NEW YORK STATE | Department of Health | Medicaid Redesign Team

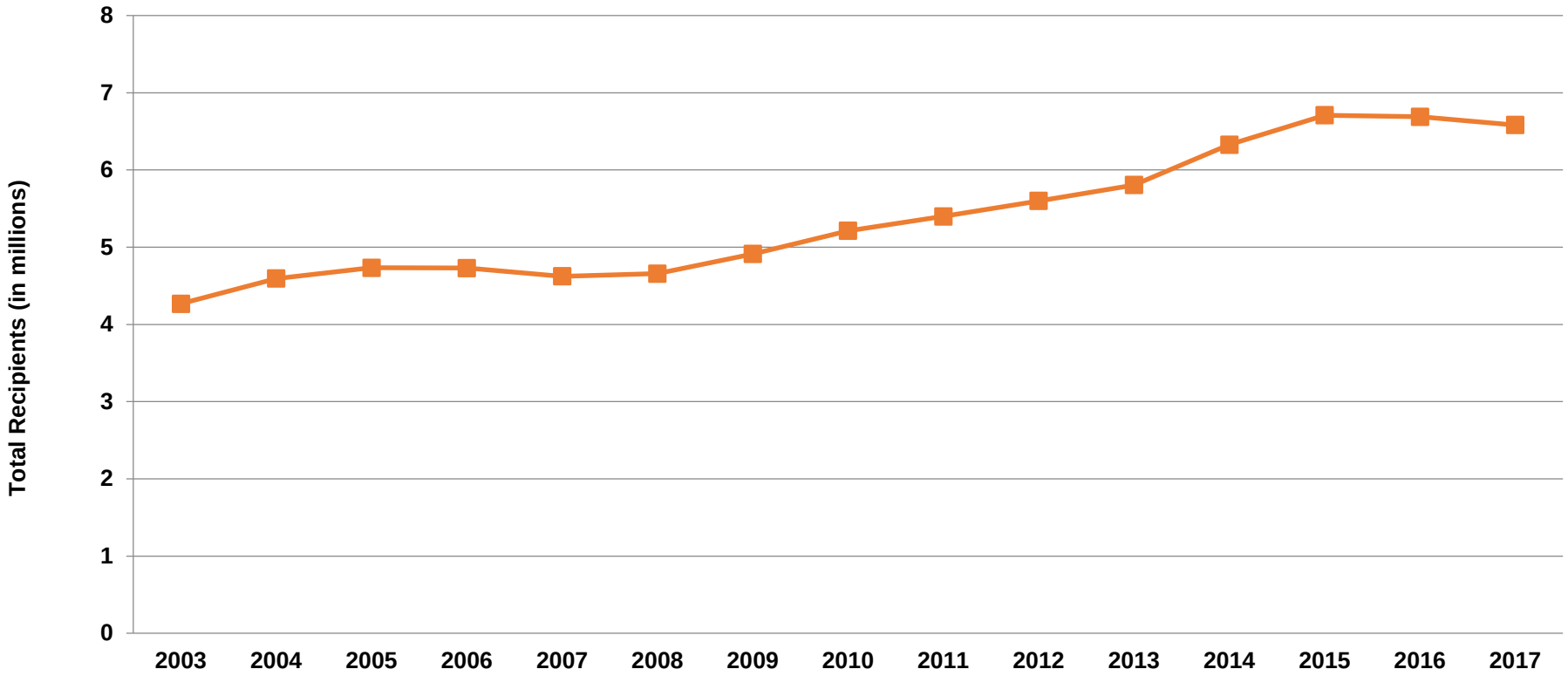
Medicaid in New York: Fostering Collaboration to Improve Health

Donna Frescatore,
NYS Medicaid Director

July 18, 2018

Medicaid in New York

Statewide Medicaid Enrollment (CY 2003-2017)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
# 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	6,708,697	6,689,794	6,582,624

Source: NYS DOH OHIP DataMart (based on claims paid through June 2018)

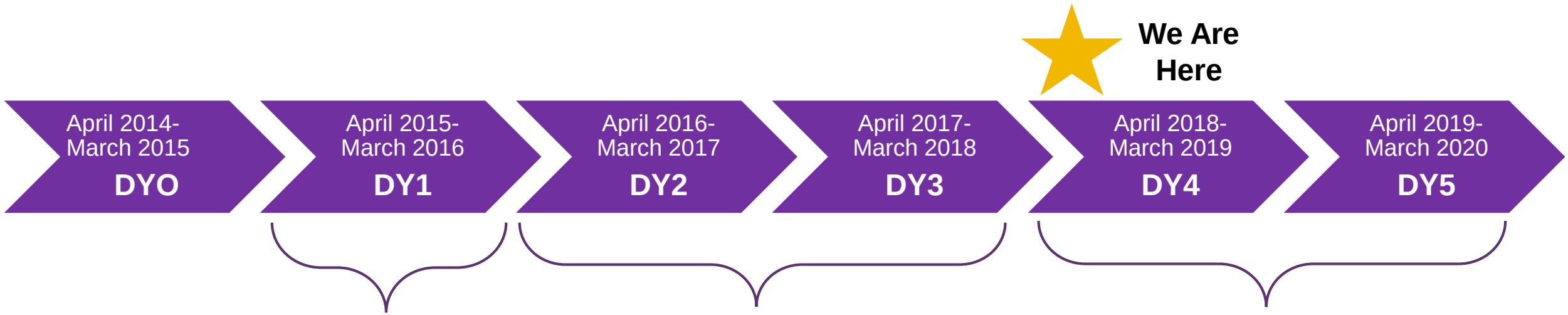
NEW YORK STATE OF OPPORTUNITY. Department of Health

The Delivery System Reform Incentive Payment Program (DSRIP)

Delivery System Reform Incentive Payment (DSRIP): The Basics

- $6.42 Billion investment under MRT Section 1115 Waiver
- Unprecedented Delivery System Reform
- 25 Provider Performing Systems (PPS) across the State
- Meets the Needs of Local Communities
- Overall Goal: Reduce Avoidable Hospital Use by 25% over years

DSRIP: Where Are We Now?



Focus:
Infrastructure Development

Focus:
System/Clinical Development

Focus:
Project Outcomes & Sustainability

Statewide Accountability Measures Results- 2017-18

PASS ✔

Statewide Performance Metrics

PASS ✔

Success of DSRIP Projects Statewide

PASS ✔

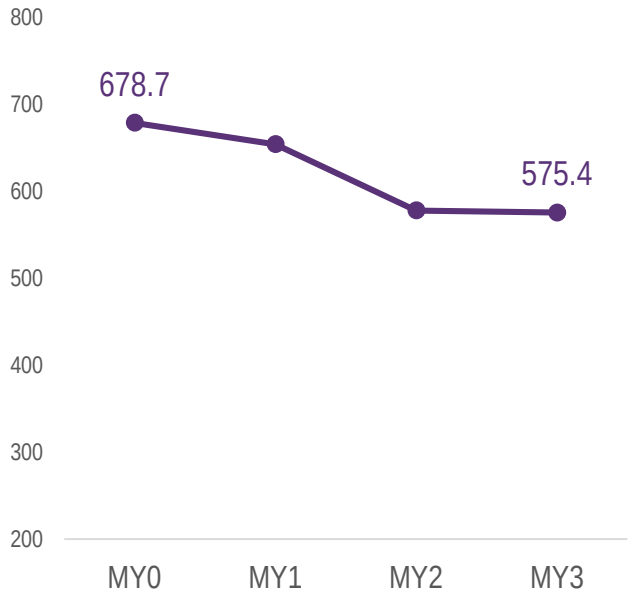
Medicaid Inpatient and ER Spending

PASS ✔

Medicaid Dollars in VBP Contracts

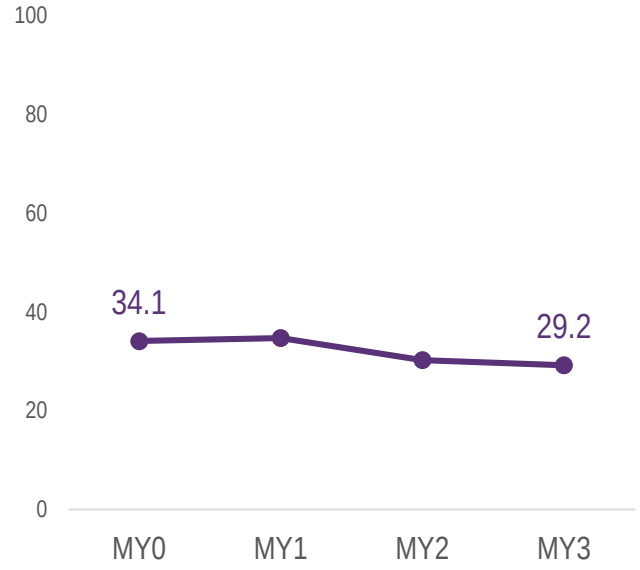
Preventable Hospital Use Continues to Decline

Preventable Readmissions
(per 100,000 Medicaid members)



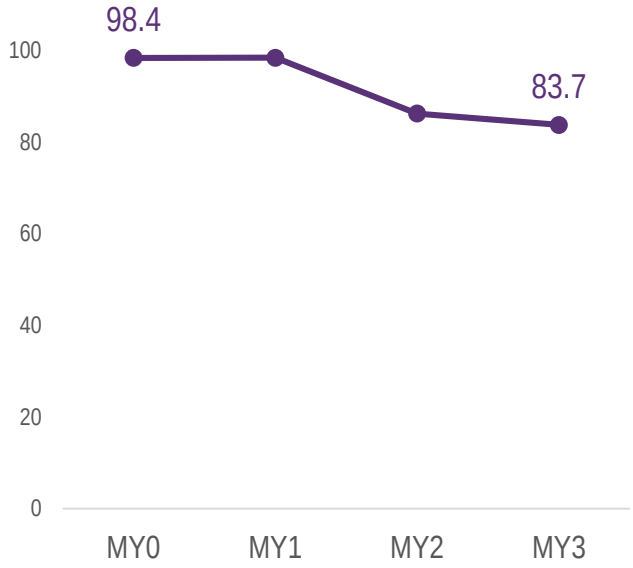
All PPS rate change since baseline: -15.2%

Preventable ED Visits
(per 100 Medicaid members)



All PPS rate change since baseline: -14.3%

Preventable ED Visits (BH Population)
(per 100 Medicaid members)



All PPS rate change since baseline: -14.9%

Data Source: All PPS rate

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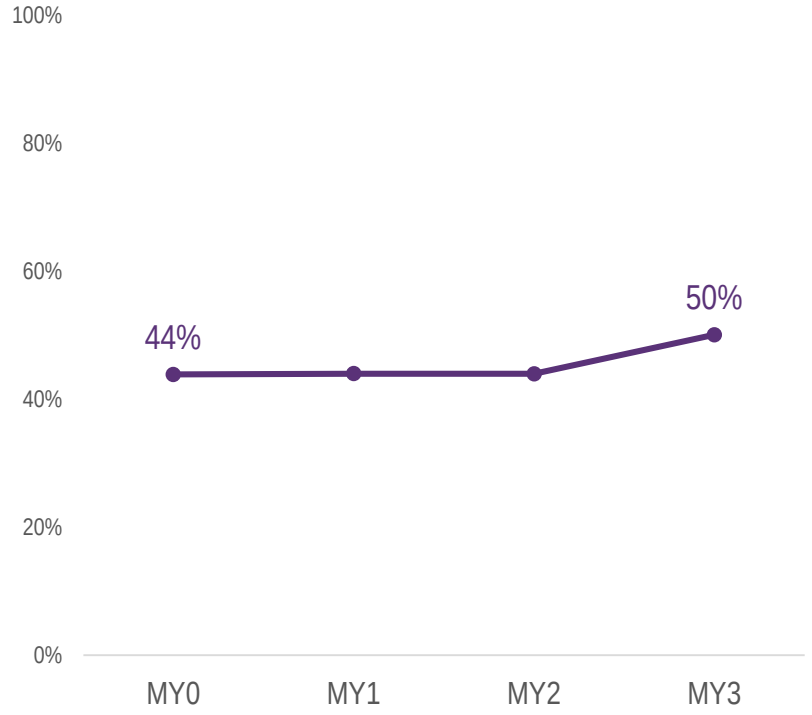
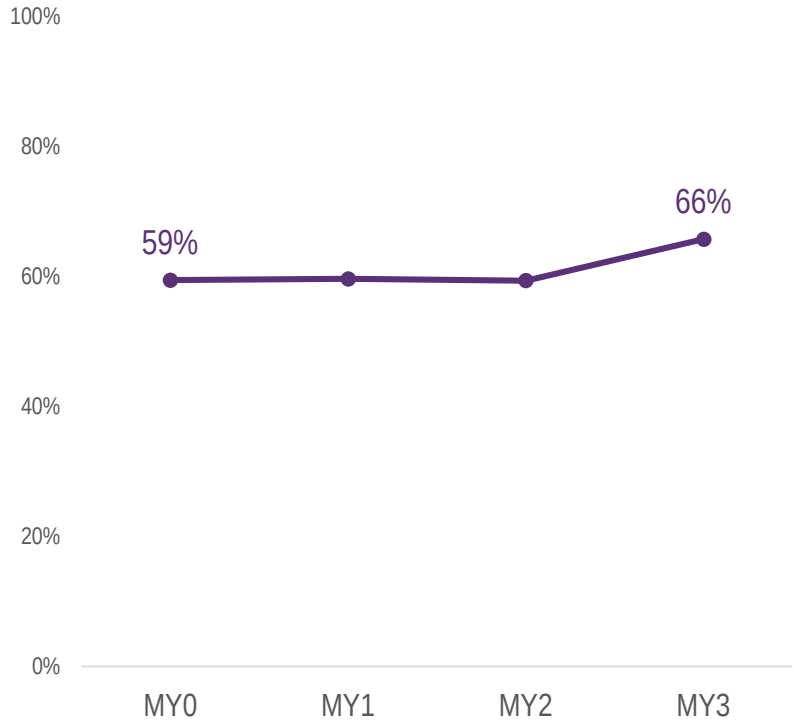
Behavioral Health Measures: Mental Illness

Follow-up After Hospitalization for Mental Illness Within 7 Days



All PPS rate change since baseline: 14.1%

Follow-up After Hospitalization for Mental Illness Within 30 Days



All PPS rate change since baseline: 10.6%

Data Source: All PPS rate

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DSRIP
Beyond the Measures

Health Pulse

April 27, 2018

Nassau Queens PPS lowers emergency room visits from Creedmoor campus

When the partners of Nassau Queens Performing Provider System considered how to lower emergency room visits for their patients, they developed a heat map showing where residents were more likely to end up in the ER or hospital. One hot spot: the campus of Creedmoor Psychiatric Center, where outpatients who receive treatment or live in community residences on campus are responsible for an outsize number of ER visits. Most frequently they are taken to Zucker Hillside Hospital in Glen Oaks and Long Island Jewish Medical Center, a partner in Nassau Queens PPS, in New Hyde Park.

To tackle the problem, Nassau Queens PPS, the DSRIP network led by Nassau University Medical Center, Catholic Health Services of Long Island and Northwell Health's LIJ, created a Local Emergency Assistance and Diversion team in July to intervene when an individual on the campus was in crisis.

The program has made 211 visits to clients from July to January 2018, and in 205 cases it was able to de-escalate the situation without a trip to the emergency room. Of course, that doesn't take into account the ER visits that occurred when the LEAD team wasn't called. That's why the group is trying to increase awareness about the option.

"The key to me for this whole thing is the use of the peer—that's someo
Javis, director of behavioral health at Nassau Queens PPS. "It's been fo
noted that the peer workers can discuss their own strategies for dealin
clients to take their medication and participate in group counseling.

The Leader-Herald

May 10, 2018 | Today's Paper | Submit News | Subscribe Today

Fulton County telehealth initiative moves forward

LOCAL NEWS

FEB 7, 2017

JOHNSTOWN — Fulton County supervisors last week authorized acceptance of nearly $17,000 in state funds for county Public Health Department's new telehealth pilot initiative.

The Board of Supervisors' Human Services Committee voted Tuesday to accept $16,900 in funding through the Nor
County Delivery System Reform Incentive Payment, or DSRIP Program. An agreement is proposed for five years. T
full board will vote Feb. 13 on the final resolution.

@crainshealth

Watertown Daily Times

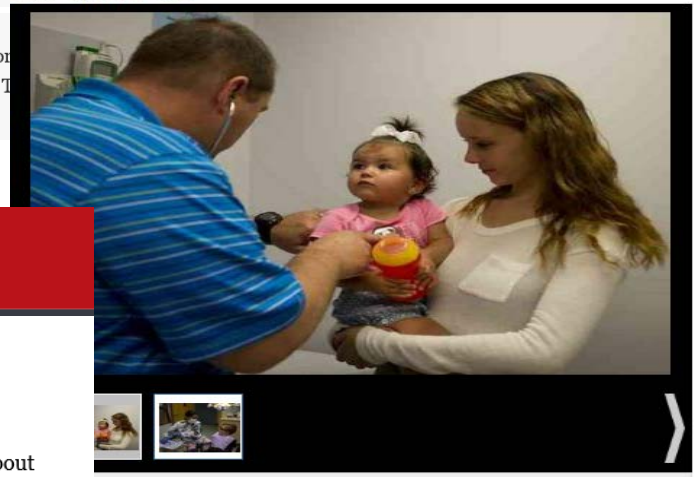
Serving the communities of Jefferson, St. Lawrence and Lewis counties, New York

In print daily. Online always.

Seeing results: Implementing DSRIP program has benefited north country

PUBLISHED: MONDAY, APRIL 30, 2018 AT 5:15 AM

◄ PREV Item 1 of 2 NEXT ►



WATERTOWN DAILY TIMES

holds her child, Izabella, while licensed practical nurse Steve Young listens to her heartbeat ck-up at the North County Family Health Center in Watertown in 2015.

Like 0 Share Tweet

lfway through their timeline, those the goals of the Delivery System ntive Payment program in Northern ve made steady progress.

15, DSRIP is a five-year plan to health care services are delivered to use Medicaid. It seeks to reduce ospital visits by 25 percent during is period.

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POLITICO

A DSRIP story

By DAN GOLDBERG | 05/03/2018 09:58 AM EDT

WHAT INTEGRATION LOOKS LIKE — It isn't easy for Angela to talk about last July 19. That's the day a man jumped out from the bushes outside her Staten Island home and attacked her. Her ribs were broken, as were several blood vessels in her face. There were other wounds, too, but they are not visible. Angela, who asked that her last name not be used to protect her privacy, spoke to POLITICO following an appointment with a psychiatrist at The Center for Integrative

te's

Bronx nursing home using telemedicine to prevent ER trips

Providence Rest, a nonprofit Bronx nursing home, has started working with StationMD, a Scotch Plains, N.J.-based telemedicine company to reduce unnecessary emergency room visits by its patients.

The six-month pilot is funded by an innovation grant from Bronx Partners for Healthy Communities, a Performing Provider System participating in the state Delivery System Reform Incentive Payment program. The goal of the pilot is to reduce hospital readmissions for medically frail patients.

Jean Bartley-Christie, director of nursing at 200-bed Providence Rest, said the service is most useful on nights and weekends when the nursing home has less physician coverage. On-call physicians or nurse practitioners during those times are less likely to know the patient and might not have access to patients' medical records.

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Making a Difference In Patients' Lives

Patient "D"

- 22 emergency room visits in five years
- 20 inpatient hospitalizations, six of which were crisis situations.

DSRIP Intervention:

- With guidance and support from a PCP Care Manager, a collaborative care plan was designed to address patient's social and medical needs
- Introduced to a Certified Diabetes Educator and nutritionist
- Introduced to new strategies for weight loss and management (DSRIP project (3.c.i)
- Received options for getting medical advice after-hours that did not include ER utilization.

Result:

- Since enrolling in care management, the patient has not had any hospitalizations or emergency room visits.

Making a Difference In Patients' Lives

- **Patient "Z"**
  - Adult female hospitalized 3 times in past year.
  - Drivers of utilization assessment revealed: Unstable housing, lack of connection with support services, not able to keep appointments or fulfill discharge plans; and boredom.

- **DSRIP Intervention:** Hospital Transition of Care Wellness Team with its CBO partners connected Patient Z to:
  - PEOPLe Inc. Housing Coordinator who helped prevent eviction.
  - Partial hospitalization program and to PEOPLe, Inc Peer Advocate to support completion of program
  - Crisis respite services to avoid future hospitalizations
  - Recovery specialist to work on goal-setting

- **Results:**
  - Patient Z is looking to be certified as Peer Advocate and the Transition of Care Wellness team helped her access online courses to help attain this personal goal.
  - No additional hospital admissions since the third admission in February 2018.

Making a Difference In Patients' Lives

"Y" and 7 year-old son

- 8 ER visits for son's asthma in 12 months
- 20 inpatient hospitalizations, six of which were crisis situations.

DSRIP Intervention:

- Meets with Spanish speaking Community Health Workers in ER
- Mom has trouble managing son's medicine – connected with Certified Asthma Educator
- Rescheduled missed appointments; reminders and escorts to appointments
- CHW coordinates meetings with school counselors
- Obtains nutritional services
- Initiatives children's health home services

Result:

- Keeping appointments; reduced ER visits Since enrolling in care management, the patient has not had any hospitalizations or emergency room visits.

Making a Difference In Patients' Lives

- **Fulton County Public Health Department**
  - Awarded an $80,000 grant from AHI PPS
  - Will expand telehealth stations to all communities in the county
  - Partnered with Nathan Littauer and St. Mary's hospitals, Fulton-Montgomery Community College, and the Fulton County Office for the Aging and Youth to implement a countywide Telehealth initiative

- **DSRIP Intervention:**
  - Allows participants to connect in real time to a healthcare provider at a local hospital via an encrypted HIPPA/FERPA compliant platform
  - Use of the telehealth technology can include clients' minor-to-major emergent health issues or requests for prescription refills.

- **Return on Investment:**
  - The post-pilot implementation has the potential of affecting 55,000 county residents, improving access to care, and decreasing unnecessary emergency room visits.

Medicaid Accelerated eXchange (MAX) Series: A Proven Success

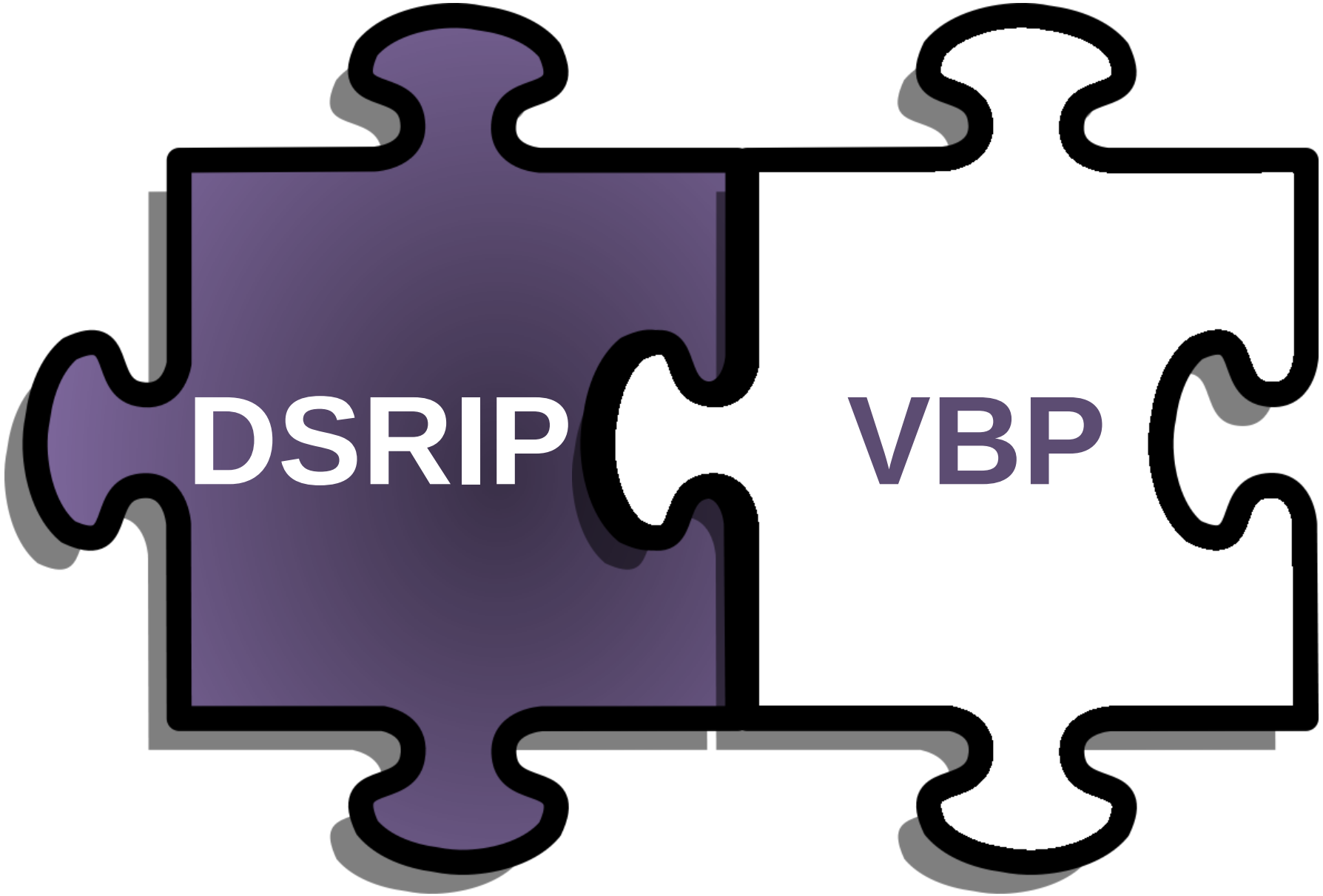
- MAX Series empowers hospital and community partners in their care redesign efforts increase patient and workforce satisfaction and reduce avoidable hospitalizations.

- More than 900 professionals from 68 hospitals and 11 community-based practices from around the State have participated in the MAX series to date.

- Early results:
  - 18 % reduction in hospital readmissions
  - 8 % reduction in hospitalizations overall
  - MAX series has helped nearly 15,000 high-cost, high-need Medicaid members

- Let’s keep the momentum going

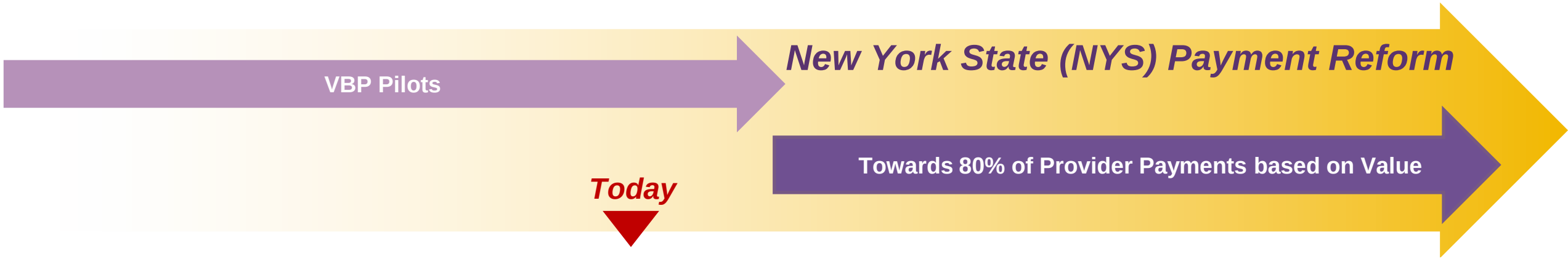
The Move to Value Based Payments


DSRIP
VBP

Payment Reform: Moving Towards Value Based Payments

- By DSRIP Year 5 (2020), all Managed Care Organizations must employ payment methods that reward value over volume for at least 80% of their provider payments
- The VBP Roadmap outlines how NYS aims to achieve this goal and establishes standards and guidelines for VBP contracts between MCOs and providers.
- If Roadmap goals are *not* met, overall DSRIP dollars from CMS to NYS will be significantly reduced

VBP: Timeline and Key Milestones



April 2017

Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP

April 2018

≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above

April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher *

April 2020

80% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher *

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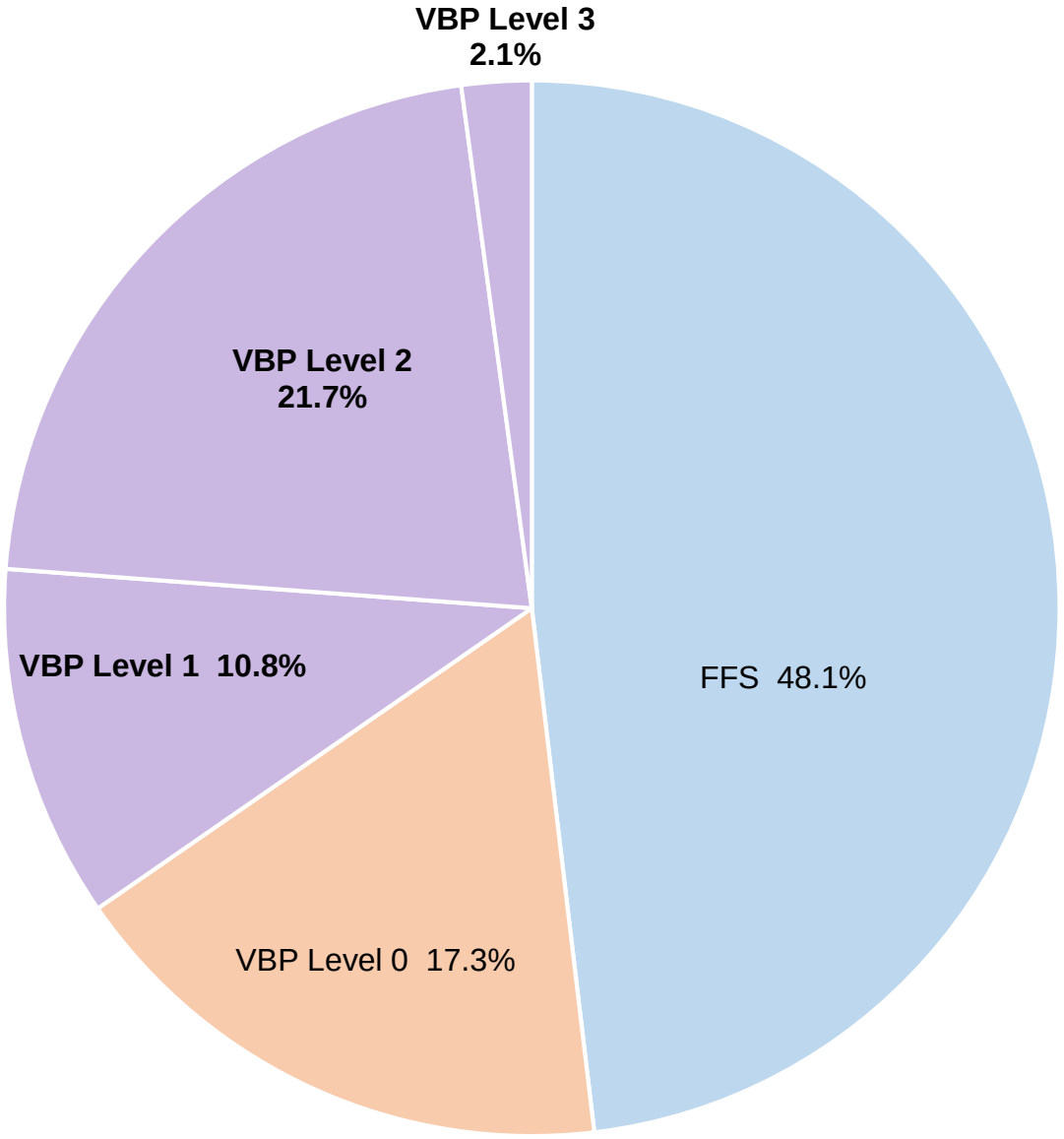
Key Aspects of VBP Arrangements

VBP contracts are defined by a common set of core components:

- Arrangement Type
- Level of Risk
- Quality Measures
- Social Determinants of Health Intervention
- Attribution Methodology & Member Volume
- Target Budget Setting and/or Shared Savings/Risk

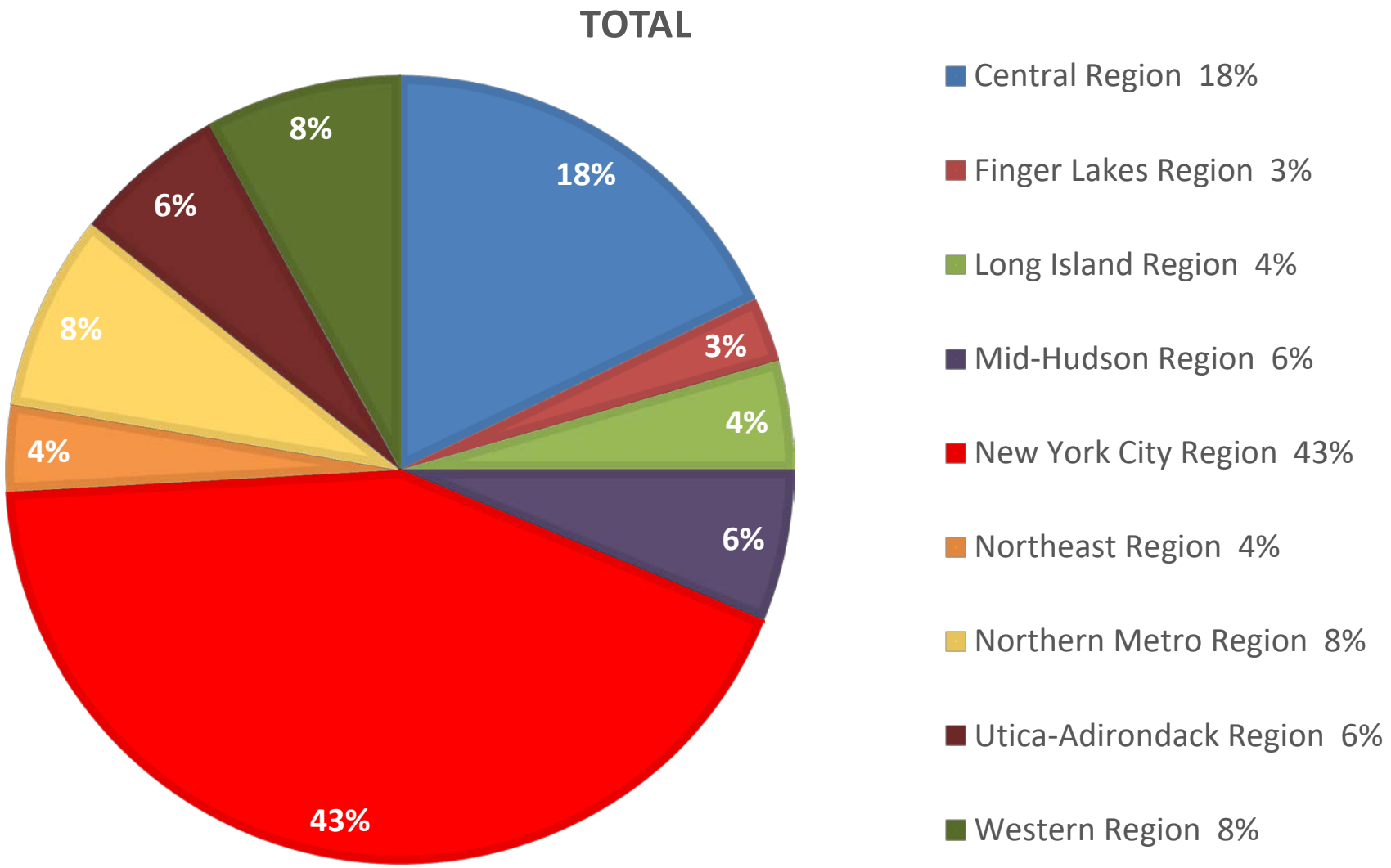
VBP: Current Status

- $7.46 B in VBP Arrangements
- 34.6% of Contracts



* Total Medical Expenses for period 4/1/17- 12/31/17
* Reflects exclusions specified in the Roadmap associated with e.g., Financially Challenged Providers; High Cost Specialty Drugs, Transplant Drugs, Certain Emergency services as well as the spending for various Supplemental programs (i.e., QIP, EIP, EPP, AHPP).

VBP Progress by Region



* Regions are designated by MMCOR regions

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VBP In Action

Example 1: New York City

MCO and Provider	• Several Managed Care Organizations • Large Provider Group
VBP Arrangement and Risk	• Total Cost General Population • Risk Level 2
Cohort	• 150,000 attributed lives. Focus on high utilizers of care
VBP / SDH Intervention	• Implementing an assessment and referral process to link members who need SDH interventions (i.e., food/housing) to care.

Example 2: Central New York

MCO and Provider	• Hospital Health Center • Two Managed Care Organizations
VBP Arrangement and Risk	• Total Cost General Population VBP Arrangement • VBP Risk Level 2
Cohort	• 35,000 attributed lives, includes high population of refugees
VBP / SDH Intervention	• Increases health outcomes to link members to walkable space and access to farmer's markets within their community.

VBP Innovator Program: An Overview

- Experienced VBP contractors who are continuing to chart the path into VBP
- Assume full responsibility for some functions typically carried out by MCOs, and share in others.
- Eligible for 90 – 95% of premium pass through
- Maximum flexibility and innovation to providers in delivering care for their attributed population.

Innovators must demonstrate proficiency in five areas:

1. A commitment to contracting for a high or full risk VBP Level 2 or Level 3 Total Care for General Population (TCGP) or Subpopulation arrangement

2. Upholding health plan network adequacy

3. Past success in VBP contracting for TCGP or Subpopulation arrangements

4. The ability to meet minimum attribution thresholds
    - TCGP: ≥ 25,000 Medicaid non–dual members
    - Subpopulation: ≥ 5,000 Medicaid members

5. Financial solvency

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Social Determinants of Health: Call For Innovations

- Nearly 200 innovation applications!
  - Community Based Organizations
  - Healthcare Providers
  - Technology Solution Companies

- A panel of experts will review the applications and chose the top innovations

- Social Determinants of Health Innovation Summit:
  - Planned for September 26, 2018

Maternal and Baby Health

- Maternal Mortality
- First 1,000 days on Medicaid Initiative
- Medicaid Initiatives

First 1000 Days on Medicaid

- Specific and laser focused on improving outcomes and access to services for children in their first 1000 days
- Focused on what is doable in the near-term
- Affordable
- Implementable through Medicaid levers

Expand Centering Pregnancy

- Pilot project in the neighborhoods/communities of poorest birth outcomes to encourage obstetrical providers serving Medicaid patients to adopt the Centering Pregnancy group–based model of prenatal care which has shown dramatic improvements in birth–related outcomes and reductions in associated disparities

  - Designed to enhance pregnancy outcomes through a combination of prenatal education
  - Centering Healthcare Institute (CHI) to provide both training workshops for providers as well as on–going implementation support and technical assistance
  - Ensure that implementation includes screening and referral for social determinants of health (environment, housing, educational attainment, etc.)

New York's Medicaid Doula Pilot Project

- On April 23rd, Governor Cuomo announced a comprehensive initiative to target maternal mortality and reduce racial disparities in health outcomes. This initiative includes a Medicaid pilot program to cover doulas.

- Finalizing Doula Pilot Design:
  - Geographic areas
  - Eligibility
  - Scope of services
  - Certification
  - Reimbursement
  - Evaluation
  - Outreach and awareness

- Contact us at: doulapilot@health.ny.gov

Children's Medicaid and Behavioral Health System Transformation Update

- Working with a broad group of stakeholders across the continuum of Behavioral Health, I/DD, Foster Care and Medically Fragile Children and Pediatrics
- Developed a broad scale approach to bring together a comprehensive set of aligned Home and Community Based Services into a comprehensive and integrated managed care design for our highest risk children and families.
- The design will end the fragmented HCBS access and delivery process, and expand the availability of HCBS and other services and integrates them with promising new health home care management and community support services into a single structure

- New York State Office for People With Developmental Disabilities is working with providers and families to improve care management services through a health home structure delivered through Care Coordination Organizations (CCOs).
- Centralized, resourced and integrated, CCOs will help members and families access and navigate existing services.
- Creates a bridge to the capacities the system needs to responsibly bring this population into managed care-increases access while preserving years of carefully designed services.

Looking Forward

Questions?

Additional information available at:

www.health.ny.gov/dsrip

www.health.ny.gov/vbp

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