



# The New York State DSRIP Program: A Model for Reforming the Medicaid Delivery System

December 11, 2014, 2:00 – 3:30 pm ET

*Allison Hamblin, Center for Health Care Strategies*

*David Sandman, New York State Health Foundation*

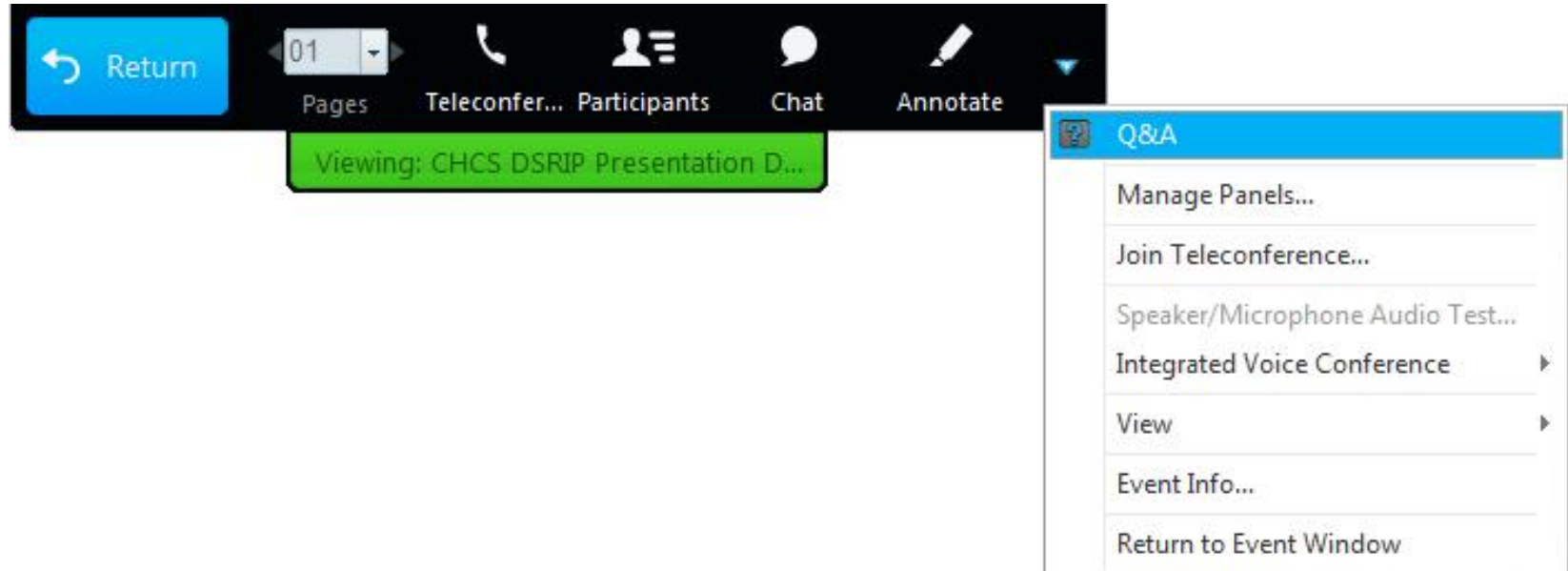
*Jason A. Helgerson, Gregory S. Allen, and Peggy Chan, New York State Department of Health*

*Made possible by The New York State Health Foundation*

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# Welcome and Introductions

## **Center for Health Care Strategies**

- Allison Hamblin, Vice President of Strategic Planning

## **New York State Health Foundation**

- David Sandman, Senior Vice President

## **Office of Health Insurance Programs, New York State Department of Health**

- Jason A. Helgerson, Medicaid Director
- Gregory S. Allen, Director of Policy
- Peggy Chan, Director, Delivery System Reform Incentive Payment (DSRIP) Program



# NYS HEALTH FOUNDATION

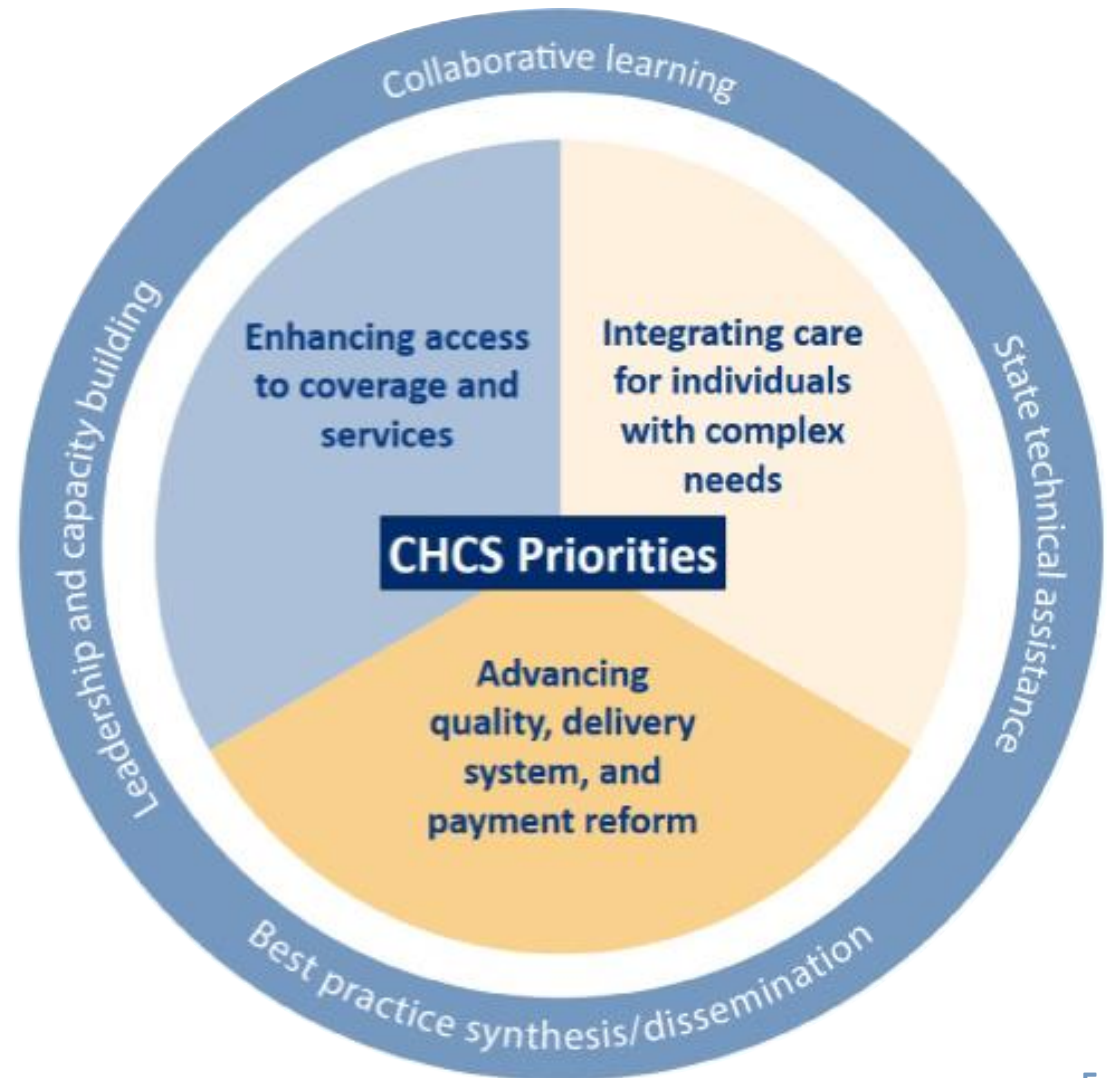
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# About the Center for Health Care Strategies

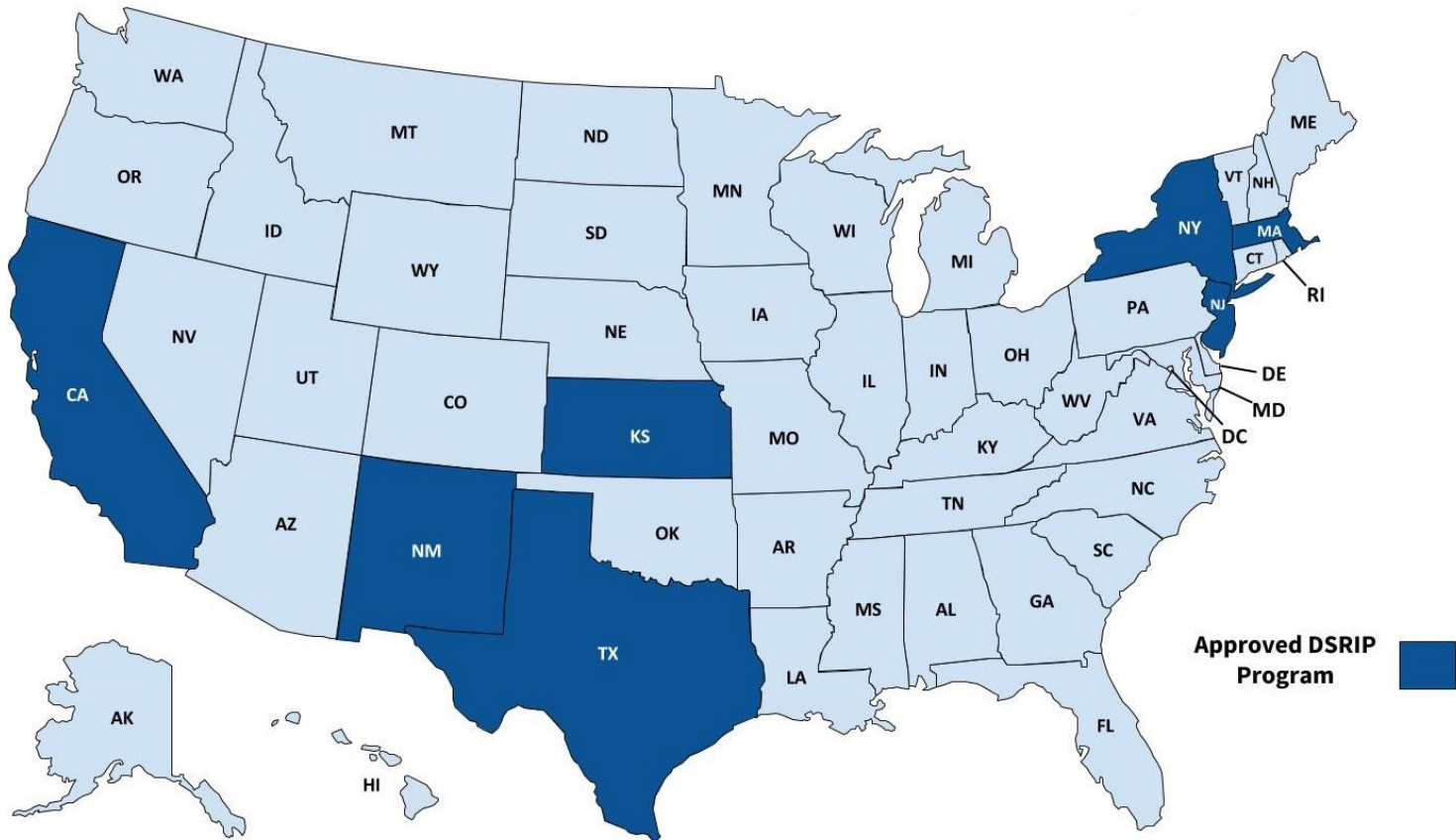
A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care



# What is DSRIP?

- The Delivery System Reform Incentive Payment (DSRIP) Program is an **incentive payment model** that rewards providers for performance on **delivery system transformation projects** that improve care for low-income patients
- Funded federally via Medicaid 1115 waivers, DSRIPs shift hospital supplemental payments from paying for coverage to **paying for improvement efforts**
- There is a large range in DSRIP funding amounts and durations across states, with per state funding as high as **\$11+ billion** and lasting **up to 5.5 years**
- DSRIP projects and milestones are **state-specific** and tend to have an **increasing focus on outcomes** over time

# CMS Has Approved Seven DSRIP Programs



\*NOTE: In addition to the states highlighted above, Florida and Oregon operate “DSRIP-like” programs.

# National DSRIP Program Trends

- First DSRIP programs were implemented in 2010-2011
- DSRIPs have evolved over time, with program requirements gradually becoming more prescriptive
- Recent models tend to:
  - ▶ Support wider-scale payment and delivery system reform
  - ▶ Encompass a broader set of providers than hospitals, including health and social service providers
  - ▶ Include a more narrow, defined set of project options





# NEW YORK'S DSRIP PROGRAM: A MODEL FOR REFORMING THE MEDICAID DELIVERY SYSTEM

**December 11, 2014**

**Jason A. Helgerson, Medicaid Director**

**Gregory S. Allen, Director of Policy**

**Peggy Chan, Director of DSRIP**

Office of Health Insurance Programs

NYS Department of Health



# BEGINNINGS OF MEDICAID REDESIGN

- In 2010, Medicaid reform was not on the agenda
- In 2011, Governor Cuomo changed the game by creating the Medicaid Redesign Team (MRT)
- This was the first effort of its kind in New York State
- By soliciting public input and bringing affected stakeholders together, this process has resulted in a collaboration which reduces costs while focusing on improving quality and reforming New York's Medicaid system.

## The MRT Worked in Two Phases:

### *Phase 1:*

Provided a blueprint for lowering Medicaid spending in state fiscal year 2011-12 by \$2.2 billion.

### *Phase 2:*

Developed a comprehensive multi-year action plan to fundamentally reform the Medicaid program.



## MAJOR MRT REFORMS IMPLEMENTED

- Cost Control: Reduced Medicaid's annual spending growth rate from 13% to less than 1%
- Global Spending Cap: Introduced fiscal discipline to an out of control government program; focus on transparency with monthly report on spending.
- Care Management for All: Expanded existing and created new models of improved primary/coordinated care that will both improve outcomes and lower costs, moving Medicaid members from fee-for-services to managed care.
- PCMH and Health Homes: Investments in high-quality primary care and care coordination through major MRT reforms such as Patient Centered Medical Homes and the creation of Health Homes.



## FISCAL IMPACT OF MRT

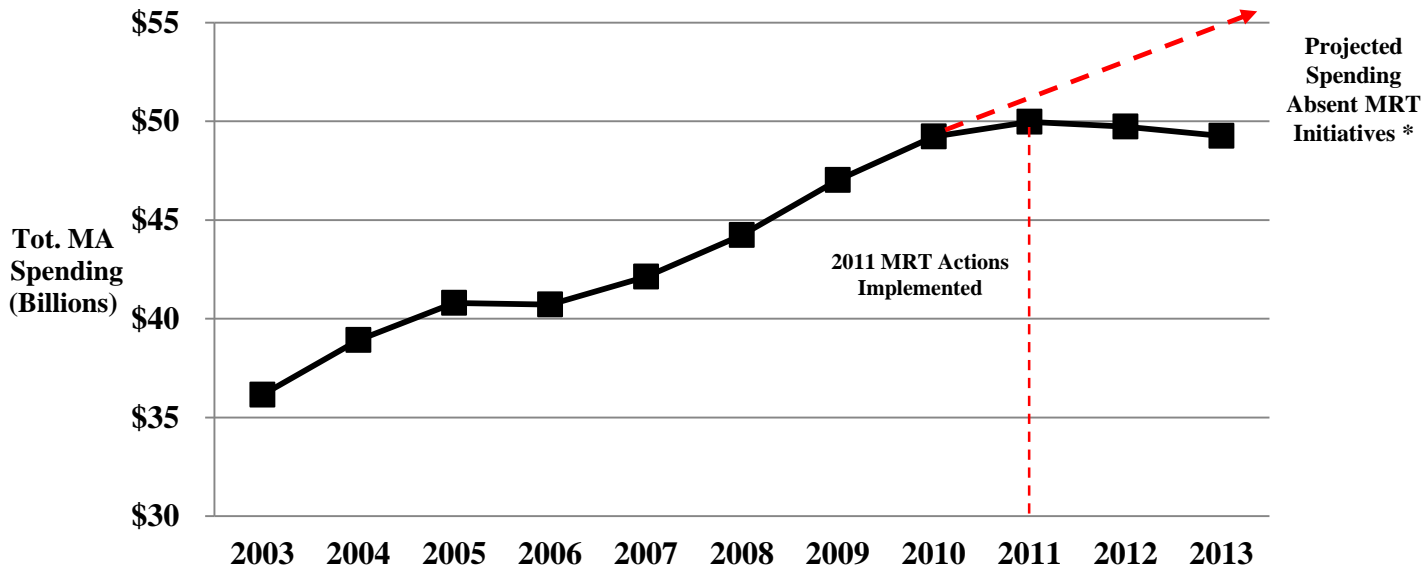
- At its core, MRT was about trying to ensure that the Medicaid program was financially sustainable.
- After years of out of control cost growth the state budget was no longer able to afford Medicaid driven budget problems.
- MRT and its approach to cost containment was to launch many initiatives simultaneously with the goal being to both generate immediate cost savings while also launching multiple systemic reforms designed to generate future cost savings.
- To date, the MRT fiscal impact has been staggering – billions of dollars have been saved.



# TOTAL MEDICAID SPENDING OVER TIME (SFY 03-13)



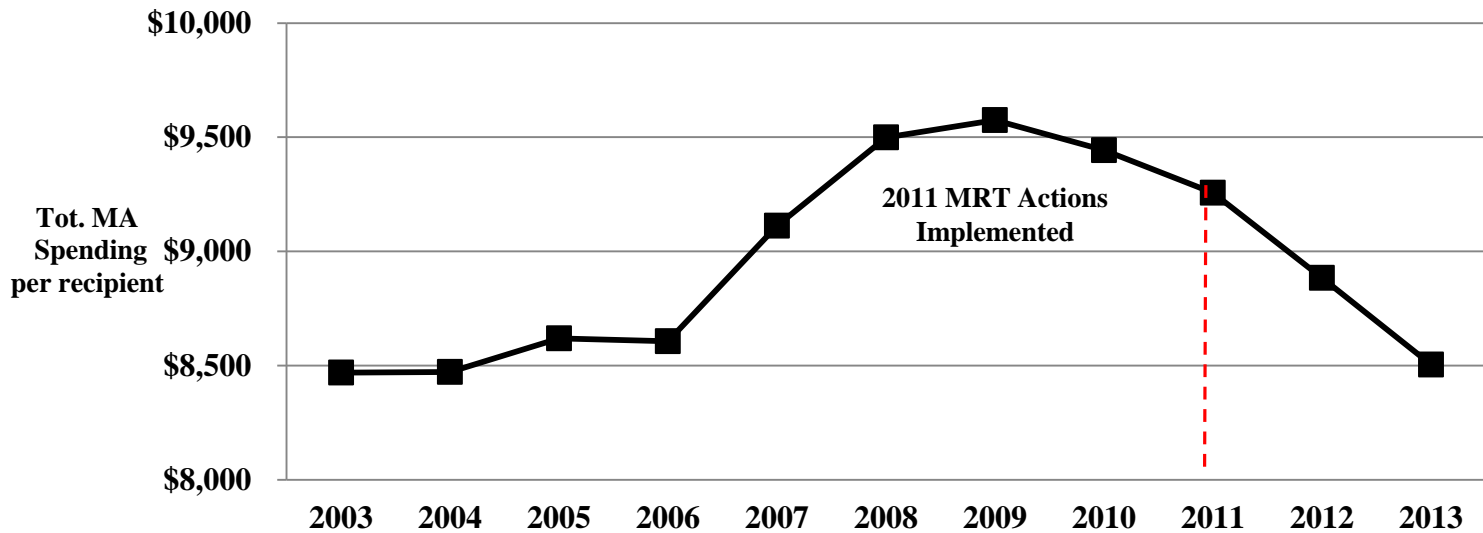
# NYS STATEWIDE TOTAL MEDICAID SPENDING (CY 2003-2013)



Calendar Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b># of Recipients</b>	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	5,792,568
<b>Cost per Recipient</b>	\$8,469	\$8,472	\$8,620	\$8,607	\$9,113	\$9,499	\$9,574	\$9,443	\$9,257	\$8,884	\$8,504



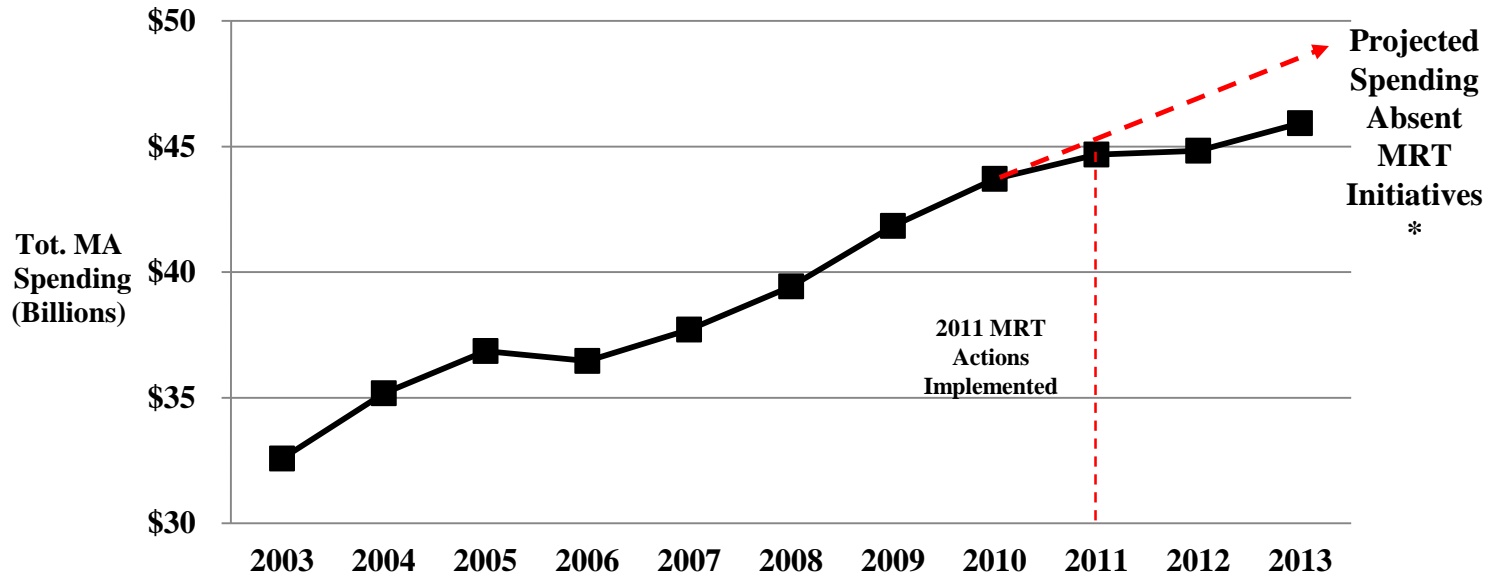
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Cost per Recipient	\$8,469	\$8,472	\$8,620	\$8,607	\$9,113	\$9,499	\$9,574	\$9,443	\$9,257	\$8,884	\$8,504



# NYS STATEWIDE TOTAL MEDICAID SPENDING FOR ALL CATEGORIES OF SERVICE UNDER THE GLOBAL SPENDING CAP (CY 2003-2013)



Calendar Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b># of Recipients</b>	4,266,538	4,593,566	4,732,564	4,729,167	4,621,911	4,656,361	4,910,528	5,211,559	5,397,870	5,597,551	5,791,893
<b>Cost per Recipient</b>	\$7,635	\$7,657	\$7,787	\$7,710	\$8,158	\$8,467	\$8,520	\$8,386	\$8,277	\$8,008	\$7,929





## MEDICAID REDESIGN: MRT WAIVER AMENDMENT

- In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized agreement on the MRT Waiver Amendment.
- Allows the state to reinvest \$8 billion of the \$17.1 billion in federal savings generated by MRT reforms.
- 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*



## MRT WAIVER AMENDMENT: STATE/FEDERAL FINANCING

The MRT Waiver Amendment allows New York to reinvest \$8 billion in MRT generated savings back into New York's health care delivery system. The federal reinvestment is provided in two ways:

- 1) \$6 billion through Inter-Governmental Transfers (IGT) match
- 2) \$2 billion through Designated State Health Program (DSHP) match

Funding uses over 5 years:

- **\$500 Million for the Interim Access Assurance Fund (IAAF)** – Time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without unproductive disruption.
- **\$6.42 Billion for Delivery System Reform Incentive Payments (DSRIP)** – Including DSRIP Planning Grants, performance payments, and state administrative costs)
- **\$1.08 Billion for other Medicaid Redesign purposes** – This funding will support Health Home development, and investments in long term care workforce and enhanced behavioral health services.



# 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*



## NYS DSRIP PLAN: KEY COMPONENTS

- Key focus on reducing avoidable hospitalizations by 25% over five years.
- Statewide initiative open to large public hospital systems and a wide array of safety-net providers.
- Payments are based on performance on process and outcome milestones.
- Providers must develop projects based upon a selection of CMS approved projects from each of three domains.
- Key theme is collaboration! Communities of eligible providers will be required to work together to develop DSRIP project proposals.




# PERFORMING PROVIDER SYSTEMS (PPS): LOCAL PARTNERSHIPS TO TRANSFORM THE DELIVERY SYSTEM

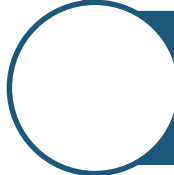
## Partners should include:

- *Hospitals*
- *Health Homes*
- *Skilled Nursing Facilities*
- *Clinics & FQHCs*
- *Behavioral Health Providers*
- *Home Care Agencies*
- *Other Key Stakeholders*

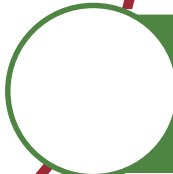
## Responsibilities must include:



Community health care needs assessment based on multi-stakeholder input and objective data.



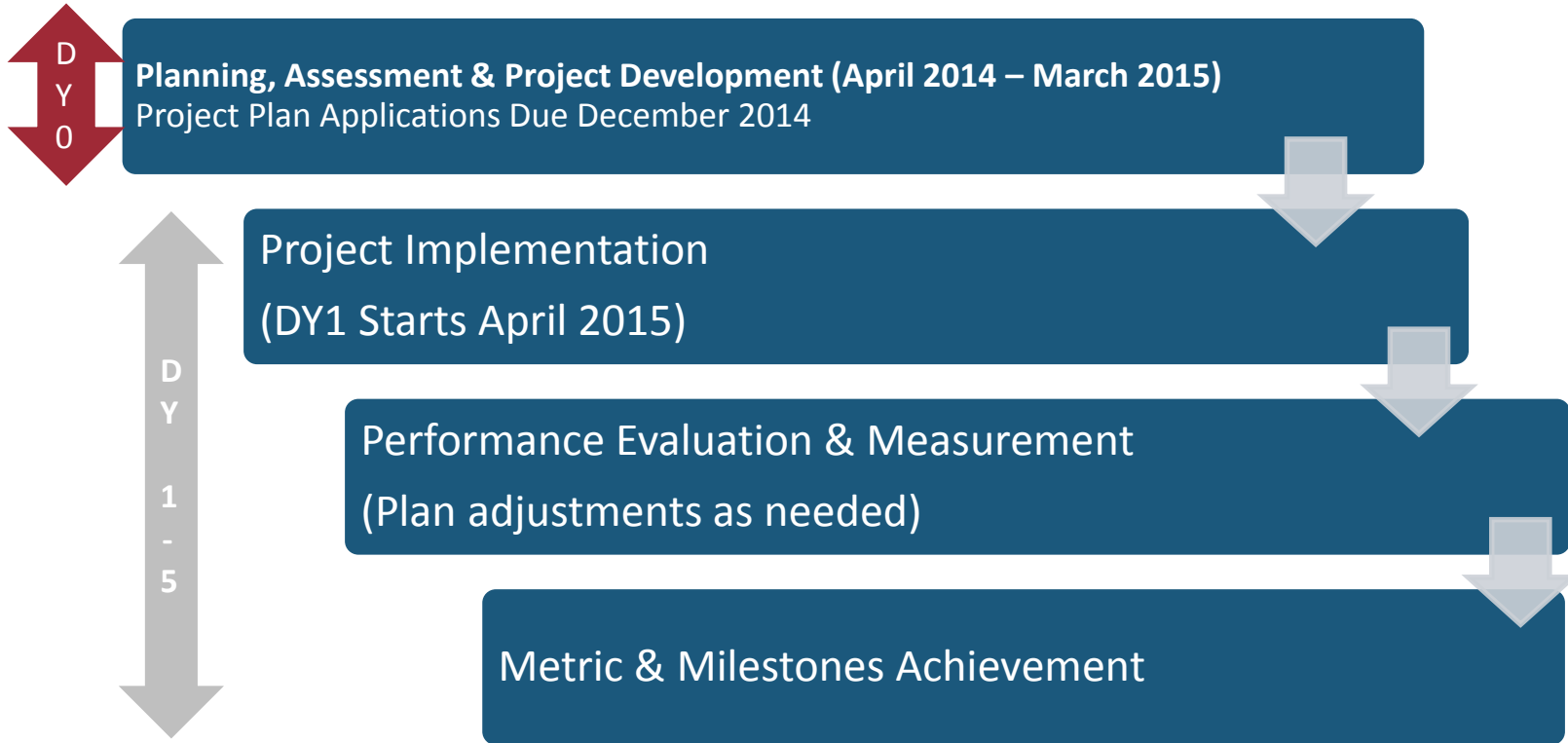
Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies.



Meeting and reporting on DSRIP Project Plan process and outcome milestones.



# UPDATED DSRIP PROJECT TIMELINE



## DSRIP ATTRIBUTION: MATCHING MEMBERS TO A PPS

- Attribution is the process used in DSRIP to assign a member to a Performing Provider System (PPS).
- Attribution makes sure that each Medicaid member is assigned to one and only one PPS.
- Attribution uses geography, patient visit information and health plan PCP assignment to “attribute” a member to a given PPS.
- Patient visit information is used to establish a “loyalty” pattern to a PPS (based on all their provider members) where most of the member’s services are rendered.



# DSRIP DESIGN GRANT OVERVIEW

- Funds are to be used to support development of emerging Performing Provider Systems (PPSs)
- Develop specific and comprehensive DSRIP Project Plans:
  - Community Needs Assessment
  - Stakeholder Engagement
  - Planning of specific projects
- Awards have been split over two equal payments
  - Second payment was conditional on deliverables
- All PPSs who receive DSRIP Design Grant must prepare and submit a DSRIP Project Plan due December 22, 2014.





## DSRIP DOMAINS

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

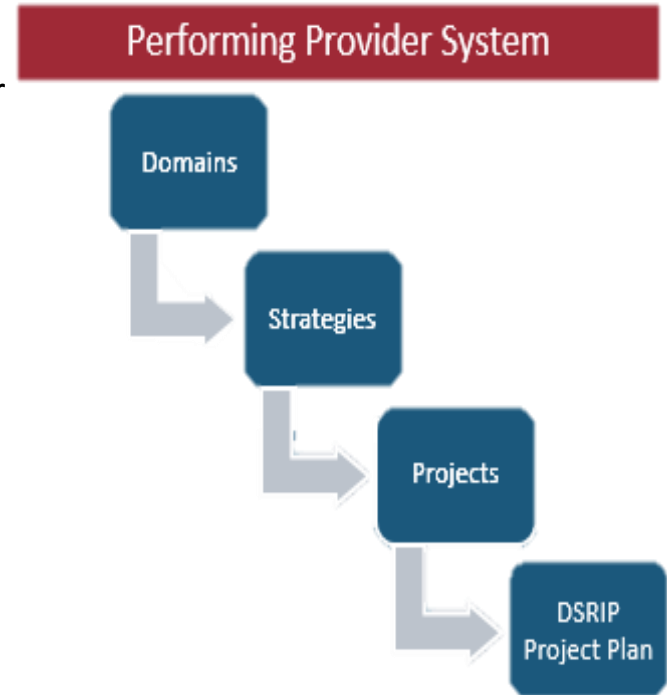
- *Domain 1 – Overall Project Progress*
- *Domain 2 – System Transformation*
- *Domain 3 – Clinical Improvement*
- *Domain 4 – Population-wide Strategy Implementation – The Prevention Agenda*

Through innovations in these four domains, the statewide DSRIP plan is designed to reduce avoidable hospitalizations by 25% over five years.



# DSRIP PROJECTS

- Safety net providers must choose a specified number of projects from Domains 2, 3 and 4. Domains 2 and 3 are further broken into specific strategy areas. Under each strategy are a number of projects.
- Each project has the following components specifically tied to the goal of reducing avoidable hospitalizations:
  - ✓ *Clearly defined process measures;*
  - ✓ *Clearly defined outcome measures;*
  - ✓ *Clearly defined measures of success relevant to provider type and population impacted; and*
  - ✓ *Clearly defined financial sustainability metrics to assess long-term viability.*



# DSRIP PROJECT PLAN REQUIREMENTS

## The project must be:

- A new initiative for the Performing Provider System (PPS);
- Substantially different from other initiatives funded by CMS, although it may build on or augment such an initiative;
- Documented to address one or more significant issues within the PPS service area and be based on a detailed analysis using objective data sources;
- A substantial, transformative change for the PPS;



# DSRIP PROJECT PLAN REQUIREMENTS

- Demonstrative of a commitment to life-cycle change and a willingness to commit sufficient organizational resources to ensuring project success;
- Developed, in concert, with other providers in the service area with special attention paid to coordination with Health Homes actively working within their area; and
- Applications from single providers will not be considered!



# DSRIP PROJECTS: SAMPLE FROM PROJECT TOOLKIT

Project Numbers	DESCRIPTION
<b>Domain 2: System Transformation Projects</b>	
<b>A.</b>	Create Integrated Delivery Systems
<b>2.a.i</b>	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
<b>2.a.ii</b>	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))
<b>2.a.iii</b>	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
<b>2.a.iv</b>	Create a medical village using existing hospital infrastructure
<b>2.a.v</b>	Create a medical village/alternative housing using existing nursing home infrastructure



# DSRIP PROJECTS: SAMPLE FROM PROJECT TOOLKIT

Domain 3: Clinical Improvement Projects	
<b>A.</b>	<b>Behavioral Health</b>
<b>3.a.i</b>	Integration of primary care and behavioral health services
<b>3.a.ii</b>	Behavioral health community crisis stabilization services
<b>C</b>	<b>Diabetes Care</b>
<b>3.c.i</b>	Evidence-based strategies for disease management in high risk/affected populations (adults only)
<b>3.c.ii</b>	Implementation of evidence-based strategies to address chronic disease – primary and secondary prevention projects (adults only)
<b>D.</b>	<b>Asthma</b>
<b>3.d.i</b>	Development of evidence-based medication adherence programs (MAP) in community settings– asthma medication
<b>3.d.ii</b>	Expansion of asthma home-based self-management program
<b>3.d.iii</b>	Implementation of evidence-based medicine guidelines for asthma management



# DSRIP PROJECTS: SAMPLE FROM PROJECT TOOLKIT

Domain 4: Population-wide Projects: New York's Prevention Agenda	
<b>A.</b>	Promote Mental Health and Prevent Substance Abuse (MHSA)
<b>4.a.i</b>	Promote mental, emotional and behavioral (MEB) well-being in communities
<b>4.a.ii</b>	Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
<b>4.a.iii</b>	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
<b>B.</b>	Prevent Chronic Diseases
<b>4.b.i.</b>	Promote tobacco use cessation, especially among low SES populations and those with poor mental health.
<b>4.b.ii</b>	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)



# OUTCOMES/PERFORMANCE MEASUREMENT APPROACH

- Annual improvement targets will use a methodology of **reducing the gap to the goal by 10%**.
- For example, if the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 3.8 percent increase in the result (target 55.8 percent).
- Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.
- Performing Provider Systems may receive ***less than their maximum allocation*** if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty).





## PAYMENT DEEP DIVE

- **Amounts received will be determined based on performance of the providers engaged on each approved project and the PPS's overall performance in achieving project goals.**
  - This can result in significant reductions in payments, even during the first year of DSRIP – missing 1 out of 5 milestones, for example, could lead to 20% reduction in funding for that year.
- **Each PPS may also receive additional funds from the High Performance Fund if “high performance” levels are met.**
  - **Tier 1** is met when the PPS closes the gap in their DSRIP project plan by 20% between current and high performance levels as defined by DOH
  - **Tier 2** is met when the PPS's performance meets or exceeds the 90<sup>th</sup> percentile of statewide performance for a specific measure

### Statewide Accountability:

- **PPS funds received may be reduced for missed milestones statewide**
  - The reduction is applied proportionately to all PPSs
  - High Performance Fund payments are not subject to the reduction.



# PAYMENT DEEP DIVE

Each PPS will initially be compensated for project and infrastructure development, with a gradual transition to payment for achieving outcomes. *From the start, however, payments are based on realizing milestones.*

- **Incentive payments will initially be calculated based on the progress of process milestones/metrics:**

- ✓ *Approval of DSRIP plan; semi-annual reports*
- ✓ *Meeting scale and speed targets set in the Project Application per project*
- ✓ *Meeting other project-specific Domain 1 metrics*

- As projects progress, less payment will be allocated to achieving process milestones and more will be allocated to meeting outcome milestones

- ✓ *Preventable (re)admissions and ER visits*
- ✓ *Patient experience measures (CAHPS)*
- ✓ *Project-specific clinical improvement and health outcome metrics*

Project Valuation from DSRIP Program

		Pay for Performance (P4P)				
Fee for Service and "Pay for Reporting" (P4R)						
Performance Payment†		CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
Project progress milestones (Domain 1)	P4R	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population Health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%
PPS Infrastructure Development	P4R	100%	85%	55%	35%	15%
Clinical Improvement and Health Outcomes	P4P	0%	15%	45%	65%	85%



## VALUATION BASED ON:

- 1) **Project Index Score**
  - 60 possible points per project
- 2) **Project PMPM**
  - Multiplies project index score by state's pre-set valuation benchmark
- 3) **Plan Application Score**
  - Out of 100 possible points per application
- 4) **Maximum Project Value**
  - Multiplies project PMPM, plan application score, the number of attributed lives per project, and the duration of the project
- 5) **Maximum Application Value**
  - Each maximum project value per PPS application added together



## STATEWIDE PERFORMANCE AND ACCOUNTABILITY

- Beginning in Year 3, limits on funding available and provider incentive payments may be subject to reductions based on statewide performance.
- Statewide performance will be assessed on a pass or fail basis for a set of four milestones.
- The state must pass all four milestones to avoid DSRIP reductions.
- If penalties are applied, CMS requires the state to reduce funds in an **equal** distribution, across all DSRIP projects.
- The DSRIP high performance fund will not be affected by any penalties.



## STATEWIDE PERFORMANCE: MILESTONES

- 1) Statewide performance on a universal set of delivery system improvement metrics as defined in Attachment J.
- 2) Composite measure of success of projects statewide on project specific and population-wide quality metrics.
- 3) Growth in statewide total Medicaid spending, including MRT spending, that is at or below the target trend rate, and growth in statewide total inpatient and emergency room spending at or below the target trend rate.
- 4) Implementation of the state's managed care contracting plan and movement toward a goal of 90 percent of managed care payments to providers using value-based payment methodologies.



## PPS EVALUATION

### Broad goals of NYS DSRIP evaluation:

- 1) Assess program effectiveness on a statewide level with respect to the MRT triple aim of improved care, better health, and reduced cost.
- 2) Conduct PPS-level comparisons to obtain information on the effectiveness of specific projects and strategies selected and the factors associated with program success.
- 3) Obtain stakeholder feedback regarding the planning and implementation of the DSRIP program, and on the health care service experience under DSRIP reforms.



## PPS EVALUATION

The following objectives will be achieved toward evaluation goals:

- 1) Evaluate the extent to which Performing Provider Systems achieve health care system transformation.
- 2) Evaluate the extent to which health care quality is improved through clinical improvement in the treatment of selected diseases and conditions.
- 3) Evaluate the extent to which population health is improved as a result of implementation of the DSRIP initiative.
- 4) Assess the extent to which avoidable hospital use is reduced as a result of DSRIP.
- 5) Evaluate the impact of DSRIP on health care costs.
- 6) Obtain detailed information on patient experience and satisfaction, and the strengths and weaknesses of the DSRIP initiative at the implementation and operational stages from administrative and provider perspectives.



## LEARNING COLLABORATIVES

- **New York will host learning collaboratives for all PPSs to engage in peer-to-peer and community stakeholder input on project level development of action plans, implementation approaches, and project assessment.**
- **Key personnel from the PPSs, stakeholders, and designated personnel from the state will be responsible for guiding the Learning Collaborative.**
- **The Learning Collaborative will be designed to promote and/or perform the following:**
  - 1) Sharing of DSRIP project development including data, challenges, and proposed solutions based on PPS's quarterly progress reports
  - 2) Collaborating based on shared ability and experience
  - 3) Identifying key project personnel
  - 4) Identifying best practices
  - 5) Providing updates on DSRIP program and outcomes
  - 6) Track and produce an FAQ document
  - 7) Encourage the principles of continuous quality improvement cycles





## PAYMENT REFORM & VALUE-BASED CONTRACTING

- **As part of the agreement between New York and CMS, New York is required to take steps to ensure DSRIP investments will be recognized and supported by the state's managed care plans.**
- **New York must submit a roadmap in Spring 2015 detailing how contract terms will be amended and provider capacities and efficiencies in managed care rate-setting will be reflected.**

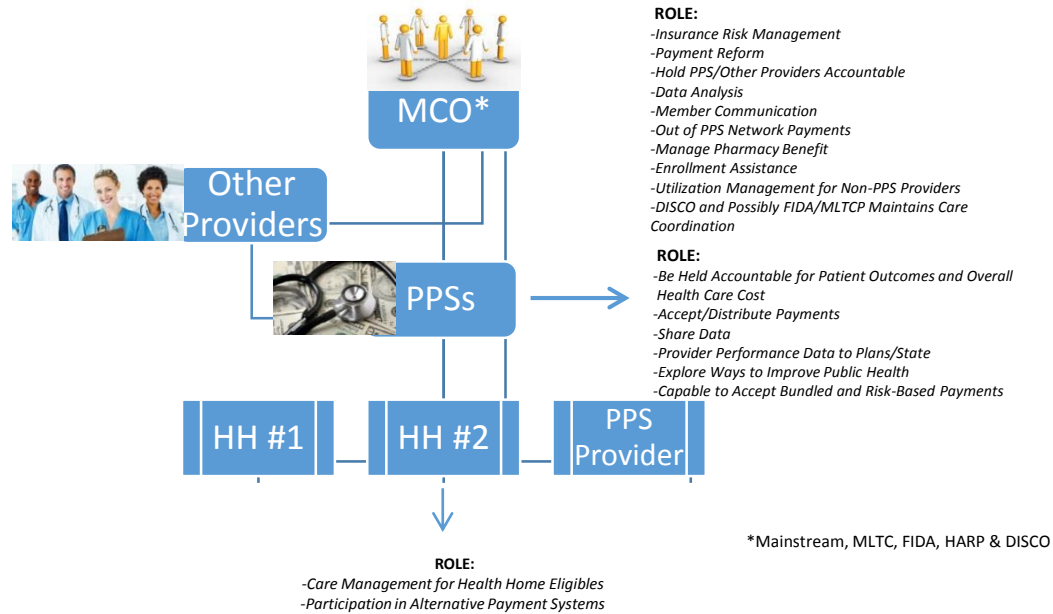
### **Roadmap Guidelines:**

- Will outline how New York and plans will implement goal of 90% of managed care payments to providers through value-based payments
- Will be a multi-year plan
- Must be flexible to reflect future DSRIP progress and accomplishments
- Requires CMS approval
- Must be updated annually



# THE DSRIP VISION: 5 YEARS IN THE FUTURE

## How The Pieces Fit Together: MCO, PPS & HH



## LESSONS LEARNED FROM CMS

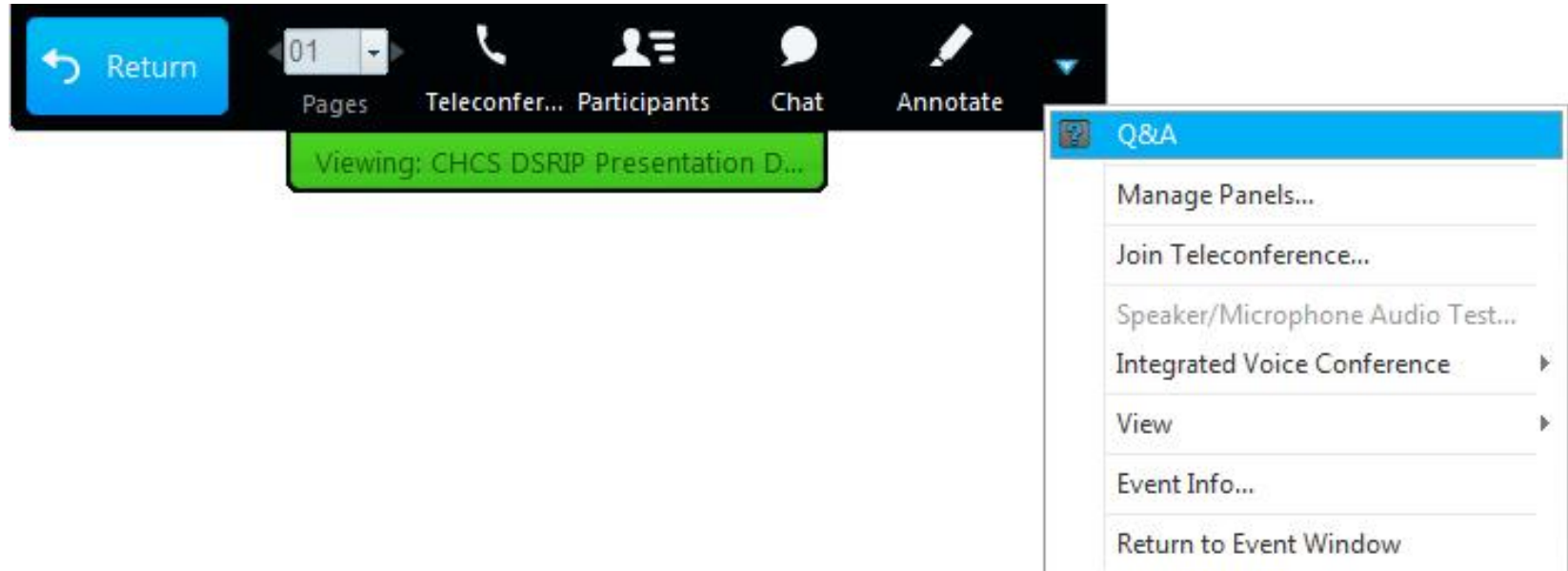
- **Flexibility:** New York's original proposal evolved from 13 grant programs to a three-part program: Interim Access Assurance Fund, DSRIP Program & Performance Payments, Other MRT Investments
- **Accountability:** Moving from a grant program proposal to a primarily DSRIP proposal ensures accountability at both the provider and statewide level
- **Targeted Proposal:** Ensure proposal addresses community-specific issues – New York's safety net providers will engage with other New York providers to address key health issues at a community level
- **Leadership:** Governor Cuomo tirelessly advocated for waiver amendment approval and reinvestment of MRT-generated federal savings for New York's safety net providers and Medicaid members



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