NEW YORK STATE | Department of Health | Medicaid Redesign Team

The Long and Winding Road-map: From Waiver Services to VBP and Other Stops Along the Way

Mental Health Association in New York State, Inc. Annual Meeting

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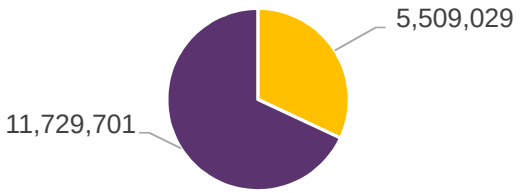
BH Statewide Overview

- A disproportionate amount of total cost of care and hospital visits in NYS can be attributed to the BH population

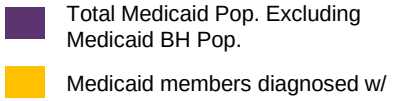
Overview:

- Medicaid members diagnosed with BH account for **20.9%** of the overall Medicaid population in NYS
- The average length of stay (LOS) per admission for BH Medicaid users is **30%** longer than the overall Medicaid population's LOS
- Per member per month (PMPM) costs for Medicaid Members with BH diagnosis is **2.6** times higher than the overall Medicaid population

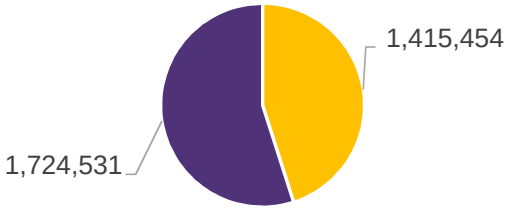
Medicaid members diagnosed with BH account for 32% of Medicaid Primary Care Physicians (PCP) visits



Total PCP Visits from Medicaid Members: 17,238,730

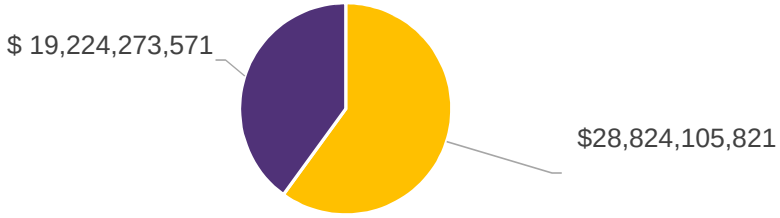


Medicaid members diagnosed with BH account for 45.1% of all ED Visits



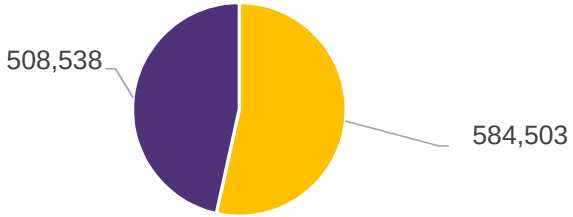
Total ED visits from Medicaid Members: 3,139,985

Medicaid members diagnosed with BH account for 60% of the total cost of care in NYS



Total Medicaid Cost of Care in NYS: $48,048,379,392

Medicaid members diagnosed with BH account for 53.5% of admissions



Total Medicaid Admissions: 1,093,041

*Source: SIM Database. 2014 Claims Data – analysis based on data from January – December 2014. New York State.**

** This data includes Medicaid Members with 1+ Claims with primary or secondary diagnosis of behavioral health issues*

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Current Challenges in BH

- Large system with wide range of provider services and expertise
- Heavy reliance on fee-for-service (FFS) payment methodology that incentivizes volume and may not pay for what is really needed
- Lack of accountability for high-need patients
- Few incentives to support BH / PC integration
- Barriers to information sharing within health and social services systems (MCO, criminal and juvenile justice, homeless systems)
- Lack of follow-up care following discharge from inpatient admissions
- High re-admission rates for BH and substance use disorder (SUD) populations

Source: The New York Department of Health. A Plan to Transform the Empire State's Medicaid Program: Multi-Year Action Plan. NYSDOH DSRIP Website. Published 2012.

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The 1115 Waiver

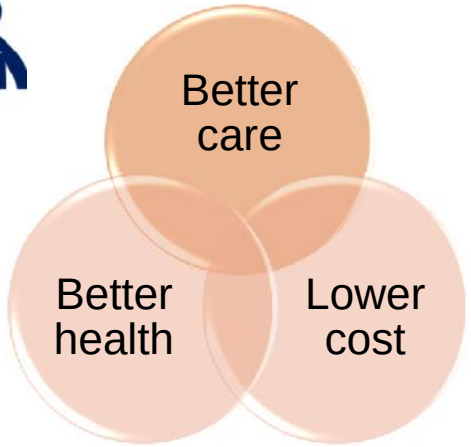
Governor Cuomo created the Medicaid Redesign Team (MRT) to develop reforms to improve health outcomes and further savings. $6.42 billion dollars of savings were reinvested and designated to DSRIP. The MRT developed a multi-year action plan. We are still implementing that plan today.

1115 Waiver → **MRT** →

$17.1 billion
Federal savings generated by MRT reforms

$8 billion
Savings reinvested in NYS

$6.42 billion
Designated to DSRIP



CMS Triple Aim

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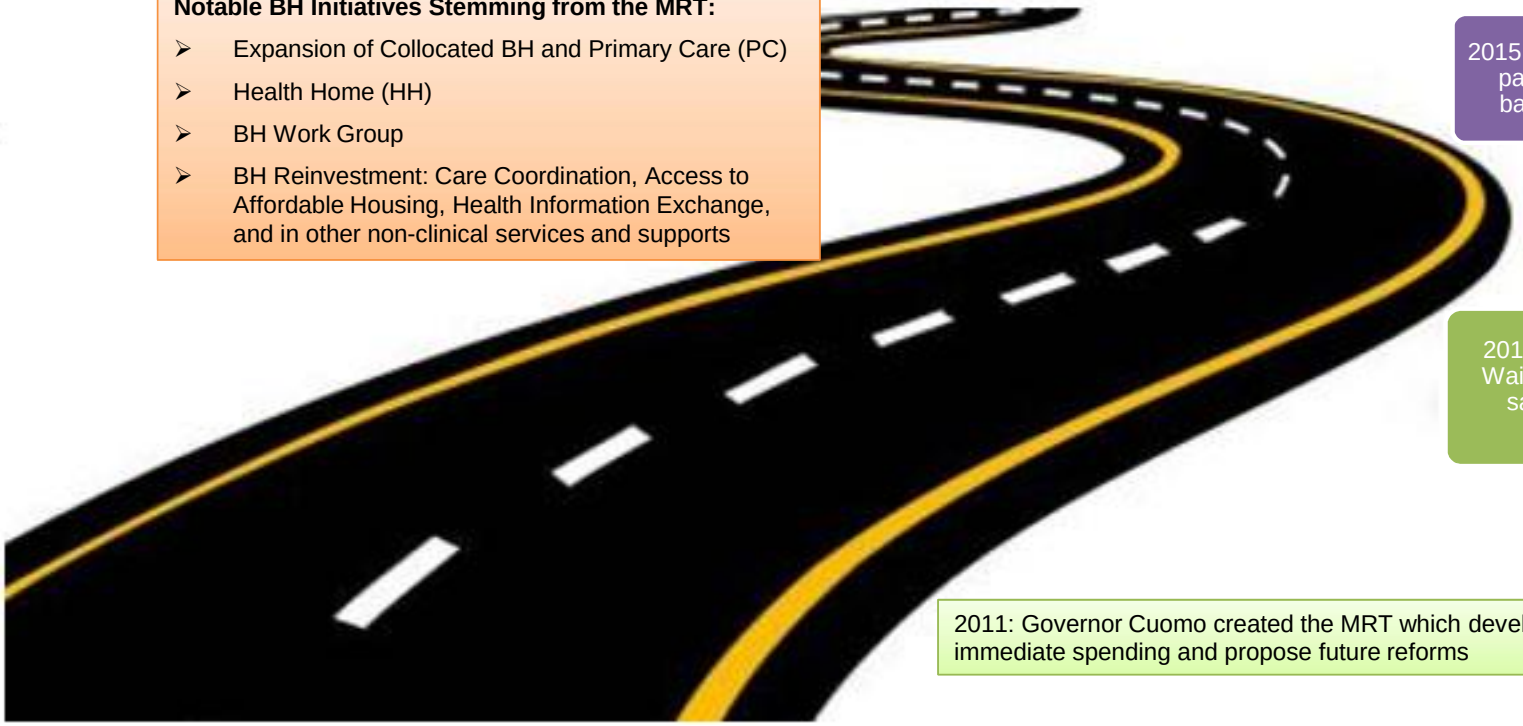
Road-map Toward Improved MH

From Waiver Services to VBP and other Stops Along the Way

Behavioral Health (BH)

Notable BH Initiatives Stemming from the MRT:

- Expansion of Collocated BH and Primary Care (PC)
- Health Home (HH)
- BH Work Group
- BH Reinvestment: Care Coordination, Access to Affordable Housing, Health Information Exchange, and in other non-clinical services and supports



VBP

2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards 80% value based payments by the end of the waiver period.

DSRIP

2014: As part of the MRT plan NYS obtained a 1115 Waiver which would reinvest MRT generated federal savings back into redesigning NYS's healthcare delivery system known as **DSRIP**

MRT

2011: Governor Cuomo created the MRT which developed a series of recommendations to lower immediate spending and propose future reforms

DSRIP Objectives aligned with MH

DSRIP as a transformation tool

- DSRIP was built on the Center for Medicare and Medicaid Services' (CMS) and the State's goals towards achieving the Triple Aim:
  - ✓ Better care
  - ✓ Better health
  - ✓ Lower costs
- To transform the system, DSRIP will focus on the provision of high quality, integrated primary, specialty and BH care in the community setting with hospitals used primarily for emergent and tertiary level of services
- Its holistic and integrated approach to healthcare transformation is set to have a positive effect on healthcare in NYS

Source: The New York State DSRIP Program. NYSDOH Website. & New York's Pathway to Achieving the Triple Aim. NYSDOH DSRIP Website. Published December 18, 2013.

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BH Landscape

NYS Healthcare Initiatives:

-Set the framework for healthcare delivery system reform
-Establish local performance network and specialized projects
-Promote better care delivery through performance incentives

HARP Role:

-Manage care for adults with significant BH needs
-Facilitate the integration of physical health, MH, and substance abuse services for individuals requiring specialized approaches
- Offer access to enhanced benefit packages designed to provide the individual with specialized services not currently covered under the State plan

**PPS= Performing Provider Systems*
***HARP= Health and Recovery Plans*

MCO

DSRIP

VBP

PPS*

VBP Contractors

HARP**

HH

Advanced & Integrated BH/PC

MCO 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
-Fully Integrated Duals Advantage (FIDA)/Managed Long Term Care (MLTC) plans maintain care coordination

PPS/ VBP Contractor Role:

-Be held accountable for patient outcomes and overall healthcare cost at local level
-Accept/distribute performance payments
-Share actionable performance data with network
-Provide process data to Plans/State
-Explore ways to improve population health

Program Role:

-Provide coordinated and integrated care to targeted populations
-Care management for Medicaid members
-Participation in alternative payment systems
-Support all reforms and help link systems through integrated care management

HH Role:

-Manage care for high risk populations

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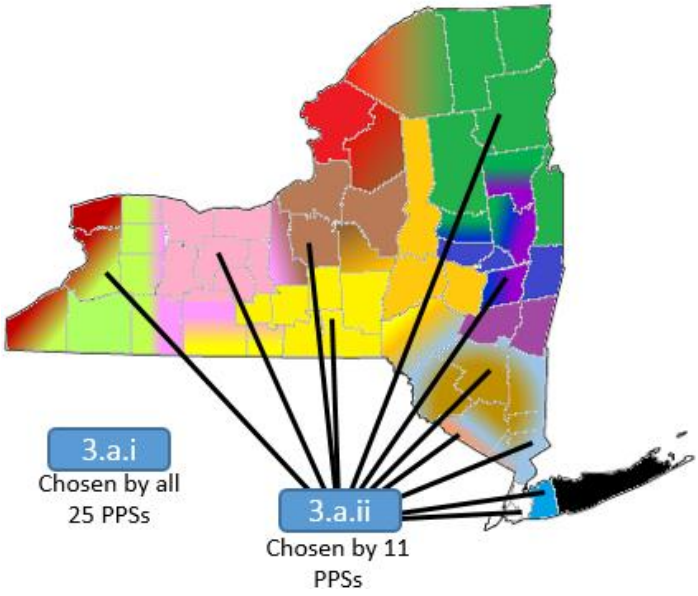
DSRIP as a Tool for Improved MH Delivery

DSRIP Domain 3 Requirements driving service integration

- In the early stages of DSRIP, PPS were required to implement at least one BH strategy project from the Domain 3 – Clinical Improvement Projects category.

3.A Projects: BH

- 3.a.i - Integration of PC and BH services
- 3.a.ii – BH community crisis stabilization services
- 3.a.iii - Implementation of evidence-based medication adherence program (MAP) in community-based sites for BH medication compliance
- 3.a.iv - Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
- 3.a.v - Behavioral Interventions Paradigm (BIP) in Nursing Homes



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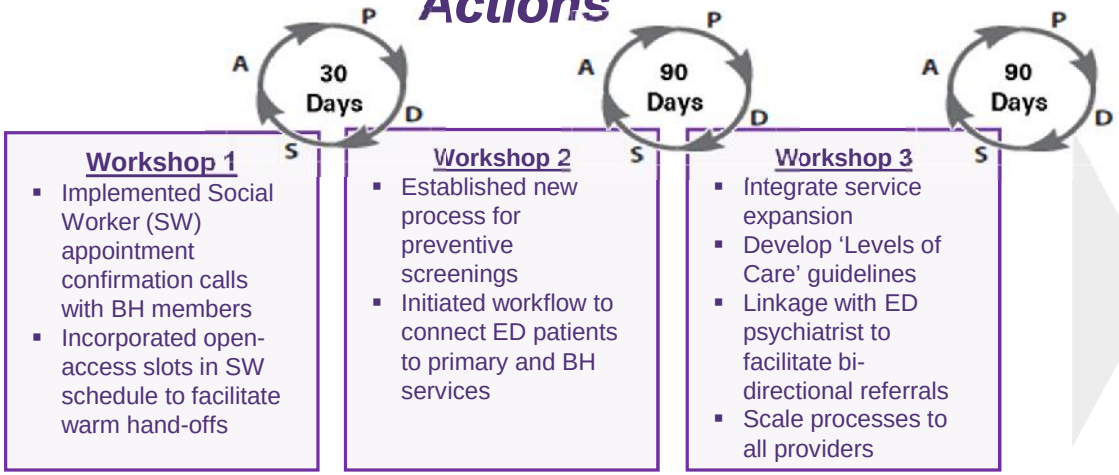
Case Study: Medicaid Accelerated Exchange (MAX) Integrating BH and PC Services

Lutheran – Case Study

(Data reflects Dec '15 – May '16)

The cohort is defined as BH members with a chronic condition of diabetes
Representing approximately 50 patients

Actions



Workshop 1
- Implemented Social Worker (SW) appointment confirmation calls with BH members
- Incorporated open-access slots in SW schedule to facilitate warm hand-offs

Workshop 2
- Established new process for preventive screenings
- Initiated workflow to connect ED patients to primary and BH services

Workshop 3
- Integrate service expansion
- Develop 'Levels of Care' guidelines
- Linkage with ED psychiatrist to facilitate bi-directional referrals
- Scale processes to all providers

Interim Results

	Before *(Dec'15 - Mar'16)*	After *(Apr'16 - May'16)*	a
Screening Compliance	32%	91%	+59%
BH no-show rate	16.5%	4.3%	-12.2%

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Case Study: MAX Integrating BH and PC Services

Care Compass Network – Case Study

337 adults 20-50 years with mild/acute depression scoring 10+ on the PHQ

Patient Success Story: PCP 'warm hand-off' and introduction of SW to patient in exam room!

Process Improvements

Patient Identification	Care Planning	Management	Follow-up
▪ Implemented referral and warm handoff processes ▪ Implemented waiting room screening processes ▪ Expanded screening to include SBIRT	▪ Implemented full-time SW ▪ Implemented integrated care plan ▪ Continuous provider education ▪ Data tracking and reporting ▪ Electronic Medical Record referral process	▪ Brief intervention and connection facilitated by SW ▪ Collaborative care planning and management ("Mini huddles") ▪ BH shadowing of PCP to further embed BH into practice	▪ Implemented ED follow-up process with Lourdes SW ▪ Implemented Health Home processes

Quantitative Results

	Baseline (Timeframe: Sept. '15 – Feb. '16)	Post-MAX Launch (Timeframe: Mar. '16 – Aug. '16)
Data Element	**Total Baseline**	**Total Post-MAX**
PHQ Screening Compliance	0	**1,297**
Warm Handoff Count (Patients received brief intervention with SW and attended a follow up session with SW)	0	**156**
Number of Patients with a score of 15 or higher who were connected to BH	0	**85**
Improvement in PHQ Score	**36 showed an improvement of between 1-12 reduction in PHQ-9**	

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Moving towards VBP

Reforming the Payment System toward Value

- HH care management payments will be part of VBP arrangements

Value Based Payments (VBP)

An approach to Medicaid reimbursement that rewards value over volume	An approach to incentivize providers through shared savings and financial risk	A method to directly tie payment to providers with quality of care and health outcomes	A component of DSRIP that is key to the sustainability of the program

- By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments
- **This will ensure DSRIP transformation efforts remain successful**

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published March 2016.

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Different Types of VBP Arrangements

- HH care management payments will be part of VBP arrangements

Types	Total Care for General Population (TCGP)	IPC	Care Bundles	Special Need Populations
Definition	Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population	Patient Centered Medical Home (PCMH) or Advanced Primary Care (APC), includes: • Care management • Practice transformation • Savings from downstream costs • Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related)	Episodes in which all costs related to the episode across the care continuum are measured • Maternity Bundle	Total Care for the Total Sub-pop • HIV/AIDS • MLTC • HARP
Contracting/Network Parties	IPA*/ACO**, Large Health Systems, FQHCs, BH Providers and Physician Groups	IPA/ACO, Large Health Systems, FQHCs, BH providers and Physician Groups	IPA/ACO, FQHCs, Physician Groups and Hospitals	IPA/ACO, FQHCs, BH Providers and Physician Groups

**IPA= Individual Provider Association*
***ACO= Accountable Care Organization*

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Questions?

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