Department of Health | Office of Health Insurance Programs

A Path Forward: The Move to DSRIP, VBP, and Behavioral Health Integration

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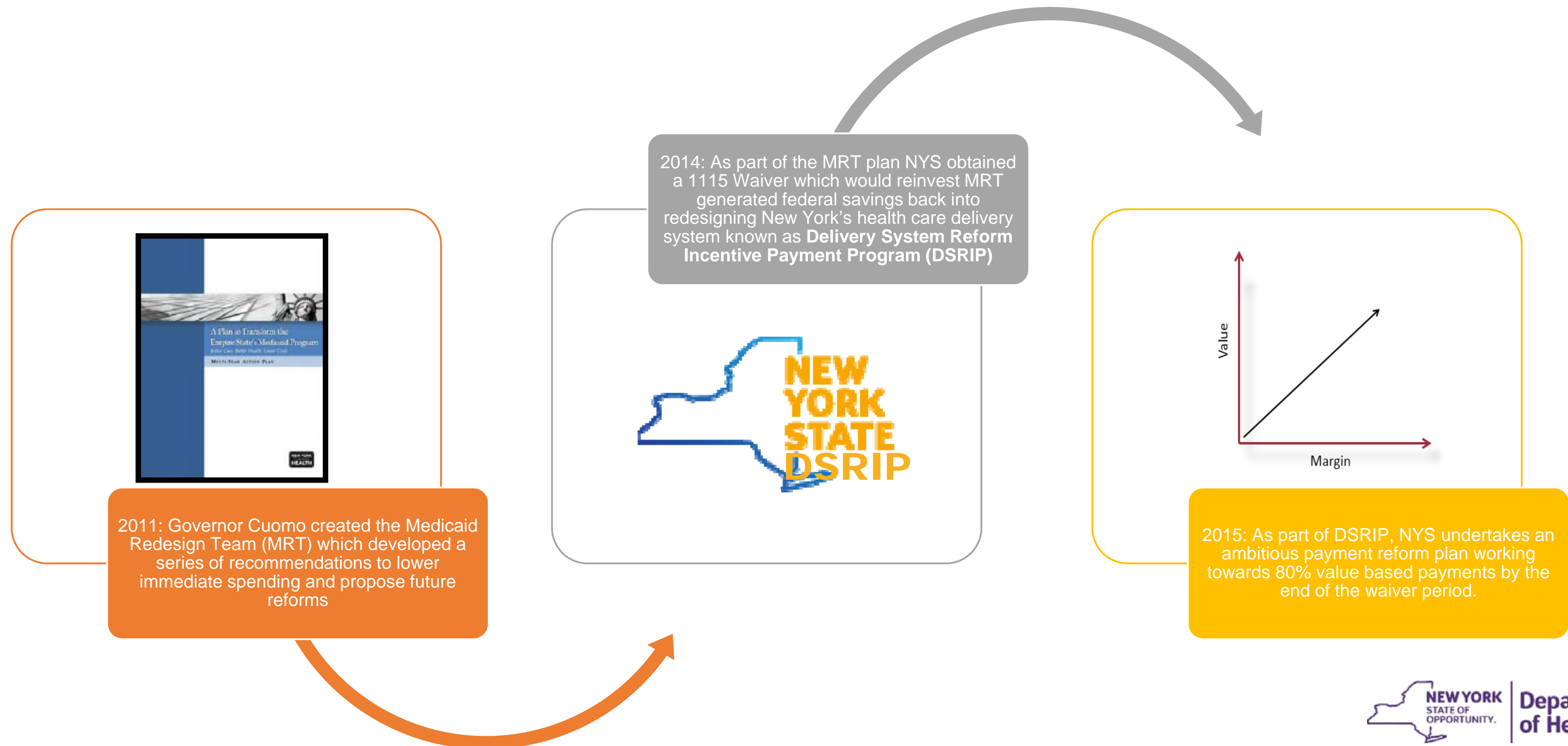
Overview

- Medicaid Redesign
- DSRIP: A Transformed Health System
- The Move to Value Based Payment
- Behavioral Health and System Transformation
- HARP and Health Homes Update
- The Future State of Health Care

New York State Medicaid Transformation



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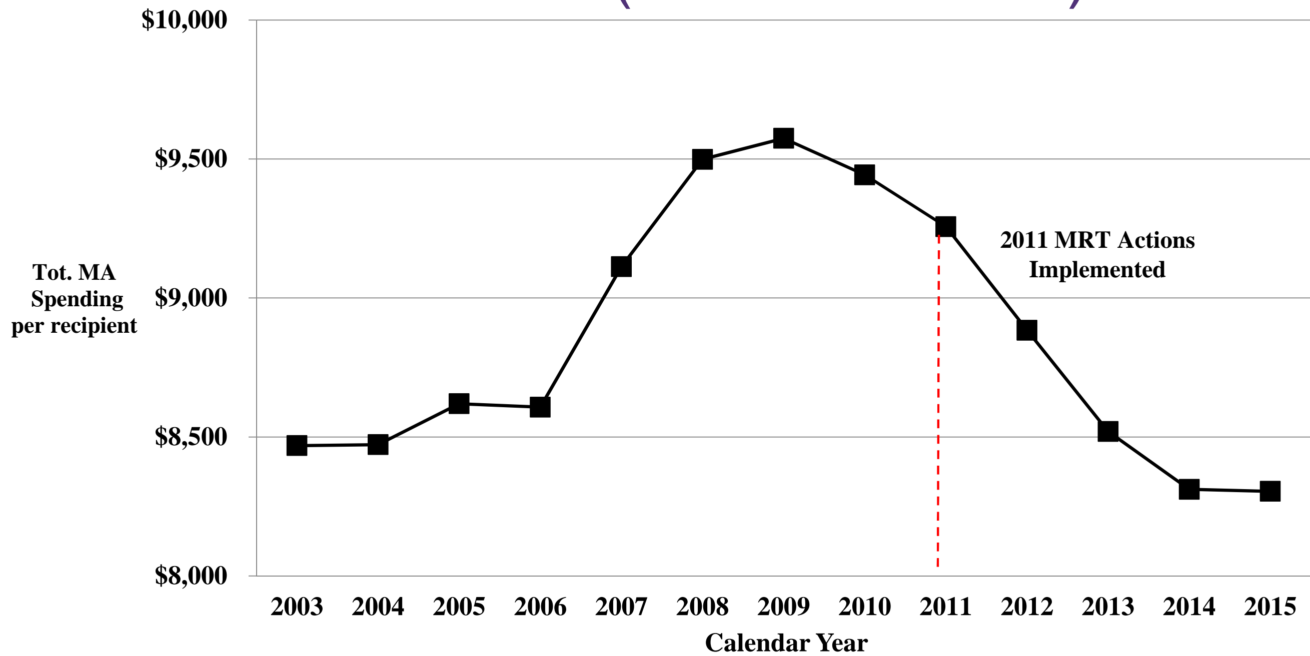
Key Components of MRT Reforms

- **Global Spending Cap**
  - Introduced fiscal discipline, transparency and accountability
  - Limit total NYS Medicaid spending growth to 10 year average rate for the long-term medical component of the Consumer Price Index (currently estimated at 3.6 percent).
- **Care Management for All**
  - NYS Medicaid was still largely fee for service; moving Medicaid members to managed care helped contain cost growth and introduced core principles of care management
- **Patient Centered Medical Homes and Health Homes**
  - Stimulating PCMH development and invest in care coordination for high-risk and high-cost patients through the NYS Health Homes Program
- **Targeting the Social Determinants of Health**
  - Address issues such as housing and health disparities through innovative strategies (e.g. promoting member incentives and contracting with community based organizations).

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



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
# of Recipients	4,267,573	4,594,667	4,733,617	4,730,167	4,622,782	4,657,242	4,911,408	5,212,444	5,398,722	5,598,237	5,805,282	6,327,708	6,7,00,524
Cost per Recipient	$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)

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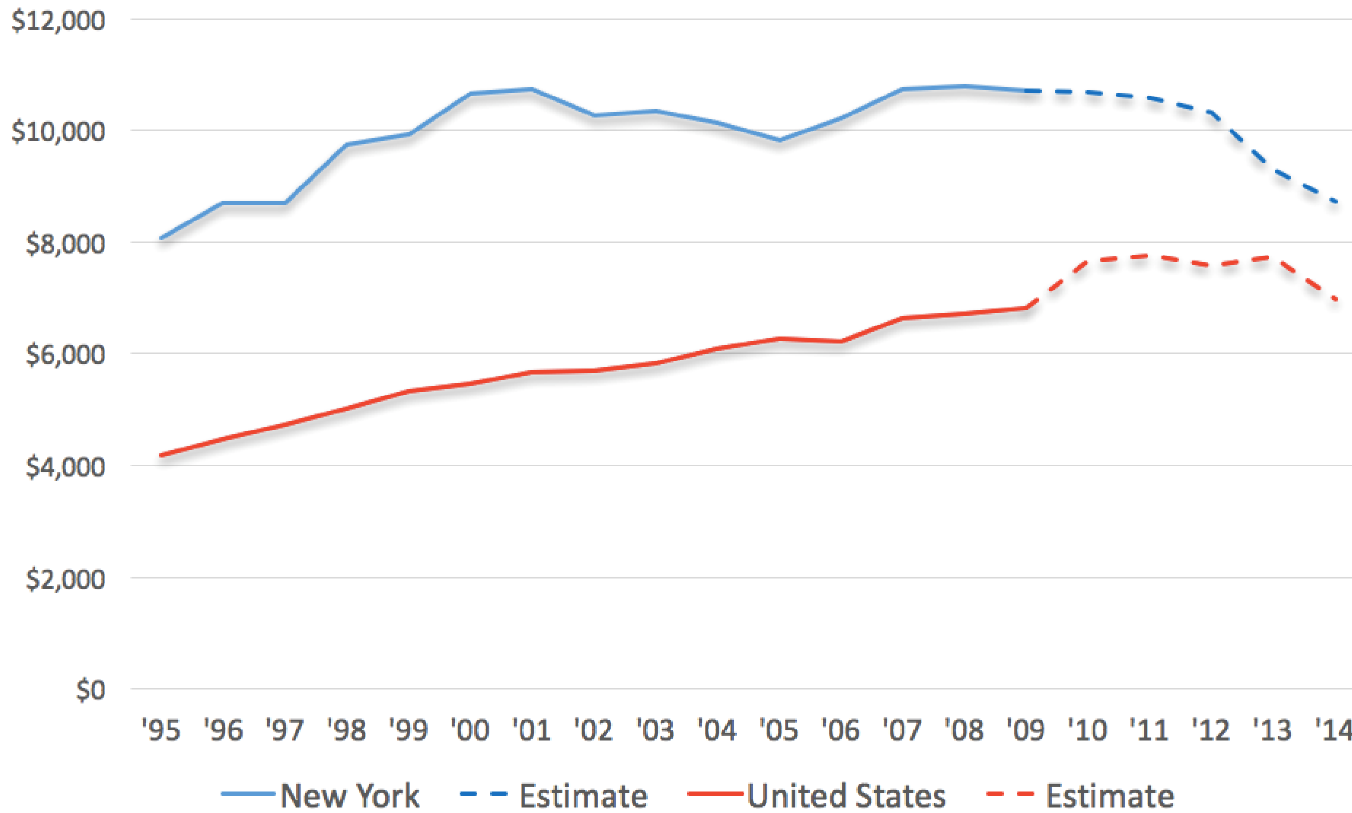

Sources: CMS, Kaiser Commission on Medicaid and the Uninsured

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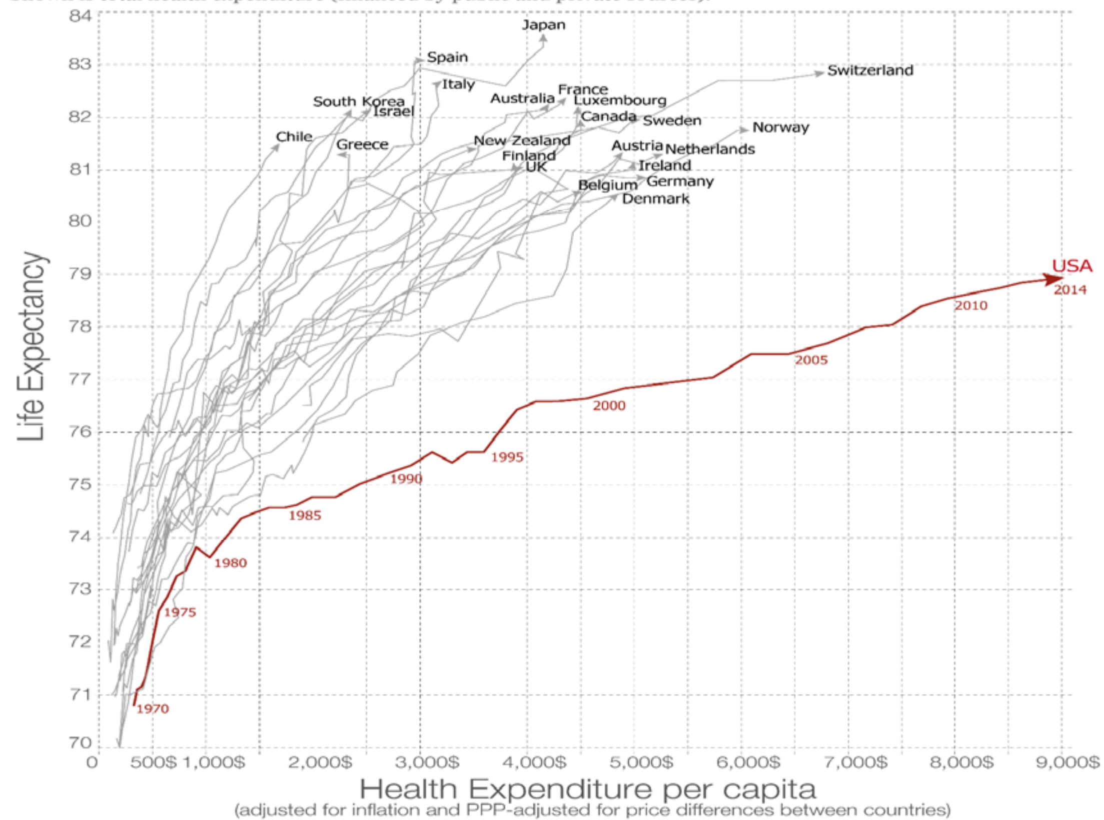
We Still Have Work To Do:



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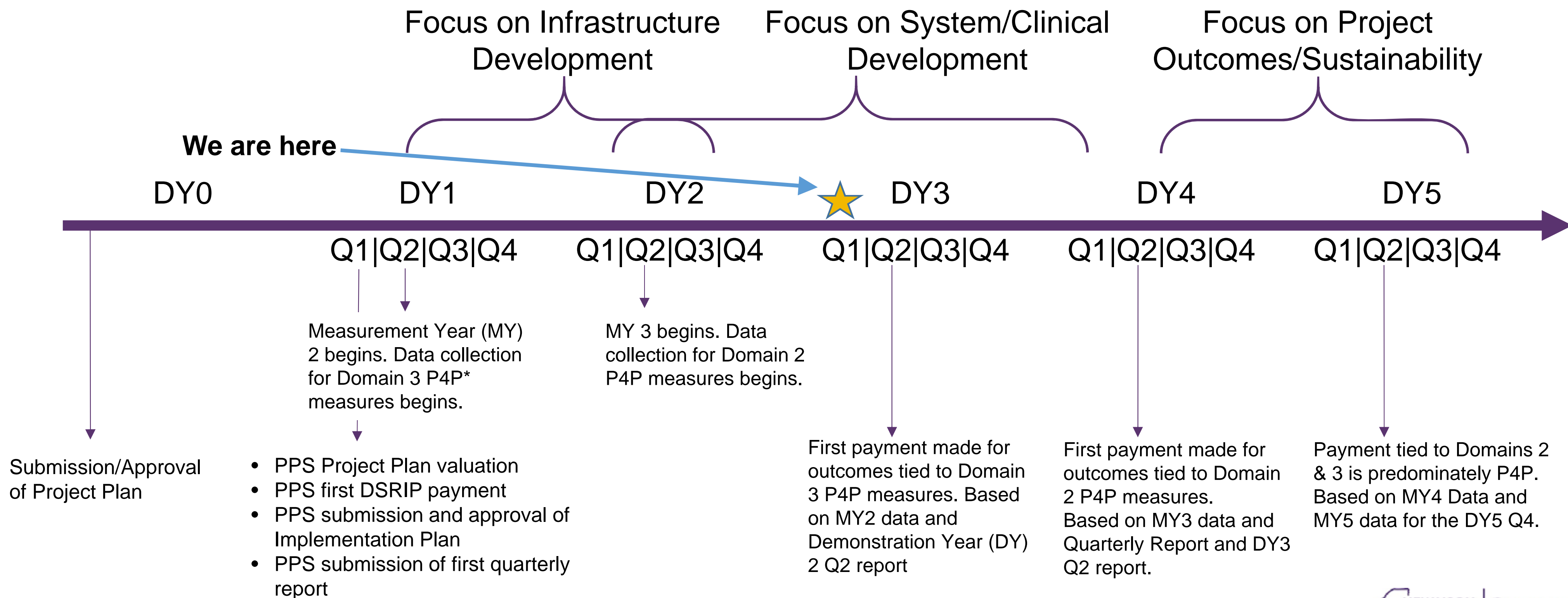
DSRIP: A Transformed Health System

An Important Turning Point: Where Are We Now?

Performing Provider Systems (PPS) have transitioned from planning to implementing projects.



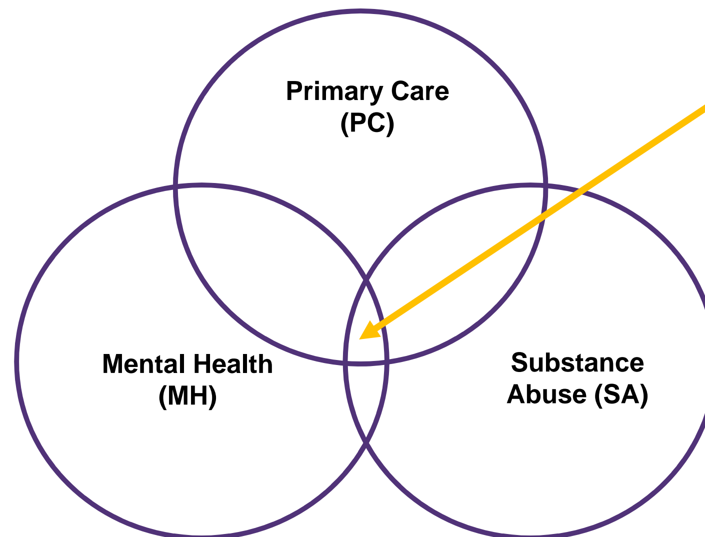
Source: Based on Independent Assessor Project Approval and Oversight Panel Presentation. Nov 9 – 10, 2015. NYS DSRIP Website

** P4P = pay for performance*

The Need for Service Integration

Healthcare providers recognize that many patients have comorbid physical and behavioral healthcare needs, yet services in New York State have traditionally been provided and billed for separately.

The integration of physical and behavioral health services can help **improve the overall quality of care** for individuals with multiple health conditions by **treating the whole person** in a more comprehensive manner



** Within DSRIP, the term "Behavioral Health" also encompasses mental health and substance abuse*

DSRIP Program Objectives

➢ *DSRIP objectives are aligned with the objectives of BH Organizations*

- DSRIP was built on the Center for Medicare and Medicaid Services' (CMS) and the State's goals towards achieving the Triple Aim:
  - ✓ Better care
  - ✓ Better health
  - ✓ 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

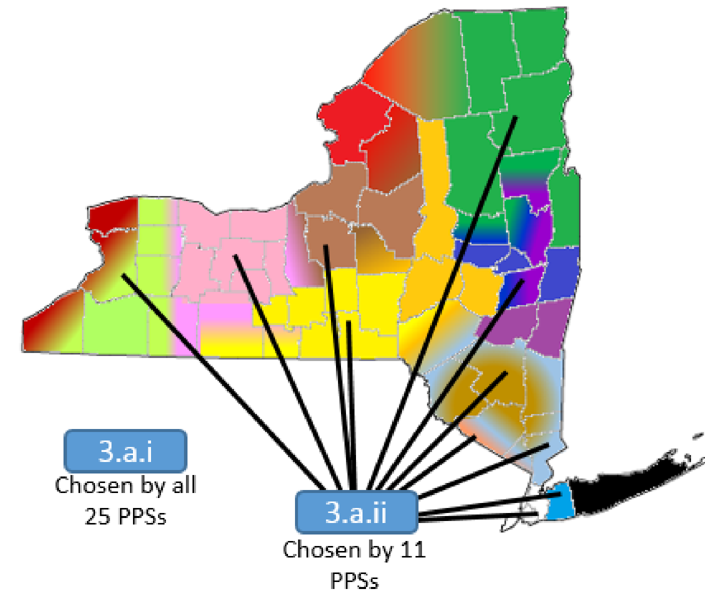
Source: The New York State DSRIP Program. NYSDOH Website. & New York's Pathway to Achieving the Triple Aim. NYSDOH DSRIP Website. Published December 18, 2013.

DSRIP Requirements to Achieve Service Integration

In the early stages of DSRIP, PPSs were required to implement at least one behavioral health strategy project from the Domain 3 – Clinical Improvement Projects category.

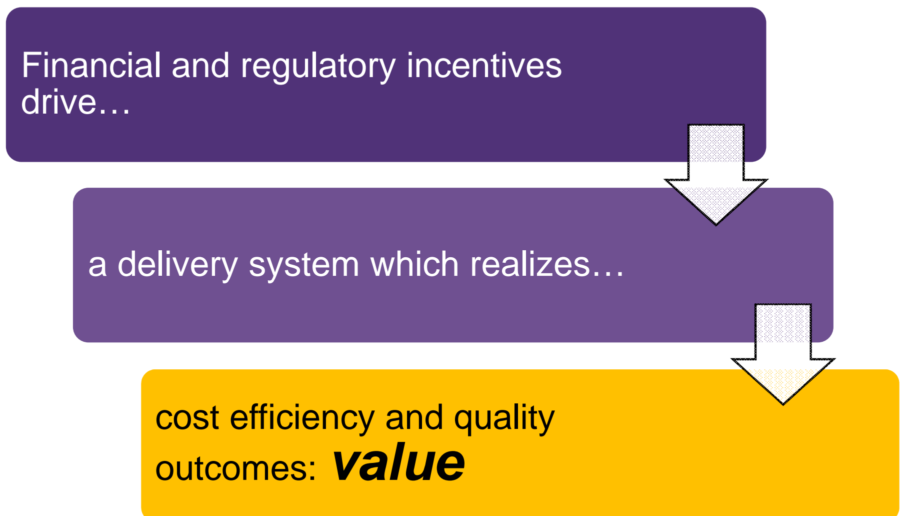
3.A Projects: Behavioral Health

- 3.a.i - Integration of primary care and behavioral health services
- 3.a.ii - Behavioral health community crisis stabilization services
- 3.a.iii - Implementation of evidence-based medication adherence program (MAP) 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



Delivery Reform and Payment Reform: Two Sides of the Same Coin

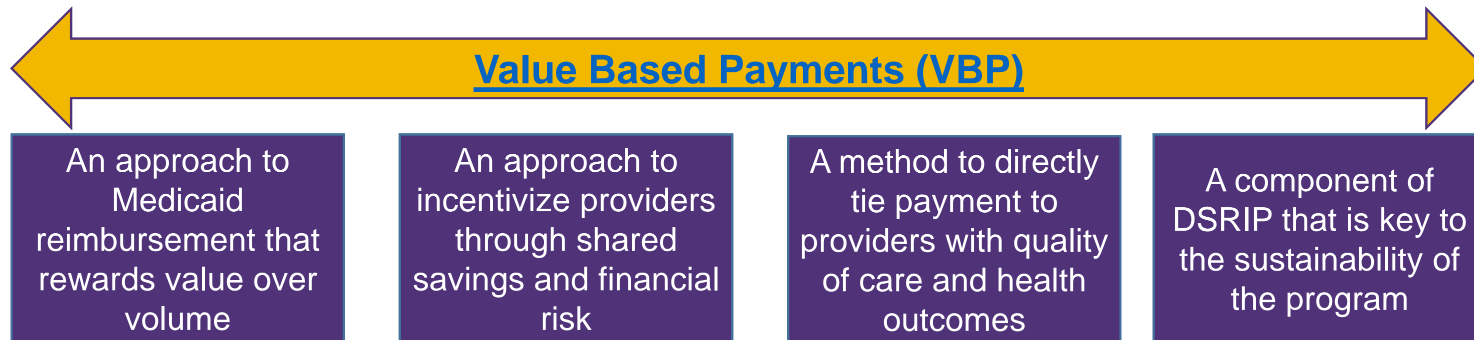
- A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS current delivery system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - Fee for service (FFS) pays for inputs rather than outcome; an avoidable re-admission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination or integration
- The financial success of providers must be linked to providing value.



The Move To Value Based Payment

Value Based Payments: Why is this important?

- By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments.
- Health Home care management payments will be part of VBP arrangements.



Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.

VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

2016	2017	2018	2019	2020

DSRIP Goals	***April 2017***	***April 2018***	***April 2019***	***April 2020***
	Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP	**≥ 10% of total MCO expenditure in Level 1 VBP or above**	**≥ 50% of total MCO expenditure in Level 1 VBP or above. ≥ 15% of total payments contracted in Level 2 or higher**	**80-90% of total MCO expenditure in Level 1 VBP or above ≥ 35% of total payments contracted in Level 2 or higher**

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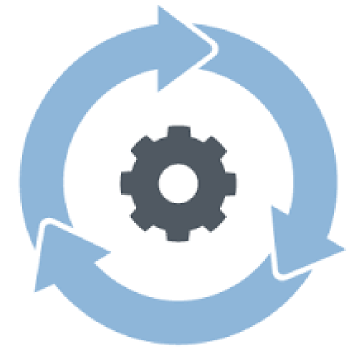
Multiple VBP Arrangement Options Exist

There is no single path towards Value Based Payments. Rather, there are a variety of options that MCOs and providers can jointly choose from:

- Total Care for General Population (TCGP)
- Integrated Primary Care (IPC)
- Maternity Bundle*
- Total Care for Health and Recovery Plans (HARP) Subpopulation
- Total Care for HIV/AIDS Subpopulation
- Total Care for Managed Long Term Care (MLTC) Subpopulation
- Total Care for Intellectually or Developmentally Disabled (I/DD) Subpopulation



*Indicates Episodic Bundle VBP Arrangement

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.

Behavioral Health and System Transformation

Overview

- Public behavioral health system serves ~750,000 Medicaid recipients per year
- Medicaid members diagnosed with BH account for **20.9%** of the overall Medicaid population in NYS
- The average length of stay (LOS) per admission for BH Medicaid users is **30%** longer than the overall Medicaid population's LOS
- Per member per month (PMPM) costs for Medicaid Members with BH diagnosis is **2.6** times higher than the overall Medicaid population
- Estimated annual behavioral health spend: $7B (~50% for inpatient BH)

Current Challenges in BH

- Large system with wide range of provider services and expertise
- Heavy reliance on fee-for-service (FFS) payment methodology that incentivizes volume and may not pay for what is really needed
- Lack of accountability for high-need patients
- Few incentives to support BH / PC integration
- Barriers to information sharing within health and social services systems (MCO, criminal and juvenile justice, homeless systems)
- Lack of follow-up care following discharge from inpatient admissions
- High re-admission rates for BH and substance use disorder (SUD) populations

Source: The New York Department of Health. A Plan to Transform the Empire State's Medicaid Program: Multi-Year Action Plan. NYSDOH DSRIP Website. Published 2012.

Improving Behavioral Health for System Transformation

- Integration is key
- Use DSRIP and VBP to drive change
- Improving behavioral health will be a major factor for statewide performance

Health Homes

Health Homes Serving Children- Successful Beginnings

- Successful launch of Health Homes Serving Children – December 2016
  - ✓ As of March 31, 2017
    - 7,585 children enrolled in Health Home
    - 3,839 in outreach
  - ✓ Monthly meetings with SPOA to help establish good communication between SPOAs and Health Homes and facilitate SPOA referrals made to Health Home through MAPP
  - ✓ Care Management Agency required to inform SPOA of the outcome of their referral (i.e., identify themselves as the assigned care manager and discuss how SPOA and county can be helpful)
  - ✓ State providing SPOA contacts to Health Homes on every Webinar

2017-18 Enacted Budget: Restructuring and Reprogramming Health Home Outreach

- Effective October 1, 2017, modify the Per Member, Per Month (PMPM) Health Home outreach fee and reinvest a portion of the savings in outreach approaches that pay for value and better locate and connect eligible members to Health Home (requires CMS approval)
- Provides reprogramming opportunities to leverage best practices to better link and enroll high risk members to Health Homes, for example, higher PMPMs for first 3 months of enrollment of high risk members, and use of Health Home peers

Effective 10/1/17 (Gross $)	2017-18	2018-19
Outreach ($100 PMPM)	$27.5	$55.0
Reprogrammed Outreach (Estimates Assume Federal Match)	20.0	60.0
Total Outreach Resources	**47.5**	**115.0**
Savings	20.0	20.0

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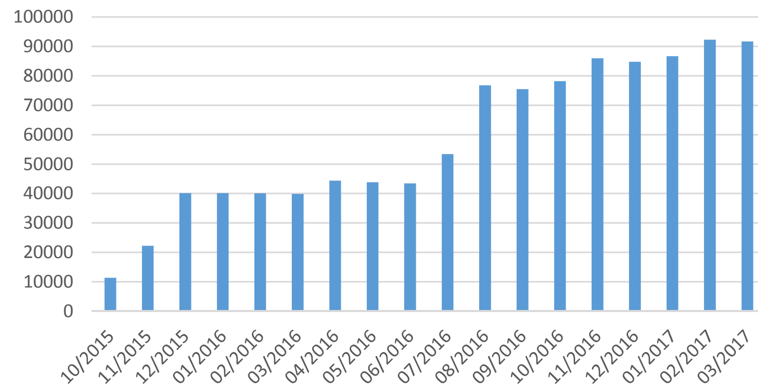
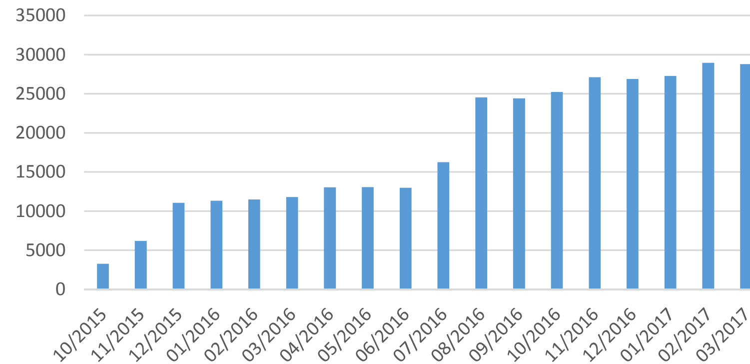
Challenge: Increasing HARP/HH Enrollment and Linking HARP Members to HCBS

March 2017	HARP Enrolled	HARP and Health Home Enrolled	Percent HARP Enrolled in Health Home
NYC	54,498	16,565	30.4%
Rest of State	36,996	12,099	32.7%
Statewide	91,494	28,664	31.3%





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Challenges and Solutions: Health Home and HARP/HCBS Implementation

Challenge: Complex and Layered Assessment Process and Completing Plans of Care

- ✓ ***Solution: Eliminate Full CMHA as of March 7, 2017***

Challenge: Low HARP/HH enrollment (30%)

- ✓ ***Solution: Implementation of PSYCKES flag for HARP members not enrolled in Health Home – encourage and provide information to providers and clinics to link HARP members to link and enroll members in Health Home***

Challenge: Delayed payment for assessments, system crashes

- ✓ ***Solution: CMAs directly bill for CMHA fee***

Challenge: Link HARP members to HCBS and HCBS Provider readiness, ramp-up

- ✓ ***Solutions: Consumer Education initiatives (HARP, HCBS, and HH), Procedures for improving access to HCBS for members not enrolled in Health Home, and development of HCBS Roadmap as training resource for CMAs and HCBS providers***

Best Practices that Work for HARP and HH/HCBS Linkage

- ✓ Use of Peers to engage in HH and the Adult BH HCBS process
- ✓ Getting to know your partners: HH Care Manager, MCO, HCBS provider
- ✓ Dedicated HARP teams (at MCO and HH CMA)
- ✓ Standardized processes (Plan Of Care, MCO, HCBS referrals)
- ✓ Care Managers that help individuals understand what HCBS can do to assist in their recovery
- ✓ Leveraging PPS

Focusing on Health Home Performance

- State is continuing focus on Health Home performance management – ownership and accountability that is measured by performance and health outcomes
- By end of June 2017 site Redesignation Visits completed for all 32 Health Homes – one component of performance management
  - Includes implementation of Technical Assistance and Quality Monitoring based on outcomes
  - Performance Improvement Plans – Development, Implementation and Monitoring
  - Policy Revision and standardization
- Rollout of Comprehensive Performance Management Program – May 2017
- Health Home / MCO Workgroup, which CLMHD attends, provides opportunity to exchange best practices

Future Efforts: The Move Beyond Health Care

The Future of Healthcare in New York

- We need a future system where we think more broadly, on a community basis, where all of the systems that impact an individual’s well being are coordinated
- We could measure the outcomes that society cares about, moving beyond health care metrics

✓ Workforce Availability

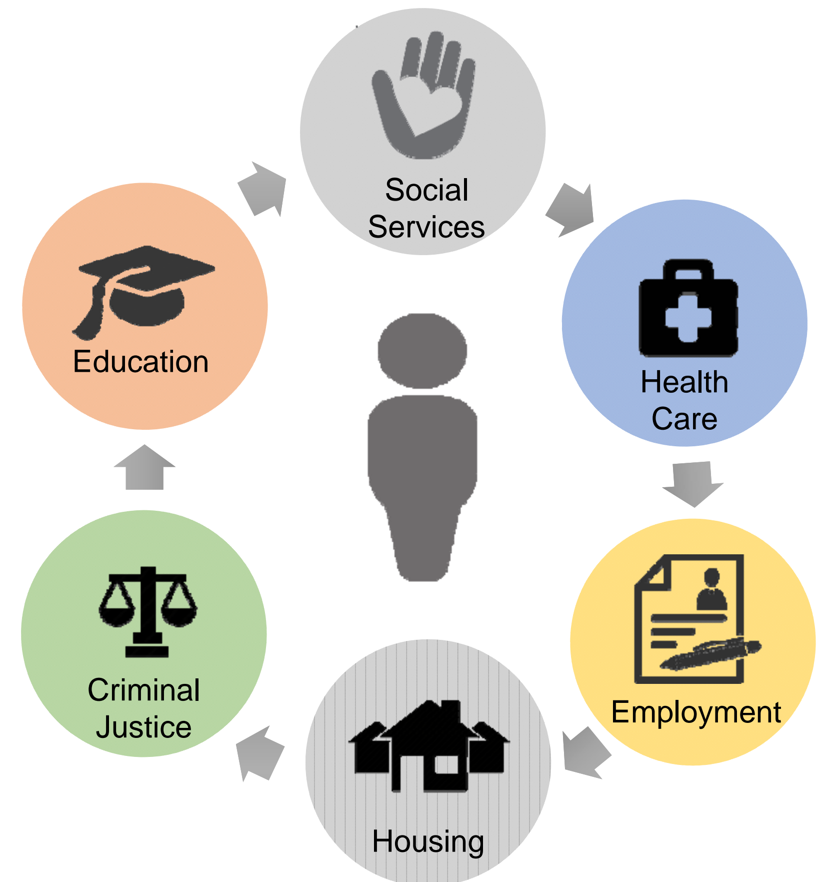
✓Quality of Life

✓ Community Engagement

✓Mortality

True System Alignment

- Break down siloes within health care and build relationship to other sectors
- We need to think even more broadly about the systems that serve out communities
- We are working towards developing an ecosystem designed to achieve the most important outcomes to a community.



Questions?

Additional information available at:

https://www.health.ny.gov/mrt

https://www.health.ny.gov/dsrip

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