DSRIP Terms & Acronyms

Care Compass Network (CCN) has compiled a comprehensive list of commonly used terms and acronyms that will help you navigate through the DSRIP.

A

Achievement Value: Points received by a Performing Provider System (PPS) for reaching a specified performance target/ milestone during a specific reporting period. Achievement values are either expressed as 0=not meeting benchmark or 1 meeting benchmark. Achievement values are used to determine incentive payments based on performance.

Advanced Primary Care (APC): Leading model for efficient management and delivery of quality health care services that builds on the principles embodied by the National Committee for Quality Assurance (NCQA)- certified medical home. An APC practice utilizes a team approach, with the patient at the center. The care model emphasizes prevention, health information technology, care coordination and shared decision-making among patients and their providers. The APC model is designed to leverage the strengths of New York State's emerging NCQA-certified medical homes while laying out a graduated path for all practices to advance toward integrated care.

Agency for Healthcare Research and Quality (AHRQ): Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans.

Attachment I: An attachment to the NY Delivery System Reform Incentive Payment (DSRIP) Special Terms and Conditions that contain the program Funding and Mechanics Protocol. Attachment I describes the review and valuation process for DSRIP project plans, incentive payment methodologies, reporting requirements, and penalties for missed milestones.

Attachment J: An attachment to the NY Delivery System Reform Incentive Payment (DSRIP) Special Terms and Conditions that contain the Strategies Menu and Metrics Attachment J details the specific delivery system improvement strategies and metrics that are eligible for DSRIP funding. The strategies are listed in Part I and the metrics are listed in Part II.

Attribution: A formula used to determine how a population is assigned to an affiliated group of providers responsible for the care of the population. For Delivery System Reform Incentive Payment (DSRIP), attribution will be done utilizing a hierarchical geographic and service loyalty methodology, to ensure that a Medicaid member is only assigned to one Performing Provider System (PPS)

Avoidable Hospital Use: this term is used to designate all avoidable hospital service use including avoidable emergency department use, avoidable hospital admissions and avoidable hospital readmissions within 30-days. This can be achieved through better aligned primary care and community based services, application of evidence based guidelines for primary and chronic disease care, and more efficient transitions of care through all care settings.

B

Baseline Data: A set of data collected at the beginning of a study or before intervention has occurred. For the Delivery System Reform Incentive Payment (DSRIP), Performing Provider System (PPS) improvement targets will be established annually using the baseline data for DSRIP Year 1 and then annually thereafter for DSRIP Year 2-5. The state must use existing data accumulated prior to implementation to identify performance goals for performing providers.

Behavioral Interventions Paradigm in Nursing Homes (BIPNH): As an additional behavioral health measure for provider systems, this strategy uses Nurse Practitioners at Skilled Nursing Facilities (SNF) and Psychiatric Social Workers to provide early assessment, reassessment, intervention and care coordination to reduce transfer of patients from a SNF facility to an acute care hospital by early intervention strategies, to stabilize patients before crisis levels occur.

Bundles of Care: Where Managed Care Organizations (MCO) and providers contract for a bundle of services and is generally thought of in two categories, Acute and Chronic bundles of services. Acute examples might be maternity care episodes or strokes, while Chronic examples might be Asthma or Diabetes where bundles would be looked at over an entire continuous year of care.

C

Care Management System (CMS): Focuses on team-based, seamless coordinated care and sharing care/life plans within the platform to treat the whole person. A CMS **also** stores Social Determinants of Health that can be accessed by all members of the care team. Tenant Users can use the system to track preferences for assessments, define care team roles, track program participation and progress, and review care management programs, all in real-time.

Care Transitions: A program that provides a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by patients who are at a high risk of readmission, e.g. those with cardiac, renal, diabetes, respiratory and/ or behavioral health disorders. Many factors can impact a patient's successful transition and can include health literacy, language issues, and lack of engagement with the community health care system.

Center for Medicare and Medicaid Services (CMS): Federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

Client Identification Number (CIN): An eight-digit number that identifies the Medicaid member that is eligible to receive benefits.

Clinical Improvement Milestones: Noted under Domain 3 of the Delivery System Reform Incentive Payment (DSRIP), these milestones focus on a specific disease or service category, e.g. diabetes palliative care, that is identified as a significant cause of avoidable hospital use by Medicaid members. Milestones can either relate to process measures or outcomes measures and can be valued either on reporting or progress to goal, depending on metric. Every Performing Provider System (PPS) must include one strategy from behavioral health. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement over baseline, using a valid, standardized method.

Coalition: Partnerships that are formed between providers to apply collectively as a single Performing Provider System (PPS). Coalitions must designate a lead coalition provider who will be held responsible for ensuring that the PPS meets all the requirements of the Delivery System Reform Incentive Payment (DSRIP). Coalitions will be evaluated on performance on DSRIP milestones collectively as a single Performing Provider System (PPS).

Cohort: Is a group of individuals (typically includes 50-200 individuals) that are defined by their personal, clinical, or social needs; and/ or by a triggering event. A cohort may be a static group of individuals or dynamic, meaning the group members change over time.

Collaborative Care Model for Depression: Helps alleviate the burden placed on the primary care clinicians. This evidence-based approach consists of a trained Behavioral Health Care Manager, a designated Psychiatrist Consultant and the primary care provider to deliver care to patients diagnosed with depression. Collaborative Care Model provides the needed support and resources for primary care clinicians to properly treat and manage their patients, while helping to reduce costs, avoid duplication of services, emergency room visits, and/or prescribing medications/ treatments that are not effective.

Community Based Organization (CBO): A public or private non-profit (including a church or religious entity) that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety of the community.

- **Tier 1** – A non-profit, non-Medicaid billing, community based social and human services organizations (e.g. Housing, social services, religious organizations, food banks, and mobility management)
- **Tier 2** – Non-profit, Medicaid billing, non-clinical service providers (e.g. transportation and care coordination)
- **Tier 3** – Non-profit, Medicaid billing and clinical service providers licensed by the NYS Department of Health (DOH), Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services (OASAS), and independently owned primary care.
- **Other** – Any organization that does not meet all characteristics of the definitions above (e.g. a for-profit organization)

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Surveys that ask consumers and patients to report on and evaluate their experience with health care. The surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The CAHPS program is funded and overseen by the U.S. Agency for Healthcare Research and Quality (AHRQ).

D

Designated State Health Programs (DSHP): State health programs not normally eligible for matching federal funds. Under the 1115 Partnership Waiver, Center for Medicare and Medicaid Services (CMS) has the authority to match funding for state health programs in which CMS recognizes as providing a vital service to Medicaid members.

Delivery System Reform Incentive Payment Program (DSRIP): As part of New York's Medicaid Redesign Team (MRT) Waiver Amendment, DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goals stabilizing the safety-net system and reducing avoidable hospital use by 25% over 5 years. DSRIP is the largest piece of the MRT Waiver Amendment with a total allocation of $6.9 billion.

Domain: Overarching areas in which Delivery System Reform Incentive Payment (DSRIP) strategies are categorized. Performing Provider Systems (PPS) must employ strategies from the domains two through four in support of meeting project plan goals and milestones. Domain one encompasses project process measures and does not contain any strategies. The Domains are:

- Domain 1 – Overall project progress
- Domain 2 – System transformation
- Domain 3 – Clinical improvement
- Domain 4 – Population-wide strategy implementation

Delivery System Reform Incentive Payment (DSRIP) Plan Checklist: Criteria used to review submitted DSRIP Plans to ensure completeness. The checklist will be utilized as a robust review process for each submitted DSRIP Project.

Delivery System Reform Incentive Payment (DSRIP) Project: Individual method created by a Performing Provider System (PPS) to transform the delivery of care that support Medicaid members and uninsured as well as address the broad needs for the population the Performing Provider System (PPS) services. DSRIP projects will be designed to meet and be responsive to community needs while meeting three key elements: appropriate infrastructure, integration across settings and assumes responsibility for a define population.

Delivery System Reform Incentive Payment (DSRIP) Project Plan: Detailed plans that Performing Provider Systems (PPS) submit to the state detailing DSRIP strategies they have selected to be directly responsive to the needs and characteristics of their community in order to DSRIP's objectives.

Delivery System Reform Incentive Payment (DSRIP) Strategies: A cluster of DSRIP projects grouped together because they address the same issue within a given Domain. For each collection of strategies, there is a set of metrics that the Performing Provider System (PPS) will be responsible for if they do any one of the projects within that strategy.

Demonstration Year (DY): A period of time that covers one full year in which the Delivery System Reform Incentive Payment (DSRIP) program will run.

Demonstration Year 1 – April 1, 2015 to March 31, 2016
Demonstration Year 2 – April 1, 2016 to March 31, 2017
Demonstration Year 3 – April 1, 2017 to March 31, 2018
Demonstration Year 4 – April 1, 2018 to March 31, 2019
Demonstration Year 5 – April 1, 2019 to March 31, 2020

E

Electronic Health Record (EHR): An Electronic health record (EHR) or electronic medical record (EMR) is the means by which patient health information is stored and shared digitally.

Evaluation Plan: Part of the Delivery System Reform Incentive Payment (DSRIP) pre-implementation activities, the state must submit an evaluation plan for DSRIP, including the budget and adequacy of approach to meet the scale and rigor of the requirements of Special Terms and Conditions (STC's), and also provide the identification of the selected Independent Evaluator.

F

Federal Financial Participation (FFP): The portion of Medicaid health program expenditures that are paid by a Federal Government.

Fee-For-Service (FFS): A payment system where payment is for a specific service provided and is volume based, regardless of health outcomes.

H

Health and Human Services (HHS): Provides effective health and human services and foster advances in medicine, public health, and social services. HHS works to enhance and protect the health and well-being of all Americans.

Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services, HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA's grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers, and children. HRSA also supports the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery.

Health Coach: The use of evidence-based skillful conversation, clinical interventions and strategies to actively and safely engage client/patients in health behavior change. Health coaches are certified to safely guide clients and patients who may have chronic conditions or those at moderate to high risk for chronic conditions.

Health Home: A management service that involves all of an individual's caregivers, allowing them to communicate with each other so the individual's health is viewed holistically. The care manager oversees the individual's overall health to assure the individual is receiving everything he/ she needs, and that the individual is out of the emergency department and out of the hospital. It is not a physical place.

Healthcare Effectiveness Data and Information Set (HEDIS): Tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care. The National Committee for Quality Assurance (NCQA) collects HEDIS data directly from Health Plan Organizations and Preferred Provider Organizations for multiple purposes and the data collected are maintained in a central database with strict controls to protect confidentiality.

High Performance Fund: A portion of the Public Hospital Transformation Fund and Safety Net Performance Provider System Transformation Fund will be set aside to reward Performing Provider Systems (PPS) that exceed their metrics and achieve high performance by exceeding a preset higher benchmark for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health populations.

Home Health Care: A range of in-home services to treat and care for an illness or injury. It is a cost-effective, and more convenient alternative to a hospital visit or a skilled nursing facility.

I

Independent Assessor: An independent entity, with expertise in delivery system improvement, whose role is to conduct a transparent review of all proposed/ submitted Delivery System Reform Incentive Payment (DSRIP) project plans and make project approval recommendations to the state using CMS-approved criteria. In addition, the independent assessor will also assist with the mid-point assessment and any other ongoing reviews of DSRIP project plans.

Independent Evaluator: An independent entity, with expertise in delivery system improvement, who's role is to assist with continuous quality improvement within the Delivery System Reform Incentive Payment (DSRIP) program.

Index Score: An evaluation or score assigned to the Delivery System Reform Incentive Payment (DSRIP) projects, based on five elements (1. potential for achieving system transformation, 2. potential for reducing preventable event, 3. percent of Medicaid members affected by project, 4. potential cost savings and, 5. robustness of evidence-based suggestions). Project index scores are set by the state and are released prior to the application period.

Integrated Delivery System (IDS): An organized, coordinated, and collaborative network of various healthcare providers that care connected with the aim to offer a coordinated, continuum of services to a particular patient population or community. A goal of an efficient Integrated Delivery System is to be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population or community served, and has systems in place to manage and improve them.

INTERACT Project: INTErventions to Reduce Acute Care Transfers is a quality improvement program that focuses on inpatient transfer avoidance for Skilled Nursing Facilities (SNF), the management of acute change in a resident's condition to stabilize the patient and avoid transfer to an acute care facility. The program includes clinical and educational tools and strategies for use in every day practice in long-term care facilities. The current version of the INTERACT project was developed by the Interact interdisciplinary team under the leadership of Dr. Ouslander, MD with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by the Commonwealth Fund. There is significant potential to further increase the impact of INTERACT by integrating INTERACT II tools into nursing home health information technology through a standalone or integrated clinical decision support system.

Integrated Primary Care (IPC): Including behavioral health primary care, effective management of chronic disease, medication management, community-based prevention activities and clear alignments with community based, home, and social services agencies (Patient Centered Medical Home PCMH/ Advanced Primary Care APC models). This type of care is continuous in nature, has a strong population focus, based in the community, culturally sensitive, oriented towards primary and secondary prevention, and aims to act as the primary source of care for the majority of everyday care need.

Intergovernmental Transfer (IGT): Intergovernmental Transfer (IGT) entities that are eligible to contribute allowable governmental funds for use by the state for the non-federal share of the Delivery System Reform Incentive Payment (DSRIP) payments for a Performing Provider System (PPS). They include government-owned Hospitals and other government entities such as counties.

Interim Access Assurance Fund (IAAF): Temporary, time limited, funding available from n IAAF to protect against degradation of current access to key health care services and avoid gaps in the health delivery system. New York is authorized to make payments for the financial support of selected Medicaid providers.

L

Lead Coalition Provider: Provider that is primarily responsible for ensuring that the coalition partnerships meet all requirements of Performing Provider Systems (PPS), including reporting to the state and Center for Medicare and Medicaid Services (CMS).

Learning Collaborative: Learning collaboratives are required forums for Performing Provider Systems (PPS) to share best practices and get assistance with implementing their Delivery System Reform Incentive Payment (DSRIP) projects. The state will support regular learning collaboratives regionally and at the state level (with at least one face-to-face statewide collaborative annually), and may be organized geographically, by the goals of the DSRIP, or by the specific 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).

Low Utilizer: A Medicaid member that has less than 3 claims for qualifying services and exclusively visits the hospital, eye doctor, or dentist (rather than visiting their primary care physician).

M

Managed Care Organization (MCO): An insurance organization paid a premium to provide care to the enrolled patient. This organization then negotiates the payment to a provider when services are delivered.

Maximum Application Valuation: Represents the highest possible financial value placed on a Performing Provider System's (PPS) final Delivery System Reform Incentive Payment (DSRIP) plan. The Maximum Application Valuation is the sum of all the maximum project valuation for each of the projects within a Performing Provider System DSRIP application.

Maximum Project Valuation: Represents the highest possible financial value placed on an individual project within a Performing Provider System's (PPS) final Delivery System Reform Incentive Payment (DSRIP) plan.

Meaningful Use (MU): The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

Measure Steward: An individual or organization that owns a measure and is responsible for maintaining the measure.

Measurement Year (MY): A time period of one year where data is gathered and analyzed.

Measurement Year 1 – July 1, 2014 to June 30, 2015
Measurement Year 2 – July 1, 2015 to June 30, 2016
Measurement Year 3 – July 1, 2016 to June 30, 2017
Measurement Year 4 – July 1, 2017 to June 30, 2018
Measurement Year 5 – July 1, 2018 to June 30, 2019

Medicaid Accelerated eXchange (MAX) Series: Focuses on a small population of patients who account for a disproportionate amount of use and cost (High-Utilizers) bringing a great opportunity to provide better care for those who need it most.

Medicaid Redesign Team (MRT) Waiver Amendment: An amendment allowing New York to reinvest $8 billion in Medicaid Redesign Team generated federal savings back into NY's health care delivery system over five years. The waiver amendment contains three parts: Managed Care, State Plan Amendment and the Delivery System Reform Incentive Payment (DSRIP). The amendment is essential to implement the MRT action plan as well as prepare for ACA implementation.

Metric Specification Guide: A state developed guide that will provide additional information on the metrics and measures, data sources for each measure (whether the measure is collected by the state or the provider), the reference for the data steward for each metric (i.e. the National Quality Forum reference number, etc.) and the high-performance level for each pay-for-performance metric.

Mid-point Assessment: s part of the Delivery System Reform Incentive Payment (DSRIP) review and ongoing funding, during DSRIP Year 3 of DSRIP, the state's independent assessor shall assess Performing Provider Systems (PPS) performance to determine whether their DSRIP project plans merit continued funding. Based on the findings, the independent assessor makes a recommendation to the state. The state then uses the assessor's recommendations to determine whether a project plan should be continued, discontinued or continued with alterations to the project plan.

Milestone: Delivery System Reform Incentive Payment (DSRIP) project actions or activity goals, achieved over time.

Motivational Interviewing (MI): An evidence-based approach, often used in the clinical setting, which supports people living with various chronic conditions to make positive behavioral changes. MI upholds four principles: Expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy.

Measurement Year (MY): Refers to the metrics that are collected by the providers within a PPS region. Measure Year goes from July 1st to June 30th.

N

National Committee for Quality Assurance (NCQA): A private, not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what's important, how to measure it, and how to promote improvement.

Network: A group of providers/ agencies formed for the purpose of providing a core set of services to a defined cohort that establishes service integration.

Network Partners: Members of the network whose services are integrated with a Value Based Lead Payment Contractor (VLC) and/or other network partners.

New York State Health Innovation Plan (SHIP): In April 2013, the New York State Department of Health was awarded a State Innovation Models (SIM) grant by the Centers for Medicare and Medicaid Innovation (CMMI) to develop a State Healthcare Innovation Plan (hereafter "the Plan") and is a roadmap to achieve the "Triple Aim" for all New Yorkers: improved health, better health care quality and consumer experience and lower costs. The intent and goal of the Plan is to identify and stimulate the spread of promising innovations in health care delivery and finance that result in optimal health outcomes for all New Yorkers.

Non-Utilizer: A Medicaid member with continuous enrollment for the previous 12 months without a gap in enrollment great than three months, who has no claims for qualifying services. These services include primary care, specialist care, care received in an emergency department or an inpatient hospital admission.

P

Palliative Care: A multi-disciplinary approach to caring for patients with a serious illness, focusing on providing relief from the burdens of their symptoms. It focuses on providing people with relief from the symptoms, pain, physical stress, and mental stress of a diagnosis.

Partnership Plan (NY): As part of the Section 1115 of the Social Security Act, the Partnership Plan Section 1115(a) Demonstration for New York, uses a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The Center for Medicare and Medicaid (CMS) has approved New York's request for an amendment to New York's Partnership Plan, authorizing the creation of a Delivery System Reform Incentive Payment (DSRIP) Fund.

Patient Centered Medical Home (PCMH): A way of organizing primary care that emphasizes care coordination and communication to provide patients with timely, well-organized and integrated care, and enhanced access to teams of providers within a health care organization.

Pay-For-Performance (P4P): Payment model that rewards providers for meeting certain pre-established performance targets or measures for quality and efficiency.

Pay-For-Reporting (P4R): Payment model that rewards providers for reporting on certain per-determined metrics.

Percentage Achievement Value (PAV): the ratio of the actual Achievement Value (AV) points earned by a Performing Provider System (PPS) for meeting performance metrics during a reporting period to the total possible achievement value points that could have been earned by the Performing Provider System during the reporting period.

Performing Provider Systems (PPS): Entities that are responsible for performing the Delivery System Reform Incentive Payment (DSRIP) project. DSRIP eligible providers, which include both major public general hospitals and safety net providers, collaborating together, with a designated lead provider for the group.

Plan Application Score: Each Performing Provider System's (PPS) final plan application will receive a score (out of 100 possible points) based on the application's fidelity to the project description, likelihood of achieving the Delivery System Reform Incentive Payment (DSRIP) objectives by implementing the project. The plan application score is one variable used in calculating the maximum value of a project.

Population Health: Is the study of populations to understand the current health characteristics and outcomes of a population, including diseases or conditions, patterns of utilization, age, gender, geographical locations, and the Social Determinants of Health. Population Health is an approach that aims to improve health outcomes by considering the impact of medical and social services. This highlights the need for partnerships among health care systems, agencies, and community organizations to make measurable impacts on communities.

Population-wide Project Implementation Milestones: Also known as Doman 4, Delivery System Reform Incentive Payment (DSRIP) performing provider systems (PPS) responsible for reporting progress on measures from the New York State Prevention Agenda. These metrics will be measured for a geographical area denominator of all New York State residents, already developed as part of the Prevention Agenda.

Potentially Preventable Emergency Room Visits (PPVs): Part of the nationally recognized measures for avoidable hospital use. The measures identify emergency room visits that could have been avoided with adequate ambulatory care.

Potentially Preventable Readmissions (PPRs): Part of the nationally recognized measures for avoidable hospital use. PPRs measure readmissions to a hospital following a prior discharge from a hospital and that is clinically-related to the prior hospital admission.

Prevention Agenda: As Part of the Domain 4, Population-wide Strategy Implementation Milestones, the Prevention Agenda refers to the "blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomics, and other groups who experience them", as part of New York State's Health Improvement Plan.

Prevention Quality Indicators – Adults (PQIs): Part of the nationally recognized measures for avoidable hospital use that can be used with hospital inpatient discharge data to provide a perspective on the quality of pediatric healthcare. Specifically, PDIs screen for problem that pediatric patients experience as a result to exposure to the healthcare system and that may be amendable to prevention by changes at the system or provider level. Similarly, the PDIs are population based and can be adjusted for covariates for evaluation.

Project Design Grants: As part of the Delivery System Reform Incentive Payment (DSRIP) pre-implementation activities, the state will provide allotted amounts to providers for DSRIP Design Grands from a designated Design Grand Fund. These grants will enable providers to develop specific and comprehensive DSRIP Project Plans. Applicants who receive project design grants are expected to submit a DSRIP project plan or they will have to refund DSRIP Project Design Grant awards.

Project Progress Milestone: Also known as Domain 1, measures the investments in technology, tools, and human resources that strengthen the ability of the Performing Provider Systems (PPS) to serve target populations and pursue the Delivery System Reform Incentive Payment (DSRIP) project goals. The Project Progress milestones include monitoring of the project spending and post-DSRIP sustainability. In addition, submission of quarterly reports on project progress specific to the PPS DSRIP project and its Medicaid and low-income uninsured patient population.

Project Toolkit: A state developed guide that will provide additional information on the core components of each Delivery System Reform Incentive Payment (DSRIP) strategy, how they are distinct from one another, and the rationale for selecting each strategy (i.e. evidence base for the strategy and its relation to community needs for the Medicaid and uninsured population). In addition, the strategy descriptions provided in the toolkit will be used as part of the DSRIP Plan Checklist and can serve as a supplement to assist providers in valuing projects.

Project Valuation: Process by which the state assigns monetary value to Performing Provider Systems' (PPS) final project plans.

Public Hospital Transformation Fund: A Delivery System Reform Incentive Payment (DSRIP) funding pool available to Performing Provider System (PPS) applicants led by a major public hospital system.

Q

Quality Strategy: A requirement of the 1115 Waiver, delineates the goals of the New York State Medicaid managed care program and the actions taken by the New York State Department of Health (NYSDOH). To ensure the quality of care delivered to Medicaid managed care enrollees. The strategy has evolved over time as a result of programmatic changes, member health needs, clinical practice guidelines, federal and state laws, lessons learned, and best practices; it has been successful as it has documented improvement in the quality of health care being provided to enrollees.

R

Rapid Cycle Evaluation: As part of the Delivery System Reform Incentive Payment (DSRIP) Project Plan submission requirements, the Performing Provider Systems (PPS) must include in its' plan, an approach to rapid cycle evaluation, which informs the system in a timely fashion of tis 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 be overseen and managed.

Referral Source: a referral source is an agency or organization that has the ability to identify new cohort members who meet the cohort criteria and provide information about the new cohort members to the network. The referral source may or may not also be a Value-Based Lead Payment Contractor, Tier 1 Community-Based Organization, or another network member.

Review Tool: As part of the Delivery System Reform Incentive Payment (DSRIP) Project Plan application review, the state, in collaboration with the Independent Assessor, will develop and use a standardized review tool used to review DSRIP Project Plans and ensure compliance with the DSRIP Special Terms and Conditions (STCs) and associated protocols. 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.

Risk Stratification: Process of separating populations into low-risk, high-risk, and rising-risk groups. This creates **actionable data** to better serve individuals and manage healthcare resources more effectively.

S

Safety Net Performance Provider System Transformation Fund: A Delivery System Reform Incentive Payment (DSRIP) funding pool available to non-public DSRIP eligible providers (includes hospitals, nursing homes, clinics including FQHCs, behavioral health providers, etc).

Safety Net Provider (SNP): Entities that provides care and directly bills Medicaid. The term "safety net" is used because for many low-income and vulnerable populations, safety net providers are the "invisible net of protection" for individuals whose lack of health coverage or other social and economic vulnerabilities limits their ability to access mainstream medical care.

1. Must be either a public hospital, Critical Access Hospital or Sole Community Hospital and who must pass two tests:
    a. At least 35% of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals
    b. At least 30% of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals or must serve at lest 30% of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community

--OR—

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

Shared Savings: A payment strategy that offers incentives for provider entities to reduce healthcare spending for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts.

Skilled Nursing Facility (SNF): A organization that is licensed by the state's Department of Health, that provide skilled nursing care and/ or rehabilitation services to help injured, sick, or disabled individuals to get back on their feet.

Social Determinants of Health Categories (SDoH): Definition of a Social Determinant of Health according to the NYS Department of Health are evidence-based interventions that aim to improve certain social determinants of health. These categories are a starting point for CCN and the state to pave the way to positively affect the social determinants that have a significant negative impact on Medicaid members in the state of New York.

Five Categories of SDoH:

1. **Economic Stability** Housing, employment, food, transportation
2. **Education** Lack of access to education and English literacy deficiencies; Community Health Advocacy; providing materials on a third-grade reading level for patients can comprehend
3. **Health and Healthcare** Lack of access to all types of health care including mental health, behavioral health including homecare and advance directive planning
4. **Neighborhood and Environment** Safety, physical barriers, substandard housing/ living
5. **Social, Family and Community Context** Criminal justice, trauma, discrimination issues

Special Terms and Conditions (STC): Describes the general rules and requirements of the Delivery System Reform Incentive Payment (DSRIP) program.

Statewide Accountability: New York State meeting overall state milestones as described in the STCs and Attachment I. Statewide achievement of performing goals and targets must be achieved and maintained for full access to the funding level as specified in the Special Terms and Conditions (STCs).

Statewide Planning and Research Cooperative System (SPARCS): A comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State.

System Transformation Milestones: Also known as Domain 2, these are outcomes based on a community needs assessment, which reflect measures of inpatient/outpatient balance, increased primary care/ community-based services utilization, rates of global capitation, partial capitation, and bundled payment of providers by Medicaid managed care plans and measures for patient engagement.

T

3M: A company that provides software for analysis of potentially preventable events.

Telehealth: The Health Resources and Services Administration (HRSA) define telehealth as the use of electronic information and telecommunication technology to support and promote remote healthcare, patient and professional health education, and health administration. Telehealth can be done via the internet, video conferencing, media streaming, and wireless communications.

Telemedicine: Allows health care providers to evaluate and diagnose patients remotely using various telecommunications technology.

Total Achievement Value: The sum of all Achievement Value (AV) points a Performing Provider System (PPS) has obtained for meeting performance metrics during a reporting period.

U

Uninsured: An uninsured individual that is not enrolled in Medicaid, does not have commercial insurance, or any other comprehensive insurance coverage.

V

Valuation Benchmark: An external benchmark expressed in per capital value that is based on a similar delivery reforms and used in the project valuation process. The valuation benchmark is set based on the overall scope of applications received with a maximum statewide value of $15.

Value Based Payment: A system that rewards quality outcomes and improved health versus paying for a specific service performed.

Value Based Payment Lead Contractor (VLC): An entity which leads contract negotiations with a Managed Care Organization (MCO) and contracts on behalf of a broader network. This is a NYS Department of Health term that relates to the Value Based Payment Roadmap. CCN has leveraged this term to represent the lead agency who contracts with CCN around a Phase III Cohort Program(s) on behalf of the cohort network.

Value Based Purchasing: A strategy to measure, report, and reward excellence in health care delivery. Effective health care services and high performing health care providers are rewarded with an increased reputation through public reporting, enhanced payments through reimbursements, and increased market share.

Vital Access Provider (VAP): A provider of health care services in a community that is a hospital, nursing home, diagnostic and treatment center, home care providers and denotes the state's determination to ensure patient access to a provider's services otherwise jeopardized by the provider's payer mx or geographic isolation. A VAP designation is a threshold determination that will qualify providers for some level of supplemental financial assistance to support their longer-term financial viability.

Vital Access Provider (VAP) Program: Funding available to qualified healthcare providers for supplemental financial assistance to improve community care in support of ensuring financial stability and advance ongoing operational change to improve community care.