the target trend rate (Measure applies in DY 3, DY 4 and DY 5).

Both of the above measures will be measured on a PMPM basis in the most recent state fiscal year from the state fiscal year that immediately precedes it, with applicable spending including both federal and non-federal shares combined. Per member per month spending in each measure is determined by dividing statewide total spending by the number of person-months of Medicaid eligibility in the state for

the state fiscal year. The most recent state fiscal year is the last state fiscal year ending prior to the start of the DSRIP Year. For total Medicaid spending, the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year), for DYs 4 and 5 only. For inpatient and emergency room spending the target trend rate is the ten-year average rate for the long-term medical component of the Consumer Price Index (as used to determine the state's Medicaid Global Spending Cap for that year) minus 1 percentage points for DY 3 and 2 percentage points for DYs 4 and 5.

iv. Implementation of the managed care plan, including targets agreed upon by CMS and the state after receipt of the managed care contracting plan in STC 39 of this section related to reimbursement of plans and providers consistent with DSRIP objectives and measures. These targets will include one associated with the degree to which plans move away from traditional fee for service payments to payment approaches rewarding value.

h. The state must pass all four milestones to avoid DSRIP reductions. If the state fails on any of the 4 milestones, the amount of the potential reduction is set as follows:

The state must pass 50 percent of the inpatient/emergency room spending reduction goals to avoid DSHP penalties. This will be the sole test for any DSHP penalty. The amount of the potential reduction is set as follows:

	DSRIP Year 3	DSRIP Year 4	DSRIP Year 5
DSHP Penalty	$23.39 million (5 percent)	$34.35 million (10 percent)	$35.74 million (20 percent)
DSRIP Penalty	$74.09 million (5 percent)	$131.71 million (10 percent)	$175.62 million (20 percent)

If DSRIP and DSHP penalties are applied, the state reduce funds in an equal distribution of projects, and will not affect the high performance fund.

15. Designated State Health Programs (DSHP). The state may claim FFP for certain DSHP expenditures, following procedures and subject to limits as described below.

a. Limit on FFP for DSHP. The amount of FFP that the state may receive for DSHP may not exceed the limit described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

$ millions

Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total
188.0	345.4	476.6	467.8	343.5	178.7	2,000

The FFP limit for 2014 is the lowest of the following amounts:

i. $188 million,

ii. The combined non-Federal share of IAAF Payments, DSRIP Project Design Grant payments and DSRIP administrative costs in 2014, and

iii. The federal share of total matchable DSHP expenditures in 2014 as outlined below.

b. DSHP List 1. The state may claim FFP in support of DSRIP for List 1 DSHP expenditures made after March 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP.

i. Health Care Reform Act programs

A. AIDS Drug Assistance
B. Tobacco Use Prevention and Control
C. Health Workforce Retraining

ii. State Office on Aging programs
A. Community Services for the Elderly
B. Expanded In-Home Services to the Elderly

iii. Office of Children and Family Services: Committees on Special Education direct care programs

iv. State Department of Health, Early Intervention Program Services

c. DSHP List 2. The state may claim FFP in support of DSRIP for List 2 DSHP expenditures made after December 31, 2014. The state may not claim FFP until after the date on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Homeless Health Services

ii. Childhood Lead Poisoning Primary Prevention

iii. Healthy Neighborhoods Program

iv. Cancer Services Programs

v. Obesity and Diabetes Programs

vi. TB Treatment, Detection and Prevention

vii. TB Directly Observed Therapy

viii. General Public Health Work

ix. Newborn Screening Programs

d. DSHP List 3. The state may claim FFP in support of DSRIP for List 3 DSHP expenditures not used for DD Transformation. The state may not claim FFP until after the **date** on which CMS has approved a DSHP Claiming Protocol for the specific DSHP

i. Office of Mental Health

A. Licensed Outpatient Programs
B. Care Management
C. Emergency Programs
D. Rehabilitation Services
E. Residential (Non-Treatment)
F. Community Support Programs

ii. Office for People with Developmental Disabilities

A. Day Training
B. Family Support Services
C. Jervis Clinic
D. Intermediate Care Facilities
E. HCBS Residential
F. Supported Work (SEMP)
G. Day Habilitation
H. Service Coordination/Plan of Care Support
I. Pre-vocational Services
J. Waiver Respite
K. Clinics - Article 16

iii. Office of Alcoholism and Substance Abuse Services

A. Outpatient and Methadone Programs
B. Prevention and Program Support Services

e. DSHP Claiming Protocol. The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for DSRIP. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment L of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

i. The sources of non-federal share revenue, full expenditures and rates.

ii. Program performance measures, baseline performance measure values, and improvement goals. (CMS may, at its option, approve the DSHP Claiming Protocol

for a DSHP without this feature.)

iii. Procedures to ensure that FFP is not provided for any of the following types of expenditures:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures
M. Rent and utility subsidies normally funded by the United State Department of Housing and Urban Development
N. Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave
O. Revolving capital fund
P. Expenditures made to meet a maintenance of effort requirement for any federal grant program
Q. Administrative costs
R. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
S. Cost of services for which payment was made by Medicare or Medicare Advantage
T. Funds from other federal grants

f. DSHP Claiming Process.

i. Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS.

ii. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to document through an Accounting and Voucher system its request for DSHP payments. The vouchers will be detailed in the services being requested for payment by the state and will be attached to DSHP support.

iii. Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP.

iv. Federal funds are not available expenditures disbursed before April 1, 2014, or for

services rendered prior to April 1, 2014.

v. Federal funds are not available for expenditures disbursed after December 31, 2014, or for services rendered after December 31, 2014.

vi. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share.

vii. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures.

viii. Any changes to the DSHP listed above shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

g. Reporting DSHP Payments. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSRIP DSHP" (if in support of DSRIP) or "IAAF DSHP" (if in support of Interim Access Assurance Fund payments) as well as on the appropriate forms CMS-64.9I and CMS-64PI.

16. Budget Neutrality Review. In conjunction with any demonstration renewal beyond December 31, 2014, CMS reserves the right to modify the budget neutrality agreement consistent with budget neutrality policy.

17. Improved Management Controls. The state and CMS agree that, in conjunction with any Partnership Plan demonstration renewal beyond December 31, 2014, the state will undertake additional activities and steps to strengthen internal controls, compliance with federal and state Medicaid requirements and financial reporting to ensure proper claiming of federal match for the Medicaid program, and to self-identify and initiate timely corrective action on problems and issues. To support the development of these additional special terms and conditions, the state will provide a report to CMS by October 1, 2014, outlining its assessment of current strengths and weaknesses of the state's system of internal and financial management controls (taking into account any audit findings from federal or state oversight agencies including the HHS Office of Inspector General, the state Office of Inspector General, and CMS); the steps the state proposes to take to strengthen compliance, documentation and transparency; and the expected path for resolution of any outstanding deferrals or disallowances initiated by CMS as of the date of this amendment.

18. DSRIP Transparency. During the 30 day public comment period for the DSRIP Program Funding and Mechanics protocol (Attachment I), DSRIP Strategies Menu and Metrics (Attachment J), the state must have conducted at least two public hearings regarding the state's DSRIP amendment approval. The state must utilize teleconferencing or web capabilities for at least one of the public hearings to ensure statewide accessibility. The two public hearings must be held on separate dates and in separate locations, and must afford the

public an opportunity to provide comments. Once the state develops its standardized review tool the independent assessor will use for the DSRIP project plans, the tool must also be posted for public comment for 30 days.

a. Administrative Record. CMS will maintain, and publish on its public Web site, an administrative record that may include, but is not limited to the following:

i. The demonstration application from the state.
ii. Written public comments sent to the CMS and any CMS responses.
iii. If an application is approved, the final special terms and conditions, waivers, expenditure authorities, and award letter sent to the state.
iv. If an application is denied, the disapproval letter sent to the state.
v. The state acceptance letter, as applicable.
vi. Specific requirements related to the approved and agreed upon terms and conditions, such as implementation reviews, evaluation design, quarterly progress reports, annual reports, and interim and/or final evaluation reports.
vii. Notice of the demonstration's suspension or termination, if applicable.

b. CMS will provide sufficient documentation to address substantive issues relating to the approval documentation that should comprehensively set forth the basis, purpose, and conditions for the approved demonstration.

19. Submission of Draft Evaluation Design. The state shall submit a draft DSRIP evaluation design to CMS no later than 120 days after the award of the demonstration, including, but not limited to data that the state proposes to be used to evaluate DSRIP. The state must employ aggressive state-level standards that align with its managed care evaluation approach.

20. Submission of Final Evaluation Design. The state shall provide the Final Evaluation Design within 30 days of receipt of CMS comments of the Draft Evaluation Design. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design and the final evaluation plan will be included as Attachment M of these STCs.

21. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

22. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration, including:

i. safety net system transformation at both the system and state level;

ii. accountability for reducing avoidable hospital use and improvements in other health an public health measures at both the system and state level and

iii. efforts to ensure sustainability of transformation of/in the managed care environment at the state level.

The research questions will be examined using appropriate comparison groups and studied in a time series.

b. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

c. Performance Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration in terms of cost of services and total costs of care, change in delivery of care from inpatient to outpatient, quality improvement, and transformation of incentive arrangements under managed care. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the state will incorporate comparisons to national data and/or measure sets. A broad set of metrics will be selected. To the extent possible, metrics will be pulled from nationally recognized metrics such as from the National Quality Forum, Center for Medicare and Medicaid Innovation, meaningful use under HIT, and the Medicaid Core Adult sets, for which there is sufficient experience and

baseline population data to make the metrics a meaningful evaluation of the New York Medicaid system.

d. Data Collection: This discussion shall include: A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:

i. Medicaid encounter and claims data in TMSIS,
ii. Enrollment data,
iii. EHR data, where available
iv. Semiannual financial and other reporting data
v. Managed care contracting data
vi. Consumer and provider surveys, and
vii. Other data needed to support performance measurement

e. Assurances Needed to Obtain Data: The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available

f. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, health plan and program level, as appropriate, and shall include population and intervention-specific stratifications, for further depth and to glean potential non-equivalent effects on different sub-groups. Sensitivity analyses shall be used when appropriate. Qualitative analysis methods shall also be described, if applicable.

g. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

h. Evaluator: This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

23. Interim Evaluation Report. The state is required to submit a draft Interim Evaluation Report 90 days following completion of DY 4 of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 24 of this section for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The state shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

24. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from DY 5. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding

assessments due to data lags to complete the summative evaluation. Within 360 days of the end for DY 5, the state shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.

25. The Final Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.

b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waiver sand other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

26. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan at post approval. The state will present on its interim evaluation report that is described to in STC 23 of this section. The state will present on its summative evaluation in conjunction with STC 24 of this section.

27. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website

within 30 days of approval by CMS.

28. **CMS Notification**. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

29. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

30. **Cooperation with Federal Evaluators**. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of DSRIP, the state and its evaluation contractor shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

31. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

32. **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

33. **Deferral for Failure to Provide Summative Evaluation Reports on Time.** The state agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

34. **DSRIP Implementation Monitoring.** The state must ensure that they are operating its DSRIP program according to the requirements of the governing STCs. In order to demonstrate adequate implementation monitoring towards the completion of these requirements, the state will submit the following:

    a. DSRIP monitoring activities, in STC 35 of this section as a part of the operational protocol in STC 10 (h) of this section indicating how the state will monitor compliance with demonstration requirements in the implementation of this demonstration, including monitoring and performance reporting templates. Monitoring and performance templates are subject to review and approval by CMS.

b. Data usage agreements demonstrating the availability of required data to support the monitoring of implementation.

c. Quarterly Report Framework indicating what metrics and data will be available to submit a quarterly report consistent with STC 36 of this section.

35. DSRIP Monitoring Activities. As part of the state's Operational Protocol described in STC 10 (h) of this section and Attachment K, the state will submit its plans for how it will meet the DSRIP STCs through internal monitoring activities. The monitoring plans should provide, at a minimum, the following information:

a. The monitoring activities aligned with the DSRIP deliverables as well as the CMS evaluation design to ensure that entities participating in the DSRIP process are accountable for the necessary product and results for the demonstration.

b. The state shall make the necessary arrangements to assure that the data needed from the performing providers, coalitions, administrative activities, independent assessor and independent evaluator that are involved in the process for DSRIP deliverables, measurement and reporting are available as required by the CMS approved monitoring protocol.

c. The state shall identify areas within the state's internal DSRIP process where corrective action, or assessment of fiscal or non-fiscal penalties may be imposed for the entities described in STC 10(e) of this section, should the state's internal DSRIP process or any CMS monitored process not be administered in accordance with state or federal guidelines.

d. The monitoring protocol and reports shall be posted on the state Medicaid website within 30 days of submission to CMS.

36. DSRIP Quarterly Progress Reports. The state must submit progress reports in the format specified by CMS, no later than 60-days following the end of each quarter along with the Operational Protocol Report described above. The first DSRIP quarterly reports will be due by August 30, 2014. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the three goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment L, must include, but are not limited to the following reporting elements:

a. Summary of quarterly expenditures related to IAAF, DSRIP Project Design Grant, and the DSRIP Fund;
b. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
c. Summary of activities associated with the IAAF, DSRIP Project Design Grant, and the DSRIP Fund. This shall include, but is not limited to, reporting requirements in STC 3 of this section and Attachment K, the Operational Protocol:

i. Provide updates on state activities, such as changes to state policy and procedures, to support the administration of the IAAF, DSRIP Project Design Grant and the DSRIP Fund;
ii. Provide updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
iii. Provide summary of state's analysis of DSRIP Project Design;
iv. Provide summary of state analysis of barriers and obstacles in meeting milestones;
v. Provide summary of activities that have been achieved through the DSRIP Fund; and
vi. Provide summary of transformation and clinical improvement milestones and that have been achieved.

d. Summary of activities and/or outcomes that the state and MCOs have taken in the development of and subsequent approval of the Managed Care DSRIP plan; and

e. Evaluation activities and interim findings.

The state may comment and submit a revised Attachment L no later than 30 days after approval of these STCs. CMS will approve necessary changes and update the attachment as necessary. Any subsequent changes to Attachment L must be submitted to CMS prior the end of the reporting period in which the change to the Quarterly Report would take place.

37. Annual Onsite with CMS. In addition to regular monitoring calls, the state shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

38. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

39. Medicaid Managed Care DSRIP Contracting Plan. In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the state's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the state must submit a roadmap for how they will amend contract terms and reflect new provider capacities and efficiencies in managed care rate-setting.

Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year. The state shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

a. What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
b. How and when plans' currents contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
c. How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
d. How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
e. How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
f. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.
g. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.
h. How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

40. New York MRT-DSRIP Deliverables Schedule.

Due Date/Submission Date	Activity/Deliverable
April 14, 2014	CMS approves STCs and DSRIP Attachments
	New York posts the DSRIP Funding and Mechanics Protocol and the DSRIP

	Strategies Menu and Metrics for public comment for 30 days
	New York posts IAAF Qualifications and Application on for public comment for 14 days;
	14 day IAAF application period begins once comment period closes
	IAAF awards can be distributed after 14 day application period closes
	State has 10 days to submit its first report for IAAF payments (STC 1(b)(iii)(A) of this section)
	State will make baseline data for DSRIP measures available
	State submits its proposed independent assess statement of work (SOW) for its independent assessor contract procurement
May 1, 2014	State must accept DSRIP STCs or offer technical corrections, including for the DSRIP Operational Protocol and the Quarterly Reporting formats
	State has 10 days to submit changes to the DSRIP Funding and Mechanics Protocol and the DSRIP Strategies Menu and Metrics once public comment period closes
	CMS will review changes to the DSRIP Funding and Mechanics Protocol and DSRIP Strategies Menu and Metrics and take action no later than 30 days after state submits changes
	State accepts DSRIP Design Grant applications and make Design Grant awards
	State posts DSRIP Project Plan Review Tool that independent assessor will use to score submitted DSRIP Project Plan applications for 30 days
August 1, 2014	State submits draft DSRIP evaluation design
August 30, 2014	State submits its first quarterly report, including its operational report (STCs 35 & 36)
October 1, 2014	State submits its Improved Management Controls report to CMS
	State accepts DSRIP Project Plan applications
	State will perform initial review of submitted DSRIP Project Plan applications

	Independent assessor will perform full review of DSRIP project plan applications
	Independent assessor will post reviewed DSRIP Project Plan applications for public comment for 30 days
New York Partnership Plan Renewal Period – January 1, 2015	
	Independent assessor approval recommendations made public
	State Distributes DSRIP Project Plan awards for approved performing provider systems
Quarterly Deliverables – Quarterly Report and Operational Report	
August 30, 2014	
November 30, 2014	
February 28, 2015	
May 30, 2015	

***Note**: Activities/Deliverables without a specific Due Date/Submission Date could occur at any time during the timeframes with dates certain, for example the public comment period for the DSRIP Funding and Mechanics Protocol could occur any time after April 14, 2014, based on the state's discretion, so long as the activities are completed and related deliverables are submitted. Should the state renew the demonstration, the quarterly reporting will continue during the renewal period.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements**. The state must comply with all general financial requirements set forth in Section X.

2. **Reporting Requirements Related to Budget Neutrality**. The state must comply with all reporting requirements for monitoring budget neutrality set forth in section XI.

3. **Monthly Calls**. CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment of individuals using LTSS and non-LTSS users broken out by duals and non-duals, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to Section V, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

4. **Quarterly Operational Reports**. The state must submit progress reports in accordance with the guidelines in Attachment D taking into consideration the requirements in STC 7 of this section, no later than 60 days following the end of each quarter (December, March, and June