

# **DSRIP Program: An Overview**

**Medicaid Matters  
DSRIP Statewide Community Engagement Forum**

**October 21, 2016**

## New York Has Fared Poorly on Several Measures of Avoidable Hospital Use and Costs

- *NYS Health Foundation, "Getting More Bang for the Buck: The Quality Question"*

### New York State Ranked 50<sup>th</sup> for Potentially Avoidable Hospital Use and Cost of Care

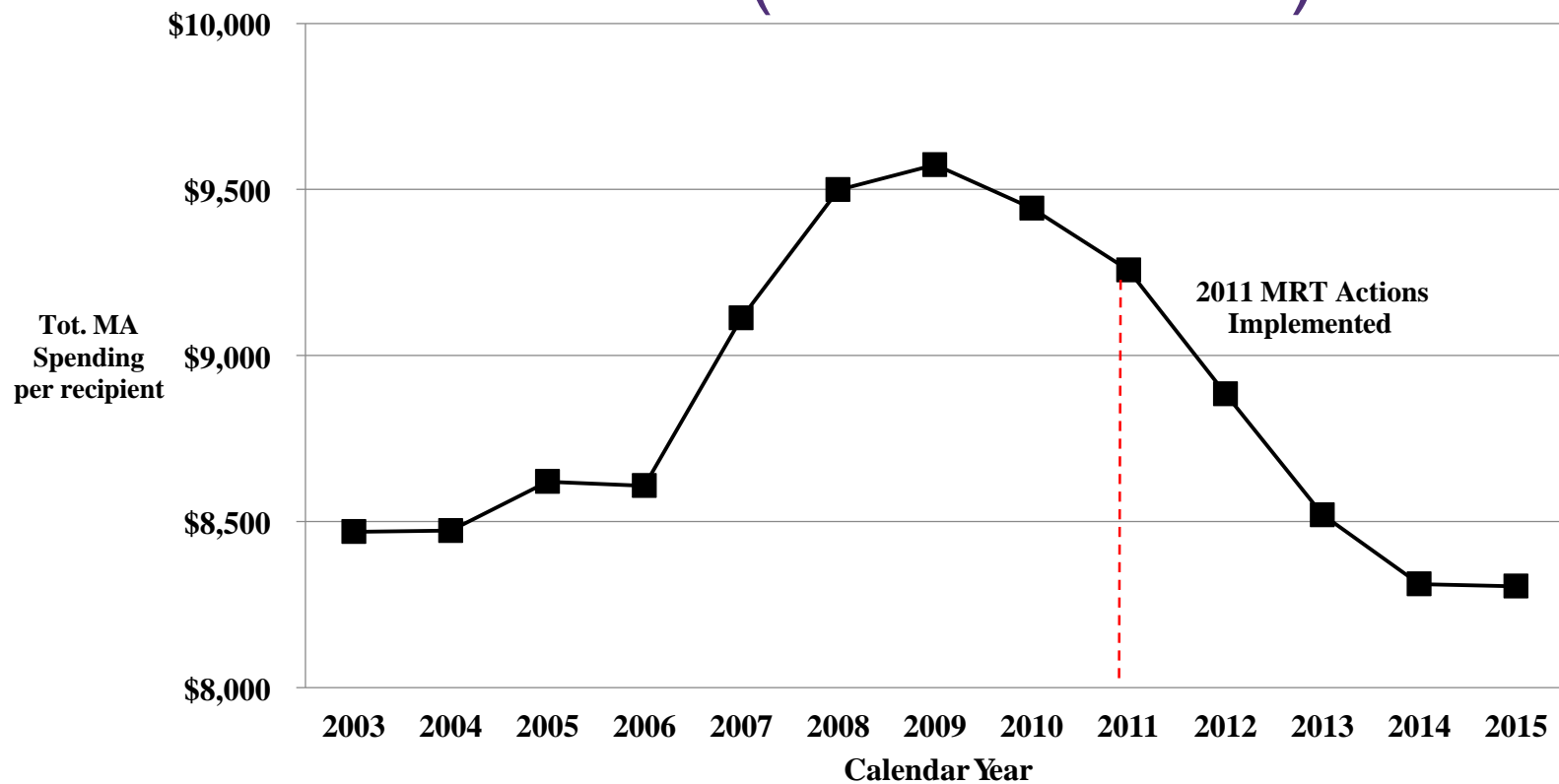
Hospital Admissions for pediatric asthma per 1000 children	35
Percent of adult asthmatics with ED or urgent care visit in past year	31
Percent of home health patients with a hospital admission	49
Hospital Care Intensity Index based on inpatient days and inpatient visits among Chronically Ill Medicare beneficiaries in the last 2 years of life	50

SOURCE: Commonwealth Fund, October 2009 -"Aiming Higher: Results from a State Scorecard on Health System Performance, 2009"

# MRT WAIVER AMENDMENT

- Medicaid Redesign Team convened January 2011 to develop an action plan to reshape Medicaid system to reduce avoidable costs and improve quality.
- In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized agreement on the MRT Waiver Amendment.
- Allows the state to reinvest \$8 billion of the \$17.1 billion in federal savings generated by MRT reforms.
- The MRT Waiver Amendment will:
  - ✓ *Transform the state's Health Care System*
  - ✓ *Bend the Medicaid Cost Curve*
  - ✓ *Assure Access to Quality Care for all Medicaid members*

# NYS Statewide Total Medicaid Spending per Recipient (CY2003-2015)

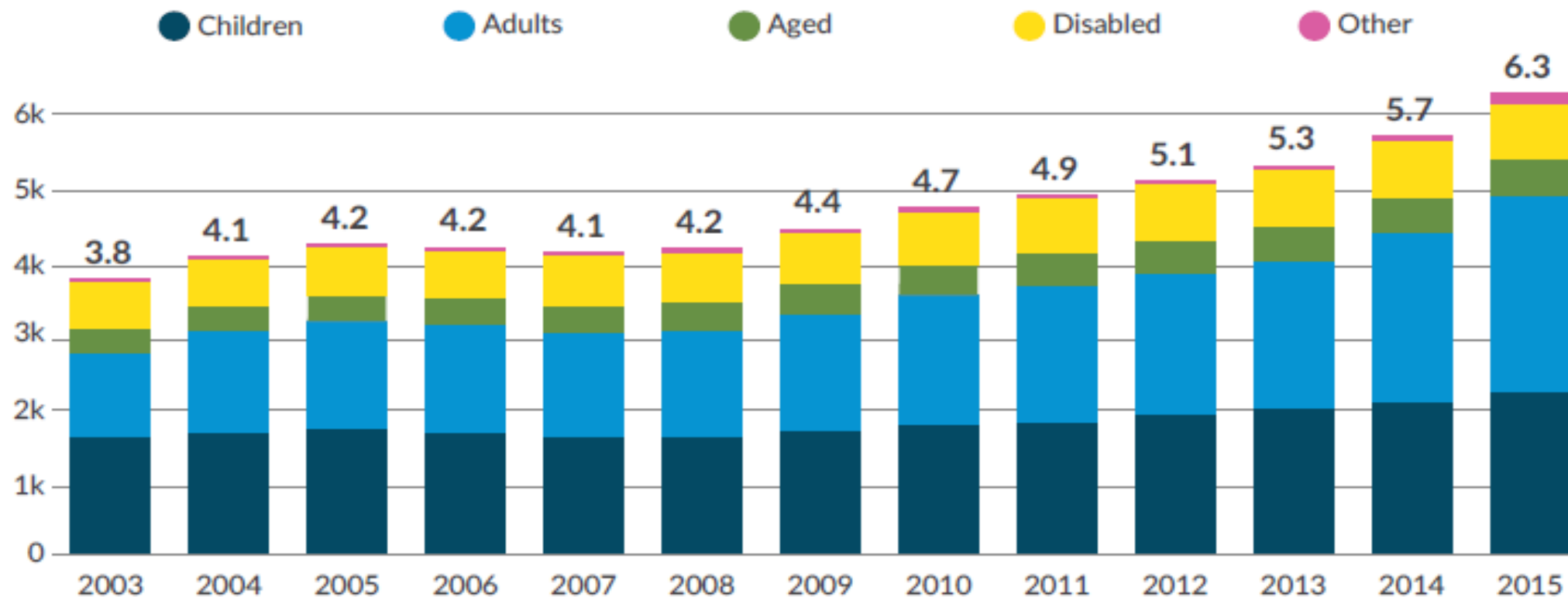


	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
<b>Cost per Recipient</b>	\$8,469	\$8,472	\$8,620	\$8,607	\$9,113	\$9,499	\$9,574	\$9,443	\$9,257	\$8,884	\$8,520	\$8,312	\$8,305

Source: NYS DOH OHIP DataMart (based on claims paid through June 2016)

# New York State Medicaid Enrollment

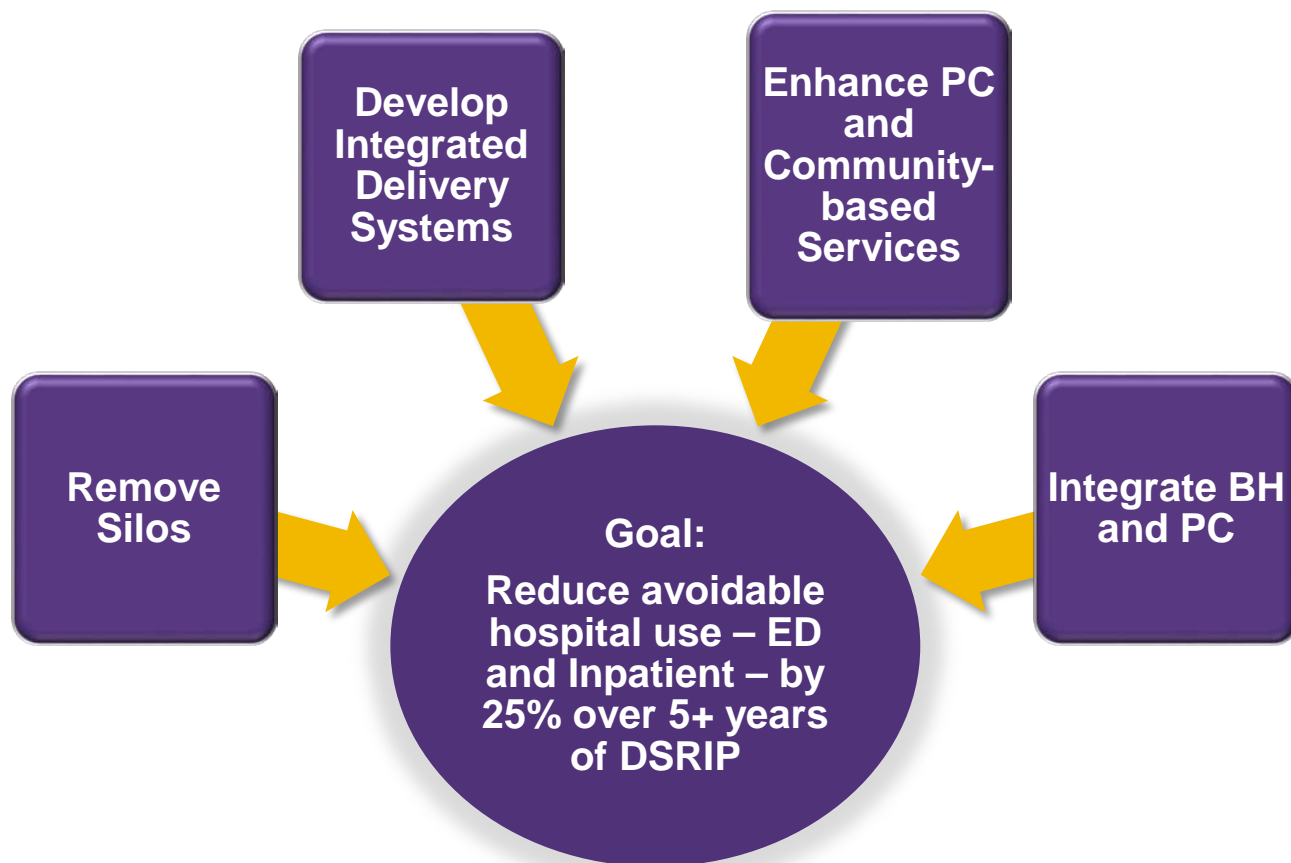
(enrollment in millions)



Note: Data for all years except 2015 are annual averages of monthly enrollment; 2015 data is enrollment for October 2015. Data for 2014 is estimated based on average ratio of Medicaid beneficiaries to enrollees for 2012 and 2013. Adult enrollment figures include Family Health Plus.

Sources: New York State Department of Health, email to Citizens Budget Commission Staff; and New York State Department of Health, *Medicaid Quarterly Reports of Beneficiaries, Expenditures, and Units of Service* (2012 - 2014).

# DSRIP Objectives

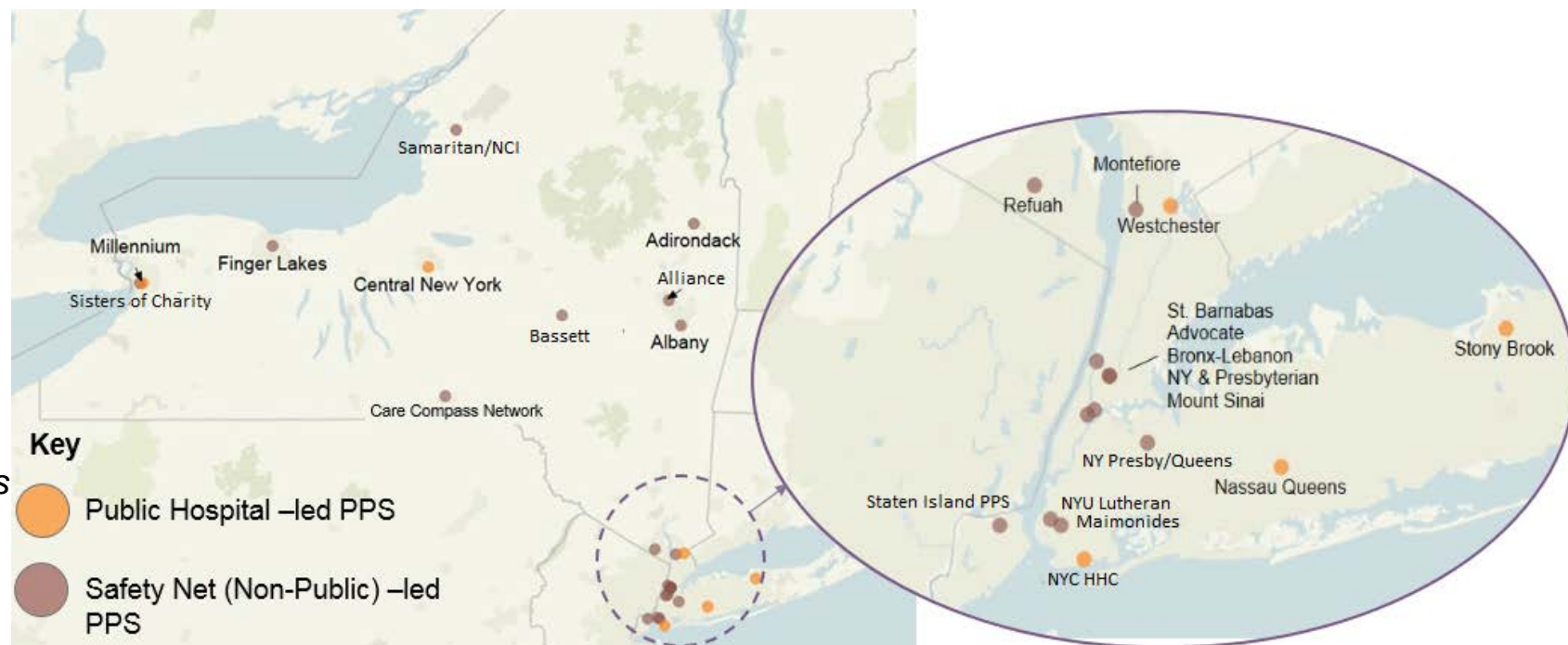


- DSRIP was built on CMS's and the NYS's goals towards achieving the Triple Aim:
  - ✓ Better care
  - ✓ Better health outcomes for members
  - ✓ Lower costs
- To transform the system, DSRIP will focus on the provision of high quality, integrated primary, specialty and BH care in the community setting with hospitals used primarily for emergent and tertiary level of services
- Its holistic and integrated approach to healthcare transformation is set to have a positive effect on healthcare in NYS

# 25 PPS and Local Partnerships

- PPS are networks of providers that collaborate to implement DSRIP projects
- PPS assess community health care needs, build a DSRIP Project Plan, and report on progress and milestones
- Each PPS was required to include providers to form the entire care continuum:

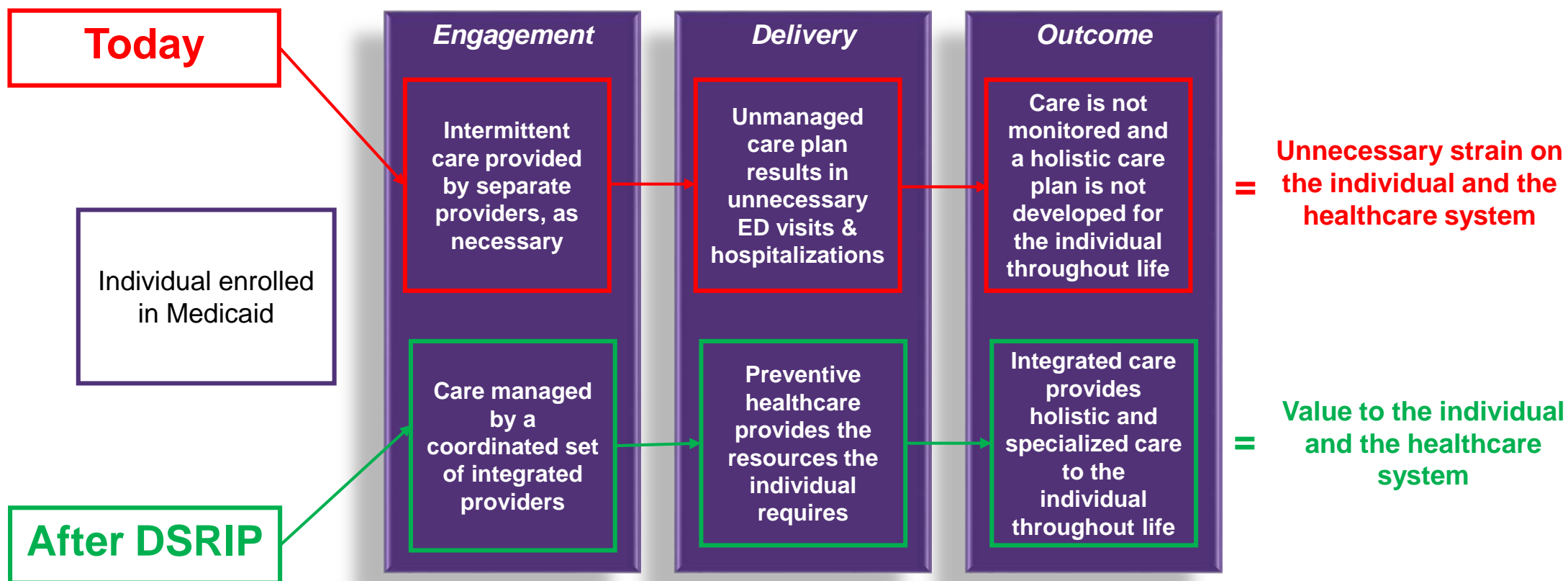
- ✓ *Hospitals*
- ✓ *HH*
- ✓ *Social Service Departments and Local Government Units*
- ✓ *BH Providers*
- ✓ *Skilled Nursing Facilities*
- ✓ *FQHCs*
- ✓ *Home Care Agencies*
- ✓ *Physicians/Practitioners*
- ✓ *Other Community-based Services*
- ✓ *Other Key Stakeholders*



Source: The New York State DSRIP Program. NYSDOH DSRIP Website.

# DSRIP Health Outcomes for Individuals

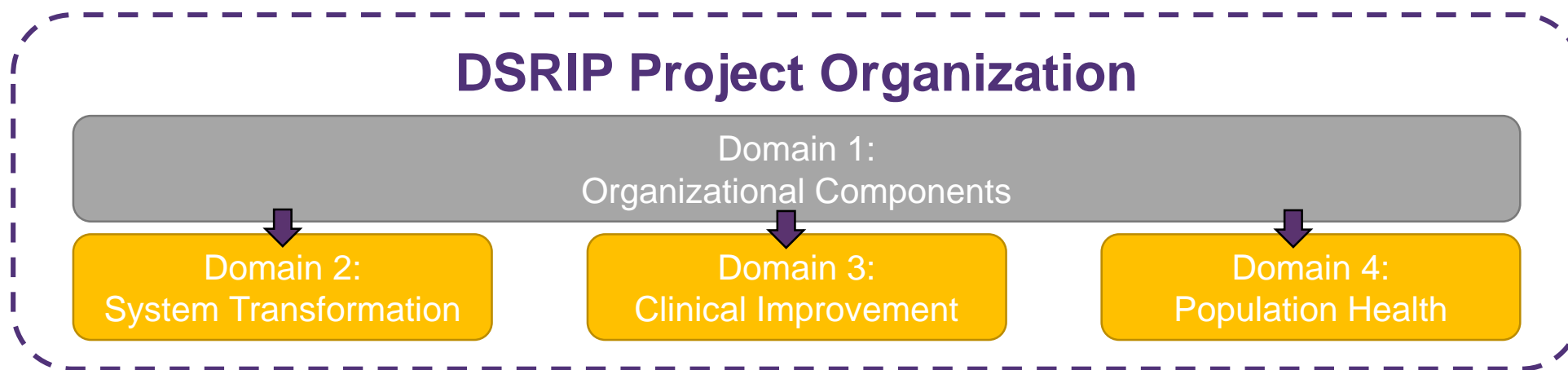
DSRIP will have a positive impact on health outcomes for individuals



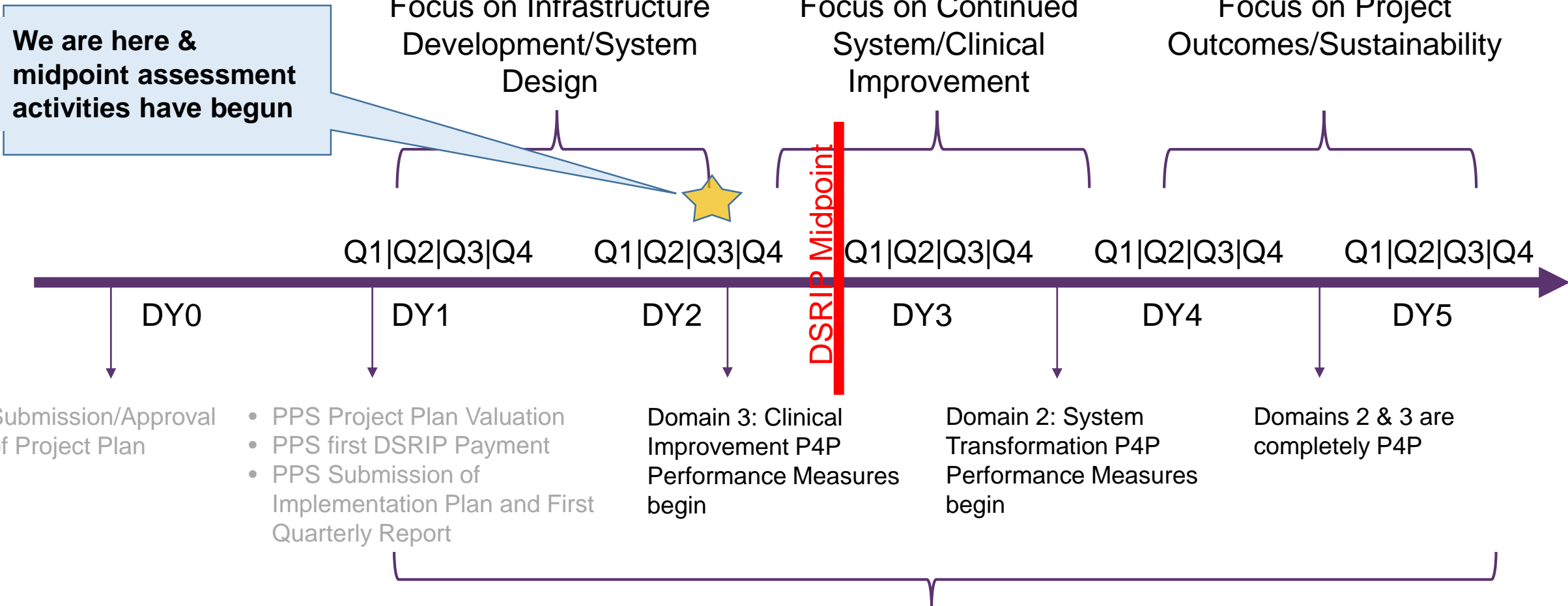


# DSRIP Implementation Through Projects

- PPSs committed to healthcare reform in their initial DSRIP applications by choosing a set of projects that best matched the needs of their unique communities
- DSRIP payment is contingent upon PPSs reporting and performing on those selected projects
- DSRIP projects are organized into three domains:



# DSRIP Implementation Timeline and Key Benchmarks



Domain 4: PPS working in collaboration with community and diverse set of service providers to address statewide public health priorities; system improvements and increased quality of care will positively impact health outcomes of total population.

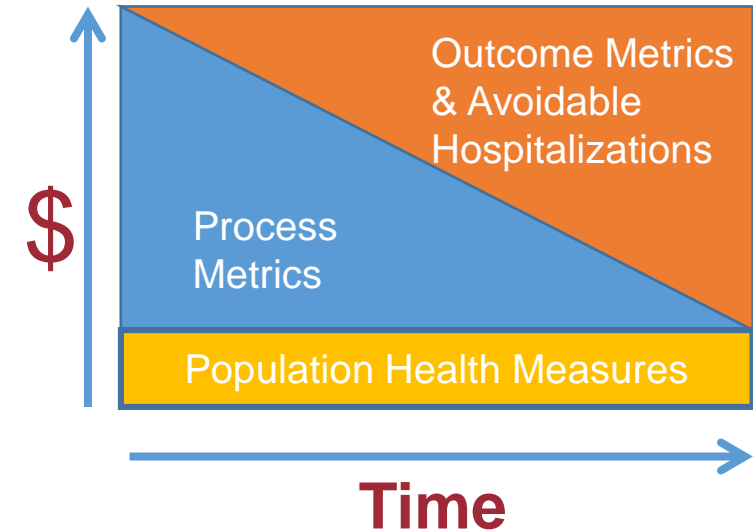
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# Implementation – Building What Wasn't There

- ***Project Implementation Start-up***
- ***New Partnerships and Business Relationships***
  - ❖ Prelude to the “value” in value-based payment paradigm.
  - ❖ Community-based providers and smaller CBOs feel challenged for VBP.
- ***Current Capacity vs. Capacity-building***
- ***Funds Flow***
- ***New Friends and Mutual Interests***
- ***Reaching into Workforce***
- ***Fact-based Optimism***

# Outcomes/Performance Measurement Approach

- Annual improvement targets a methodology of reducing the gap to the goal by 10%.
- Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.
- 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).



Project Valuation from DSRIP Program

	Fee for Service and "Pay for Reporting" (P4R)		Pay for Performance (P4P)			
	Performance Payment <sup>1</sup>	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
Project progress milestones (Domain 1)	P4R	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population Health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%
PPS Infrastructure Development	P4R	100%	85%	55%	35%	15%
Clinical Improvement and Health Outcomes	P4P	0%	15%	45%	65%	85%

## Statewide Accountability

- PPS funds received may be reduced for missed milestones statewide
  - The reduction is applied proportionately to all PPSs

# Examples of PPS Funds Flow Strategies

Project valuation is the maximum PPS is eligible to earn based on quarterly reports and performance after initial successful application award.

- Some early funds flow have been based on:
  - Attribution for particular provider categories
  - PPS engagement in planning
- Current strategies in use:
  - Contracted project implementation role and services
  - Pay for performance
  - Capacity building and business model
  - PPS RFPs for CBOs to assist in assessing value and business framework

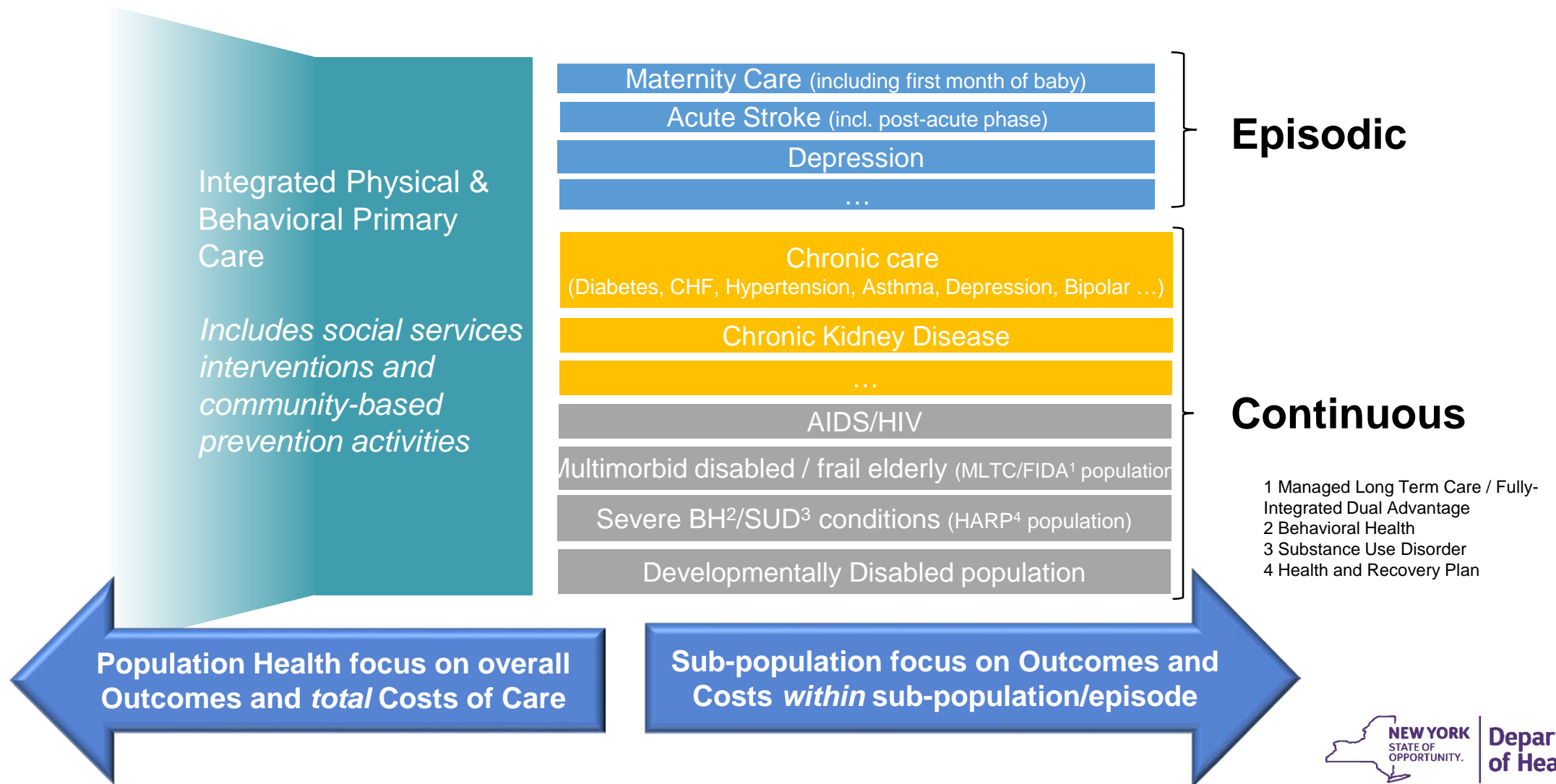
# Payment Reform: Moving Towards Value Based Payments

The Value Based Payment Roadmap outlines how New York State will achieve the goal of 80-90% value based payments by DY5

- By the end of DSRIP Year 5 (2020), all Managed Care Organizations must employ non-fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- A five-year VBP Roadmap outlining how NYS aims to achieve this goal was required by the Medicaid Redesign Team (MRT) Waiver early May
- The State and Centers for Medicare and Medicaid Services (CMS) are committed to the VBP Roadmap
- Core stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If the VBP Roadmap goals are *not* met, overall DSRIP dollars from CMS to NYS will be significantly reduced

# The VBP Roadmap and the DSRIP Vision

The VBP Roadmap starts with the DSRIP Vision on How an Integrated Delivery System should Function

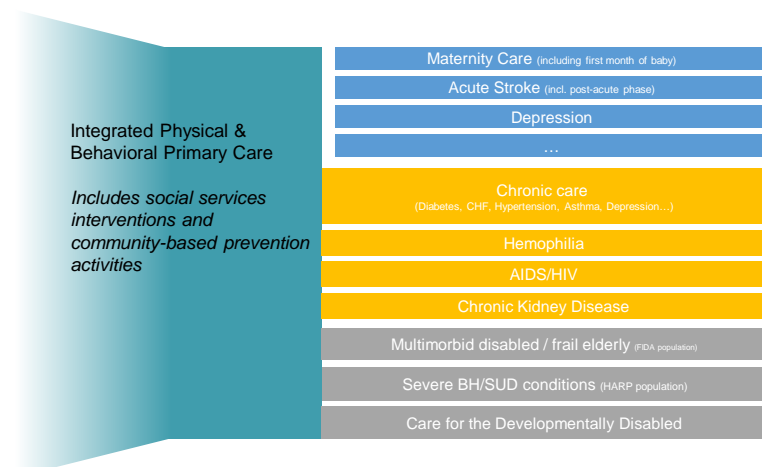


# The Path towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- *For the total care for the total attributed population of the PPS (or part thereof) – ACO model*
- *Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care*
- *For integrated Advanced Primary Care (APC)*
- *For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities*



**MCOs and PPSs may choose to make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS**



# Value Based Payments: Levels and Targets

In addition to choosing what integrated services to focus on, Managed Care Organizations (MCOs) and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
No Risk Sharing	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

- Goal of  $\geq 80-90\%$  of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of  $\geq 35\%$  of total costs captured in VBPs in Level 2 VBPs or higher

# Examples of CBO Engagement

# Bronx Partners for Health Care (SBH) PPS - CBO Engagement

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Asthma home-based services

- 15 years experience
- Community health workers
- Know the Bronx
- Speak the languages
- Strong track record



- Diabetes Self-Management Program (Stanford model)
- Lower Extremity Amputation Prevention Program (LEAP)
- Paid training for 20 coaches = individuals recruited from community
- Classes for 600-800 students from community **hot spots**

**request  
for  
proposal**

CBO-driven

- Process & Criteria
- Content & Curriculum

Community-based BH and social services targeted for funding in DY2:

- **Cultural Competency Training**
- **Critical Time Intervention**
- **Behavioral Health “Call to Action”**
- **Community Health Literacy**

# Mount Sinai PPS

## *Valuing CBO Partners to create a cohesive Delivery System*

The **Clinical Value Scorecard** – developed to identify potential contributions of organizations using industry benchmarks for their provider type.

- Using partner subject matter experts, developed survey questions under five key categories to help assess partners using industry specific benchmarks for their provider type (CBOs)
- The five “performance sections”: business model, patient perspective, efficiency measures, accreditations and designations and quality measures.
- Responses in the sections will help us objectively identify a partner’s potential contributions to the PPS

### CBO Pilot Project

- CBOs will engage in pilot projects to demonstrate the impact their services can make on DSRIP outcomes.
- This will lead to innovated means by which to contract with CBOs
- Innovative ways to integrate CBO's services into value-based payment arrangements

# Paths for CBOs to Consider

- PPS needs are for community organizations who can demonstrate how they can assist in meeting project requirements
- How can the CBO integrate into the provider team?
  - Timely and responsive communication
  - Electronic/IT interface
  - Successful working relationship
- Transition from grants to service unit model
- Become “Center of Excellence” to increase referrals for paid units of service
- Establish track record to position value as a subcontractor to a VBP contractor or an MCO

# VBP and Social Determinants

*VBP Roadmap Link:*

[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrrip/2016/2016-jun\\_annual\\_update.htm#two2d](http://www.health.ny.gov/health_care/medicaid/redesign/dsrrip/2016/2016-jun_annual_update.htm#two2d)

- VBP contractors in Level 2 or Level 3 agreements will be required, as a statewide standard, to implement at least one social determinant of health intervention.
- Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk. Providers/provider networks/MCOs may also contract with community based organizations to satisfy this recommendation. Contracted CBOs should expect the inclusion of a value based component in the contract, such as pay for performance, and be held to performance measure standards.
- Many CBOs have years of experience improving SDH. The CBO should work with the providers/provider networks and MCOs to deliver interventions that support SDH and advance DSRIP goals.

# Value Based Payment Roadmap CBO Categories

- Tier 1 – Non-profit, non-Medicaid billing, community based social and human service organizations (e.g. housing, social services, religious organizations, food banks).
- Tier 2 – Non-profit, Medicaid billing, non-clinical service providers (e.g. transportation, care coordination).
- Tier 3 – Non-profit, Medicaid billing, clinical and clinical support service providers (licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services).
- Starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO

**Questions?**

**Thank You!**

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