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DSRIP Programs:

Delivery System Reform Incentive Payment

The Current Situation

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DSRIP: What it Is & What it Isn't

Carrot --- to reduce costs for States with high Medicaid expenses

DSRIP redirects Medicaid and supplemental payments for uncompensated care at hospitals to any healthcare provider who improve quality and contains costs.

CMS' goals:

1. Integrate healthcare systems in different regions
2. Move from "fee for service" to "fee for quality"
3. Collaborate across providers to create care coordination
4. Reduce Federal spending

States obtain a Medicaid Section 1115 waiver, and providers are rewarded for implementing successful delivery system and payment reform projects.

- *Not a stick --- DSRIP is optional*
- No Federal implementation
- No precise CMS definition of "successful" implementation
- No precise detail from CMS as to what projects should look like
- Not focused on Medicare

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Drivers Behind DSRIP

CMS created the DSRIP program due to:

- General Healthcare Industry Drivers
  - US spends more than other first world countries but its outcomes are worse.
  - Per CMS Office of the Actuary, Sept 2014, healthcare spending is projected to increase to 19.3% of GDP by 2023, up from 17.2% in 2014.
  - While there is 'noise' around those numbers, GDP and the percentage of healthcare spending are projected to increase due to the aging population.

Robert Wood Johnson revised its projections downwards based on healthcare's spending growth at 3.6% year-on-year in 2013, the lowest rate of increase since 1960. However, the Kaiser Foundation's statistics indicate the deceleration is due to the downturn in the economy from 2007 to 2009, and the current recovery is pushing spending up with spending rising 5% in 2014.

- Medicaid "Super-Utilizers"
  - 1% of the population account for 22% of total annual healthcare spending.
  - 5% of Medicaid beneficiaries account for 54% of total annual Medicaid spending.

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State Programs: Commonalities

States which have signed up to date: CA, MA, TX, NJ, KS, NM, NY.

In each State:
1. CMS holds the State DOH accountable and the State DOH holds each provider group accountable for meeting DSRIP program objectives.
2. If DSRIP program objectives are not met, waiver payments are not made.
3. Providers join to form a DSRIP Entity and the Entity applies for eligibility.
4. DSRIP Entities select project & dollar goals, and submit them to the State for approval.
5. Entities "assemble" a reporting structure to provide data on their progress.

Five Key Themes:
1. ***Collaboration, Collaboration, Collaboration!***
2. Overall "Project Value" drives dollars and is based on:
    - number and types of projects;
    - number of Medicaid members served;
    - application quality
3. Payments are performance based
4. Statewide performance matters
5. Probability of lasting change is important

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DSRIP Project Examples

Provider groups, or "DSRIP Entities", must collaborate on a minimum number of DSRIP projects in 3 different Domains, plus maintain good-standing in Domain 1.

The Domains need to address:
- Infrastructure development
- Care innovation and redesign

Projects are to build on each other…

Domains and Project Examples
1. Overall Project Progress Domain
    - reports on status, spending, number of beneficiaries
    - reports on percent of completed projects
2. System Transformation Domain – 2 projects required. Examples:
    - Improved intervention for at-risk home health patients
    - Expanded usage of telemedicine
3. Clinical Improvement Domain – 2 projects required. Examples:
    - Integration of primary care and behavioral health services
    - Evidence based strategies for disease management in diabetes, asthma, etc.
4. Population-wide Impact Domain – 1 project required. Examples:
    - Promote tobacco use cessation
    - Increase early access to HIV care

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State Based Programs: Differences

State	Implementation Yr & Duration	Total Program Funding	Federal Funding	Eligible Providers	Projects
CALIFORNIA REPUBLIC	2010 (5 yrs)	$6.5 B	$3.3 B	21 public hospitals -- including county hospitals and some Uni of CA hospitals	388 projects in 4 domains.
Massachusetts	2011 (3 yrs + 3 yr extension in 2014)	$659.0 M	$659.0 M	7 safety net hospitals -- private NFP, private FP, public	49 projects in 4 domains.
Texas	2012 (5 yrs)	$11.4 B	$6.6 B	20 Regional Health Partnerships including all provider and non-provider types	1,491 projects in 4 domains.
New Jersey	2012 (4 yrs + 1 yr extension)	$611.0 M	$292.0 M	50 hospitals - any hospital may participate	50 projects in 8 disease-related focus areas.
KANSAS	2013 (3 yrs)	$100.0 M	$34.0 M	2 hospitals - State university hospital and children's hospital	4 projects in 4 domains.
New Mexico (Pending)	2014 (5 yrs)	$30.0 M	$30.0 M	Sole community hospitals and state university hospital	Outcome measures in 2 domains.
New York	2015 (5 yrs + 1yr extension)	$8.0 B	$6.4 B	25 Performing Provider Systems including all provider and non-provider types	258 projects in 4 domains.

*Adapted from Medicaid & CHIP Payment & Access Commission, Ben Finder & Robert Nelb, March 24, 2015 and from HFMA Metro-NY Chapter Mid-Year Reimbursement Seminar September 8, 2014. Presentation by Neelesh Shah, President & CEO, Performance Logic Presentation

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<u>NY State: Likely Roadmap for the Future</u>
- Key Steps to Create a DSRIP Entity
- Governance
- Implementation: Plans & Risks
- Funding

NY State: Likely Roadmap for Future

1. Large program - $8 billion; second behind TX
2. Most flexible - Open to all provider and non-provider types
3. Current - Most extensive work with CMS and "learning" from previous implementations; taking "the best" from before

<u>NY State Goals:</u>
- NY State established a Medicaid Redesign Team (MRT) in 2011 with goals of:
  - reforming NY State's healthcare system and reducing costs
  - saving $17.1 billion in <u>federal</u> dollars over 5 years
- 2014 refined goal:
  - cut unnecessary Medicaid hospital admissions by 25% in five years

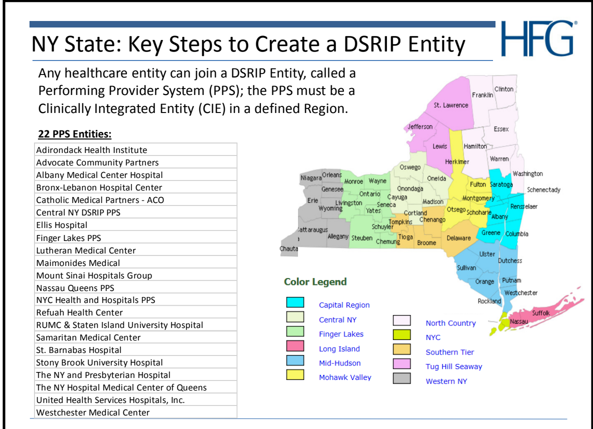
<u>Potential Outcomes:</u>
- DSRIP Federal Funding is $6.4 billion
  - ➢ **DSRIP = SEED CAPITAL** for $17.1 billion goal
- The NY hospital industry estimates that cutting hospital admissions by 25% will lead to an overall drop in hospital admissions of 5%, implying overall lower demand and leading to hospital closures and downsizings.

NY State: Key Steps to Create a DSRIP Entity

Any healthcare entity can join a DSRIP Entity, called a Performing Provider System (PPS); the PPS must be a Clinically Integrated Entity (CIE) in a defined Region.

<u>22 PPS Entities:</u>

22 PPS Entities
Adirondack Health Institute
Advocate Community Partners
Albany Medical Center Hospital
Bronx-Lebanon Hospital Center
Catholic Medical Partners - ACO
Central NY DSRIP PPS
Ellis Hospital
Finger Lakes PPS
Lutheran Medical Center
Maimonides Medical
Mount Sinai Hospitals Group
Nassau Queens PPS
NYC Health and Hospitals PPS
Refuah Health Center
RUMC & Staten Island University Hospital
Samaritan Medical Center
St. Barnabas Hospital
Stony Brook University Hospital
The NY and Presbyterian Hospital
The NY Hospital Medical Center of Queens
United Health Services Hospitals, Inc.
Westchester Medical Center



NY State: Key Steps to Create a DSRIP Entity

To be defined as a Clinically Integrated Entity and create a PPS, existing competitors must cooperate, collaborate and share information.

To support collaboration, DOH and State Agencies waive and reduce regulations in many areas. Examples:

Regulations / Reductions through
- Antitrust / Public Advantage and ACO Certificates
- Integration of services & space / plan approvals & waivers
- Certificate of Need / reduced numbers of areas for review
- Geographic service areas for home health agencies / amendments
- Transfers of patients; Definition of long-term care patients; Limitation on the number of observation beds / waivers

Possible roles for PPS "partners" or members
1. Governance Partner: Has attributed patient beneficiaries and a governance role
2. Participating Partner: Has attributed patient beneficiaries but no governance role
3. Affiliate: no attributed patient beneficiaries but participates in a PPS structure

   - Caution: Competition for Medicaid beneficiaries - Every Medicaid beneficiary, or "allocated life", *can **only** be attributed to **one** PPS*

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NY State: Governance

To date, within the Regions, existing providers have joined together and:

1. Picked a leader and defined roles – defined by:
   - ✓ Capital contribution
   - ✓ Attributed patient beneficiaries
   - ✓ Regional representation
   - ✓ Provider type
   - ✓ Number of projects undertaken
2. Determined how to be an effective governing entity – and legally established that entity. Most popular governance models:
   - Delegation of power: a new legal entity is created to govern and operate the PPS; that entity will function as an oversight Board
   - Full Integration: a single legal entity with full control over all other members
3. Defined that new entity's duties for the projected 5 year period
4. Outlined the projects and the timeline for submitting the results to the DOH
5. Begin work on submissions --- successful quarterly submission of deliverable is the basis on which the PPS is paid by DOH

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NY State: Implementation Plans

Implementation Plans are:
- A set of deliverables and metrics that determine how much the PPS will get paid with *commitments on Implementation Timelines*
  - "Achievement Values" of "0" or "1" to drive the % of payment relative to the Maximum Project Value for each Milestone

Implementation Plans are not:
- Detailed work plans
- Plans for the PPS to move forward with implementation

Process to create Plans:
- Establish PPS-level workgroups with individuals from each member
- Met at least twice (sometimes more) to discuss approach
- Create responses, with additional review by:
  - Leadership Group
  - Executive Committee
  - DOH Implementation Plan Committee

Taken from the Nassau-Queens PPS, DSRIP Entity PAC presentation. Leaders: Catholic Healthcare System of Long Island; Long Island Jewish Hospital System; NuHealth System.

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NY State: Risks to Implementation

Patient-related Risks
-Patients may not wish to change utilization patterns or follow recommendations
-Risk of securing staff who can offer culturally or linguistically appropriate care
-Difficulties identifying and engaging patients through appropriate means

Provider-related Risks
-Provider reluctance to make changes to workflow and reporting requirements
-Provider lack of willingness to transition to value-based models of care
-Provider challenges associated with meeting required DSRIP changes while managing patients with other insurance

System Risks
-Inability to access key data to manage DSRIP projects and goals… **IT requirements!**
-Inability to obtain core supports from regional and statewide clinical data exchanges
-Potential for DSRIP fatigue due to complexity and demands of the program over time

Financial Risks
-Shortage of capital and operational funds to meet speed and scale commitments
-Lack of financial controls to manage DSRIP finances, incentives, etc.
-Challenges associated with decreasing avoidable hospital use by 25%

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NY State: Funding

Total Potential Funding is based on:
- Overall project value; and
- Score assigned at the time of application

Funding based on:
- Pay-for-Reporting:
  - Common among all States - initial payments are on process metrics, submitted to the State on a quarterly basis.
- Pay-for-performance:
  - In NY, after approximately 1 ½ years, payments will be on outcome metrics, submitted to the State on a quarterly basis

In NY, achievement of metrics is based on performance of entire PPS, not individual providers, and ultimate funding is determined by the success of all PPS entities across the State.

PPSs may receive less than the total project maximum valuation if they do not meet metrics, including **speed and scale.**

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NY State: Funding - Example from DOH

Projects	Index Score	Maximum Index Score	Project Index Score	Valuation Benchmark	Project PMPM	PPS Attribution Total	DSRIP Project Plan Application Score	# of DSRIP Months	Maximum Project Value
2.a.i	56	60	0.93	$2.00	$1.87	250,000	0.95	60	$26,600,000
2.a.iii	46	60	0.77	$2.00	$1.53	250,000	0.88	60	$20,240,000
2.b.iii	43	60	0.72	$2.00	$1.43	250,000	0.92	60	$19,780,000
2.b.iv	43	60	0.72	$2.00	$1.43	250,000	0.81	60	$17,415,000
3.a.i	39	60	0.65	$2.00	$1.30	250,000	0.94	60	$18,330,000
3.a.ii	37	60	0.62	$2.00	$1.23	250,000	0.82	60	$15,170,000
3.b.i	30	60	0.50	$2.00	$1.00	250,000	0.98	60	$14,700,000
3.c.i	30	60	0.50	$2.00	$1.00	250,000	0.81	60	$12,150,000
4.a.iii	20	60	0.33	$2.00	$0.67	250,000	0.83	60	$ 8,300,000
4.b.ii	17	60	0.28	$2.00	$0.57	250,000	0.80	60	$ 6,800,000
2.d.i	56	60	0.93	$2.00	$1.87	125,000	0.87	60	$12,180,000
								Total DSRIP Project Valuation	**$171,665,000**

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DSRIP Challenges

Funding Unknowns
- Final application scores and rankings from DOH (i.e. the metrics are not final)
- Expenditures needed to achieve goals – at both the DSRIP Entity and the State level

Key Obstacles
- Complex reporting requirements that rely on IT systems -- with more manual processes at the outset
- Obtaining comparable reporting at the member level so that all member information can be aggregated at the DSRIP Entity level
- Engagement of the Uninsured patients, the Non Utilizers and the Low Utilizers
- Ability to contract with other Entities to access shared savings

Next Steps
- Refine estimated DSRIP dollars by project
- Understand project requirements relative to available funding
- Determine how to treat key issues (e.g. how the uninsured are managed)
- Determine monitoring strategy for Performance Reporting

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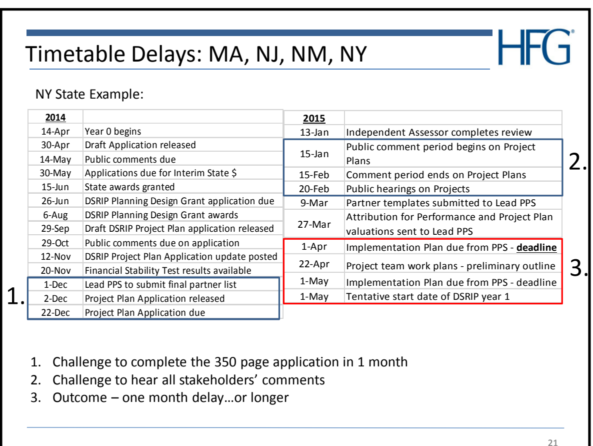

Timetable Delays: MA, NJ, NM, NY

NY State Example:

2014	
14-Apr	Year 0 begins
30-Apr	Draft Application released
14-May	Public comments due
30-May	Applications due for Interim State $
15-Jun	State awards granted
26-Jun	DSRIP Planning Design Grant application due
6-Aug	DSRIP Planning Design Grant awards
29-Sep	Draft DSRIP Project Plan application released
29-Oct	Public comments due on application
12-Nov	DSRIP Project Plan Application update posted
20-Nov	Financial Stability Test results available
1-Dec	Lead PPS to submit final partner list
2-Dec	Project Plan Application released
22-Dec	Project Plan Application due

1.

2015	
13-Jan	Independent Assessor completes review
15-Jan	Public comment period begins on Project Plans
15-Feb	Comment period ends on Project Plans
20-Feb	Public hearings on Projects
9-Mar	Partner templates submitted to Lead PPS
27-Mar	Attribution for Performance and Project Plan valuations sent to Lead PPS
1-Apr	Implementation Plan due from PPS - **deadline**
22-Apr	Project team work plans - preliminary outline
1-May	Implementation Plan due from PPS - deadline
1-May	Tentative start date of DSRIP year 1

2.

3.

1. Challenge to complete the 350 page application in 1 month
2. Challenge to hear all stakeholders' comments
3. Outcome – one month delay…or longer

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Conclusion

Delays due to:

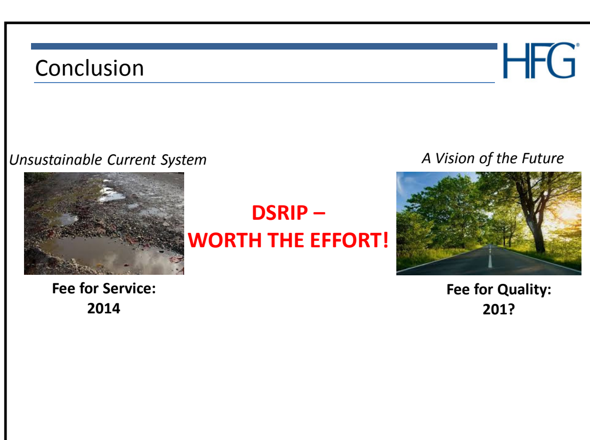
- Amount of required resources and difficulty of implementation – *IT is CRITICAL*
- States' DSRIP program evaluations are not always received on time
- Uncertainty as to whether the reforms themselves will sustain the program without further State or provider investment

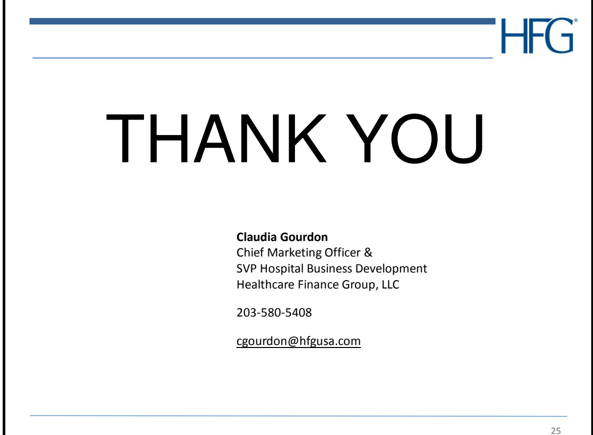
Ambitious Program – Tricky Implementation

Determination to succeed due to:

- The need to reduce medical costs, which is driving reductions in federal spending, and the need to reduce the unevenness of healthcare quality across different demographic groups
- Significant amounts of Federal monies are allocated to DSRIP waiver program
- New and prospective regulations are driving hospitals to align and cooperate in order to survive and grow
- Hospital consolidation has been accelerating and DSRIP will further that trend

Conclusion

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