



DSRIP Update: New Project, Attribution & Valuation

August 1, 2014

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PRESENTATION OVERVIEW

What Has Changed in DSRIP?

- New Project (2.d.i)
- Beneficiary Attribution Logic
- Project Valuation

Next Steps in DSRIP DY0

- Timeline





WHAT HAS CHANGED IN DSRIP?

New DSRIP Project
Beneficiary Attribution Logic
Project Valuation



ABOUT THE NEW DSRIP PROJECT

- As part of the public comment period on the waiver and attachments, advocates strongly encouraged the state to include uninsured members in DSRIP so that this population could also utilize the benefits of a transformed health care system.
- Also, concerns were raised about outreach and engagement of non-utilizing and low-utilizing Medicaid populations to make sure that these populations benefited from DSRIP.



ABOUT THE NEW DSRIP PROJECT

- To address these concerns, CMS and NYS have agreed to create a new project.
- This project will be focused on increasing patient and community activation related to health care, paired with increased resources that can help the uninsured (UI) as well as non-utilizing (NU) and low utilizing (LU) populations gain access to and utilize the benefits associated with DSRIP PPS projects, particularly primary and preventative services.



NEW PROJECT: PATIENT & COMMUNITY ACTIVATION FOR UI, NU & LU POPULATIONS

D. Increasing Outreach Efforts and Expanding Access to Community Based Care for Special Populations

Project #	Description	Index Score * (out of 60 pts)
2.d.i	Implementation of Patient and Community Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	56

This project will focus on the UI, NU & LU populations and will require a PPS to:

- ✓ Develop practices/programming that promote activation and engagement,
- ✓ Increase the volume of non-emergency (primary, behavioral & dental) care provided to the UI, NU & LU population
- ✓ Form linkages between community based primary and preventive services as well as other community based health services to sustain and grow the community and patient activation in the region it serves.



PROJECT 2.d.i: OUTCOME METRICS*

PPS approved for project 2.d.i will be evaluated on the following metrics*:

- 1. Change in primary and preventative care service utilization patterns (visit volume of non-emergent services) by NU & LU Medicaid beneficiaries.**
- 2. Change in Patient Activation Measure (PAM) from PPS PAM baseline**



*Metrics for project 2.d.i are still being finalized in collaboration with CMS.

PROJECT 2.d.i: OUTCOME METRICS*

What is Patient Activation Measure (PAM)?

- PAM is a measurement scale, based off of a questionnaire, that assesses a patient's self-reported knowledge, skill, and confidence for self-management of his/her health or chronic condition.
- Each PPS will collect baseline PAM data from a sample of the project's target population (UI,NU,LU) in the PPS region using a questionnaire and following procedure developed by the state in collaboration with CMS.
 - ✓ *PPS questionnaire/assessment tool will use no less than the 13-item version of PAM tied to specific, health related quality of life, self-management behaviors.*
- By using PAM to identify a patient's stage of activation (PAM Score), PPS providers can:
 - ✓ *individualize their care plans based upon a beneficiary's level of activation*
 - Level 1: Disengaged & Overwhelmed*
 - Level 2: Becomes aware, but still struggling*
 - Level 3: Taking Action*
 - Level 4: Maintaining behaviors and pushing further*
 - ✓ *easily asses how effective an intervention is with a particular beneficiary.*
- There will be follow-up surveys/questionnaires over the course DSRIP to measure effectiveness of the PPS' PAM intervention on patient-level knowledge and activation over the course DSRIP.
 - ✓ *Effectiveness will be assessed by moving portions of members from target populations to higher levels of activation.*



*Metrics and procedures for assessing project 2.d.i are still being finalized in collaboration with CMS.

13-ITEM PATIENT ACTIVATION MEASURE (PAM)

1. When all is said and done, I am the person who is responsible for managing my health condition.
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function.
3. I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition.
4. I know what each of my prescribed medications does.
5. I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask.



More information on Patient Measure Activation can be found at Insignia Health's website:

<http://www.insigniahealth.com/solutions/patient-activation-measure>

13-ITEM PATIENT ACTIVATION MEASURE (PAM)

7. I am confident that I can follow through on medical treatments I need to do at home.
8. I understand the nature and causes of my health condition.
9. I know the different medical treatment options available for my health condition.
10. I have been able to maintain the lifestyle changes for my health that I have made.
11. I know how to prevent further problems with my health condition.
12. I am confident I can figure out solutions when new situations or problems arise with my health condition.
13. I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.

More information on Patient Measure Activation can be found at Insignia Health's website:

<http://www.insigniahealth.com/solutions/patient-activation-measure>



PROJECT 2.d.i CAVEATS: “THE 11TH PROJECT”

- 1) In order to be eligible for this project, a PPS is expected to pursue a 10 project DSRIP application and must also demonstrate the following:
 - a. network’s capacity to handle an 11th project*
 - b. how the network is suited to serve the UI, NU and LU populations in its region*
- 2) As a key component of the safety net, any DSRIP major public hospital* PPS in a specified region would have the right of first refusal in taking on this additional project
 - ✓ If no public hospital PPS exists in a region (or the public PPS decides not to pursue the 11th project below), then one or more non-public PPS in that region may be approved to carry out the 11th project.*

*For the DSRIP Program, the health systems qualify as public hospitals are:

- i. Health and Hospitals Corporation of New York City (HHC)
- ii. State University of New York Medical Centers (SUNY)
- iii. Nassau University Medical Center (NUMC)
- iv. Westchester County Medical Center (WCMC)
- v. Erie County Medical Center (ECMC)



PROJECT 2.D.I CAVEATS: “THE 11TH PROJECT”

- 3) All of the uninsured in a region as well as a state determined portion of the non-utilizing & low-utilizing Medicaid members will be attributed to project 2.d.i.
- ✓ *Attribution for the other ten projects the PPS is pursuing would include all uninsured in the region, a state determined portion of the NU & LU populations in the region as well as the utilizing Medicaid members, as appropriate per attachment I.*

Note: If a PPS is the only PPS approved by the state in a defined region (minimum: single county level) then all the Medicaid members (100 % of UM+NU+LU) in that region will be attributed to that single PPS.

- ✓ *PPS will not be required to pursue 11 projects to receive NU & LU attribution.*
- ✓ *Sole PPS will not receive UI population in attribution w/o 11th project*



UM= Utilizing Medicaid Members
NU= Non-Utilizing Medicaid Members
LU= Low-Utilizing Medicaid Members
UI= Uninsured Population

DSRIP DOMAINS & PROJECT REQUIREMENTS

Project implementation is divided into four Domains for project selection and reporting:

- Domain 1 – Overall Project Progress
 - ✓ *No Projects in Domain 1 – this domain “houses” the project’s process measure for all three domains*
- Domain 2 – System Transformation*
 - ✓ *All PPS must select at least two (and up to four [or five*]) projects from Domain 2*

*Only PPS approved to conduct project 2.d.i will be able to select a maximum of five projects from Domain 2 (and 11 projects in total). All other PPS will maintain the opportunity to choose up to four projects from Domain 2 (and up to 10 projects in total).



DSRIP DOMAINS & PROJECT REQUIREMENTS

- Domain 3 – Clinical Improvement
 - ✓ *All PPS must select at least two (but no more than four) projects from Domain 3*
- Domain 4 – Population-wide Strategy Implementation – The Prevention Agenda
 - ✓ *All PPS must select at least one (but no more than two) projects*



Note: Project selection criteria for Domains 3 & 4 remain unchanged.



DSRIP ATTRIBUTION UPDATE



DSRIP ATTRIBUTION: MATCHING MEMBERS TO A PPS

- Attribution is the process used in DSRIP to assign a member to a Performing Provider System (PPS).
- Attribution makes sure that each Medicaid member is assigned to one and only one PPS.
- Although using a different process, attribution also assigns a portion of the uninsured individuals in each region to a PPS.
- Attribution uses geography, patient visit information and health plan PCP assignment to “attribute” a member to a given PPS.
- Patient visit information is used to establish a “loyalty” pattern to a PPS (based on all their provider members) where most of the member’s services are rendered.



DSRIP ATTRIBUTION: UNINSURED, NU & LU MEDICAID RECIPIENTS

- There are approximately 1.1M Medicaid members enrolled in the program, but not using any services in a given year = non-utilizing (NU) members.
- Additionally, the state will set a threshold to define a cohort of low-utilizing (LU) members (e.g., there are approximately 750K Medicaid members that utilize three or fewer services per year that have little to no connectivity with their PCP or care manager).
- These NU & LU members will be removed from general utilizing member pool of beneficiaries and a state determined portion of this population will be reattributed to the PPS approved to operate project 2.d.i (aimed at targeting these populations) in a given region.
- A portion (in most cases 100%) of the region's uninsured population will also be attributed to the PPS approved to operate project 2.d.i.





UPDATED DSRIP ATTRIBUTION (PPS TYPES)



UPDATED DSRIP ATTRIBUTION: PPS TYPES

Three PPS Types will be recognized for the purpose of attribution:

1. **Single PPS in a Region (Public Hospital Led/Involved or Non-Public);**
2. **Multi PPS in Region – Public Hospital* Led/Involved; and**
3. **Multi PPS – Non-Public Hospital Involved.**

*For the DSRIP Program, the health systems qualify as public hospitals are:

- i. Health and Hospitals Corporation of New York City (HHC)
- ii. State University of New York Medical Centers (SUNY)
- iii. Nassau University Medical Center (NUMC)
- iv. Westchester County Medical Center (WCMC)
- v. Erie County Medical Center (ECMC)



DSRIP ATTRIBUTION: SINGLE PPS IN GEOGRAPHICAL REGION

- If a PPS is the only PPS approved by the state in a defined region (minimum: single county level) **then all the Medicaid members (100% of UM+NU+LU) in that region will be attributed to that single PPS.**
 - ✓ *Single PPS in region will not be required to pursue 11 projects to receive all NU & LU attribution.*
- If the sole PPS is approved to operate the 11th project, the PPS will receive all of the uninsured residing in their approved region for attribution.



UM= Utilizing Medicaid Members
NU= Non-Utilizing Medicaid Members
LU= Low-Utilizing Medicaid Members
UI= Uninsured Population

DSRIP ATTRIBUTION: IT PAYS TO BE A SOLE PPS IN GEOGRAPHICAL REGION

In regions where there are multiple PPS, where practical, the state has encourage these PPS to form a single PPS and take DSRIP responsibility for an entire region.

Benefits of a Single PPS:

- Ability to create single point of focus and accountability for all regional projects
 - ✓ single community needs assessment
 - ✓ single set of projects,
 - ✓ more focused performance data flow especially for ambulatory providers, etc.
- Ability to have all non utilizing and low utilizing members in the region attributed to PPS.
- Ability to have all uninsured residing in area attributed to PPS if pursuing the 11th project.
- Ability to receive extra project application points if pursuing the 11th project.
- Best chance of developing true integrated service delivery and more focused accountability
 - ✓ Offers the best platform from which to excel at achieving DSRIP performance targets.
- Much simpler system for patients, providers and payers to participate in.



DSRIP ATTRIBUTION: MULTI PPS IN REGION – PUBLIC HOSPITAL LED/INVOLVED

- If a PPS that includes a major public hospital in their network (as lead, co-lead, or network partner) is approved in a region where there is at least one other approved PPS, then as appropriate per attachment I, the public led/involved PPS be attributed all utilizing Medicaid members (UM) that get most of their services from the PPS' network
- This public led/involved PPS will also be given the first opportunity to pursue Project 2.d.i. (“11th Project”)
- If this public led/involved PPS is approved to operate 11th project, they will be*:
 - ✓ *Attributed a portion of the NU & LU Medicaid members in the region*
 - ✓ *Attributed all uninsured members residing in their approved region attributed to their PPS for initial valuation*
- If public involved PPS does not pursue 11th project in a given region, that region will then be viewed as a region with no public involved PPS for 11th project attribution purposes (see next slide)

*If there happens to be more than one public affiliated PPS in a region and both decide to pursue project 2.d.i, the respective portions of attributed NU, LU and UI members in the region will be distributed based on the relative percentage of utilizing Medicaid (UM) recipients attributed to each PPS.



DSRIP ATTRIBUTION: MULTI PPS IN REGION – NO PUBLIC HOSPITAL INVOLVED

- If a non-public PPS is approved in a region that contains at least one other PPS for all or part of their approved region, but the region does not include a major public hospital PPS, then the non-public PPS will receive attribution of *utilizing* Medicaid members (UM) that get most of their services from the PPS' network.
- Under this scenario with no public PPS in the region, one or more non-public PPS in the region could be approved by the state to pursue the 11th project.



DSRIP ATTRIBUTION: MULTI PPS IN REGION – NO PUBLIC HOSPITAL INVOLVED (CONT.)

- If only one non-public PPS in such a region is approved to pursue the 11th project, under such circumstances, that PPS would be attributed the entire UI population as well as full portion of state determined reattributed LU & NU members in the region.
- If multiple non-public PPS in such a region are approved to pursue the 11th project, under such circumstances, each of these PPS will be assigned a share of the state-set portion of the LU & NU members and a share of the UI residing in their approved PPS region.
- ✓ Each PPS share of the UI, LU & NU members would be based on the PPS' relative percentage of utilizing Medicaid members assigned to the PPS for that region in attribution logic.



DSRIP ATTRIBUTION: PPS TYPES (OVERVIEW)

PPS Type (by Region Category)	Utilizing Medicaid (UM) Members	Non-Utilizing (NU) & Low-Utilizing (LU) Medicaid Members*	Uninsured (UI)
<u>Single</u> PPS	<u>All</u> UM members in region attributed to PPS	<u>All</u> state defined NU & LU members in region attributed to PPS (regardless of whether or not PPS opts for 11 th project)	<u>All</u> UI in region attributed to PPS if PPS is approved for 11 th project
Multi-PPS: <u>Public</u> Led/Involved	UM members in region attributed to PPS based on loyalty logic	<u>Public PPS w/ 11th</u> : Given the full state determined reattributed percentage of the NU & LU population in the region if PPS is approved for the 11 th project	<u>Public PPS w/ 11th</u> : <u>All</u> UI in region attributed to PPS if PPS is approved for 11 th project
Multi-PPS: <u>Non-Public</u> (NP) Involved	UM members in region attributed to PPS based on loyalty logic	<p><u>NP PPS w/o 11th</u>: None</p> <p><u>Single NP PPS w/ 11th</u>: Given the full state determined reattributed percentage of the NU & LU population in the region if PPS is approved for the 11th project</p> <p><u>Multiple NP PPS w/ 11th</u>: Given a portion of the state determined reattributed percentage of NU & LU population in the region based on the relative percentage of UM in the region that were attributed to the PPS.</p>	<p><u>NP PPS w/o 11th</u>: None</p> <p><u>Single NP PPS w/ 11th</u>: <u>All</u> UI in region attributed to PPS if PPS is approved for 11th project</p> <p><u>Multiple NP PPS w/ 11th</u>: If approved for the 11th project, each PPS will receive a percentage of the UI population in the region based on the relative percentage of UM (in the region) that were attributed to the PPS.</p>

*Non utilizers are those enrolled in Medicaid but not using any billed services. Low utilizers threshold is set by state (e.g., members that utilized three or fewer services per year that have little to no connectivity with their PCP or care manager). Regular utilizers (aka utilizing Medicaid members) are those not meeting the non-utilizer or low utilizer criteria.





DSRIP ATTRIBUTION (BENEFICIARY SUBCATEGORIES)



DSRIP ATTRIBUTION LOGIC: STAKEHOLDER FEEDBACK

Two key pieces of feedback on the proposed attribution process were received from stakeholders:

Concern 1: the attribution process as initially proposed did not sufficiently differentiate connectivity to a PPS for key specialty populations with unique service needs (e.g., behavioral health and developmentally disabled services were treated the same as primary care in the prior attribution proposal).

Concern 2: the attribution process as initially proposed did not adequately address how critical the MCO-assigned Primary Care Provider (PCP) should be in the attribution process if that PCP was actually delivering care to the attributed member.

The attribution changes that follow are specifically being implemented to address these two very important concerns.



DSRIP ATTRIBUTION LOGIC: MULTI-PPS SCENARIO

When there is more than one Performing Provider System in a defined geographic area¹, utilizing Medicaid members will be attributed using the following method:

STEP 1: Assign population subcategory:

Four mutually exclusive population subcategory groupings have been set up for DSRIP attribution purposes:

- 1. Developmental Disabilities (OPWDD Service Eligible – Code 95)*
- 2. Long Term Care (Only NH residents)*
- 3. Behavioral Health (SMI/Serious SUD)*
- 4. All Other*

STEP 2: Specific attribution loyalty logic that has been specifically designed for each of the four subpopulations based on a clinically relevant hierarchy of service connectivity for each category.



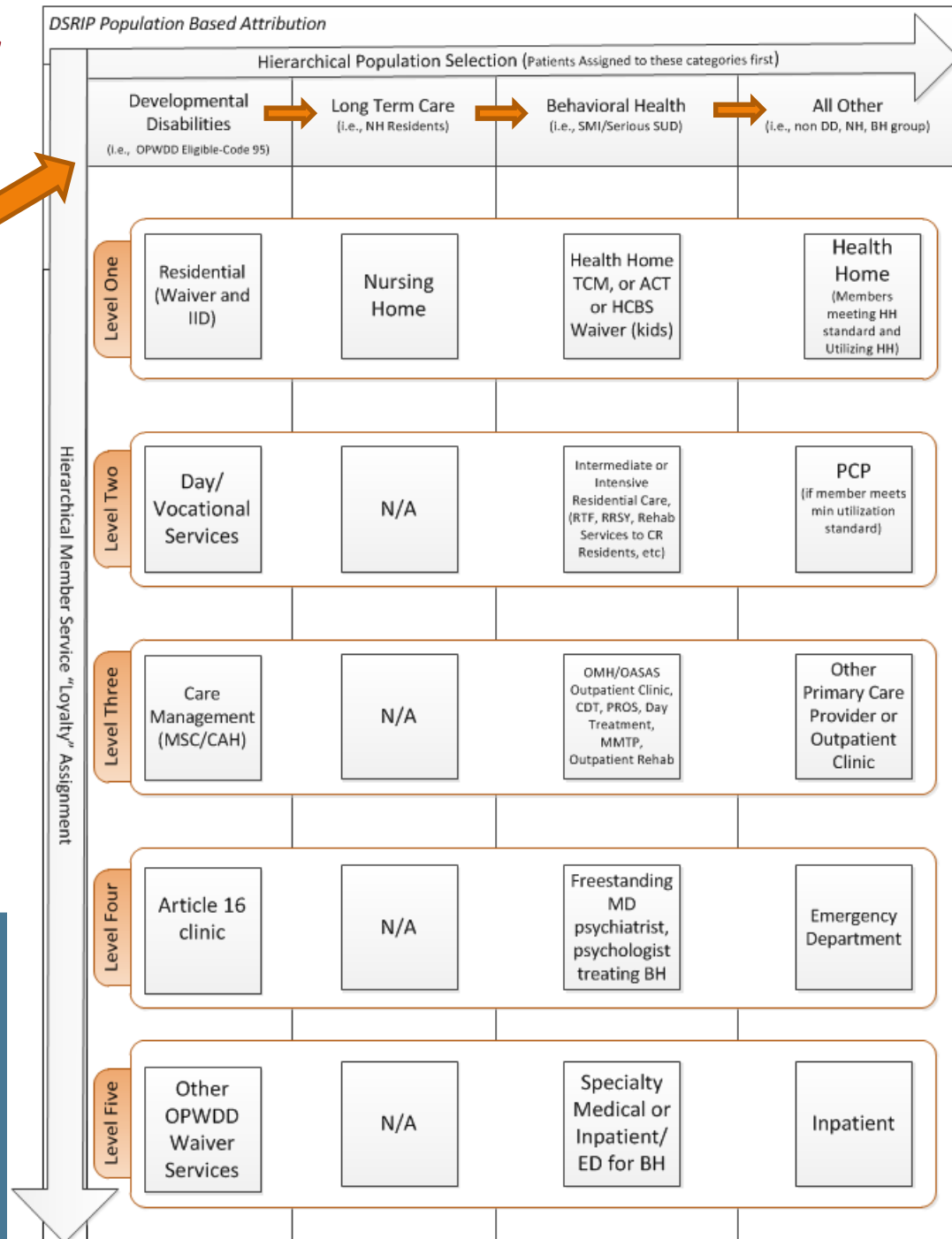
¹ The attribution loyalty logic process described here and in the following slides does not apply to a single PPS in a region – the single PPS would have all MA members attributed to it.

DSRIP ATTRIBUTION FLOW

Step 1:

Medicaid members will be placed into one of these population subcategories based on a mutually exclusive hierarchy (Left to Right)

Example: If the member meets criteria for developmental disabilities and long term care they will be assigned to developmental disabilities as that is first in the hierarchy. Similarly, if a member does not meet criteria for developmental disabilities but does meet criteria for both long term care and behavioral health they will be assigned to long term care.



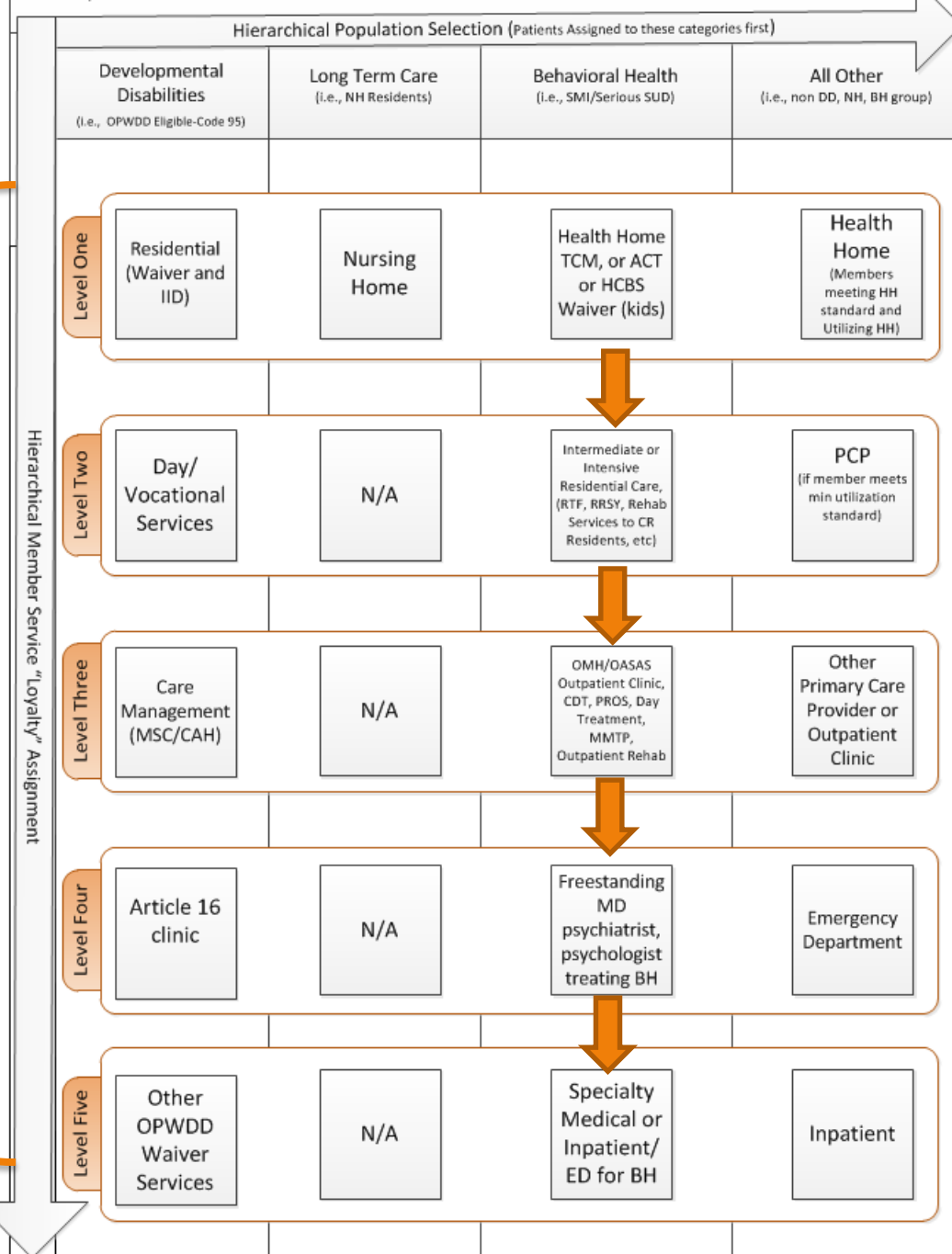
DSRIP ATTRIBUTION FLOW

Step 2:

After a member is assigned to a population subcategory, the member will then be assigned to a PPS based on a loyalty algorithm that is specific to their population subcategory.

Example: If they have been assigned to the behavioral health subcategory the algorithm will check first for care management/health home etc. connectivity and if none exists go on to look for residential connectivity and then ambulatory and so on in hierarchical order.

DSRIP Population Based Attribution



DSRIP ATTRIBUTION LOGIC: MATCHING

1. Once the PPS network of service providers is finalized, the network will be loaded into the attribution system for recipient loyalty to be assigned based on visit counts to the overall PPS network as appropriate in each of the above hierarchical population subcategories.
2. Each PPS with a loyalty-matched provider included in their DSRIP network accumulates matched visits for each service/provider combination.
 - ✓ *If a recipient is currently residing outside the Performing Provider System geographic area, the visits are excluded. However, if the recipient is residing in the approved DSRIP service area for the PPS the visits are included and recipient is matched based on location of service not based on their location of residence (e.g., residents of Columbia county receiving services in Albany County will be matched to a PPS based on Albany visits).*



DSRIP ATTRIBUTION LOGIC: MATCHING

- 3) After all visits against all providers are tallied up for a given service type, the methodology finds the PPS with the highest number of visits for the recipient in each service population subcategory loyalty level as appropriate.
 - ✓ *If a single provider is in more than one PPS network in a given region (e.g., PCP) then the tie breaking method (see next slide) may be employed for final matching purposes.*



DSRIP ATTRIBUTION LOGIC: TIE-BREAKING

If more than one PPS has the highest number of visits based on the highest priority service loyalty types noted, the methodology re-runs the above logic across all Medicaid service types to determine the following:

Tie-break Level 1:

- ✓ If additional visits in other service types cause one PPS to accumulate more visits.

Tie Break Level 2:

- ✓ If Level 1 still results in a tie, the methodology will place the recipient in a separate bucket to be assigned at the end of the attribution process. Recipients who have no predominant demonstrated provider utilization pattern will be assigned to a PPS with the most beneficiaries already assigned (by the visit attribution method) in their specific zip code or other relevant geographic area.





DSRIP PROJECT VALUATION

The maximum DSRIP project and application valuation will follow a five-step process.

While we have changed some of the ingredients, it's still the same formula!

The full DSRIP Project Valuation Process can be found in Section V of Attachment I.



DSRIP PROJECT VALUATION

- The basic methodology for calculating project valuation has gone unchanged.
- PPSs approved to implement project 2.d.i are now able to receive additional attributed beneficiaries (UI+NU+LU) for valuation calculations:
 - ✓ *Projects 1 – 10= UM + %NU + %LU + %UI beneficiaries included*
 - ✓ *Project 11 (2.d.i)= %NU + %LU + %UI beneficiaries included*
- Valuation benchmark weight for PPS pursuing 11 projects remain the same as a PPS pursuing plans with 9 or 10 projects.
- PPS approved to implement project 2.d.i may be awarded bonus points in their Project Plan application score to reflect the extra effort needed to address the project's target populations (UI, NU & LU).
 - ✓ *Extra bonus points on top of the regular bonus may be afforded to single region PPSs approved to operate project 2.d.i. (more to follow)*



UM= Utilizing Medicaid Members
NU= Non-Utilizing Medicaid Members
LU= Low-Utilizing Medicaid Members
UI= Uninsured Population



DSRIP PROJECT VALUATION SCENARIO: ILLUSTRATIVE EXAMPLE



DSRIP SCENARIO: PROJECT VALUATION

VALUATION BENCHMARK TABLE

Below is the current state valuation benchmark table with a benchmark baseline of \$6*.

Number of projects	Valuation Benchmark PMPMs [^]
5 (minimum allowed)	\$6.00
6	\$5.40
7	\$5.10
8	\$5.00
9	\$4.88
10 (Max allowed w/o 2.d.i)	\$4.88
11 (Max allowed w/ 2.d.i)	\$4.88

*Statewide Valuation Benchmark PMPM will be set by the state after DSRIP Project Plans are submitted and the overall number of DSRIP projects and participants are assessed.

[^] PMPMs decreases as more projects are added to account for the ability to leverage shared capacities (e.g., administration, IT systems etc.).



DSRIP SCENARIO 1: MAXIMUM PROJECT VALUATION (NON-PUBLIC PPS) (MULTI-PPS REGION, NOT 2.D.I ELIGIBLE)

HPI Project Plan	Project Index Score	Valuation Benchmark (8 Projects)	Project PMPM	Project Plan Application Score	# of Attributed Utilizing MA Beneficiaries	# of Attributed NU+LU+UI Beneficiaries	# of DSRIP Months	Maximum Project Valuation
Project 1: 2.a.i	0.93	\$5.00	\$4.65	.85	50,000	0	60	\$11,857,500
Project 2: 2.a.ii	0.62	\$5.00	\$3.10	.85	50,000	0	60	\$7,905,000
Project 3: 2.b.vii	0.68	\$5.00	\$3.40	.85	50,000	0	60	\$8,670,000
Project 4: 2.c.ii	0.62	\$5.00	\$3.10	.85	50,000	0	60	\$7,905,000
Project 5: 3.a.i	0.65	\$5.00	\$3.25	.85	50,000	0	60	\$8,287,500
Project 6: 3.b.ii	0.43	\$5.00	\$2.15	.85	50,000	0	60	\$5,482,500
Project 7: 3.c.i	0.5	\$5.00	2.50	.85	50,000	0	60	\$6,375,000
Project 8: 4.a.i	0.33	\$5.00	\$1.65	.85	50,000	0	60	\$4,207,500

Maximum Application Value: \$60,690,000*

*The maximum application value represents the highest possible financial allocation a Performing Provider System can receive for their project plan over the duration of their participation in the DSRIP program.

Performing Provider Systems may receive less than their maximum allocation if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty.

DSRIP SCENARIO 1: MAXIMUM PROJECT VALUATION (W/ 11TH PROJECT)

HPI Project Plan	Project Index Score	Valuation Benchmark (11 Projects)	Project PMPM	Project Plan Application Score (w/ Bonus)	# of Attributed Utilizing MA Beneficiaries	# of Attributed NU+LU+UI Beneficiaries	# of DSRIP Months	Maximum Project Valuation
Project 1: 2.a.i	0.93	\$4.88	\$4.53	.80 + .10 = .90	50,000	20,000	60	\$17,123,400
Project 2: 2.a.ii	0.62	\$4.88	\$3.02	.80 + .10 = .90	50,000	20,000	60	\$11,415,600
Project 3: 2.b.vii	0.68	\$4.88	\$3.32	.80 + .10 = .90	50,000	20,000	60	\$12,549,600
Project 4: 2.c.ii	0.62	\$4.88	\$3.02	.80 + .10 = .90	50,000	20,000	60	\$11,415,600
Project 5: 2.d.i	0.93	\$4.88	\$4.53	.80 + .10 = .90	0	20,000	60	\$4,892,400
Project 6: 3.a.i	0.65	\$4.88	\$3.17	.80 + .10 = .90	50,000	20,000	60	\$11,982,600
Project 7: 3.b.ii	0.43	\$4.88	\$2.10	.80 + .10 = .90	50,000	20,000	60	\$7,938,000
Project 8: 3.c.i	0.50	\$4.88	\$2.44	.80 + .10 = .90	50,000	20,000	60	\$9,223,200
Project 9: 3.d.iii	0.52	\$4.88	\$2.54	.80 + .10 = .90	50,000	20,000	60	\$9,601,200
Project 10: 4.a.i	0.33	\$4.88	\$1.61	.80 + .10 = .90	50,000	20,000	60	\$6,085,800
Project 11: 4.b.ii	0.28	\$4.88	\$1.37	.80 + .10 = .90	50,000	20,000	60	\$5,178,600

Maximum Application Value: \$107,406,000*

*The maximum application value represents the highest possible financial allocation a Performing Provider System can receive for their project plan over the duration of their participation in the DSRIP program.

Performing Provider Systems may receive less than their maximum allocation if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty).

Note: UM and NU, LU, UI are added together in valuation calculation.

i.e.: 50,000 + 20,000= 70,000



NEXT STEPS IN DSRIP DY0?

DSRIP Timeline



DSRIP TIMELINE: DY0

Month	Activity/Deliverable
<p style="text-align: center; font-weight: bold;">August 2014</p>	Initial Design Grant Payments made
	Independent Assessor & Support Team Start
	DSRIP Performance Dashboard goes public
	Safety-Net Appeals (Round 2)
	Community Needs Assessment Webinar (Part 2)
	DSRIP Project Plan Application and Application Review Tool posted to Web for Public Comment
	State will make baseline data for DSRIP measures available



DSRIP TIMELINE: DY0

Due Date/Submission Date	Activity/Deliverable
September 2014- March 2015	Initial PPS Attribution Logic Run for PPS (Early September)
	DSRIP Vital Access Provider (VAP) Exception Application (Mid-September)
	Electronic DSRIP Project Plan Application Released (Early October)
	PPS to submit final Network Lists (Mid-November)
	Final attribution will be made available to PPS (Late November / Early December)
	DSRIP Project Plan Applications Due (Mid-December)
	DSRIP Project Plan Awards Made (Early March 2015)





We want to hear from you!

DSRIP website:

www.health.ny.gov/dsrip

DSRIP e-mail:

dsrip@health.state.ny.us

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