DSRIP PROGRAM: A MODEL FOR REFORMING THE MEDICAID DELIVERY SYSTEM

DSRIP and Opportunities for CHWs

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Office of Health Insurance Programs
NYS Department of Health

October 2015
MRT WAIVER AMENDMENT

- Medicaid Redesign Team convened January 2011 to develop an action plan to reshape the Medicaid system to reduce avoidable costs and improve quality.

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

Calendar Year | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013
---|---|---|---|---|---|---|---|---|---|---|---
# 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 | 5,792,568
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

Tot. MA Spending (Billions)
NYS STATEWIDE TOTAL MEDICAID SPENDING PER RECIPIENT (CY 2003-2013)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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</tr>
</thead>
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</tr>
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SIX KEY THEMES OF DSRIP

1. Integrated Delivery—Creating **Performing Provider Systems** (PPSs)
2. Project Value drives $
   a) Transformation → # and types of projects
   b) # of Medicaid members served (attribution)
   c) Application Quality – Speed and Scope of Implementation
3. Performance Based Payments – Process and Outcome Measures
4. Statewide Performance Matters
5. Regulatory Relief and Capital Funding Available
6. Lasting Change
   a) Long-Term Transformation
   b) Health System Sustainability
PERFORMING PROVIDER SYSTEMS (PPS): Local Partnerships to Transform the Delivery System

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.

Responsibilities must include:

Partners should include:

- Hospitals
- Health Homes
- Skilled Nursing Facilities
- Clinics & FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Other Key Stakeholders
The Framework: The 25 PPSs that Cover the State

25 Performing Provider Systems

Key
- Public Hospital–led PPS
- Safety Net (Non-Public)–led PPS
NYC PPSs by Borough

<table>
<thead>
<tr>
<th>PPS</th>
<th>Borough</th>
<th>Bronx</th>
<th>Manhattan</th>
<th>Queens</th>
<th>Brooklyn</th>
<th>Staten Island</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate (AW Medical)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Bronx-Lebanon</td>
<td></td>
<td>✓</td>
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<tr>
<td>Brooklyn Bridges (Lutheran)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>CCB (Maimonides)</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
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<tr>
<td>Mount Sinai</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Nassau Queens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>OneCity Health (HHC)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Richmond &amp; Staten Island</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Bronx Partners for Healthy Communities (SBH)</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York and Presbyterian</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NY Hospital of Queens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
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</tbody>
</table>

New York City has two city-wide PPSs: Advocate and OneCity Health

Note: Reference for boroughs serviced by each PPS is the DSRIP scoring summaries released 2015-02-05
DSRIP Project Overview

- DSRIP includes 44 projects that are organized into three distinct domains.
  - 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**.

- 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 Focuses on Many Different Parts of the Health System, But Many Project Require Enhanced Primary Care

Domain 2: Integrated Delivery System
2.a.i

Domain 3: Clinical Quality Improvement
3.a.i, 3.b.i, 3.c.i, 3.d.i, 3.d.ii, 3.d.iii, 3.g.i, 3.g.ii

Domain 4: Community-Based Interventions
2.c.i, 3.b.ii, 3.c.ii, 4.a.i, 4.a.ii, 4.a.iii, 4.b.i
DSRIP UPDATES
# DSRIP Value-based Payment Roadmap Development Timeline

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Conceptual Development Complete</td>
<td></td>
</tr>
<tr>
<td>1st VBP Work Group Meeting</td>
<td>12/15/14</td>
</tr>
<tr>
<td>2nd VBP Work Group Meeting</td>
<td>1/23/15</td>
</tr>
<tr>
<td>3rd VBP Work Group Meeting</td>
<td>2/24/15</td>
</tr>
<tr>
<td>Submit draft VBP Roadmap to CMS for initial comments</td>
<td>3/1/15</td>
</tr>
<tr>
<td>Begin Public Comment Period</td>
<td></td>
</tr>
<tr>
<td>3rd VBP Work Group Meeting</td>
<td>3/13/15</td>
</tr>
<tr>
<td>End VBP Roadmap public comment period</td>
<td>4/1/15</td>
</tr>
<tr>
<td>4th VBP Work Group Meeting</td>
<td>4/8/15</td>
</tr>
<tr>
<td>Revised draft submission to CMS</td>
<td>4/24/15</td>
</tr>
<tr>
<td>5th VBP Work Group Meeting</td>
<td>5/1/15</td>
</tr>
<tr>
<td>6th VBP Work Group Meeting</td>
<td>6/23/15</td>
</tr>
<tr>
<td>Implementation Work Begins</td>
<td>7/22/15</td>
</tr>
<tr>
<td>CMS Final Approval</td>
<td>7/25/15</td>
</tr>
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</table>
VBP Implementation Planning: Subcommittees

- **Five VBP Subcommittees** were developed focused to focus on a number of broad policy related questions. These groups will meet between 4-6 times and plan to complete their work by January 2016. The subcommittees include the following:
  - Technical Design I
  - Technical Design II
  - Regulatory Impact
  - Social Determinants of Health & CBO’s
  - Advocacy and Engagement

- **Clinical Advisory Groups** (CAGs) are composed of individuals with: clinical experience and knowledge focused on the specific care or condition being discussed; industry knowledge and experience; geographic diversity; and/or total care spectrum experience as it relates to the specific care or condition being discussed. The initial CAGs formed include:
  - Maternity
  - Chronic Heart
  - Diabetes
  - Pulmonary
  - Substance Abuse
  - Behavioral Health
  - HIV/AIDS
  - Managed Long Term Care
  - Developmentally Disabled
  - Hemophilia
The SDH VBP Subgroup identified and evaluated social determinants across the following five categories of SDH, which were agreed upon by the larger SDH & CBO Subcommittee.

Social Determinant Categories

- Economic Stability
- Education
- Health and Healthcare
- Social, Family and Community
- Neighborhood and Environment
SHIP DSRIP Workforce Workgroup
## Workforce is a fundamental enabler for SHIP Goal

<table>
<thead>
<tr>
<th>Goal</th>
<th>Delivering the Triple Aim – <em>Healthier people, better care and patient experience, smarter spending</em></th>
</tr>
</thead>
</table>
| **Pillars** | Improve access to care for all New Yorkers, without disparity  
Elimination of financial, geographic, cultural, operational barriers access appropriate a timely way  
Integrate care to address patient needs seamlessly  
Integration of primary care, behavioral health, acute and post-acute care; and supportive care for those that require it  
Make the cost and quality of care transparent to empower decision making  
Information to enable individuals and providers to make better decisions at enrollment and at the point of care  
Pay for healthcare value, not volume  
Rewards for providers who achieve high standards for quality and patient experience while controlling costs  
Promote population health  
Improved screening and prevention through closer linkages between primary care, public health, and community- based supports |

| Enablers | Workforce strategy  
Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities  
Health information technology  
Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation  
Performance measurement & evaluation  
Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation |

October 2015  
**Workforce is a fundamental enabler for SHIP Goal**
SHIP/DSRIP Workforce Workgroup

A Workforce Workgroup has been established to provide external advice

Workgroup has ~40 external participants, representing all facets of the health care workforce

- Hospitals and Health Systems
- Physicians
- Graduate Medical Education
- Nurses
- Nurse Practitioners
- Direct Care Workers
- FQHCs
- Developmental Disability
- Unions/Training funds
- Mental Health and Substance Abuse
- Educational Institutions/Associations
- Community Health Workers
- Population Health
- Consumer Groups
- Home Care
- ACOs/Private Practice
- Physician Assistants
- Pharmacy

Workforce Workgroup has been actively engaged in the process

- Two workgroup meetings including a gallery walk and small group discussion
- Weekly leadership meetings to assess analysis and progress
- Workgroup-led “peer interviews” to gather information on the skill gap in the health care workforce
- Workgroup Survey to identify and prioritize key workforce issues
- Modeling expert group to help define assumptions around future state workforce
The Workforce Workgroup is developing recommendations to equip New York’s healthcare workforce to deliver on the Triple Aim.

- **Achieving the Triple Aim...**
  - Healthier people
  - Better care and patient experience
  - Smarter spending

- **...requires changes in the healthcare delivery model (i.e., SIM/DSRIP)...**
  - Population health focus
  - Team-based, patient-centered care
  - Shift in setting from inpatient to outpatient; greater focus on primary, preventative care

- **...with important workforce implications**
  1. What changes are needed in the **size** of the workforce?
  2. What changes are needed in the **distribution** of the workforce?
  3. How can the workforce of the future best be **structured** to maximize productivity and effectiveness?
# Emerging ideas in Workforce Workgroup Priority Areas

<table>
<thead>
<tr>
<th>Areas</th>
<th>Emerging ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Ensure sufficient primary care workforce</td>
<td>▪ Support existing workforce training programs&lt;br&gt;▪ Assist hospital-based workers to transition into ambulatory care&lt;br&gt;▪ Build career pathways for direct care workers into primary care roles</td>
</tr>
<tr>
<td><strong>B</strong> Better distribute primary care workforce to areas of need</td>
<td>▪ Support existing programs supporting underserved areas (e.g. Doctors Across New York / other loan repayment programs)&lt;br&gt;▪ Launch Rural Residency and Physician Retention programs&lt;br&gt;▪ Explore ways to expand telehealth to respond to innovations</td>
</tr>
<tr>
<td><strong>C</strong> Making most effective use of the health care workforce under the new model</td>
<td>▪ Develop industry standard titles and minimum competency set for care coordinators and other emerging roles&lt;br&gt;▪ Embed “top of license” practice within primary care workforce</td>
</tr>
<tr>
<td><strong>D</strong> Improving the supply and effectiveness of behavioral health workforce</td>
<td>▪ Pursue legislative changes where appropriate to remove barriers to effective practice (e.g., extend exemption from licensure for social workers, psychologists and mental health practitioners employed in certain State-operated and funded programs)</td>
</tr>
<tr>
<td><strong>E</strong> Train workforce for team-based care</td>
<td>▪ Encourage completion of skills modules relating to team-based care in medical curricula and continuing medical education</td>
</tr>
<tr>
<td><strong>F</strong> Shift mindsets among the health care workforce</td>
<td>▪ Convene “change leaders” to act as advocates / role models for team-based care</td>
</tr>
<tr>
<td><strong>G</strong> Improve data collection</td>
<td>▪ Amend legislation to improve or mandate workforce data collection</td>
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# Definitions of Care Coordinator Role across Different Providers

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Education</th>
<th>Experience</th>
<th>Administrative Responsibilities</th>
<th>Clinical Responsibilities</th>
<th>Level of Patient Touch</th>
<th>Number/Type of People Touched</th>
<th>Level of Specialization</th>
<th>Engagement with Outside Orgs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High school diploma</td>
<td>1 year experience in any healthcare setting</td>
<td>Booking appointments/scheduling tests</td>
<td>None</td>
<td>One-time engagement around single episode/visit</td>
<td>Case managing single individuals/panel</td>
<td>None</td>
<td>Focus only on services provided by clinical organization</td>
</tr>
<tr>
<td></td>
<td>CASAC, Associate Degree</td>
<td>5 years clinical experience with specific expertise in care coordination or care management</td>
<td>Communicating with patient caregiver/family</td>
<td>True clinical tasks e.g. drawing blood</td>
<td>Ongoing patient education</td>
<td>Coordinating a whole set of doctors/professionals within a practice (including recruiting, hiring, training)</td>
<td>Specific disease or demographic specialty</td>
<td>Engagement with non-physician professionals and outside services involved in social determinants of health</td>
</tr>
<tr>
<td></td>
<td>Bachelors' degree</td>
<td></td>
<td>Coordinating insurance, maintaining EHRs</td>
<td></td>
<td>Developing and coordinating care plans</td>
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<tr>
<td></td>
<td>RN, MSW</td>
<td></td>
<td></td>
<td>Acting as patient advocate throughout health system</td>
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**October 2015**
PPS - Cultural Competency & CBO Requirements

Important Implementation Plan Milestones

Milestone #6
*Finalize partnership agreements or contracts with CBOs*

Milestone #11
Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

Examples of Tasks from a PPS Implementation Plan:
1. Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.
2. Research best practices on patient activation and engagement, continually review new literature, complete first research review by DY1 Q3.
3. Establish project management team and timelines associated with meeting project requirements for all participating partners.
4. Utilize the 2.d.i Project Work Group to vet the practices and develop implementation plans that maximize the CBOs assets and ability to reach the target population.
5. Establish method for tracking progress on the implementation plan, utilize PMO to monitor progress and provide reports to 2di team, and to Patient and Community Engagement Committee.
6. The PPS will create a standard performance-based contract that compensates CBOs and providers for outreach and navigation services, including incentives for successfully meeting patient activation metrics/goals.
7. The PPS will contract with CBOs and health care providers that already have an established, trusted relationship with the target population, to perform
Examples of PPS CHW

“ACP will continue to recruit culturally competent providers and staff, and ensure that our workforce is reflective of our communities. We will develop and hire a cadre of Community Health Workers, for frontline interaction who are trusted members of the community. We will train frontline health workers, including physicians, nurses, care coordinators and others, to further their career development and help build healthy communities and improve patient outcomes.”

“Two grants have been recently awarded within the region served by the Ellis PPS that will provide training opportunities for Community Health Workers (CHWs). One of the grants was received by Schenectady County Community College and will train 12 CHWs using a comprehensive curriculum that includes topics such as community navigation, cultural competency and health literacy. The second is a LIGHT grant that was awarded to St. Peter’s Health Partners that will train CHWs in asthma education. The Ellis PPS will have an opportunity to hire graduates of these programs and can use the programs as a platform for increasing capacity of training opportunities for project staff.” (Ellis PPS)
UPDATED DSRIP PROJECT TIMELINE

Planning, Assessment & Project Development (April 2014 – March 2015)
Project Plan Applications Due December 2014

Project Implementation
(DY1 Starts April 2015)

Performance Evaluation & Measurement
(Plan adjustments as needed)

Metric & Milestones Achievement
THE DSRIP VISION: 5 YEARS IN THE FUTURE

How The Pieces Fit Together: MCO, PPS & HH

MCO*

Other Providers

PPSs

HH #1  HH #2  Other PPS Providers

ROLE:
- Insurance Risk Management
- Payment Reform
- Hold PPS/Other Providers Accountable
- Data Analysis
- Member Communication
- Out of PPS Network Payments
- Manage Pharmacy Benefit
- Enrollment Assistance
- Utilization Management for Non-PPS Providers
- DISCO and Possibly FIDA/MLTCP Maintains Care Coordination

ROLE:
- Be Held Accountable for Patient Outcomes and Overall Health Care Cost
- Accept/Distribute Payments
- Share Data
- Provider Performance Data to Plans/State
- Explore Ways to Improve Public Health
- Capable to Accept Bundled and Risk-Based Payments

ROLE:
- Care Management for Health Home Eligibles
- Participation in Alternative Payment Systems

*Mainstream, MLTC, FIDA, HARP & DISCO
Thank You!

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