New York State Delivery System Reform Incentive Payment (DSRIP) Program Update

Promoting Health, Overcoming Disparities

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Agenda

• What is DSRIP? A Quick Recap
• A Path Towards Value Based Payments (VBP)
• Behavioral Health & Substance Use Initiatives within DSRIP
• DSRIP Today and Looking Ahead
Statewide Summary of Behavioral Health Members

A disproportionate amount of annual total cost of care and hospital care in New York State can be attributed to the Behavioral Health population.

Overview:

- Medicaid members diagnosed with BH account for 20.9% of the overall population in New York State
- The average length of stay (LOS) per admission for Behavioral Health users is 129.8% of the overall population's LOS
- Per Member Per Month (PMPM) for Medicaid Members diagnosed with BH is 259.9% of overall average.

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**Medicaid members diagnosed with BH account for 32% of PCP visits**

- Total population: 17,238,730
- Medicaid members diagnosed with BH: 11,729,701
- Total cost: $48,048,379,392
- Per Member Per Month (PMPM) for Medicaid Members diagnosed with BH: $28,824,105,821

**Medicaid members diagnosed with BH account for 45.1% of all ED Visits**

- Total ED visits: 3,139,985
- Medicaid members diagnosed with BH: 1,415,454
- Total cost: $28,824,105,821

**Medicaid members diagnosed with BH account for 60% of the total cost of care in New York State**

**Medicaid members diagnosed with BH account for 53.5% of admissions**

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* Preliminary Data not for publication…being verified. This data includes Members with 1+ Claims with primary or secondary diagnosis of behavioral health issues.
What is DSRIP? A Quick Recap
DSRIP Explained

Goal:
Reduce avoidable hospital use – ED and Inpatient – by 25% over the 5 years of DSRIP

- Remove Silos
- Develop Integrated Delivery Systems
- Enhance Primary Care and Community-based Services
- Integrate Behavioral Health and Primary Care

• Built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health
  - Reducing costs

• DSRIP has specific behavioral health focused projects

• The holistic and integrated approach to healthcare transformation provides a template for integration of behavioral health initiatives into primary care plans
# DSRIP Program Principles

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Patient-Centered</td>
<td>Improving patient care &amp; experience through a more efficient, patient-centered and coordinated system</td>
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<tr>
<td>Transparent</td>
<td>Decision making process takes place in the public eye and that processes are clear and aligned across providers</td>
</tr>
<tr>
<td>Collaborative</td>
<td>Collaborative process reflects the needs of the communities and inputs of stakeholders</td>
</tr>
<tr>
<td>Accountable</td>
<td>Providers are held to common performance standards, deliverables and timelines</td>
</tr>
<tr>
<td>Value Driven</td>
<td>Focus on increasing value to patients, community, payers and other stakeholders</td>
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**Better care, less cost**
25 Performing Provider Systems are Receiving Funding to Drive Change

- Performing Provider Systems (PPSs) are a network of providers that collaborate to implement DSRIP projects
- Each PPS must include providers to form an entire continuum of care
  - Hospitals
  - Health Homes
  - Skilled Nursing Facilities (SNFs)
  - Clinics & Federally Qualified Health Centers (FQHCs)
  - Behavioral Health Providers
  - Home Care Agencies
  - Other Key Stakeholders

- Assessing community health care needs based on multi-stakeholder input and objective data
- Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies
- Meeting and Reporting on DSRIP Project Plan process and outcome milestones
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 selected Projects.
- DSRIP Projects are organized into Domains, with Domain 1 focused on overall PPS organization and Domains 2 – 4 focusing on various areas of transformation.
Projects with Greatest Impact on Behavioral Health

- PPSs undergo healthcare transformation throughout their networks by choosing from a set of DSRIP Projects, each of which has a specific focus.
- Many of these projects are highly applicable to the Behavioral Health & Substance Use populations:

3.a.i: Integration of primary care services and behavioral health

3.a.ii: Behavioral health community crisis stabilization services

3.a.iii: Implementation of evidence-based medication adherence program in community-based sites for behavioral health medication compliance

3.a.iv: Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs

3.a.v: Behavioral interventions paradigm (BIP) in nursing homes

4.a.i: Promote mental, emotional, and behavioral well-being in communities

4.a.ii: Prevent substance abuse and other mental emotional behavioral disorders

4.a.iii: Strengthen mental health and substance abuse infrastructure across systems
A Path Towards Value Based Payments (VBP)
By DSRIP Year 5 (2019), all Managed Care Organizations must employ value based payment systems that reward value over volume for at least 80 – 90% of their provider payments.

If VBP goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced.
Learning from Earlier Attempts: VBP as the Path to a Stronger System

• VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins by realizing value

**Current State**
Increasing the value of care delivered more often than not threatens providers’ margins

**Future State**
When VBP is done, providers’ margins go up when the value of care delivered increases

**Goal – Pay for Value not Volume**
The Path Towards Payment Reform: Multiple Approaches

- On the path towards Value Based Payments, there are a variety of options that MCOs, PPSs and Providers can jointly choose from

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

<table>
<thead>
<tr>
<th>Total Care for Total Population</th>
<th>Integrated Primary Care (IPC)</th>
<th>Bundles (Acute and Chronic)</th>
<th>Total Cost of Care for Subpopulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO contracts an arrangement with the entity (e.g. an ACO) and considers a virtual per-member-per-month (PMPM) expenditure for the total attributed population and overall outcomes of care</td>
<td>The MCO contracts Integrated Primary Care to reimburse based on savings and quality outcomes achieved</td>
<td>Costs are bundled into a single, total cost for the episode, as a virtual budget for providers for the set of services involved in treating a patient’s health event, over a specified period of time.</td>
<td>The MCO contracts an arrangement that considers a virtual per-member-per-month (PMPM) expenditure for a specific special needs subpopulation</td>
</tr>
</tbody>
</table>

Behavioral Health Examples: Bipolar Disorder, Depression & Anxiety, Trauma & Stressor, Substance Use Disorder, HARP Subpopulation
The VBP Roadmap

• To ensure long-term sustainability of the improvements made possible by DSRIP investments in the waiver, the Terms and Conditions (sec. 39) required the State to submit a multiyear Roadmap for comprehensive Medicaid payment reform.

• The VBP Roadmap serves as the framework for how MCOs can enter into VBP arrangements with providers.
Different Levels of VBP

In addition to choosing *what integrated services* to focus on, MCOs and PPSs can choose different levels of Value Based Payments:

<table>
<thead>
<tr>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
</tbody>
</table>

- Goal of ≥ 80 to 90% of total MCO → provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to level 2 or higher
Integrated Services in the VBP Roadmap

• The VBP Roadmap encompasses three different types of integrated care services that are designed to function cohesively, covering the spectrum of patient care needs, including behavioral health and substance use providers:

  • **Integrated Primary Care (IPC) Services:** Care that aims to act as the primary source of care for the majority of everyday care needs
    - This type of care includes behavioral healthcare, amongst other types of care

  • **Episodic Care (EC) Services:** Specialized services for specific health problems or conditions

  • **Specialized Continuous Care (SCC) Services:** Care for those who require ongoing specialized care services
What VBP means for Behavioral Health Providers

• Once DSRIP concludes in 2020, Behavioral Health practices will still revolve around meeting performance measures, as defined by VBP contracting

• Examples of DSRIP measures that may carry over into VBP contracts for behavioral health in the post-DSRIP world are:
  - Diabetes Monitoring for People With Diabetes and Schizophrenia
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
  - Potentially preventable ED visits (PPV) (for persons with BH diagnosis)
  - Potentially preventable readmissions (PPR) for SNF patients
  - Antidepressant Medication Management
  - Follow-Up After Hospitalization for Mental Illness within 7 (or 30) Days
  - Screening for Clinical Depression
  - Adherence to Antipsychotic Medications for Individuals With Schizophrenia
  - Percent of Long Stay Residents who have Depressive Symptoms
What VBP Means for Behavioral Health Providers – Example

• Once NYS Medicaid has transitioned to VBP through DSRIP, much of behavioral health care will paid through VBP contracting, in the form of bundled payments

All patient services related to a single illness

Sum of group services (based on encounter data the State receives from MCOs)

<table>
<thead>
<tr>
<th>Bipolar Disorder Bundle</th>
<th>Trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Inpatient claim with bipolar disorder as principal diagnosis OR • Outpatient or professional billing claim with E&amp;M (evaluation and management) service and bipolar disorder as diagnosis</td>
</tr>
<tr>
<td><strong>Confirming trigger</strong></td>
<td>• Another trigger as stated above at least 30 days after the first trigger</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Included in bundle:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All typical and complication costs for bipolar disorder during the duration of the bundle</td>
</tr>
<tr>
<td>• Complications may include, but are not limited to:</td>
</tr>
<tr>
<td>- Suicide or self inflicted injury</td>
</tr>
<tr>
<td>- overdose, poisoning - wrong drug</td>
</tr>
<tr>
<td>- accidental falls</td>
</tr>
<tr>
<td>- decubitus ulcer</td>
</tr>
</tbody>
</table>
Behavioral Health & Substance Use Initiatives within DSRIP
Medicaid Accelerated eXchange (MAX) Series

Designed based on leading practices, expertise, and experience, the MAX Series Program operates at the core of DSRIP

- **Interdisciplinary** and **multi-provider teams** of **front line clinicians** come together to redesign the way care is delivered

- **Data** is used for problem identification, monitoring and performance measurement

- In **Rapid Improvement Cycles**, teams drive results to truly impact the lives of Medicaid Members
# MAX Series Topics

The MAX Series Program currently holds workshops on Meeting Complex Patient Needs and Integrated Services

<table>
<thead>
<tr>
<th>Meeting Complex Patient Needs</th>
<th>Integrating Behavioral Health and Primary Care Services</th>
<th>Meeting Complex Patient Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce avoidable hospital use by 25% over 5 years (better care, better health, lower costs)</td>
<td>Care system redesign to better meet complex and high-cost patient needs</td>
<td>Care system redesign to better meet complex and high-cost patient needs</td>
</tr>
<tr>
<td>Care system redesign to better meet complex and high-cost patient needs</td>
<td>Ensure care coordination to improve outcomes for patients with behavioral health diagnoses</td>
<td>Launched October 22, 2015</td>
</tr>
<tr>
<td>Launched February 25, 2016</td>
<td>Launched March 24, 2016</td>
<td></td>
</tr>
</tbody>
</table>

**Phase 1: Assessment and Preparation**

**Phase 2: Workshops and Action Periods**

**Phase 3: Reporting**

[Logo: New York State Department of Health]
MAX Series in Action

Topic 1 Action Teams, who met in their first workshop, reported on early outcomes of their Action Plans, directly impacting the Behavioral Health population and services provided

**Quality Improved**
For example…
Reduction in readmission rate and increase in outpatient compliance

**Time Saved**
For example…
Time equal to 0.5 FTE saved through having access to each other’s EHR systems

**Money Saved**
For example…
$589K projected savings annually (by preventing 2,190 visits)

**Patient Stories:**

One of our patients is a 21 year old male with a medical history of mental illness and a metabolic disorder. He has been homeless for approximately three years. In 2015 this patient had 82 ED visits; these visits accounted for $68K.

We recently cared for a complex patient (over 22 hospitalizations since January 2014) who was admitted to our hospital. The patient was in denial of their HIV diagnosis.

The CBO organization was contacted and a bed was assigned for this individual. A housing application has been started, Health Home enrollment has been initiated, and his medications have been filled. He has not been back to the ED since.

The patient is now connected to a Health Home Care Coordinator in the community and will be followed up with in the community, this includes transportation to follow up care if needed. This service will address anything the patient needs including HIV care, mental health, housing, financial support etc.
MAX Series Case Study

MAX Action Teams are changing the trajectory of Medicaid members’ lives

**Quality improved** – John had 82 ED visits and 2 inpatient admissions over an 11 month period. Because he was identified as a Complex Patient in the MAX Series, the Action Team has been able to connect him with a settlement house based in the Bronx. He has not been back to the ED as of January 20, 2016.

**Time saved** – Three provider shifts are projected to be saved over the course of the year. The ~90 ED visits diverted is equivalent to 36 provider hours

**Dollars saved** – The total charges were > $68,000
Key Challenges Leading to the Need for Behavioral Health System Transformation

- Large system with a wide range of provider services and expertise
- Heavy reliance on FFS payment methodology that incentivizes volume
- Lack of accountability for high-need patients
- Few incentives to support BH/PH integration
- Barriers to information sharing within health and social services systems (managed care organizations, criminal and juvenile justice, homeless, systems)
- Lack of follow-up care following discharge from inpatient admissions
- High re-admission rates for MH and SUD populations
Key Values for Transforming the Behavioral Health System

- Person-Centered
- Recovery-Oriented
- Integrated
- Data-Driven
- Evidence-Based
Health Homes
Health Homes: An Integral Component of DSRIP

The majority of Medicaid members at highest risk for avoidable hospital use are those persons eligible for Health Home care management.

59% of hospital readmissions in NYS are related to chronic medical conditions in persons with a Substance Use Disorder or Chronic Mental Health Diagnosis.

Transforming the system will require the care management in Health Homes combined with a redesign of the health care delivery system to ensure access to primary and preventive healthcare services and to support social services.
Many Health Homes are Already Affiliated with PPSs

- Performing Provider Systems cannot implement the changes required in DSRIP without including the care management of Health Homes.
- A number of DSRIP projects in Domain 2, System Transformation, require inclusion of Health Homes as part of the transformation.
- Project 2.a.i, Create Integrated Delivery System (IDS) specifically encourages Health Homes to consider evolving into IDS, in concert with other providers.

Over 30 Health Homes are currently affiliated with DSRIP PPSs throughout the State of New York.
DSRIP Today and Looking Ahead
DSRIP Today

• DSRIP Year 1 is in the books!
  ➢ PPSs will submit their Fourth Quarterly Reports (1/1/16 – 3/31/16) on April 30th

DSRIP PPSs continue to make great progress in transforming the New York State Healthcare System
DSRIP Today – The Achievements

- **119,226** providers affiliated with DSRIP across the **25** PPSs, spanning from hospitals to behavioral health clinics to community based organizations

- **5,283,175** Medicaid members attributed to the PPSs, enabling them to take part in the transformative effects of DSRIP on NYS healthcare

- **All** DSRIP applications approved by the Independent Assessor, enabling the PPS to begin project implementation as of **March 13, 2015**
DSRIP Today – The Achievements (cont.)

• First payments made to PPSs for successful application submission on April 23, 2015, totaling $866,738,947

• PPSs submitted their first Quarterly Reports on October 31, 2015, reporting on their progress towards patient and provider engagement in their DSRIP projects. Second Quarterly reports received final approval on December 30, 2015

• Following second Quarterly Report submission, PPSs earned $165,965,413 out of a possible $168,387,230 (98.5%) in DSRIP waiver funds for the period
DSRIP Today – The Challenges

- Coordinating a massive healthcare transformation made up of 25 PPSs with overlapping geographies to ensure all Medicaid members are in a position to benefit from DSRIP

- Managing the funding mechanism needed to move more than $10 billion to providers in return for performance against the backdrop of a Fee-for-Service system in need of reform

- Ensuring that each PPS and provider, from the leading-practice hospitals to the financially fragile clinics, are given the right level of support to enable them and their patients to get the most out of DSRIP
Expanding Health Homes to Serve Children

- New York State is continuing its work to implement the Health Home Model for Children
  - September 2016 enrollment date will provide more time for 16 Contingently Designated Health Homes to complete readiness activities
- The Children’s Health Home Design and the Children’s Health and Behavioral Health MRT Initiatives make Health Homes and their network ideally positioned to provide value to DSRIP projects and meeting overall State goals
  - Expanded Health Home Eligibility criteria, which includes SED, Complex Trauma, expanded array of State Plan services and HCBS services will provide new tools to improve health outcomes of children and meet objectives of MRT initiatives for children

Vision and Goals of Medicaid Redesign for Children:
- Keep children on their developmental trajectory
- Focus on recovery and building resilience
- Identify needs early and intervene
- Maintain child at home with support and services
- Maintain the child in the community in least restrictive settings
- Provide the right services, at the right time, in the right amount
- Prevent escalation and longer term need for higher end services
Budget Update

- Cost sharing limits to Medicare Part C claims
  - Medicaid payment will now equal 85% of what Part C allowed minus what Part C paid
- Delay the School Based Health Center carve-in until July 1, 2017 and carve out family planning services
- Claim an additional 1% FMAP for U.S. Preventive Services Task Force (USPSTF) A and B recommended services
- Carve Long Acting Reversible Contraception (LARC) out of the PPS rate paid to FQHCs and require Medicaid Managed Care Plans to make a separate payment for post-partum LARC
  - Aligns with current FFS Medicaid policy
- 25-50% increase in the disallowance for early elective deliveries without medical indication
- Continue to work with the Medicaid Evidence Based Benefit Review Advisory Committee to conduct a thorough examination of the current list of covered benefits in the Medicaid program and develop a list of savings proposals to improve health care quality and lower costs
Budget Update (cont.)

• Authorized to seek a waiver to provide Medicaid services to inmates in state facilities 30 days prior to release

• Authority to provide $5 million lump sum payments to Health Home pilots currently providing transitional assistance services for individuals released from the criminal justice system and eligible for Medicaid reimbursable health and supportive services

• Ability to work with Health Homes (HH) for Children to identify and address start-up costs for implementing HH for Children within the available global cap resources for the program
  ➢ Continue the Behavioral Health Transformation Initiatives started in 2014-15 with investments in Behavioral Health infrastructure and funding to transition to Managed Care
  ➢ Implementation of HARPs for adults (October 1, 2015 for NYC and July 1, 2016 statewide)
  ➢ Children’s state plan services (scheduled start date of January 1, 2017)
  ➢ Integration of Behavioral Health services for children into mainstream Managed Care plans (scheduled start date of January 1, 2017 for NYC/Long Island and July 1, 2017 statewide)
Questions?

DSRIP Email:
dsrip@health.ny.gov
Appendix A: DSRIP Further Explained
Medicaid Redesign Team (MRT) Waiver Amendment

• In April 2014, Governor Andrew M. Cuomo announced a finalized agreement in the MRT Waiver Amendment between New York State and CMS

• Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms

• $6.4 billion designated for the Deliver System Reform Incentive Payment Program (DSRIP)

• The MRT Waiver Amendment will:

  1. Transform the State’s Health Care System
  2. Bend the Medicaid Cost Curve
  3. Assure Access to Quality Care for all Medicaid Members
Locations of 25 PPSs

Key
- Public Hospital –led PPS
- Safety Net (Non-Public) –led PPS
DSRIP Domain 2 – System Transformation

• Projects in this domain focus on system transformation and have four subcategories
  ➢ Creating an integrated delivery system
  ➢ Implementation of care coordination and transitional care programs
  ➢ Connecting settings
  ➢ Utilizing patient activation to expand access to community based care for special populations

• All PPSs selected at least two projects (and up to four projects) from Domain 2

• Metrics include avoidable hospitalizations and other measures of system transformation
DSRIP Domain 3 – Clinical Improvement

- Projects in this domain focus on clinical improvement for certain priority disease categories
- Disease categories include **behavioral health**, asthma, diabetes, and cardiovascular health
- All PPSs selected at least two projects (and up to four projects) from Domain 3
- Metrics include disease-focused, nationally recognized and validated metrics, generally from HEDIS
DSRIP Domain 4 – Population-wide Projects

• Projects in this domain focus on priorities in the State’s Prevention Agenda with health care delivery sector projects designed to influence population-wide health

• Project categories include **behavioral and emotional health, substance abuse**, chronic disease prevention, HIV & STDs, and maternal health

• All PPSs selected at least one project (and up to two projects) from Domain 4

• Metrics will be based on public health measures
## Looking Ahead – DSRIP Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>April 30</td>
<td>Final PPS Year 1 Third Quarterly Reports posted to DSRIP website</td>
</tr>
<tr>
<td>May 3</td>
<td>PPS Regional Learning Symposium (Downstate)</td>
</tr>
<tr>
<td>May 4</td>
<td>1115 Waiver Public Comment Day (Downstate)</td>
</tr>
<tr>
<td>May 17</td>
<td>PPS Regional Learning Symposium (Upstate)</td>
</tr>
<tr>
<td>May 31</td>
<td>Independent Assessor provides feedback to PPS on PPS Year 1 Fourth Quarterly Reports; 15-day Remediation window begins</td>
</tr>
<tr>
<td>June 10</td>
<td>1115 Waiver Public Comment Day (Upstate)</td>
</tr>
<tr>
<td>June 14</td>
<td>Revised PPS Year 1 Fourth Quarterly Reports due from PPS; 15-day Remediation window closes</td>
</tr>
<tr>
<td>June 29</td>
<td>Final Approval of PPS Year 1 Fourth Quarterly Reports</td>
</tr>
<tr>
<td>July</td>
<td>Implementation of Phase II MAPP Performance Dashboards</td>
</tr>
<tr>
<td>July 6</td>
<td>Final PPS Year 1 Fourth Quarterly Reports posted to DSRIP Website</td>
</tr>
<tr>
<td>July 31</td>
<td>PPS Year 2 First Quarterly Reports (4/1/16 – 6/30/16) due from PPS</td>
</tr>
<tr>
<td>Late July</td>
<td>DY1 Third DSRIP Payment to PPS</td>
</tr>
<tr>
<td>Early August</td>
<td>Initiate Mid-Point Assessment for PPS</td>
</tr>
</tbody>
</table>
Appendix B: Children’s Health and DSRIP
Children’s Health Prioritized within DSRIP

• To ensure alignment with DSRIP objectives, integrated care services selected within the DSRIP program are prioritized by the VBP Roadmap.
• The following prioritizations are particularly relevant to children’s healthcare:

  Behavioral Health
  Maternity Care
  Asthma
DSRIP Projects with the Greatest Impact on Children

• PPSs undergo healthcare transformation throughout their networks by choosing from a set of DSRIP Projects, each of which has a specific focus.

• Many of these are highly applicable to Children’s Health:
  - 3.a.i: Integration of primary care services and behavioral health
  - 3.a.ii: Behavioral health community crisis stabilization services
  - 3.d.ii: Expansion of asthma home-based self-management programs
  - 3.d.iii: Evidence based medicine guidelines for asthma treatment
  - 3.f.i: Increase support programs for maternal & child health
  - 4.a.i: Promote mental, emotional, and behavioral well-being in communities
  - 4.a.iii: Strengthen mental health and substance abuse infrastructure across systems
  - 4.d.i: Reduce premature births
DSRIP Health Outcomes for Children

• DSRIP’s healthcare transformation will likely have the greatest effect on children in Medicaid, as avoiding poor health outcomes throughout childhood will lead to a lifetime of stronger health outcomes.

• The move from hospital-based care to home & community-based care is set to have a marked effect on this population by avoiding unnecessary hospitalizations and ER visits throughout childhood and into adulthood.

• Unnecessary hospitalizations will be reduced by DSRIP programs that emphasize proactive management of high risk children through early detection.

• The progression from health care and behavioral health silos to integrated delivery systems will give children access to a higher performing continuum of care and integrated behavioral health benefits within their respective PPS networks.
DSRIP Health Outcomes for Children

**Today**

- Child in Medicaid with a chronic health condition
- Intermittent care provided by separate providers, as necessary
- Care managed by a coordinated set of integrated providers

**Engagement**

**Delivery**

- Preventive healthcare provides the resources the child requires
- Unnecessary ER visits & hospitalizations in childhood

**Outcome**

- Integrated care follows through adolescence into adulthood
- Unnecessary ER visits & hospitalizations throughout adulthood

Unnecessary strain on the child, the family, and the healthcare system

Value to the child, the family, and the healthcare system

**After DSRIP**
Behavioral Health Managed Care Transition
BH Managed Care NYC Role Out: Lessons Learned

• Make sure to claims test with each MCO
• Understand your relationship with 3rd party billing vendors and clearinghouses
• Be aware of issues related to billing PROS with CERNER/Anazasi
• Pay close attention to contracting and credentialing
• Build a robust communication process with Providers, Plans and State
• Ensure your agency is connected to larger networks in preparation for VBP
• Know where your voice can be heard – RPC meetings, MCO/Provider/State meetings, Medical Directors meeting, OMH/OASAS/DOH mailboxes
NYC Claims Information as of 4/4

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Total Claims</th>
<th>Total Pending Claims</th>
<th>Total Paid Claims</th>
<th>Total Denied Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 1</td>
<td>184,974</td>
<td>0%</td>
<td>82%</td>
<td>17%</td>
</tr>
<tr>
<td>Plan 2</td>
<td>158,149</td>
<td>1%</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>Plan 3</td>
<td>79,341</td>
<td>0%</td>
<td>90%</td>
<td>10%</td>
</tr>
<tr>
<td>Plan 4</td>
<td>79,733</td>
<td>6%</td>
<td>75%</td>
<td>20%</td>
</tr>
<tr>
<td>Plan 5</td>
<td>438,248</td>
<td>0%</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>Plan 6</td>
<td>950,029</td>
<td>1%</td>
<td>87%</td>
<td>12%</td>
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<tr>
<td>Plan 7</td>
<td>650,595</td>
<td>0%</td>
<td>82%</td>
<td>18%</td>
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<td>Plan 8</td>
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<td>73%</td>
<td>21%</td>
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<td>Plan 9</td>
<td>12,221</td>
<td>2%</td>
<td>80%</td>
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<td>Plan 10</td>
<td>19,222</td>
<td>18%</td>
<td>50%</td>
<td>32%</td>
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<tr>
<td>Total (10/01/2015-03/28/2016)</td>
<td>2,659,693</td>
<td>0.9%</td>
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<td>Last Report (10/01/2015-03/14/2016)</td>
<td>2,401,983</td>
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<td>84.3%</td>
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Monitoring and Oversight Reports

Early reports to identify systemic issues:

- ✓ Claims and Encounter Status (Real-time MCO reported)
- ✓ Denials of Care (Administrative and Medical Necessity)
- ✓ Complaints Tracking
- ✓ Network adequacy
Rest of State Implementation: Onsite Readiness Review Update

• March-May: Onsite Readiness Reviews complete for HARP and Mainstream Plans

• April: Statement of Agreements distributed to HARP Plans

• May: 1) Responses to deliverables outlined in the Statement of Agreement are due

2) 1st round of HARP Notification Letters are sent to Members

• May-June: RPC Kick Off meetings
# New York City and Rest of State Plan Designation Status

<table>
<thead>
<tr>
<th>Region</th>
<th>Plan Name</th>
<th>Designation Status</th>
<th>BHO</th>
</tr>
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<tbody>
<tr>
<td>NYC Only</td>
<td>AmidaCare Inc</td>
<td>HIV-SNP</td>
<td>Beacon</td>
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<tr>
<td>MetroPlus</td>
<td>HARP</td>
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<tr>
<td>VNS Choice</td>
<td>Select Health SNP</td>
<td>HIV-SNP</td>
<td>Beacon</td>
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<tr>
<td>Affinity Health</td>
<td>Plan Inc</td>
<td>Conditional HARP</td>
<td>Beacon</td>
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<tr>
<td>Empire Blue</td>
<td>Cross Blue Shield HealthPlus (Formerly</td>
<td>HARP</td>
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<tr>
<td>HealthPlus</td>
<td>Amerigroup)</td>
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<td>Health Insurance</td>
<td>Plan of Greater New York (Emblem)</td>
<td>HARP</td>
<td>Beacon</td>
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<td>HealthFirst</td>
<td>PHSP Inc</td>
<td>HARP</td>
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<td>NYS Catholic</td>
<td>Health Plan Inc (Fidelis)</td>
<td>HARP</td>
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<tr>
<td>United Healthcare</td>
<td>Of NY Inc.</td>
<td>HARP</td>
<td>Optum</td>
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<td>WellCare Of</td>
<td>New York</td>
<td>Mainstream</td>
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<td>Capital District</td>
<td>Physicians Health Plan</td>
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</table>
Jumpstarting Adult BH Home and Community Based Services

- Expedited Plan Of Care (POC) workflow
- Examining Adult BH HCBS rates/Incentive payments for assessments to consumers
- Tracking HCBS provider readiness to receive referrals
- Training, Training, and more Training
SUD System Transformation

Move to better integration with the following:

• Provide services (including peer services) from clinic settings within the community.

• Use LOCADTR across the system to provide an organizing framework for clinical pathways through SUD care.

• Improve access to Medication Assisted Treatment across all levels of care.

• Re-design residential care to meet individual resident needs – move away from fitting individuals to programs that are defined by length of stay or completion of phases.

• Implement Standards of SUD treatment and Scope of Practice Guidelines to support consistent quality.

• In partnership – managed care and providers to develop and test performance metrics.
Completed LOCADTR Reports (100,050)

<table>
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<tr>
<th>Program service type</th>
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<td>Managed Care Plan</td>
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<td>Inpatient Rehabilitation</td>
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<td>Detoxification Unit</td>
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<tr>
<td>Central Intake Unit</td>
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<tr>
<td>Opioid Treatment Program (OTP)</td>
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<td>Residential Program</td>
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<td>Outpatient Clinic</td>
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<td>Other</td>
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<td>Not Applicable</td>
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