NEW YORK STATE | Department of Health | Medicaid Redesign Team

Intellectual/Developmental Disabilities (I/DD) and DSRIP

Opportunities for PPSs to engage providers and Medicaid members

October 2015

Contents

- Importance of the I/DD Population from a clinical perspective
- I/DD population is a key subpopulation category in the DSRIP Program
  - Comparison of I/DD, BH and general population ER and in-patient (IP) Medicaid claims data
- PPS engagement with the I/DD population aligns with key DSRIP Program components
- Performing Provider Systems and current opportunities to engage I/DD populations
- DSRIP Program Projects and Payment Reform
  - The Future State of Healthcare in New York: Value-Based Payments
  - Opportunities for Involvement of I/DD providers in DSRIP

I/DD Population is important from a clinical perspective

- An estimated **1.5% to 2.5% of population** has an intellectual or developmental disability (I/DD).

- I/DD is a lifelong impairment:
  - Significant differences in functional status and abilities
  - Co-morbidities and co-occurring conditions are common
  - Over a lifetime, people's health status change

- Persons with I/DD who enter the ER are **more than twice as likely** to be admitted than the general population.

- An estimated **1 in 21** hospitalizations in NYS involve persons with I/DD.

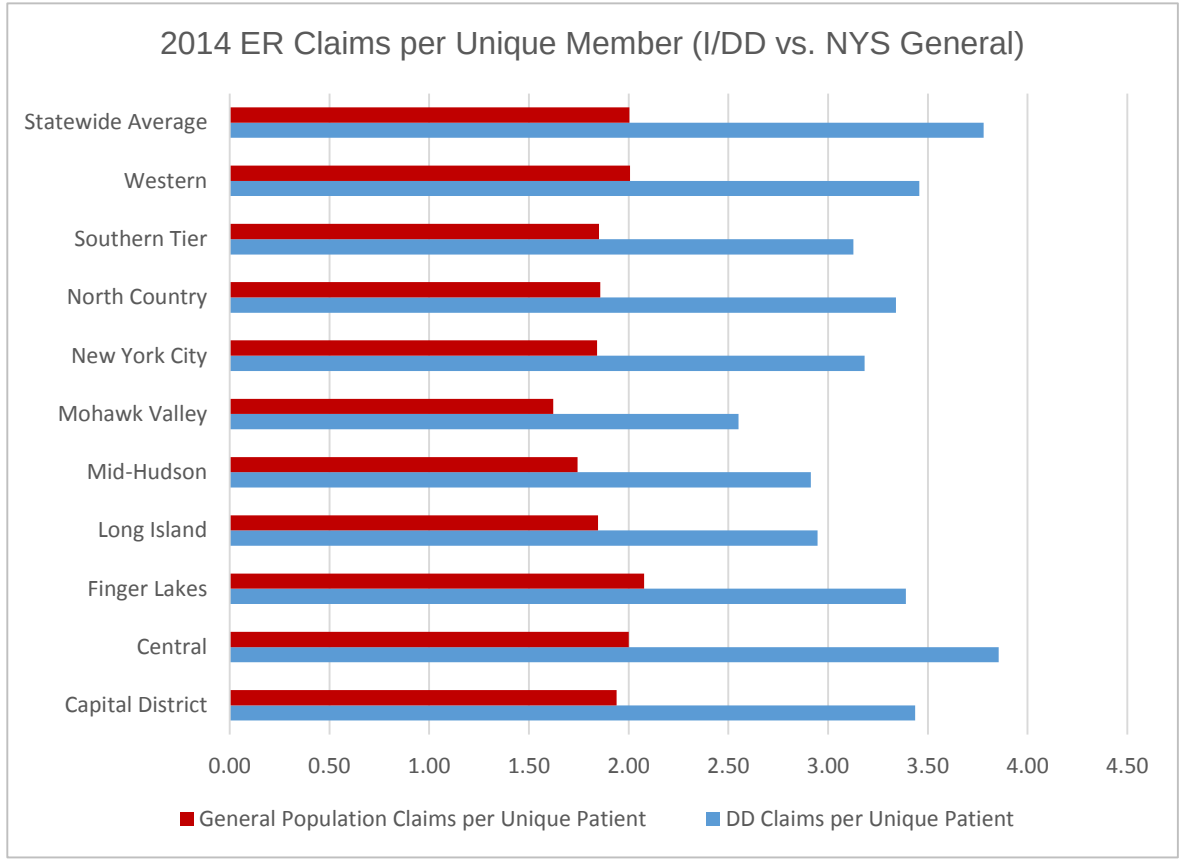
I/DD Population is a Key Subpopulation Category in the DSRIP Program

- 1% of I/DD population uses in-patient settings, yet 25% of total Medicaid expenditures for Mental Health services were on in-patient care.
  - This represents high resource utilization while hospitalized and longer lengths of stay.

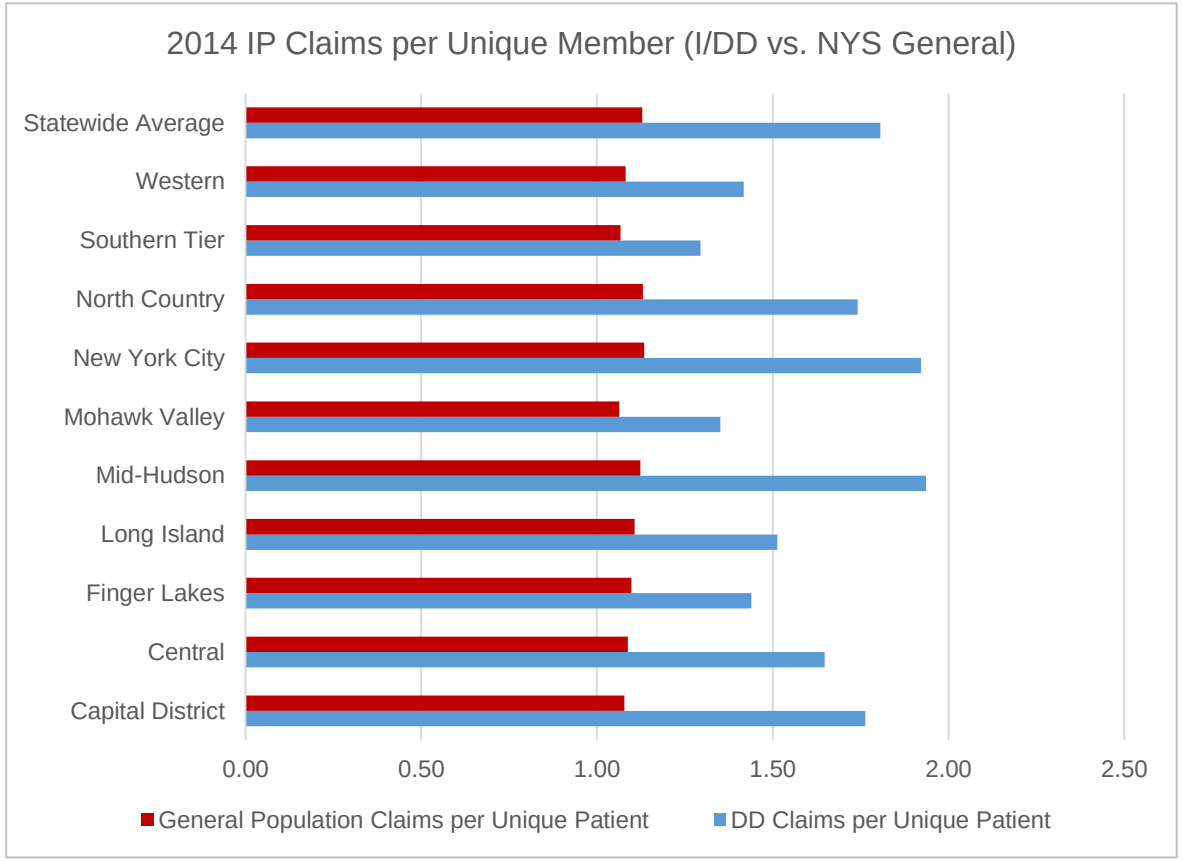
- People with I/DD often require increased staffing, are often difficult to diagnose and effectively engage in the milieu, and often have both longer lengths of stay and increased recidivism than the average person accessing acute behavioral health services.

- At any given point there are approximately 50 people with I/DD in acute in-patient settings who are identified as stable yet who have no place identified for appropriate long term supports and services.

Throughout NYS, per capita Medicaid ER and IP claims are higher in the I/DD population than the general population



ER Medicaid Claims



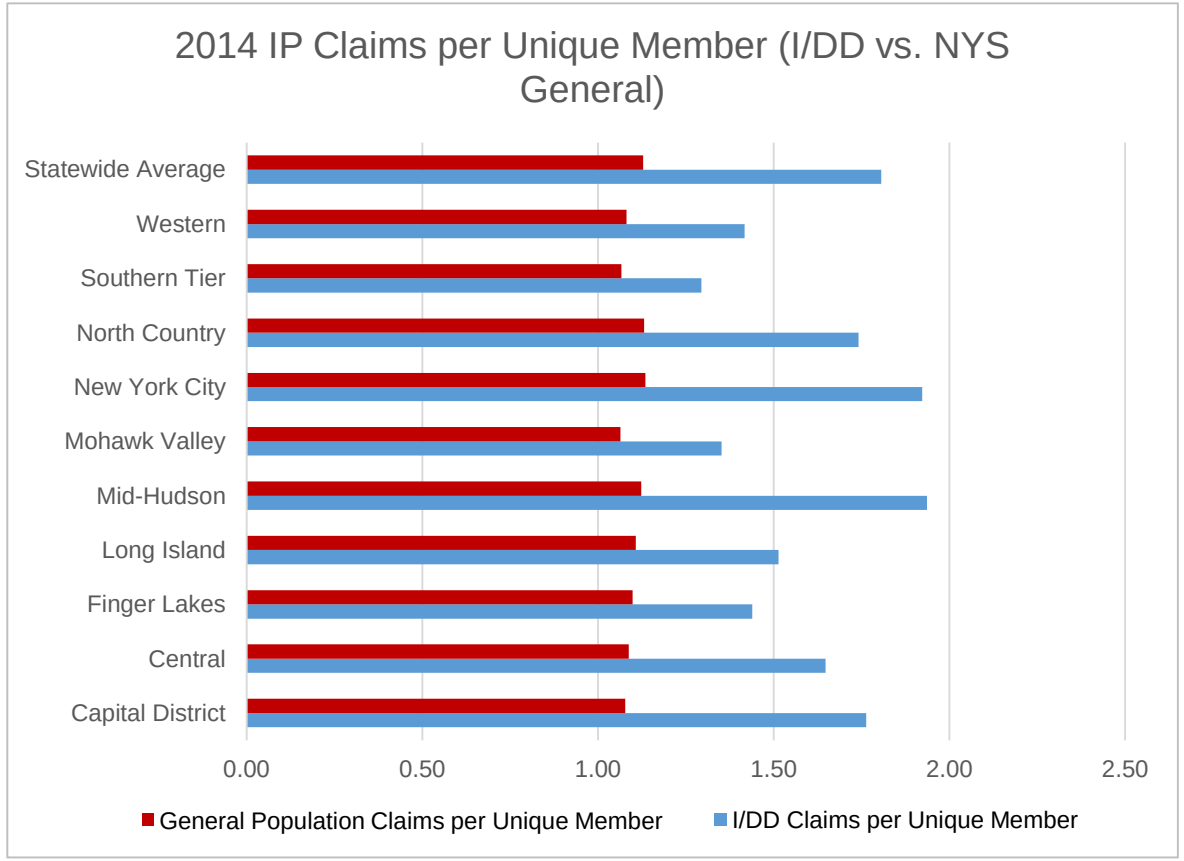
IP Medicaid Claims

** Statewide averages do not include regional duplications*

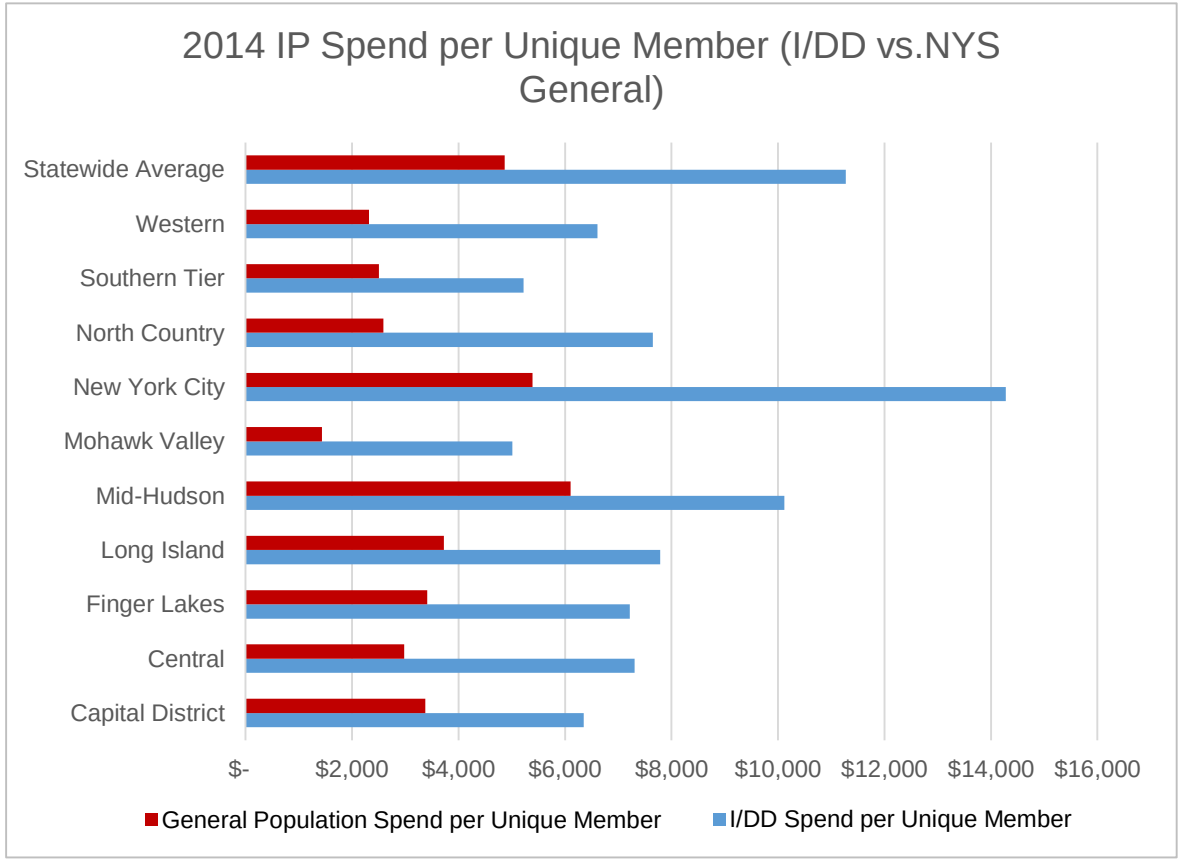
NEW YORK STATE OF OPPORTUNITY. Department of Health

I/DD Populations and In-Patient Hospitalization

I/DD vs. General Population Medicaid FFS Claims and Spend Data – In-Patient Hospitalization



IP Medicaid Claims

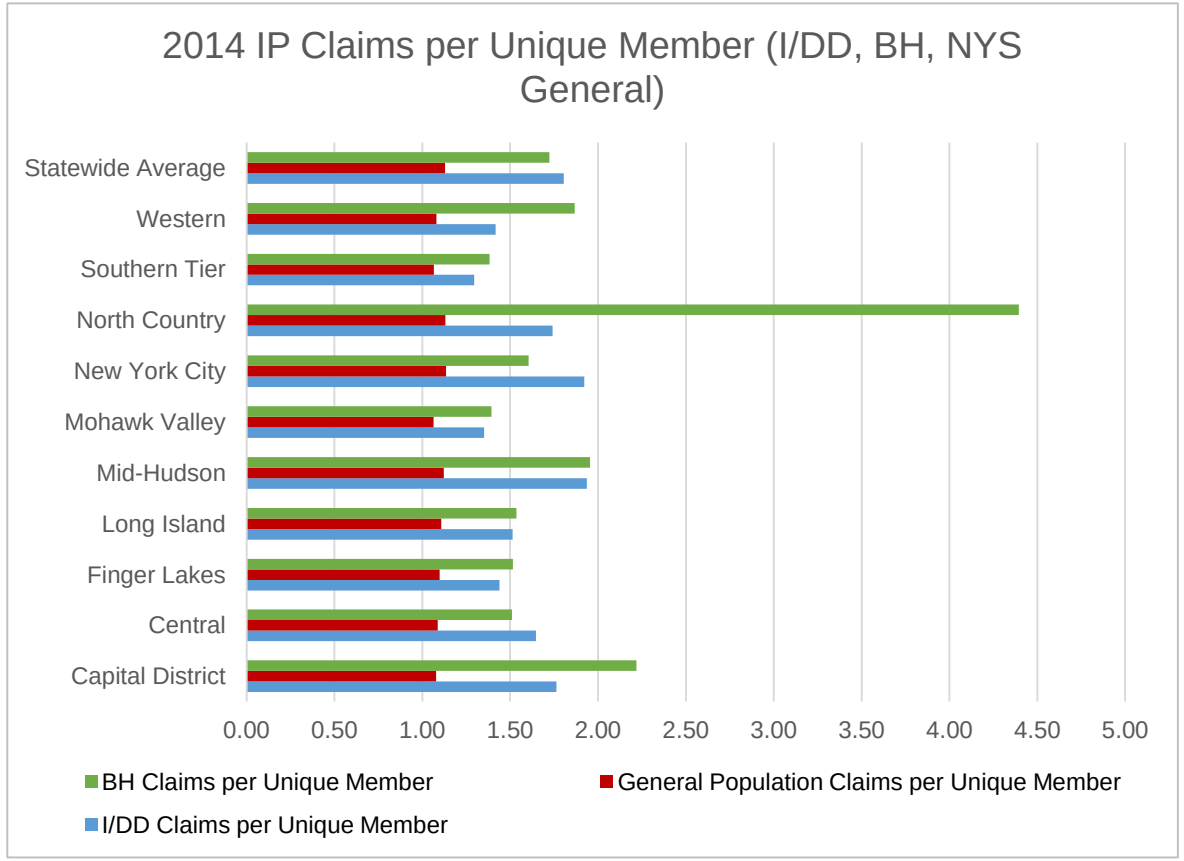


IP Medicaid Dollars Spent

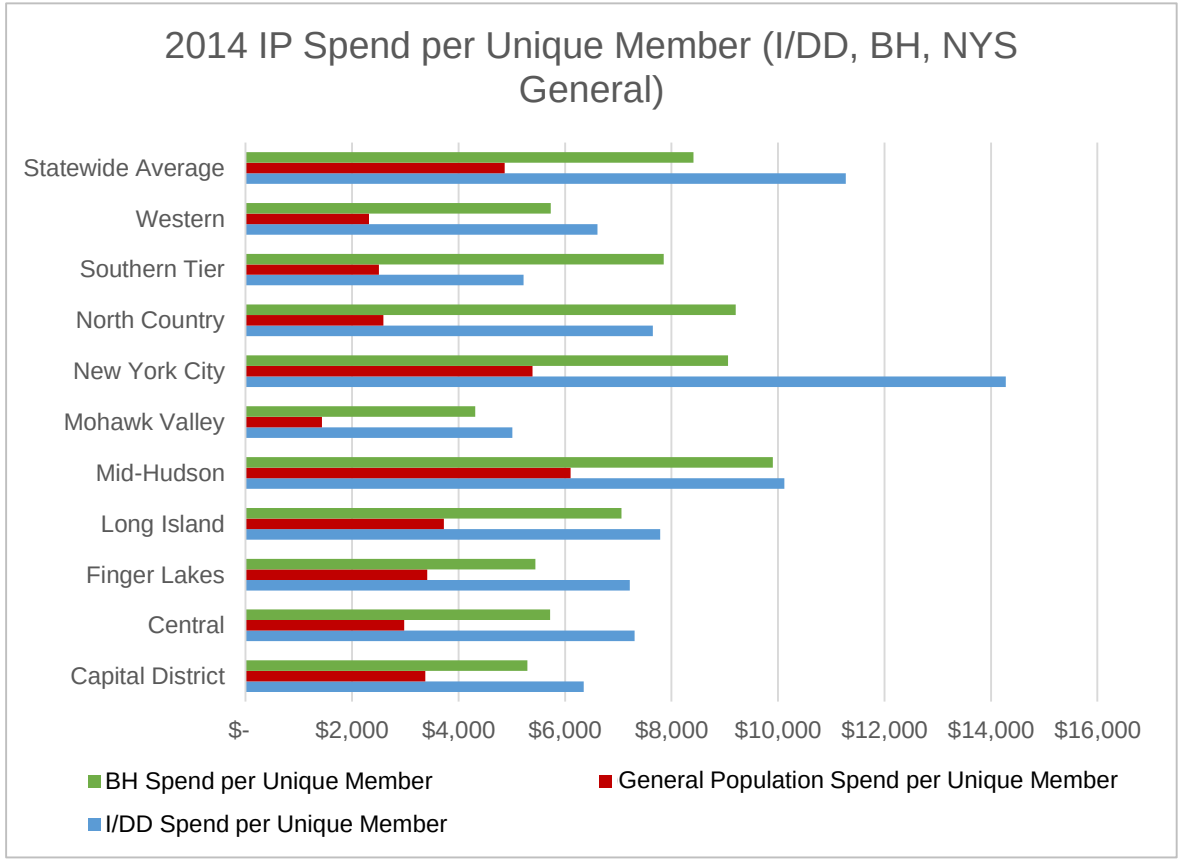
** Statewide averages do not include regional duplications*

NEW YORK STATE OF OPPORTUNITY. Department of Health

I/DD, MH, & General Population Medicaid FFS Claims and Spend Data – In-Patient Hospitalization



IP Medicaid Claims

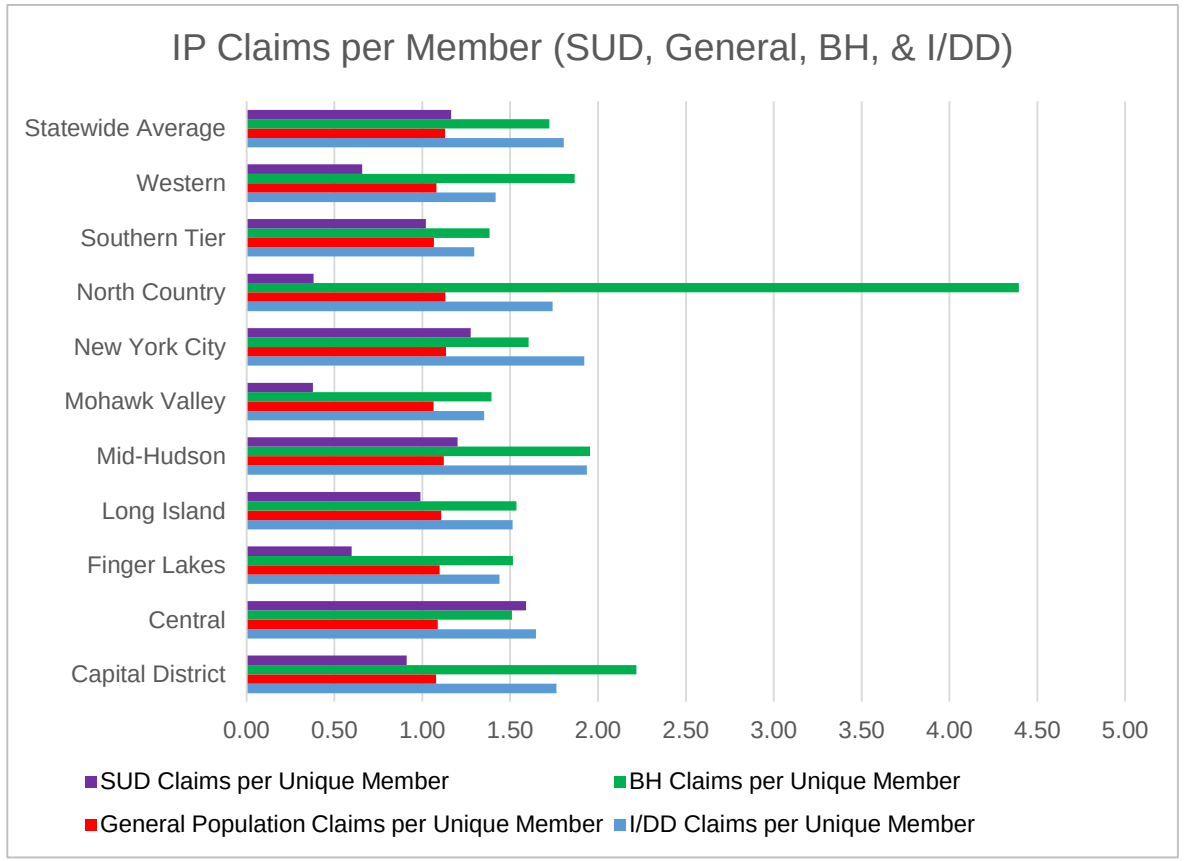


IP Medicaid Dollars Spent

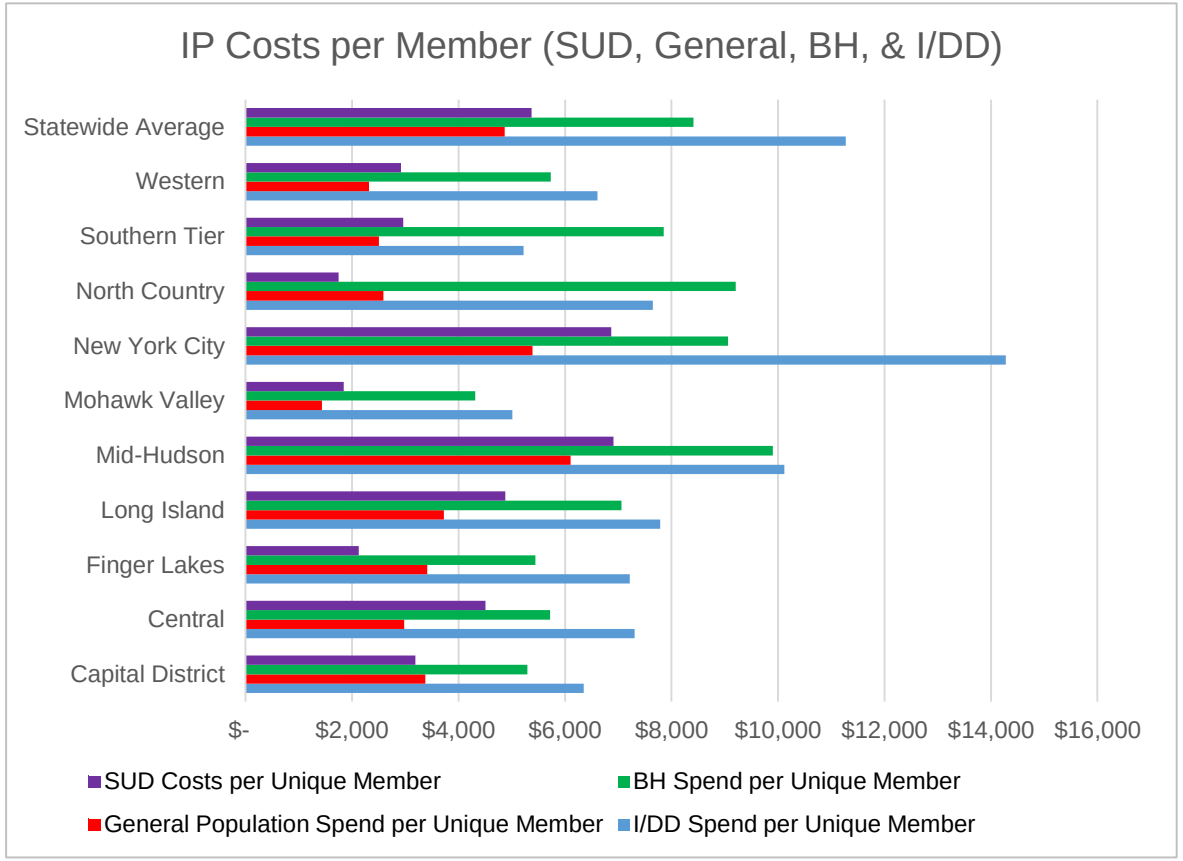
** Statewide averages do not include regional duplications*

NEW YORK STATE OF OPPORTUNITY. Department of Health

IP Claims & Cost per Member (SUD, General, BH, & I/DD)



IP Medicaid Claims



IP Medicaid Dollars Spent

** Statewide average includes duplication between regions*

NEW YORK STATE OF OPPORTUNITY. Department of Health

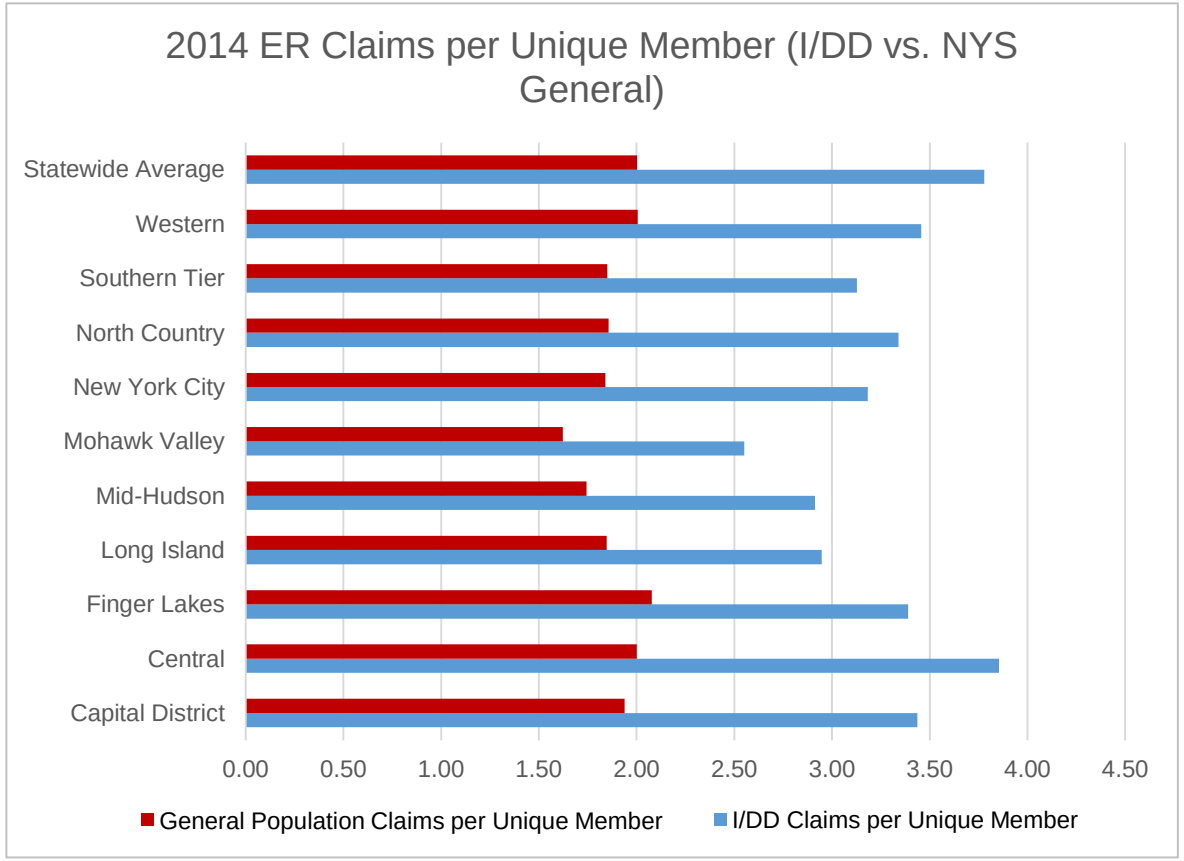
I/DD Medicaid Top 5 Claims and Spend – In-Patient Hospitalization

Top 5 DRG (In-Patient 2013) Claim Frequency	Sum of Medicaid Service Claim Counts
0053-2 SEIZURE	2155
0720-2 SEPTICEMIA & DISSEMINATED INFECTIONS	1265
0750-2 SCHIZOPHRENIA	1252
0753-2 BIPOLAR DISORDERS	966
0139-2 OTHER PNEUMONIA	711
Top 5 total	6349
Full total	35485
Top 5 as % of total	17.89%

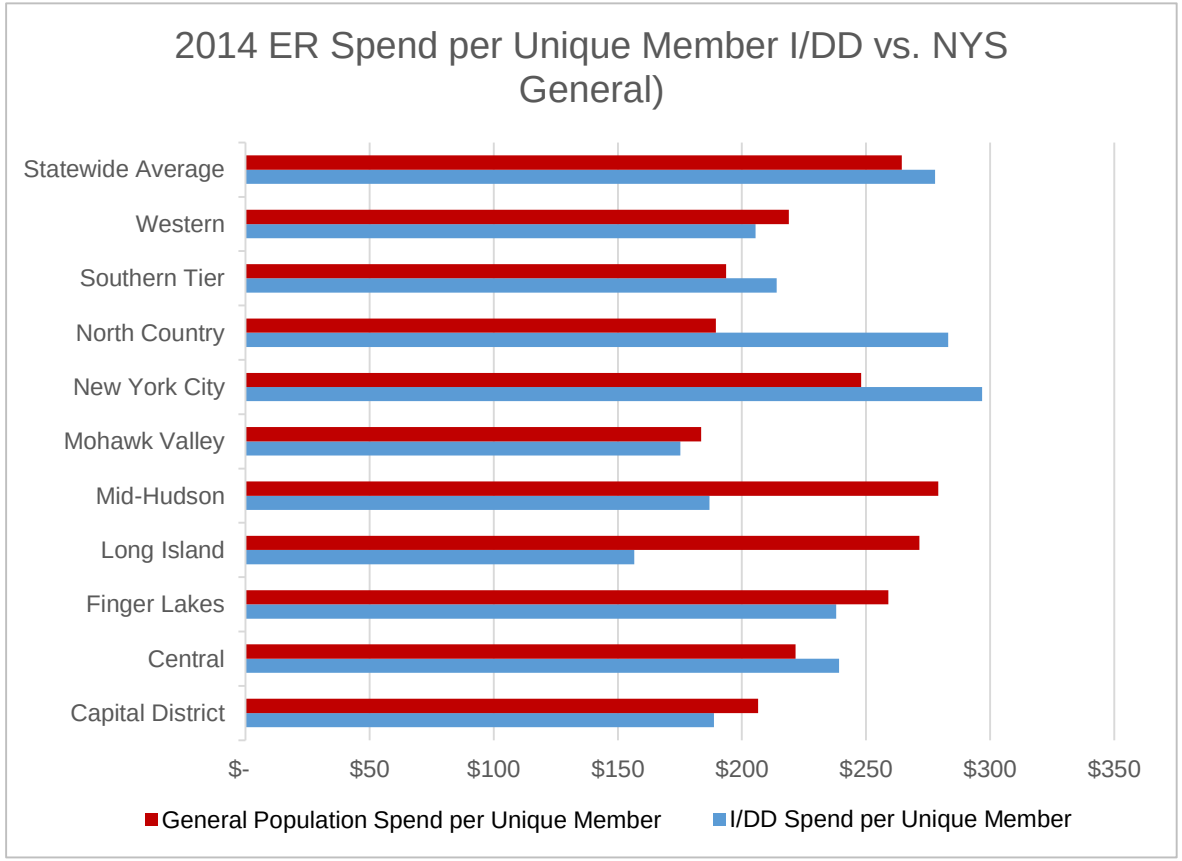
Top 5 DRG (In-Patient 2013) $	Sum of Medicaid Total Paid
0750-2 SCHIZOPHRENIA	$ 15,906,961
0053-2 SEIZURE	$ 11,764,177
0720-2 SEPTICEMIA & DISSEMINATED INFECTIONS	$ 11,449,747
0753-2 BIPOLAR DISORDERS	$ 9,647,935
0758-2 CHILDHOOD BEHAVIORAL DISORDERS	$ 4,954,447
Top 5 total	$ 53,723,269
Full total	$224,662,962
Top 5 as % of total	23.91%

I/DD Populations and Emergency Room Utilization

I/DD vs. General Population Medicaid FFS Claims and Spend Data – Emergency Room



ER Medicaid Claims

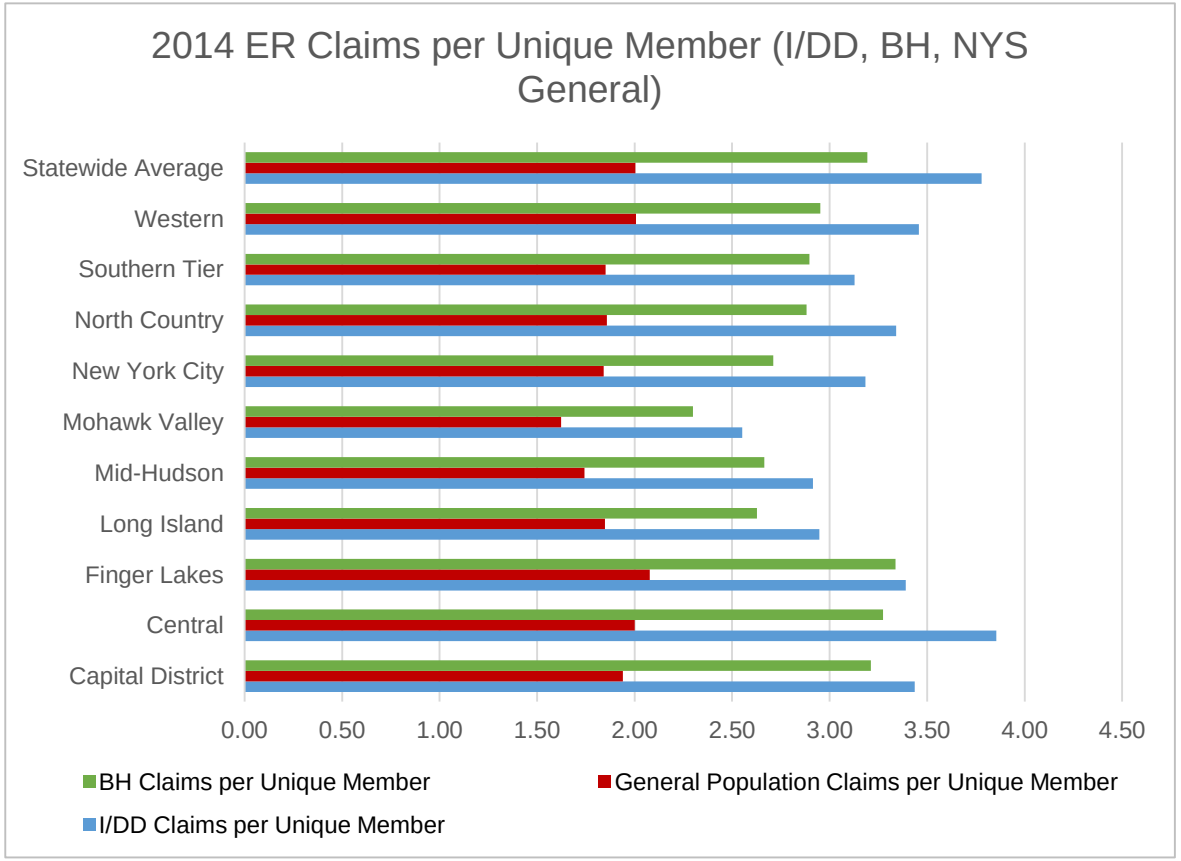


ER Medicaid Dollars Spent

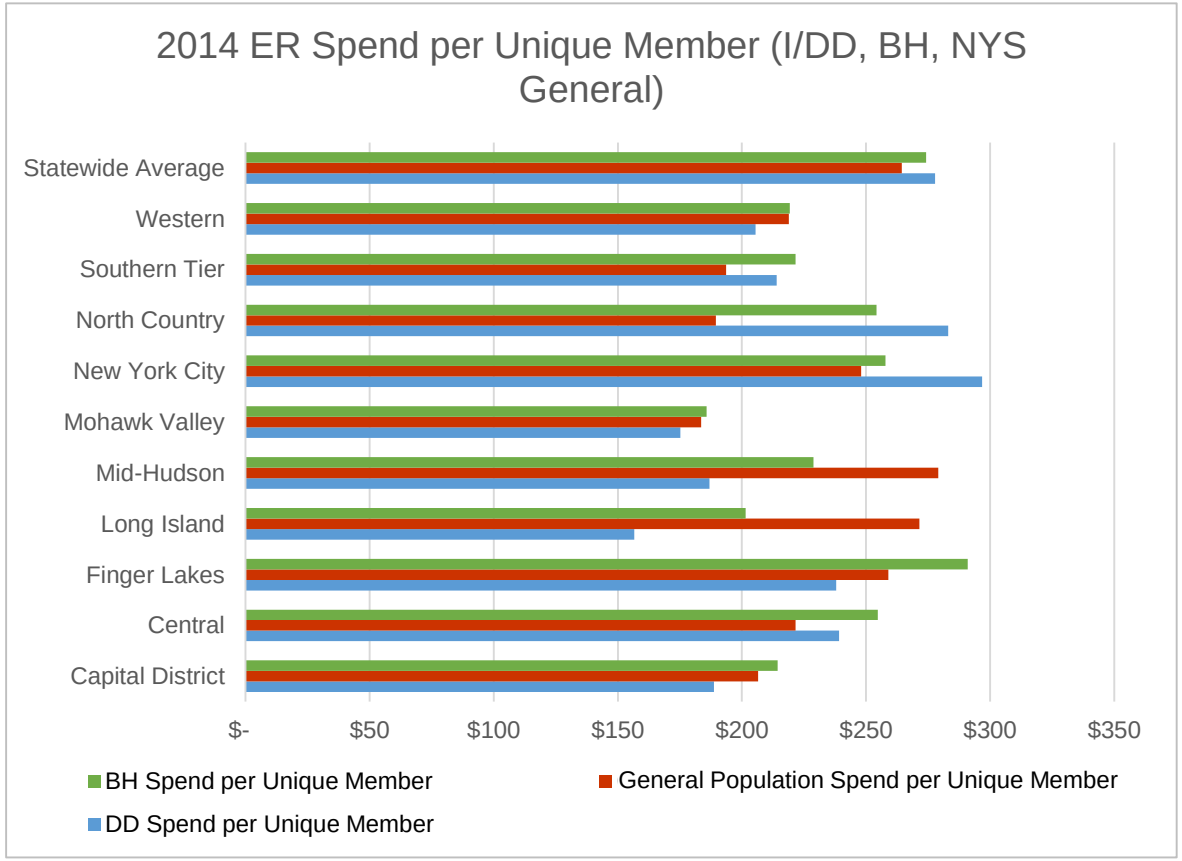
** Statewide averages do not include regional duplications*

NEW YORK STATE OF OPPORTUNITY. Department of Health

I/DD, BH, & General Population Medicaid FFS Claims and Spend Data – Emergency Room



ER Medicaid Claims

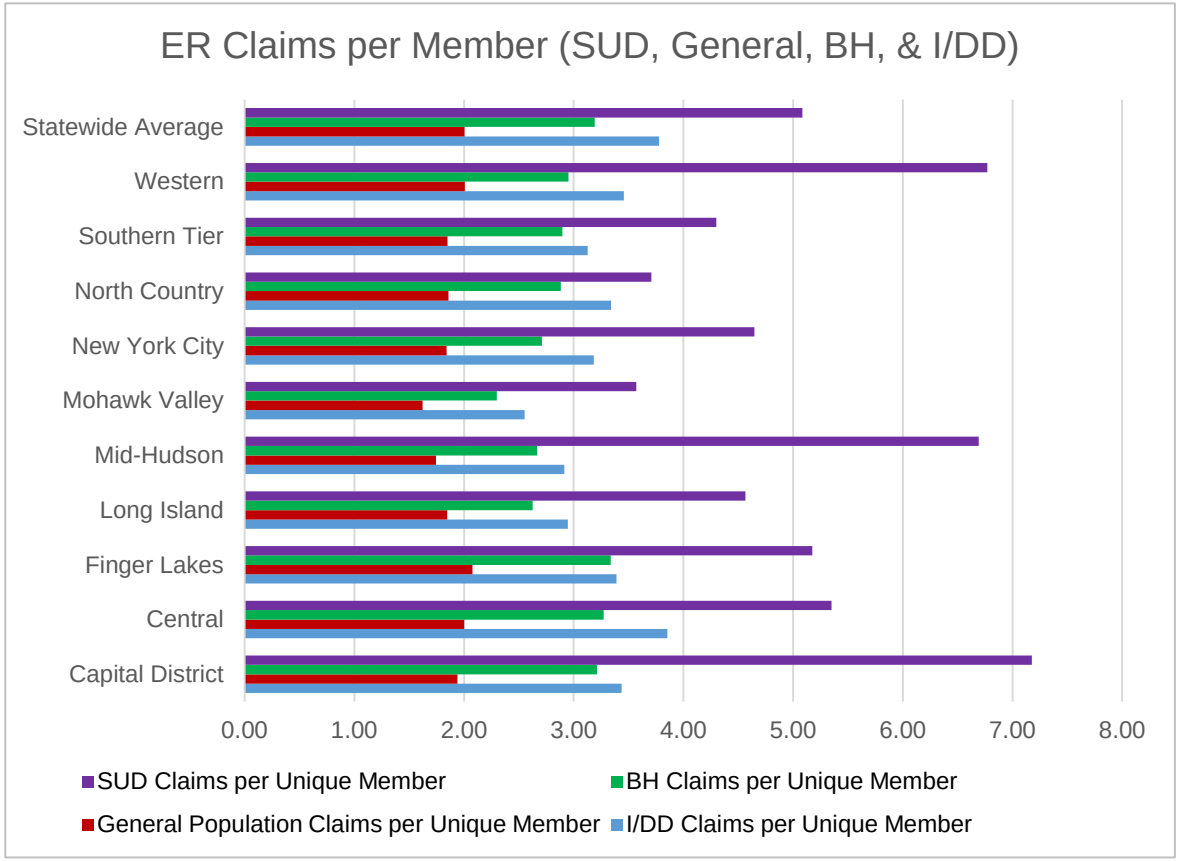


ER Medicaid Dollars Spent

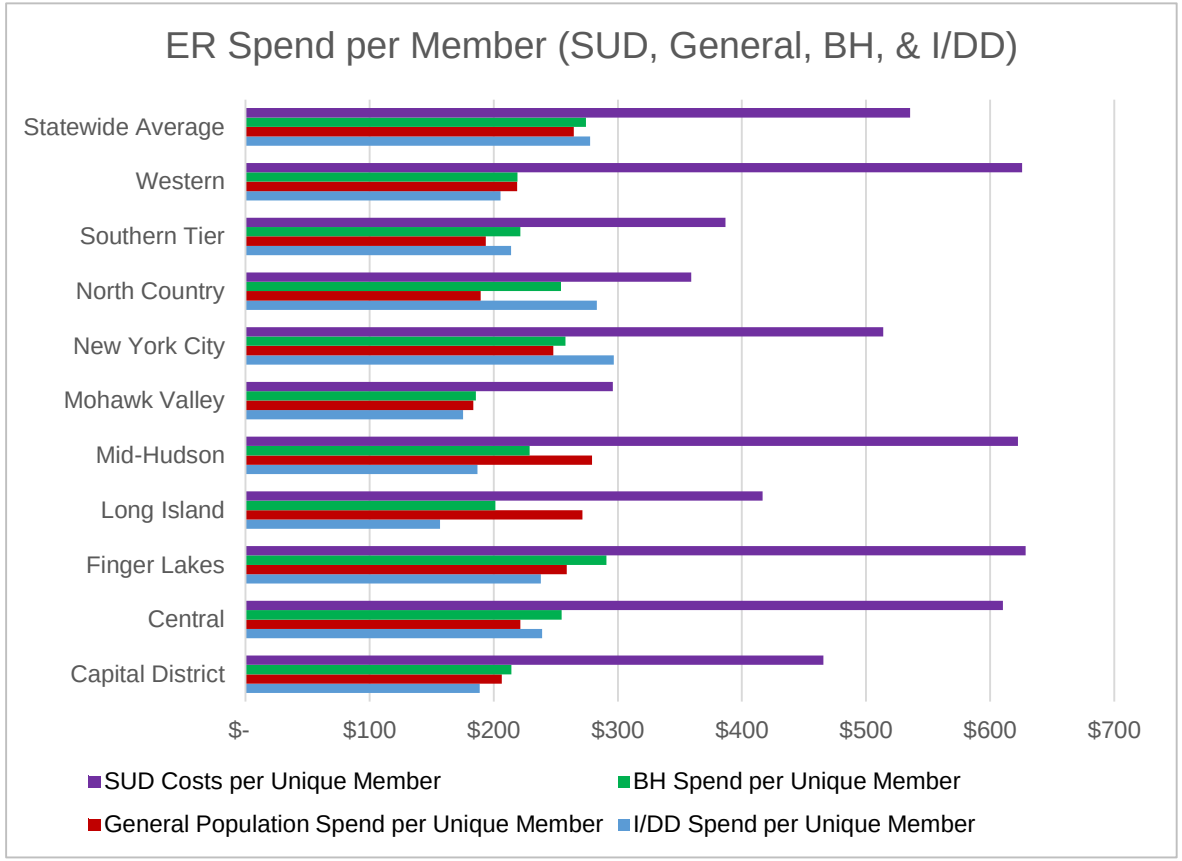
** Statewide averages do not include regional duplications*

NEW YORK STATE OF OPPORTUNITY. Department of Health

ER Claims & Spend per Member (SUD, General, BH, & I/DD)



ER Medicaid Claims



ER Medicaid Dollars Spent

** Statewide Average includes duplication between regions*

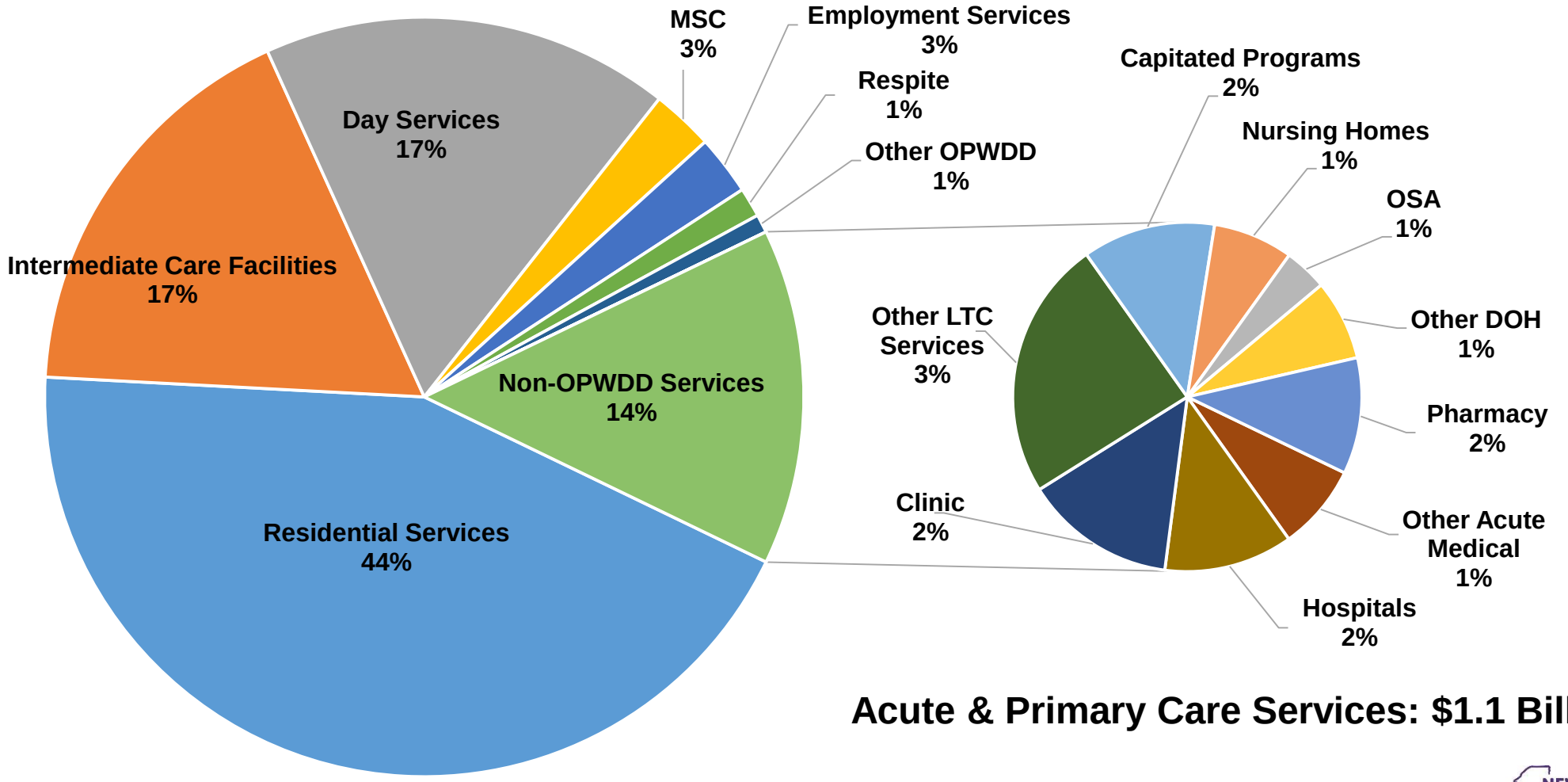
NEW YORK STATE OF OPPORTUNITY. Department of Health

Total Cost of Care (TCC) for Medicaid I/DD claims implications

- Long term care constitutes a significant portion of TCC for the I/DD population.
  - Medicaid I/DD claims for IP and ER are only looking at the Acute/Primary Care portion of the cost of treatment.
  - While TCC for the nearly 97,000 individuals analyzed within the I/DD system is $7.7B, Acute/Primary Care services account for only $1.1B of these services.

- By taking a “big picture” approach to I/DD population treatment and focusing on the coordination of both Specialty Services and Acute/Primary Care, there may be additional savings that can be generated through payment reform.

Total Cost of Care (TCC) for Medicaid I/DD claims – breakdown by service category



OPWDD Specialty Services: $6.6 Billion

Acute & Primary Care Services: $1.1 Billion

NEW YORK STATE OF OPPORTUNITY. Department of Health

I/DD Populations and DSRIP

MRT Waiver Amendment

- In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized agreement on the Medicaid Redesign Team (MRT) Waiver Amendment.

- Allows the State to reinvest $8 billion of the $17.1 billion in federal savings generated by MRT reforms for 6.3 million Medicaid members.

- The MRT Waiver Amendment will:
  - ✓ *Transform the State's Health Care System*
  - ✓ *Bend the Medicaid Cost Curve*
  - ✓ *Assure Access to Quality Care for all Medicaid Members*

PPS engagement with the I/DD population aligns with key DSRIP Program components

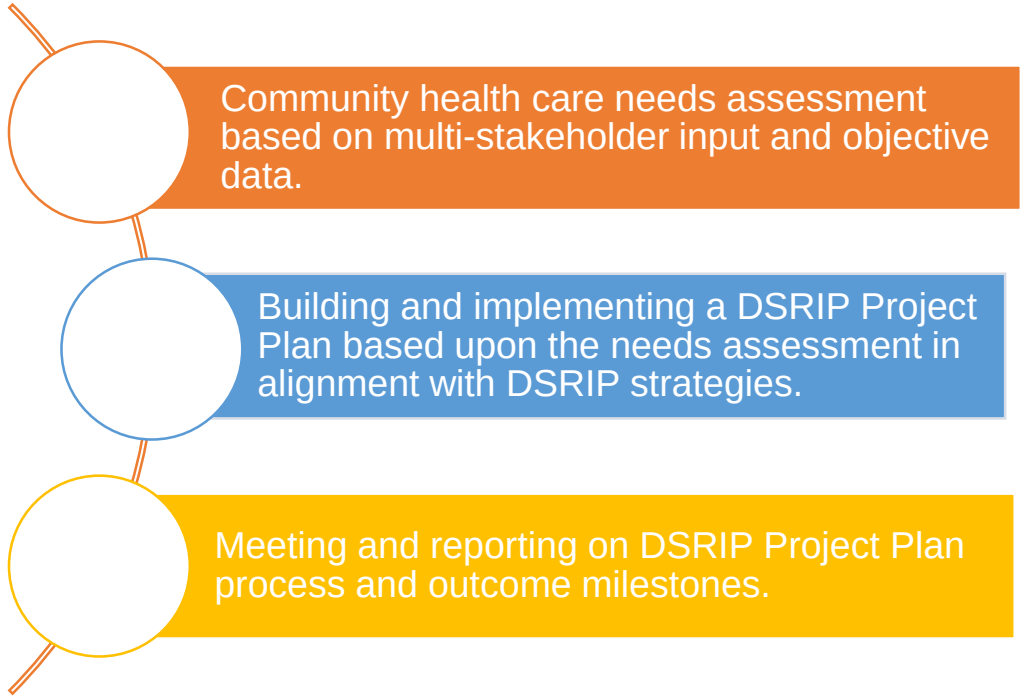
- DSRIP's overarching goal is to reduce avoidable hospital use (ED and in-patient) by 25% over 5+ years of the program by building on the CMS and State goals in the Triple AIM:
  - Improving Quality of Care
  - Improving Health
  - Reducing Cost

- This will be done by **developing integrated delivery systems**, **removing silos**, **enhancing primary care and community-based services**, and **integrating behavioral health and primary care**.
  - I/DD population represents a special population with a particularly high utilization, positioning it as a significant opportunity for PPSs to consider when designing these integrated care networks.

Performing Provider Systems (PPSs) and Opportunities to Engage

Performing Provider Systems and Local Partnerships

- PPS Partners should include:
  - ✓ *Hospitals*
  - ✓ *Health Homes*
  - ✓ *Skilled Nursing Facilities*
  - ✓ *Clinics & FQHCs*
  - ✓ *Behavioral Health Providers*
  - ✓ *Home Care Agencies*
  - ✓ *Physicians/Practitioners*
  - ✓ *Other Key Stakeholders*



Member Attribution Logic: Multi-PPS Scenario

- When there is more than one PPS in a defined geographic area, utilizing Medicaid members will be attributed using the following method*:

- **STEP 1:** Assign population subcategory:
  - Four mutually exclusive population subcategory groupings were set up for DSRIP attribution purposes:
    1. *Intellectual and Developmental Disabilities (OPWDD Service Eligible – Code 95)*
    2. *Long Term Care (Only NH residents)*
    3. *Behavioral Health (SMI/Serious SUD)*
    4. *All Other*
- **STEP 2:** Specific attribution loyalty logic that was specifically designed for each of the four subpopulations based on a clinically relevant hierarchy of service connectivity for each category.

**The attribution loyalty logic process described here and in the following slides does not apply to a single PPS in a region – the single PPS would have all MA members attributed to it.*

The Time is Right…

- PPSs are currently working on implementing their project plans and will want to work with their network partners to operationalize their chosen projects.
- Opportunity for provider organizations in these networks to have conversations with their PPS(s) about quality improvement goals and ways to reduce avoidable ED utilization and hospitalizations.
- Since I/DD advocacy groups know the population best, they have a voice in coordinating with PPSs on what can be done to avoid hospitalization.

DSRIP Program Projects and Payment Reform

DSRIP Domains and Project Requirements

Project implementation is divided into four Domains for project selection and reporting:

- **Domain 1 –Overall Project Progress**
  - This domain "houses" the project's process measure for all three domains

- **Domain 2 –System Transformation***
  - ✓ *2.a.i Creating an integrated delivery system*
  - ✓ *2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions*
  - ✓ *2.b.ix Implementation of observational programs in hospitals*
  - All PPSs must select at least two (and up to four [or five*]) projects from Domain 2

**Only PPS approved to conduct project 2.d.i will be able to select a maximum of five projects from Domain 2 (and 11 projects in total). All other PPS will maintain the opportunity to choose up to four projects from Domain 2 (and up to 10 projects in total).*

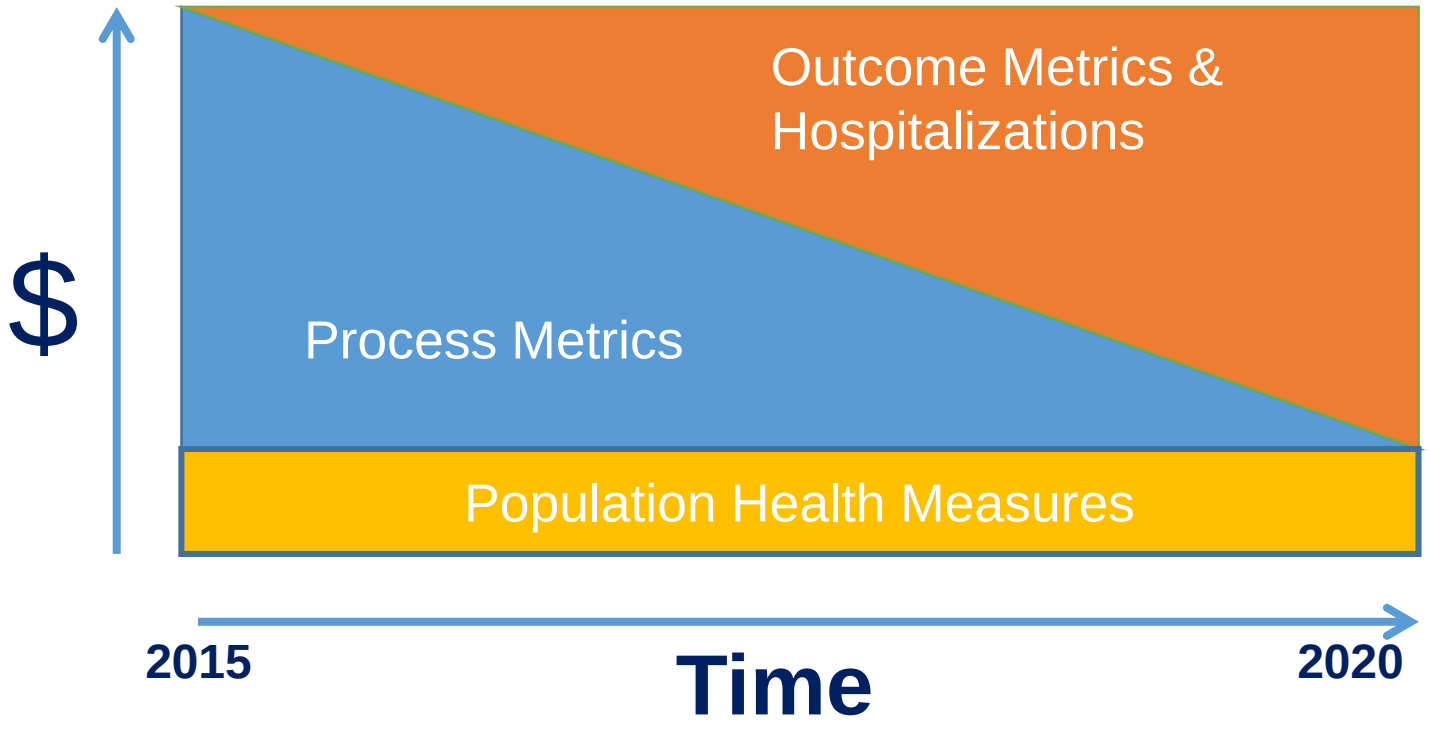
DSRIP Domains and Project Requirements

- **Domain 3 –Clinical Improvement**
  - CV disease, asthma, diabetes, perinatal care, HIV/AIDS, e.g.
    - ✓ *3.a.i Integration of primary care services and behavioral health*
    - ✓ *3.a.ii Behavioral health community crisis stabilization services*
  - All PPSs must select at least two (but no more than four) projects from Domain 3

- **Domain 4 –Population-wide Strategy Implementation –The Prevention Agenda**
    - ✓ *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.b.i Promote tobacco use cessation*
  - All PPSs must select at least one (but no more than two) projects

The Future State of Healthcare in New York: Value-Based Payments

DSRIP Program Finance Framework



DSRIP's transition to Performance-Based Payment provides a natural progression to the VBP future-state

- The transition from a pay-for-reporting (P4R) to pay-for-performance (P4P) as the DSRIP Program progress from DY1 to DY5 leads naturally to Value-Based Payment.

- Greater levels of care coordination, through both care technology and workforce integration, may enable greater levels of risk sharing among provider types and increased opportunities to take advantage of shared savings.

ACO Total Cost of Care: As an Option for I/DD Value-Based Payments

- An alternative means to still coordinate care and achieve system savings without a full-risk model.
  - Enables the provider network to continue to operate on a FFS basis and provides incentives through shared savings. These shared savings could be reserved for program expansion (waiting list relief, supported employment slots, and even non-Medicaid services (housing)).
  - Creates financial incentives for providers serving the complicated needs of the I/DD population to come together to find efficiencies and share in the financial rewards, which may further encourage I/DD ACOs and PPSs to work together.

The Future State of Healthcare in New York

NYS DSRIP Program's Vision

Today's Care	Care in DSRIP Program
PCP refers I/DD individual to mental health	I/DD Individual sees mental health at the same place and same day as medical practitioner
Acute care is given as next available, and walk-ins are scheduled for another time	Open access scheduling accommodates ALL appropriate acute care and walk-ins
Care delivered around acute illness, IP hospital stays, and ER visits	Annual exams and preventive care shift the focus to wellness for I/DD population at home and in their communities
PCP directs Care Management	Care Management needs met *a priori*, and all appointments are coordinated around Care Management
I/DD care directed by a single practitioner	I/DD care coordinated by a multidisciplinary team, each member working to the full extent of her/his scope of practice.
I/DD individual (or guardian) informs practitioner about what happened when hospitalized in another city	Integrated electronic network enables the practitioner to see the other providers' labs, imaging studies and discharge summary.

A Shared Vision for PPS Engagement With the I/DD Population

- OPWDD has begun implementation of START, a statewide crisis prevention and response model, which is focused on ensuring effective treatment and reducing dependency on higher levels of service.

- START is a national, evidence-informed model that has demonstrated effectiveness and focuses on capacity building for the system.

- This will be discussed by OPWDD in greater detail.

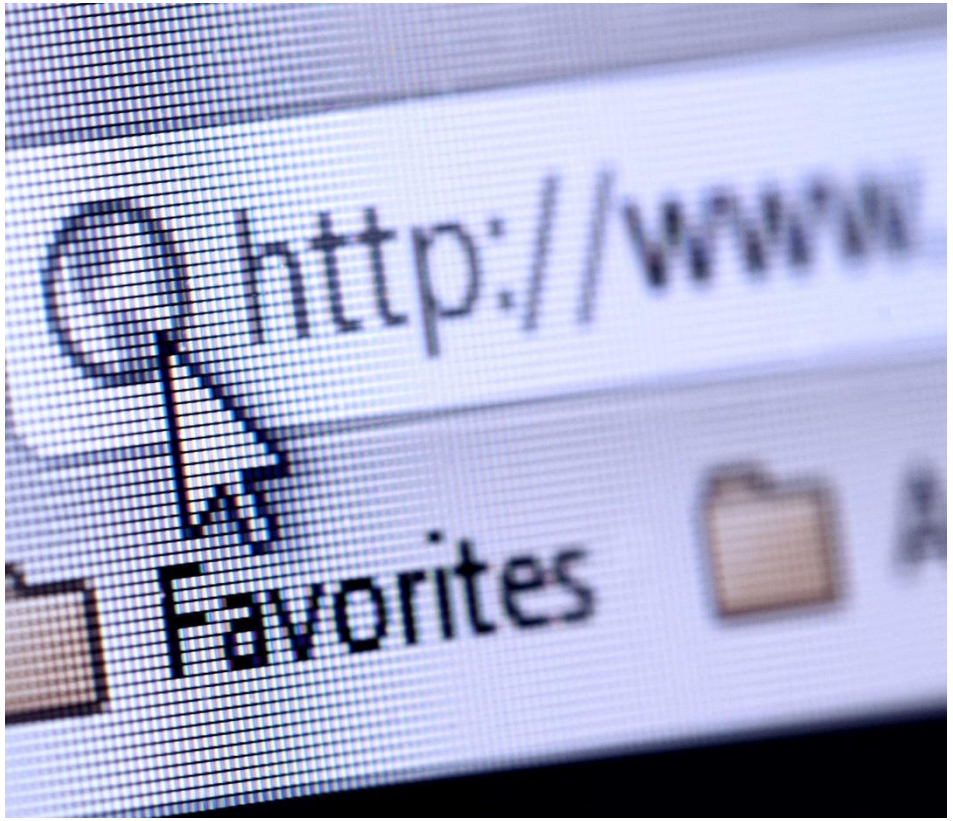
DSRIP Program Resources

DSRIP e-mail: dsrip@health.ny.gov

'Like' the MRT on Facebook:
http://www.facebook.com/NewYorkMRT

Follow the MRT on Twitter: @NewYorkMRT

Subscribe to our listserv:
http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm



NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

Better Understanding and Engagement of the I/DD Population for PPSs participating in DSRIP

October 2015

A New Safety Net Needed

- Developmental Center closures require effective community based support models

- Increasing pressure on emergency department usage and inpatient settings for people with I/DD in behavioral health crisis

Proposed Solution

- OPWDD has begun implementation of START, a statewide crisis prevention and response model, which is focused on ensuring effective treatment and reducing dependency on higher levels of service.

- START is a National, Evidence Informed Model that has demonstrated effectiveness and focuses on capacity building for the system.

NY START: Implementation Status

- NY START has two operational pilot teams delivering services in OPWDD's Region 1 and Region 3.
- The Request for Application in Region 4 was released on August 17, 2015.
- Formal service analysis and program design is underway for Region 5.
- NY START will be implemented in the final region of the state, Region 2, in 2017.

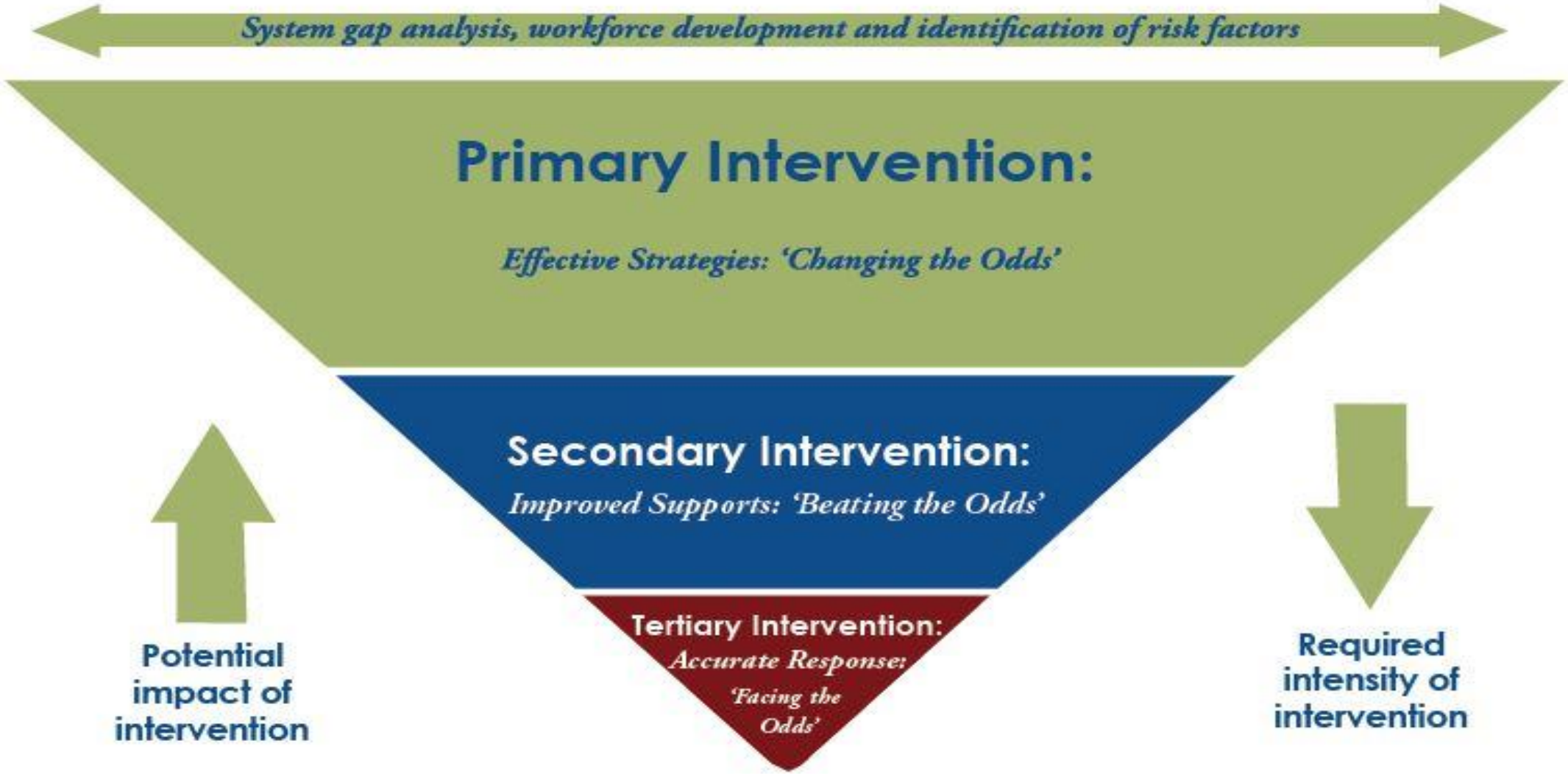
NY START Mission

NY START increases community capacity to provide an **integrated response** to people with intellectual/developmental disabilities and behavioral health needs, as well as their families and those who provide support. This occurs through **cross systems relationships**, training, education, and **crisis prevention and response** in order to enhance opportunities for healthy, successful and richer lives.

Core START Elements

- Employs data driven, evidence-informed person-centered practices and outcome measures.
- Implementation of multi-level cross system linkages (local, statewide, national) by trained START Coordinators.
- Consultation, assessment and service evaluation to augment the existing system of support.
- In-home therapeutic supports (ages 6 – adult).
- Site Based Therapeutic Resource Centers (ages 21+).
- Crisis support 24 hours/7 days a week.
- Team response time, 2-3 hours.
- Clinical education teams, online training forums, family support and education.

Public Health Model & START: Numbers Benefitting from Intervention



Developing Capacity and Partnership

Linkage Agreements help to:

- Establish cross systems collaborative framework and define expectations.
- Improve outpatient supports, community partnerships, and treatment outcomes.
- Decrease the need for hospitalization and/or the loss of community placement.

NY START SIRS* DATA

*START Information Reporting System

Early Service Outcome Information

July 31, 2015

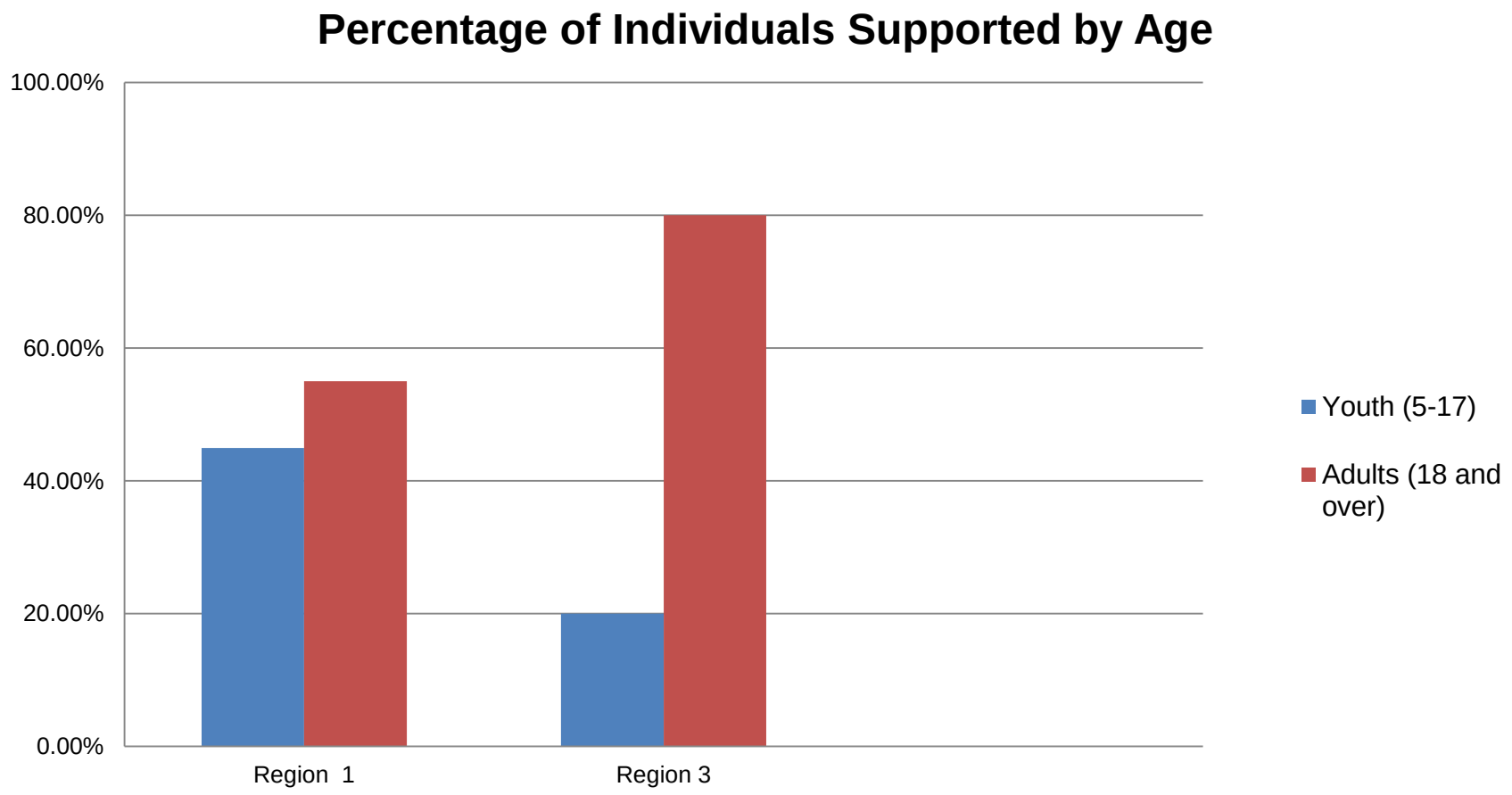
NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

NY START

OPWDD Region	*Number of individuals Accepted for NY START
Region 1 (8/2014-7/31/15)	149
Region 3 (9/2014-7/31/15)	180
Total	**329**

***Accepted – Individual accepted for START services and receiving services.**

Youth and Adult



Reduction in Psychiatric Hospital & ED Use: 2014-2015

	Region 1	Region 3
Pre START Referral Psychiatric Use	18.79%	35.56%
Post START Referral Psychiatric Use	7.38%	0.83%
Pre START Referral Emergency Department Use	26.61%	23.74%
Post START Referral Emergency Department Use	8.72%	0.56%

Service Trends
(See Addendum for Details)

- Assessment
- Outreach
- Cross System Crisis Planning
- Consultation Services
- Clinical Education Team (CET)
- Community Education

Resources and Additional Information

Additional Information on the Center for START Services and NY START can be found on the OPWDD website at the following link:

http://www.opwdd.ny.gov/ny-start/home

PPS Engagement with the I/DD Population – Shared Vision

NYS DSRIP and START Program - Shared Vision

Goals of DSRIP:	START model
Participation of stakeholders and CBOs	Linkage agreements Advisory Councils
Education of workforce	Defined, evidence based education for workforce – cross systems focus
Partnerships between PPSs and CBOs	Data related to START activities • Assessments completed • Crisis plan development • Disposition of ED presentation
Reduction of ER use **Deferment or reduced length of stay in inpatient hospital settings**	• Data on LOS and frequency of hospital admissions for START service recipients. • System engagement and capacity building for preventative approaches.
Community based treatment options	Resource Centers for up to 30 day stays focused on prevention and stabilization

Current Engagement with DSRIP Region 1 START

- Connections with Millennium Performing Provider System (hosted by Erie County Medical Center, ECMC) and the Finger Lakes PPS have been developed.
  - A letter of agreement with Millennium has been signed
  - A contract with Finger Lakes has been signed.

- Alignment with Project 3.a.ii: Behavioral Health Community Crisis Utilization Services has taken place.
  - This project targets high utilizers of behavior health emergency services.
  - The focus of this project is to reduce utilization of emergency departments and inpatient behavior health services.

- Assisting with, identifying and collaborating with crisis programs throughout the region while providing support for individuals with IDD utilizing those services.

NYS Planning:

- Health system reform to maximize preventative and primary health services to reduce need for emergency and inpatient health care is consistent with the START model.
- People served in OPWDD services are significantly under-represented in the DSRIP Networks
- Partnership related to the START model would be beneficial to DSRIP networks.
- There are alignment of goals and metrics available from START that support the areas of focus for DSRIP evaluation expectations.

OPWDD would like to engage in system planning focused on how the START model could be integrated into the DSRIP initiative.

START as consistent project in DSRIP PPSs

- START as a project will help PPSs to meet goals of DSRIP
- OPWDD seeks contracts for START with PPS networks
- OPWDD seeks to tie START funding from DOB to the successful implementation of the START service within the DSRIP initiative

Contact Information

Katherine Bishop, OPWDD
Director of Health and Community Supports
(518) 474-2789
Katherine.Bishop@opwdd.ny.gov

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Appendix

Emergency Service Trends

History of Psychiatric Hospitalization (Pre-START Referral)

Psychiatric hospitalizations at referral (year prior to enrollment in START)	Region 1		Region 3	
	Number	Percent	Number	Percent
Yes	28	18.79%	64	35.56%
No	95	63.76%	67	37.22%
Unreported *information was not available at time of referral/intake.	26	17.45%	49	27.22%

Emergency Service Trends

Psychiatric Hospitalization (Post-START Referral)

	Region 1	Region 3
Total individuals with a psychiatric in-patient admission	11	3
Percent of active cases that had a psychiatric in-patient admission	7.38%	0.83%
Total number of admissions	12	3
Average Length of Stay	10 days	22 days
Number of Individuals with more than 1 psychiatric in-patient admission	1	0
Percent of individuals with more than 1 psychiatric in-patient admission	9.09%	0%

Emergency Service Trends

History of Emergency Department Visits (Pre-START Referral)*

ED visits at referral (previous year)	Region 1		Region 3	
	Number	Percent	Number	Percent
Yes	29	26.61%	33	23.74%
No	52	47.71%	49	35.25%
Unreported	28	25.69%	57	41.01%

*** History of emergency department use was added to the SIRS database on January 1, 2015. Data for this variable was only collected for NY START referrals after that date.**

Emergency Service Trends

Emergency Department Visits (Post-START Referral)

	Region 1	Region 3
Total individuals with emergency department visits	13	1
Percent of active cases that had a emergency department visit	8.72%	0.56%
Total number of admissions	24	1
Average Length of Stay	10 days	22 days
Number of Individuals with more than 1 emergency department visit	4	0
Percent of individuals with more than 1 emergency department visit	30.77%	0%

Assessment

Work done to determine the needs of the individual and the services to be provided. Includes: information/record gathering; intake meeting; completion of assessment tools; and START action plan development.

Assessment Detail	Region 1	Region 3
Number of individuals receiving assessment in July	21	43
Range of Contacts	1 to 2	1 to 7
Average contacts per person	1.24	1.53
Total Aberrant Behavior Checklist (ABC) Assessments Completed	119	119
Total Recent Stressors Questionnaire (RSQ) Assessments Completed	120	122

Outreach

Anytime in which the START Coordinator provides education or outreach related to general issues or specific to the individual referred. START Coordinator may provide outreach to: families/natural supports; residential programs, day programs, schools, mental health facilities or any entity that may seek or need additional outreach and education.

Outreach Detail	Region 1	Region 3
Number of individuals receiving outreach in July	73	44
Range of Contacts	1-11	1-13
Average contacts per person	2.30	2.70

Plan Development

Cross System Crisis and Intervention Planning (CSCIP) – Completion of the Cross Systems Crisis Intervention and Prevention Plan: collecting and reviewing relevant information; completing brainstorming form with team; developing/writing the plan and distributing; reviewing and revising the plan; and training on and implementing the plan with the system of support.

Assessment Detail	Region 1	Region 3
Number of individuals receiving CSCIP in July	40	31
Range of Contacts	1 to 6	1 to 6
Average contacts per person	1.85	7.92
Plans Completed (July)	1	6
Plans Completed (Total)	46	68

Consultation Services

- When required, individuals receiving START services also receive clinical consultation, comprehensive service evaluation, in-home supports and crisis supports.

- The following slides will provide detail on the number of individuals from each region receiving these services.

Consultation Trends

Clinical Case Consultation – this includes any consultation provided by the START team directly to the individual's team. Consultation could be regarding behavior support plans, person-centered planning, transition planning, education meetings specific to the individual's diagnostic and clinical needs.

Clinical Consultation	Region 1	Region 3
Number of individuals receiving outreach in July	12	20
Range of Contacts	1	1 to 7
Average contacts per person	1	1.60

Consultation Trends

Comprehensive Service Evaluation - Completion of the Comprehensive Service Evaluation including receiving and reviewing records; interviewing the individual and system of support; writing the CSE; and reviewing recommendations through development of an action plan.

Comprehensive Service Evaluations	Region 1	Region 3
Number completed in (July)	0	0
Number in process (July)	11	8
Number Completed (Total since inception)	3	1

Clinical Education Team (CET)

Preparing for and holding a Clinical Education Team meeting regarding the individual referred. Including reviewing and identifying relevant recommendations with START Clinical Director; and assisting system of support with implementing recommendations.

Comprehensive Service Evaluations	Region 1	Region 3
Number completed in (July)	3	1
Number Completed (Total since inception)	6	4

Community Training

In addition to the services to individuals, both NY START programs provide training and other services to build community capacity. The following table shows trainings provided by each region since program inception.

Community Training	Region 1	Region 3
Community Education/linkage	26	13
Community-based training	34	13
Provided Training to Day Provider	7	2
Provided Training to emergency services	4	
Provided Training to other	1	0
Provided Training to physician/medical personnel	16	0
Provided Training to residential provider	11	68
Provide training to school	0	1