NEW YORK STATE | Department of Health | Medicaid Redesign Team

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

Promoting Health, Overcoming Disparities

Gregory S. Allen, MSW
Director
Division of Program Development and Management
Office of Health Insurance Programs
New York State Department of Health

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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

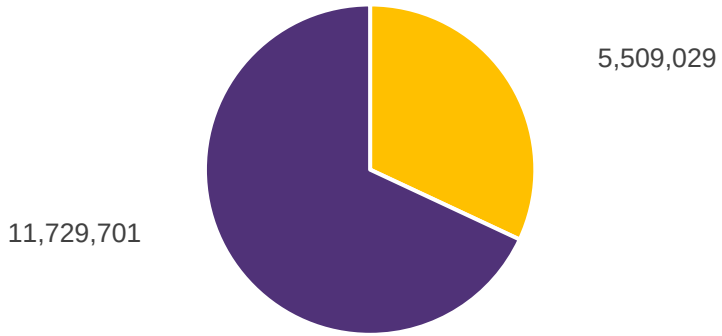
Total Pop. Excluding BH Pop.
Behavioral Health Population

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:

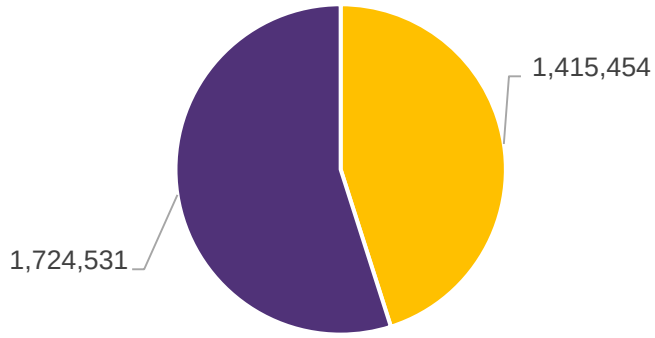
- Medicaid members diagnosed with BH account for 20.9% of the overall population in New York State
- The average length of stay (LOS) per admission for Behavioral Health users is 129.8% of the overall population's LOS
- Per Member Per Month (PMPM) for Medicaid Members diagnosed with BH is 259.9% of overall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

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



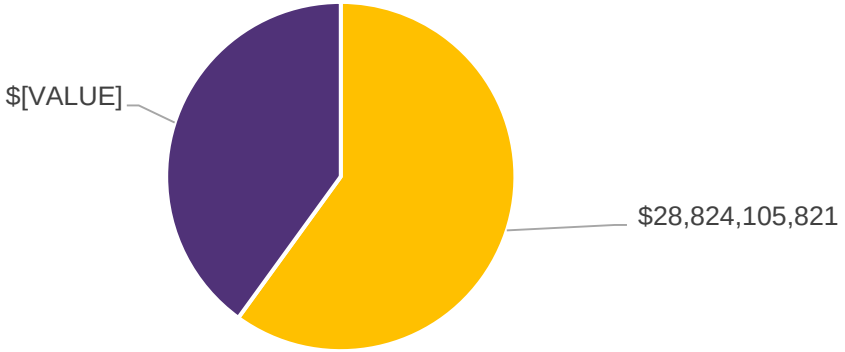
Total population: 17,238,730

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



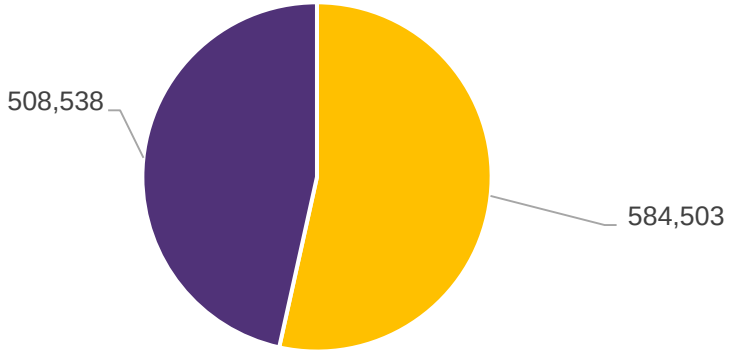
Total ED visits: 3,139,985

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



Total cost: $48,048,379,392

Medicaid members diagnosed with BH account for 53.5% of admissions



Total admissions: 1,093,041

* *Preliminary Data not for publication…being verified. This data includes Members with 1+ Claims with primary or secondary diagnosis of behavioral health issues*

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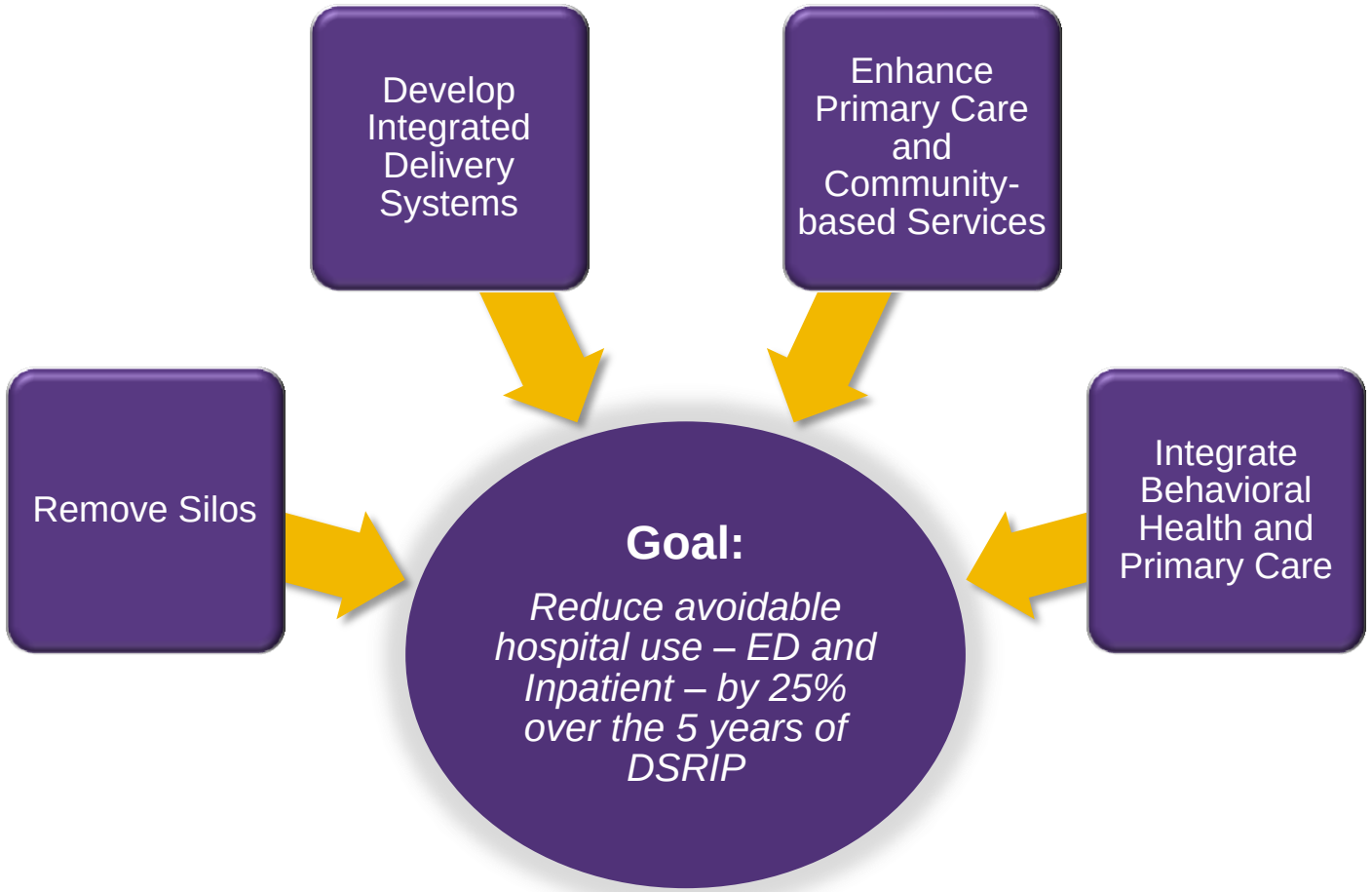
What is DSRIP? A Quick Recap

DSRIP Explained



- 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

Patient-Centered	Improving patient care & experience through a more efficient, patient-centered and coordinated system
Transparent	Decision making process takes place in the public eye and that processes are clear and aligned across providers
Collaborative	Collaborative process reflects the needs of the communities and inputs of stakeholders
Accountable	Providers are held to common performance standards, deliverables and timelines
Value Driven	Focus on increasing value to patients, community, payers and other stakeholders

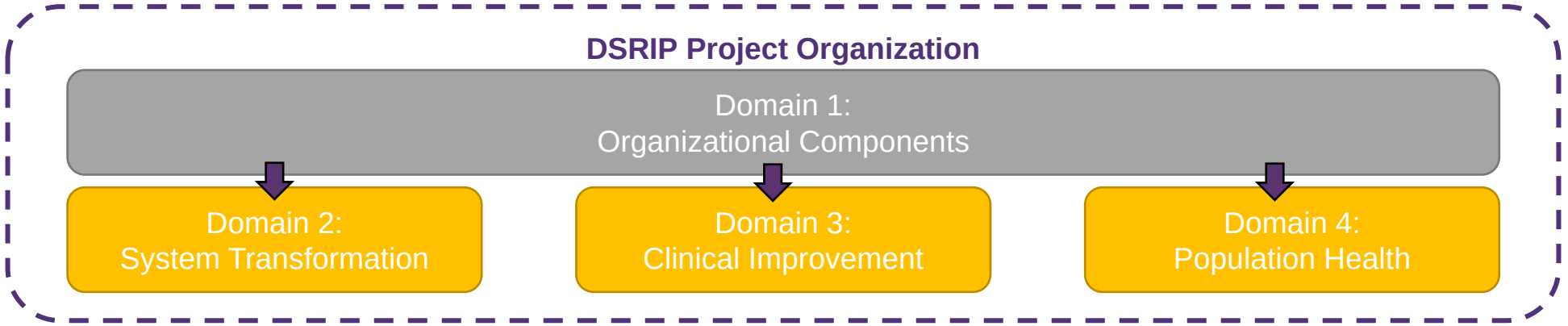
Better care, less cost

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

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

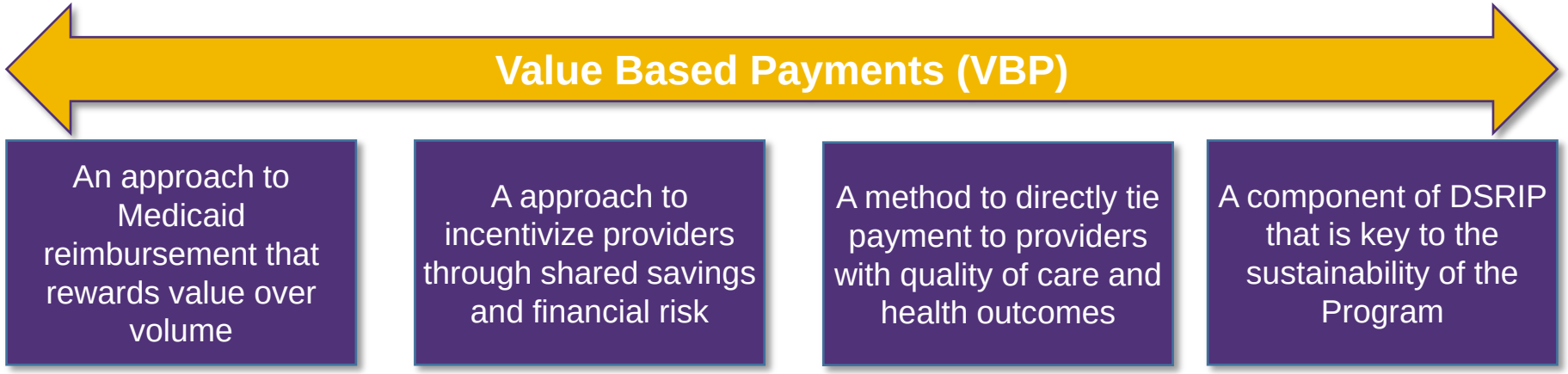
4.a.i: Promote mental, emotional, and behavioral well-being in communities

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)

Moving Towards Value Based Payments



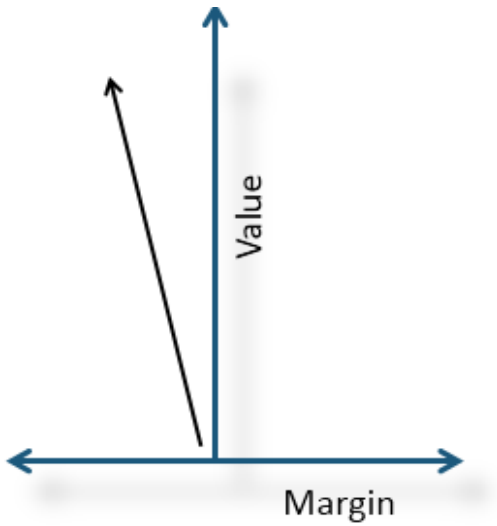
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ value based payment systems that reward value over volume for at least 80 – 90% of their provider payments
- If VBP goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced

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***

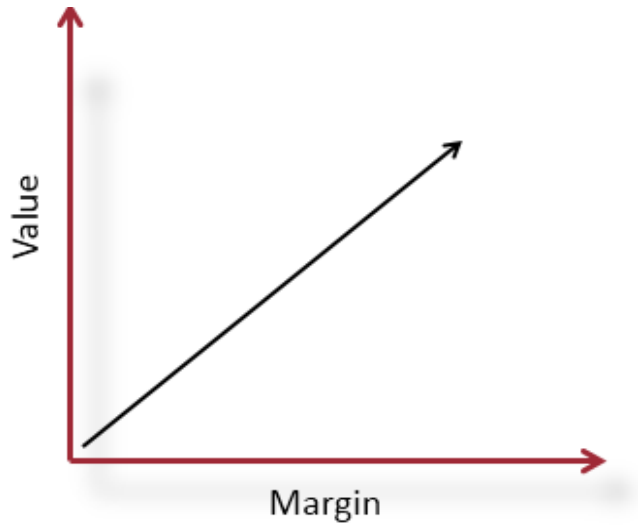
Current State

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

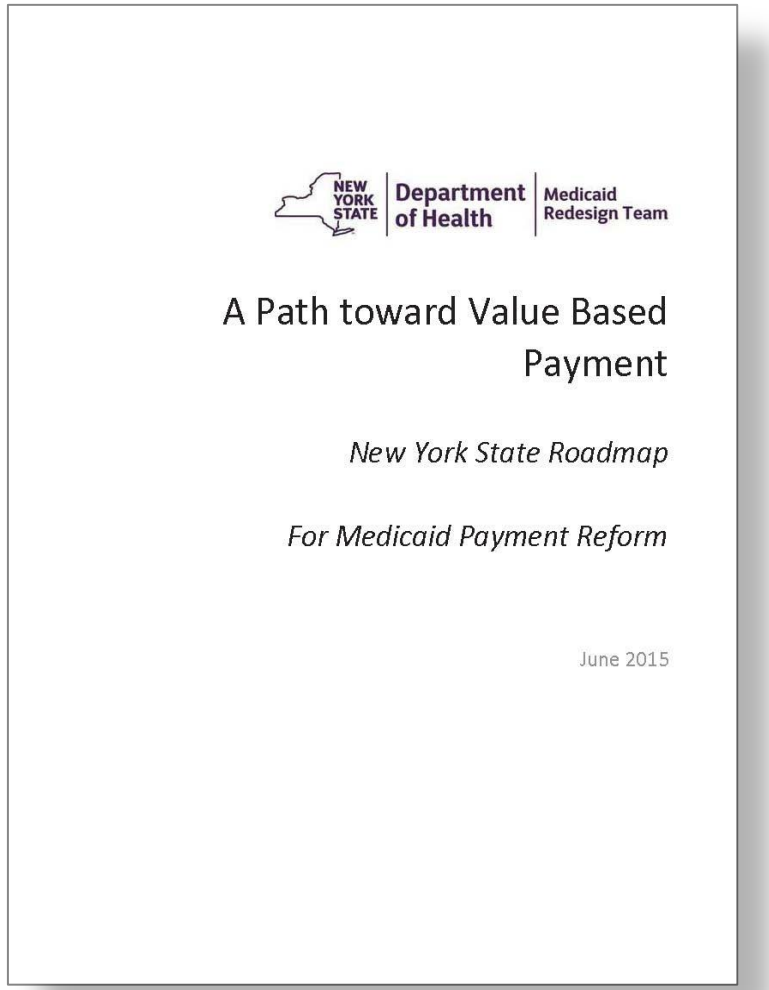
- On the path towards Value Based Payments, there are a variety of options that MCOs, PPSs and Providers can jointly choose from
- PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives)

Total Care for Total Population	Integrated Primary Care (IPC)	Bundles (Acute and Chronic)	Total Cost of Care for Subpopulation
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	The MCO contracts Integrated Primary Care to reimburse based on savings and quality outcomes achieved	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.	The MCO contracts an arrangement that considers a virtual per-member-per-month (PMPM) expenditure for a specific special needs subpopulation
	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

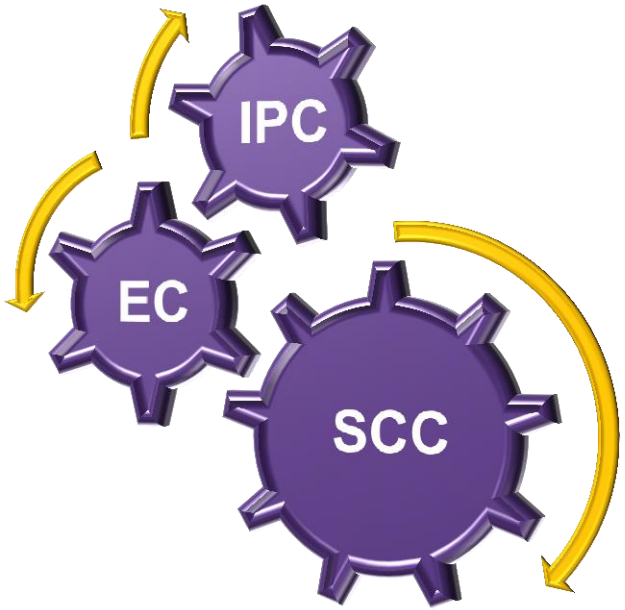
In addition to choosing *what integrated services* to focus on, MCOs and PPSs can choose different levels of Value Based Payments:

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)

- 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 heath 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

  Based on claims data

  - 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

  Based on claims data/clinical data

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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)

Bipolar Disorder Bundle

Trigger

- Inpatient claim with bipolar disorder as principal diagnosis

OR

- Outpatient or professional billing claim with E&M (evaluation and management) service and bipolar disorder as diagnosis

Confirming trigger

- Another trigger as stated above at least 30 days after the first trigger

Included in bundle:

- All typical and complication costs for bipolar disorder during the duration of the bundle

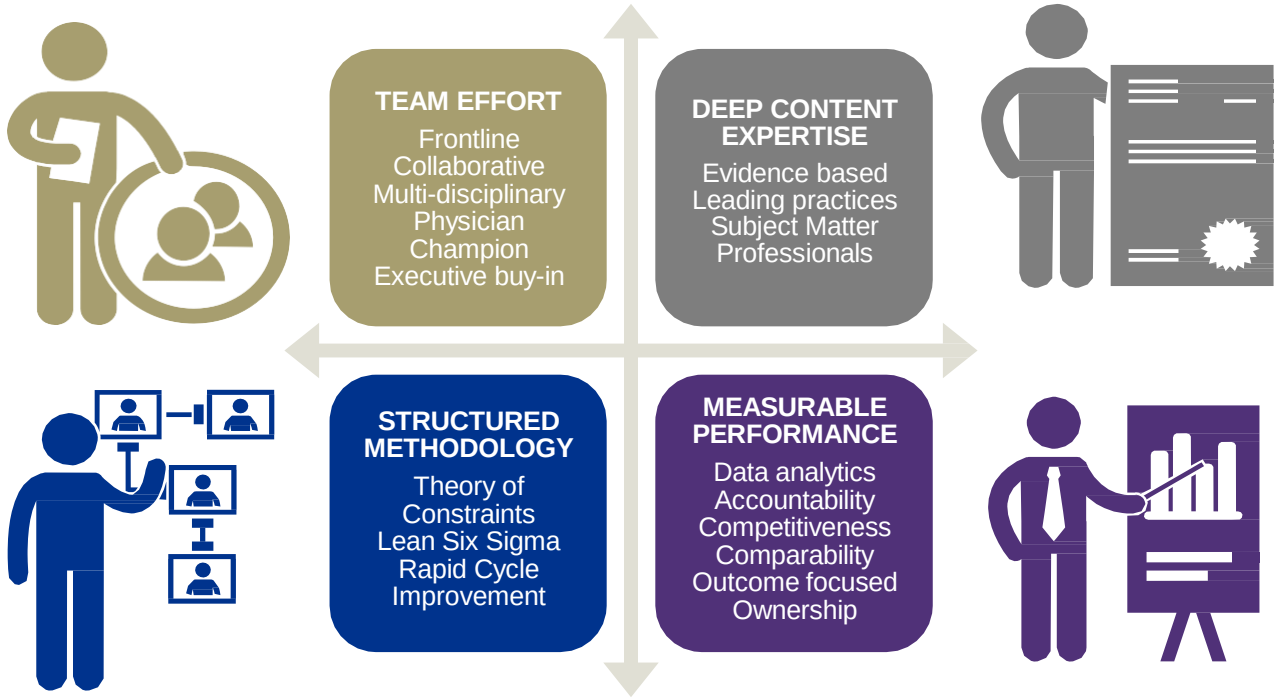
- Complications may include, but are not limited to:
  - Suicide or self inflicted injury
  - overdose, poisoning - wrong drug
  - accidental falls
  - decubitus ulcer

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

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

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	Time Saved	Money Saved
For example… **Reduction in readmission rate and increase in outpatient compliance**	For example… Time equal to **0.5 FTE** saved through having access to each other's EHR systems	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.**

➡ 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.

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 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**.

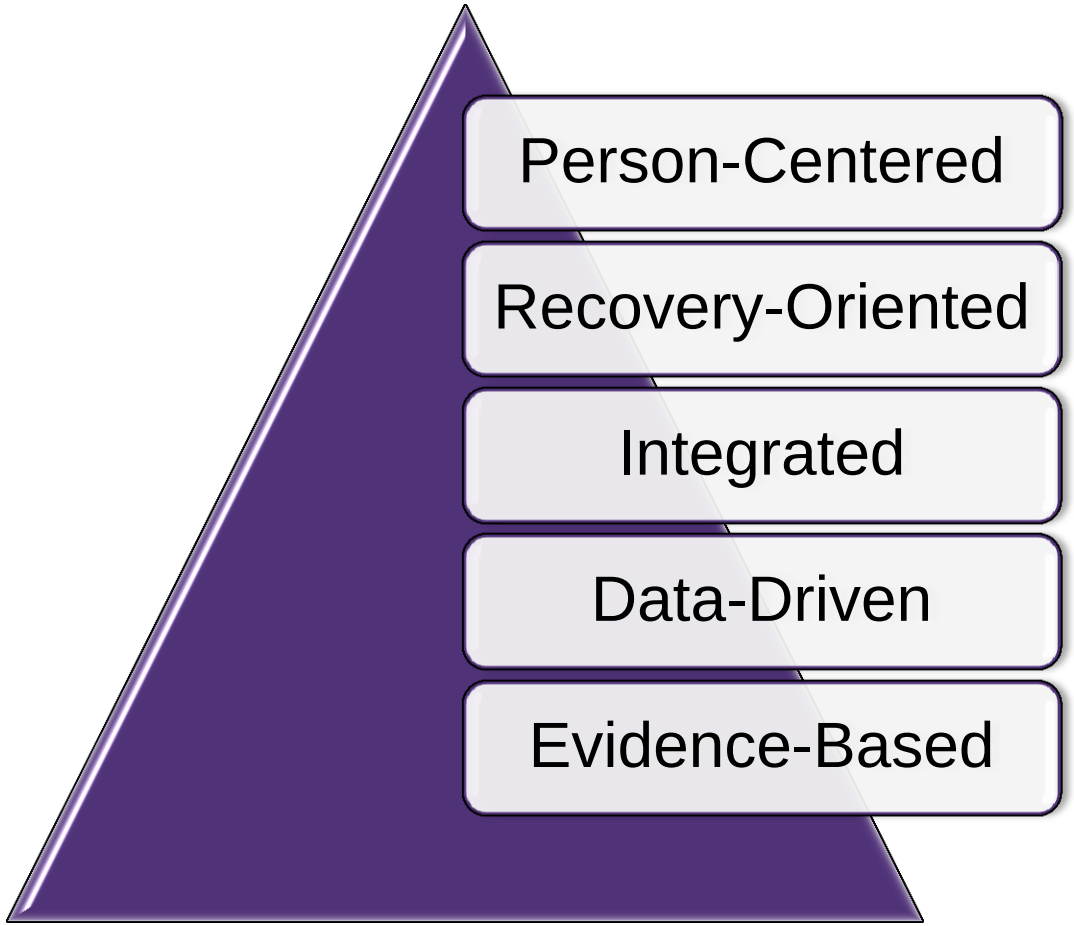
Time saved – **Three provider shifts are projected to be saved** over the course of the year. The ~**90 ED visits** diverted is equivalent to 36 provider hours

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



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

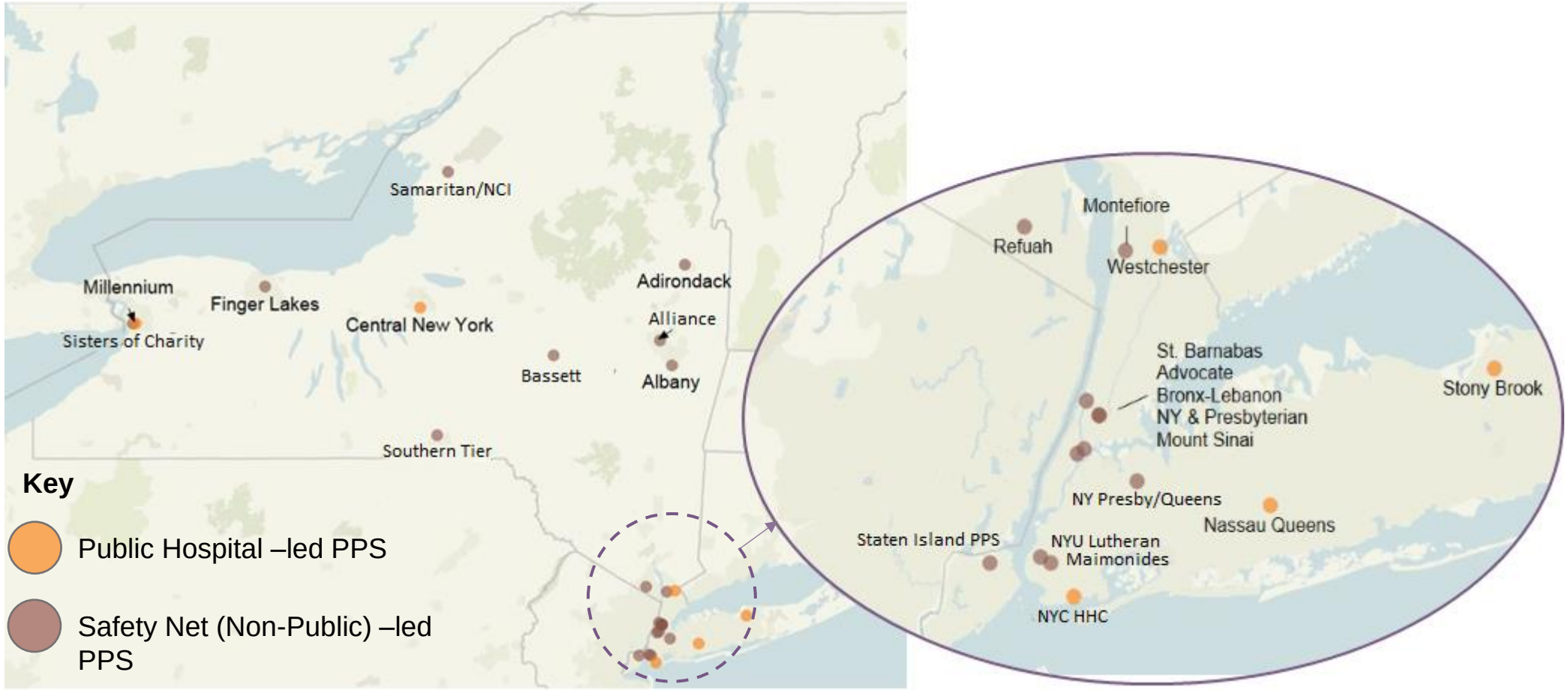
Appendix A: DSRIP Further Explained

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



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 heath 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

DSRIP Program Timeline: Today – Early August 2016	
April 30	Final PPS Year 1 Third Quarterly Reports posted to DSRIP website
May 3	PPS Regional Learning Symposium (Downstate)
May 4	1115 Waiver Public Comment Day (Downstate)
May 17	PPS Regional Learning Symposium (Upstate)
May 31	Independent Assessor provides feedback to PPS on PPS Year 1 Fourth Quarterly Reports; 15-day Remediation window begins
June 10	1115 Waiver Public Comment Day (Upstate)
June 14	Revised PPS Year 1 Fourth Quarterly Reports due from PPS; 15-day Remediation window closes
June 29	Final Approval of PPS Year 1 Fourth Quarterly Reports
July	Implementation of Phase II MAPP Performance Dashboards
July 6	Final PPS Year 1 Fourth Quarterly Reports posted to DSRIP Website
July 31	PPS Year 2 First Quarterly Reports (4/1/16 – 6/30/16) due from PPS
Late July	DY1 Third DSRIP Payment to PPS
Early August	Initiate Mid-Point Assessment for PPS

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

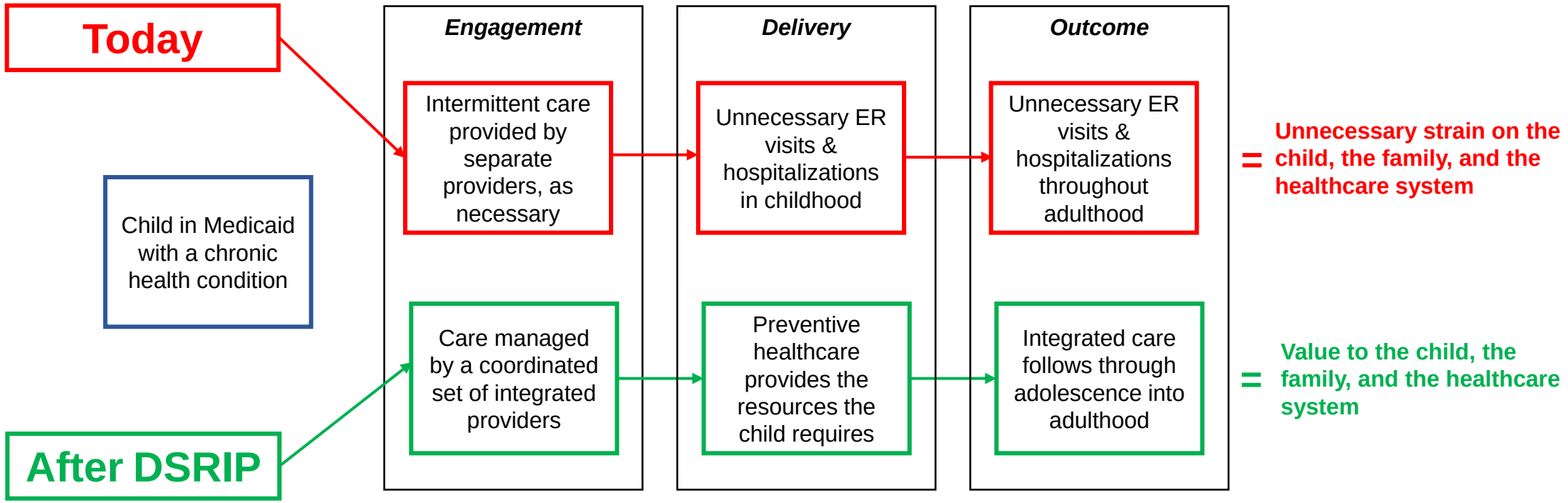
- DSRIP's healthcare transformation will likely have the greatest effect on children in Medicaid, as avoiding poor health outcomes throughout childhood will lead to a lifetime of stronger health outcomes

- 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



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Behavioral Health Managed Care Transition

April 21, 2016

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

MH & SUD Claims Stats				
Plan name	Total Claims	Total Pended Claims	Total Paid Claims	Total Denied Claims
Plan 1	184,974	0%	82%	17%
Plan 2	158,149	1%	84%	16%
Plan 3	79,341	0%	90%	10%
Plan 4	79,733	6%	75%	20%
Plan 5	438,248	0%	88%	12%
Plan 6	950,029	1%	87%	12%
Plan 7	650,595	0%	82%	18%
Plan 8	87,181	6%	73%	21%
Plan 9	12,221	2%	80%	19%
Plan 10	19,222	18%	50%	32%
Total (10/01/2015-03/28/2016)	2,659,693	0.9%	84.5%	14.7%
Last Report (10/01/2015-03/14/2016)	2,401,983	1.5%	84.3%	14.3%

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

Region	Plan Name	Designation Status	BHO
NYC Only	AmidaCare Inc	HIV-SNP	Beacon
NYC Only	MetroPlus	HIV-SNP and HARP	Beacon
NYC Only	VNS Choice Select Health SNP	HIV-SNP	Beacon
NYC and Upstate	Affinity Health Plan Inc	Conditional HARP	Beacon
NYC and Upstate	Empire Blue Cross Blue Shield HealthPlus (Formerly Amerigroup)	HARP	None
NYC and Upstate	Health Insurance Plan of Greater New York (Emblem)	HARP	Beacon
NYC and Upstate	HealthFirst PHSP Inc	HARP	
NYC and Upstate	NYS Catholic Health Plan Inc (Fidelis)	HARP	None
NYC and Upstate	United Healthcare Of NY Inc.	HARP	Optum
NYC and Upstate	WellCare of New York	Mainstream	None
Upstate Only	Capital Dsitrict Physicians Health Plan	Conditional HARP	None
Upstate Only	Excellus	Conditional HARP	Centene
Upstate Only	Independent Health Association	Conditional HARP	Beacon
Upstate Only	MVP	Conditional HARP	Beacon
Upstate Only	TotalCare(A Today's Option)	Conditional HARP	Beacon
Upstate Only	YourCare (Fomerly Univera)	Conditional HARP	Beacon
Upstate Only	Crystal Run	Conditional Mainstream	Beacon
Upstate Only	HealthNow	Conditional Mainstream	Health Integrated

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)

Program service type	N	%
Managed Care Plan	6246	6%
Inpatient Rehabilitation	11432	11%
Detoxification Unit	28552	29%
Criminal Justice Entity	15	0%
Central Intake Unit	4893	5%
Opioid Treatment Program (OTP)	4598	5%
Residential Program	3331	3%
Outpatient Clinic	40100	40%
Other	787	1%
Not Applicable	96	0%