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CENTERS OF CARE

Nassau University Medical Center

A. Holly Patterson Extended Care Facility

Family Health Centers

Elmont • Freeport• Hempstead • Roosevelt • Westbury

Delivery System Reform Incentive Payment (DSRIP)

May 12, 2014

Medicaid Redesign Team 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*

through the creation of a Delivery System Reform Incentive Payment (DSRIP) Program

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What is DSRIP?

- The DSRIP program will promote community-level collaborations and focus on system reform
  - Goal: Achieve a 25 percent reduction in avoidable hospitalizations over five years.
- Large public hospital systems and safety net providers will be required to collaborate with community organizations and physicians to implement innovative projects
  - Focus on system transformation, clinical improvement, and population health improvement.
- **All DSRIP funds are based on the Performing Provider System's performance on process and outcome milestones.**

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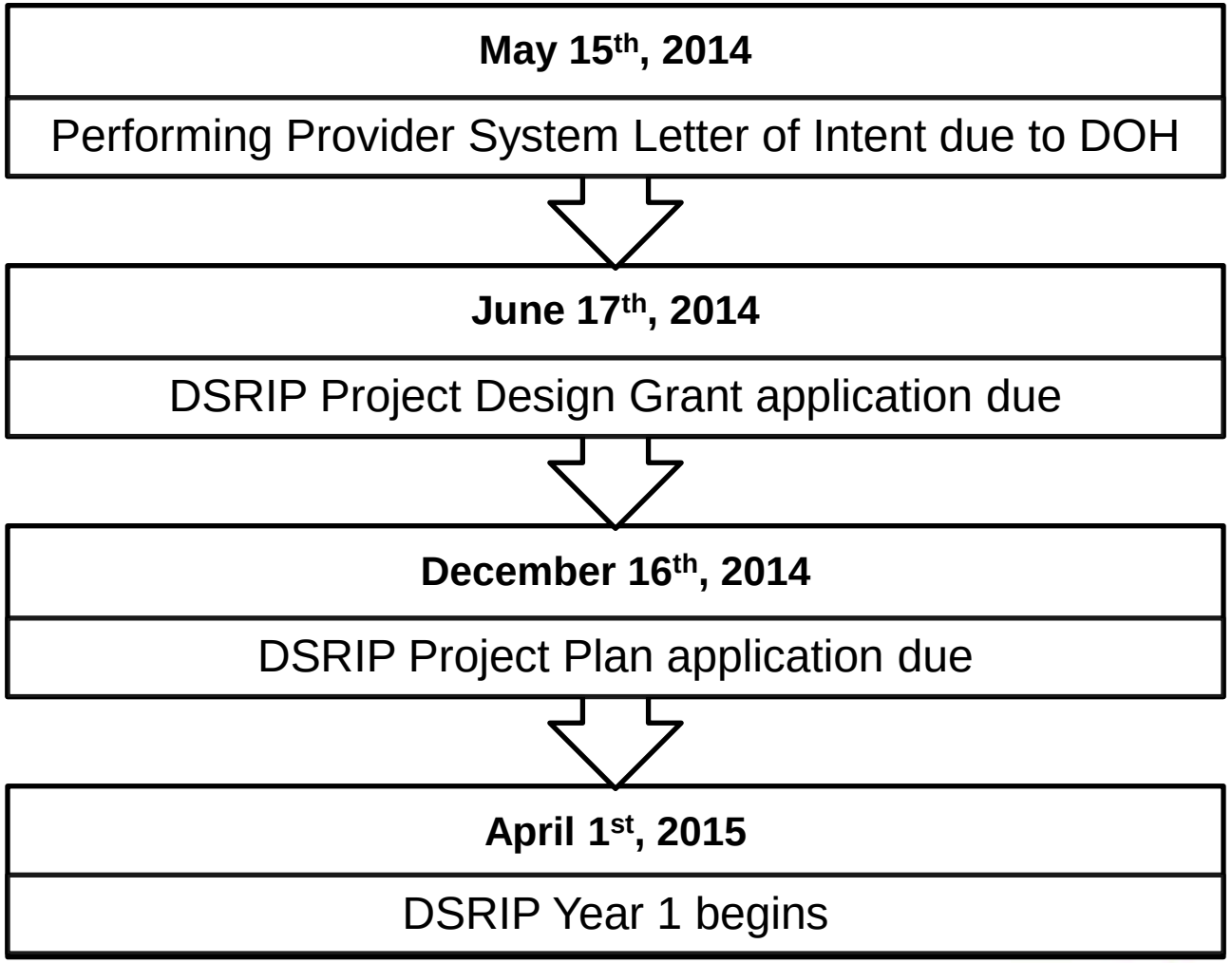
DSRIP Timeline



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Community Needs Assessment & SPARCS Data

- Necessary for DSRIP Project Design Grant application
  - Next step: More comprehensive Community Needs Assessment needed to better support our project
- NUMC rank based on volume of readmissions

(SPARCS data from April 2012-March 2013):

1. Alcohol abuse & dependence
2. Septicemia & disseminated infections
3. Opioid abuse & dependence
4. Seizure
5. Chest Pain
6. Heart Failure
7. Diabetes
8. Bipolar Disorders
9. Renal Failure
10. Chronic Obstructive Pulmonary Disease

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DSRIP Project Selection

- **Domain 2: System Transformation Projects**
  - Must choose 2 projects, Maximum of 4
  - At least 1 from sub-list A, and 1 from sub-list B or C.
- **Domain 3: Clinical Improvement Projects**
  - Must choose 2 projects, Maximum of 4
  - At least 1 from sub-list A, and 1 from sub-list A, B, C, D, E, F, G, or H.
- **Domain 4: Population-Wide Projects**
  - Must choose 1 project, Maximum of 2
  - At least 1 from sub-list A, B, C, or D.

Proposed NuHealth System Transformation Projects

Project ID	Domain 2 Project Title	Index Score
2.a.i	Create integrated delivery systems that are focused on evidenced-based medicine/population health management	56
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or advanced primary care models	37
2.b.ii	Development of co-located primary care services in the Emergency Department	40
2.b.iii	ED care triage for at-risk populations	43
2.b.iv	Care transitions intervention model to reduce 30 day readmission for chronic health conditions	43
2.b.v	Care transitions for skilled nursing facility (SNF) residents	41
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	41

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Proposed NuHealth Clinical Improvement Projects

Project ID	Domain 3 Project Title	Index Score
3.a.i	Integration of primary care and behavioral health services	39
3.a.iv	Development of withdrawal management (ambulatory detoxification) capabilities within communities	36
3.c.i	Diabetes Care-evidenced based strategies for disease management in high risk/affected populations (Adult only)	30
3.c.ii	Diabetes Care-implementation of evidenced based strategies in the community to address chronic disease-primary and secondary prevention strategies	26
3.d.i	Asthma-implementation of evidenced-based medication adherence programs-asthma medications	29
3.d.ii	Asthma-expansion of asthma home based self management program	31
3.d.iii	Asthma-implementation of evidenced-based guidelines for asthma management	31
3.g.i	Palliative Care-Conversation Ready	29
3.g.ii	Integration of palliative care services into the PCMH model	22
3.g.iii	Integration of palliative care services into nursing homes	25
3.h.i	Renal Care-Specialized medical home for Chronic Renal Failure	29

Proposed NuHealth Population-Wide Projects

Project ID	Domain 4 Project Title	Index Score
4.a.i	Promote mental, emotional and behavioral well-being in communities	20
4.b.ii	Increase access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (cancer, obesity)	17

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Project and Application Valuation

- The ***maximum project value*** is calculated by multiplying:
  - the project Per Member Per Month (PMPM),
  - the project plan application score,
  - the number of Medicaid beneficiaries attributed to the project,
  - and the duration of the DSRIP project in months.

- The ***maximum application value*** for a Performing Provider System is calculated by adding each project's maximum project value.
  - Represents the highest possible financial allocation a Performing Provider System can receive for their project plan over the duration of their participation in the DSRIP program.
  - 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.

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DRSIP Payments to Providers

- DSRIP payments for each provider are **contingent** on them **meeting program and project metrics and milestones** defined in the DSRIP Plan and consistent with the valuation process.

- Based upon a project's valuation, incentive payment values will be calculated for each metric/milestone domain in the DSRIP project plan by **multiplying the total valuation of the project in a given year by the milestone percentages specified in the chart in the next slide**.

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DSRIP Funding Distribution

Metric/ Milestone Domains	Performance Payment	Year 1 (CY 15)	Year 2 (CY 16)	Year 3 (CY 17)	Year 4 (CY 18)	Year 5 (CY 19)
Project progress milestones (Domain 1)	Pay for Reporting/ Pay for Performance	80%	60%	40%	20%	0%
System Transformation and Financial Stability milestones (Domain 2)	Pay for Performance	0%	0%	20%	35%	50%
	Pay for Reporting	10%	10%	5%	5%	5%
Clinical Improvement milestones (Domain 3)	Pay for Performance	0%	15%	25%	30%	35%
	Pay for Reporting	5%	10%	5%	5%	5%
Population Health Outcome milestones (Domain 4)	Pay for Reporting	5%	5%	5%	5%	5%

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DSRIP Performance Measures: Quality Reporting

- **Avoidable Emergency Room Visits (Potentially Preventable Visits – PPV)**
  - PPVs are ED visits for conditions that could otherwise be treated by a care provider in a non-emergency setting. The goal is to provide adequate patient monitoring and follow-up for ambulatory care sensitive conditions rather than utilize costly ED attention . e.g. ED treatment for asthma patient with SOB
  - Low PPV rates

- **Avoidable Readmissions (Potentially Preventable Readmissions – PPR)**
  - A PPR is a readmission that is clinically-related to the initial hospital admission. This is readmission due to process of care and treatment during prior admission within a specified time interval. E.g. Readmission for SSI or unfilled prescription
  - Low PPR rates

- **Preventable Quality Indicators (PQI) Suite**
  - Per 100, 000 population, ages 18 years and older
  - Diabetes, COPD, HTN, HF, PNA, Angina, Dehydration, UTI etc
  - Low PQI Composite rates

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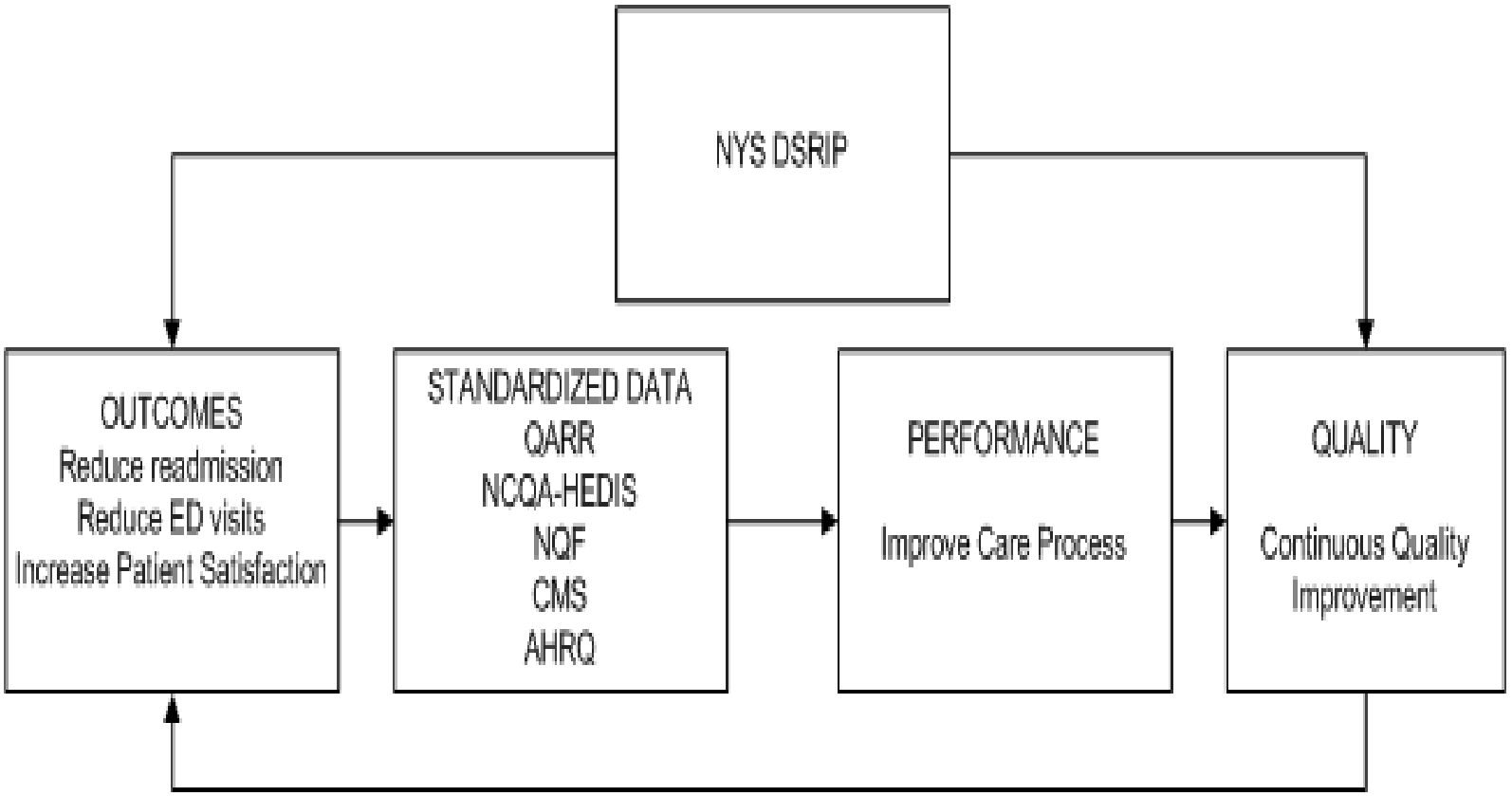
DSRIP Quality Reporting



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DSRIP Metrics: Reporting Standardized Data (Example)

❖ NQF #1932 : Diabetes Screening for people with Schizophrenia or BPD who are using Antipsychotic Meds (also an HEDIS Measure)

- ❑ **Description:** The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

- ❑ **Numerator:** One or more HgbA1c tests performed during the measurement year

- ❑ **Denominator:** Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

- ❑ **Excludes:** Patients are excluded from the population if they have had pharmacy data or claims/encounter data identifying them as diabetics.

Next Steps

- Complete the DOH contact information form and leave with Apurvi at end of meeting.
- We will be setting up meetings with each partner by project to review potential collaboration.
- More comprehensive Community Needs Assessment needed to better support our project.

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Resources

- **NYSDOH DSRIP Website:**

https://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

- **DSRIP Project Toolkit with Descriptions:**

https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

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