What is Managed Care and DSRIP?

And Why Should Assisted Living Organizations Care?

New York State Center for Assisted Living
Mid-Winter Conference

Carla Williams, MPA
Director, Healthcare Consulting Group
O'Connell and Aronowitz
How to Make Sense of It All?

- Environmental scan
  - External
    - Definitions
    - Enrollment data
    - Plan activity - contract types
    - Relationships and Referrals
    - Demographics
  - Internal
    - Performance Analysis
    - Revenue Cycle
    - Cost Allocation
    - Case load and clinical tracking
    - Contract Review Process
How to Make Sense of It All?

- **Medicaid Managed Care (MMC) Health Plans**
  - For all adults served in MMC health plans, the qualified plan will provide all Medicaid State Plan covered services for MI, SUDs and PH conditions. Must meet criteria contained in the request for qualification (RFQ) and be approved by the State to qualify to administer the BH benefit.

- **Health and Recovery Plans (HARPs)**
  - For adults meeting SMI and/or SUD targeting criteria and risk factors
  - Enhanced benefit package (referred to as “1915i-like” services) meet both targeting and needs-based criteria for functional limitations in addition. Help maintain participants in home- and community-based settings.
How to Make Sense of It All?

- Managed Long Term Care (MLTC) Plans:
  - Adults over 21 and Duals requiring more than 120 days of community based long term care services and those who meet the nursing home level of care (for Programs of All-Inclusive Care for the Elderly and Medicaid Advantage Plus).
  - Benefits: State Plan long term care services, including the LTHHCP and nursing home stays, but not any of the physical health services, which are covered by Medicare.
  - Transition began in New York City in 2012 and has continued into Long Island, Westchester and upstate urban counties; now over 120,000 people are enrolled.
How to Make Sense of It All?

- Managed Long Term Care (MLTC) Plans:
  - Individuals between the ages of 18 and 20 may voluntarily enroll in a MLTC Plan. The conditions of eligibility are:
    - require more than 120 days of community based long term care services; and
    - meet Nursing Home Level of Care criteria
  - Non-dually eligible individuals, who are not otherwise considered mandatory for Mainstream Managed Care, may voluntarily enroll in a MLTC plan with the same eligibility conditions.
How to Make Sense of It All?

- **Fully Integrated Duals Advantage (FIDA)**
  - State is also participating in the Federal Medicare/Medicaid Demonstration Program that allows for the alignment of Medicare and Medicaid payments under a capitated model.
  - Program is intended to cover all needed services - both physical health and behavioral health for the dual population that is either:
    - in need of more than 120 days of community based services or
    - residing in nursing homes.
  - The full range of BH services are included in FIDAs, including Community Residences

  NOTE: Conflict Free Assessments (CFA) to be implemented to determine eligibility for services using a standardized assessment tool administered by the Medicaid Enrollment Broker in October of 2014 and aimed at addressing the potential conflict of MLTC Plans assessing the need for service eligibility. It is anticipated that this CFA process will be applied to the HARP-eligible population as well.
Eligibility

- **Eligibility can vary depending on type of Coverage Plan.**
  - Example: Fidelis is approved to enroll Medicaid Mainstream eligible, Medicaid Managed Long Term Care eligible as well as Medicare Advantage eligible in certain counties of the state.
  - The Fully Integrated Duals Advantage (FIDA) is being developed for New York City, Nassau, Suffolk and Westchester and will be able to enroll Medicaid and Medicare eligible in 2015.
  - Develop a basic understanding of what types of individuals are eligible for which programs prior to entering into a contract.
  - Understand for which Coverage Plans your current clients are, and future clients might be, eligible.
Payment Models

The Current Payment Model

- Payors: Medicaid
- Eligibility
- Enrollment
- Claims for Services
- Payment for Services
- Providers of Services
- Services
- Covered Persons
Payment Models

The Managed Care Payment Model

**Providers Of Services**

- **Health Plans**
  - **Coverage Plans**
    - Medicaid: MMC, MMC/HB, MLTC, HARP
    - Medicare: Medicare Advantage, SNPs
    - Medicaid/Medicare: FIDA, Medicaid Advantage
    - Employers: Self or Group Policies
    - Individuals: Health Exchange Policies

- **Plan Contracts**

- **Per Member, Per Month Payments**

**Eligibility**

- **Covered Persons**

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<th><strong>Payers</strong></th>
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<td>Medicare</td>
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<tr>
<td>Employers</td>
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<tr>
<td>Individuals</td>
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<tr>
<td>Contracts</td>
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<td>Claims</td>
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<td>Payments</td>
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<tr>
<th><strong>Other Provisions</strong></th>
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12/19/2014
New World

- Your new relationships will be governed by contract
  - May need to deal with multiple Plans (and contracts), which will likely have different requirements
  - Caution is needed when working with Plans
- Information for residents may be overwhelming
- Relationship to NY Medicaid Choice and resident
- Nature of residential services for Nursing Homes: has been delayed several times
- Assessment tool impact on services and eligibility
- Term and Conditions of 1115 waiver: HBCS definition
- Actual contract provisions
Contracts define your rights and obligations (covered services, payment, compliance, EHR, workflow, processes, etc.)

Plan policies and manuals are critical

NOT vendor contracts (think mortgage)

Due diligence is not optional
  - “Template” contracts are almost universally disastrous
  - Must understand the terms of the agreement before signing
  - Fiduciary duties

Must understand the contract terms and who you are contracting with (IPA, BHO, Plan, other)
Under a Medicaid managed care program, the NYS Department of Health contracts with managed care plans:

- The plans agree to provide or arrange for the provision of an agreed upon set of services (covered benefits) in exchange for a predetermined, prepaid per member per month (PMPM) or capitation payment.
- The capitation payment does not vary based on the number of services the managed care plans provide.
- The managed care plans assume financial risk for providing all covered benefits.
There are “Health Plans”, “Product Lines” within each Plan, and "Coverage Plans" within the “Product Lines”.

- Blue Cross/Blue Shield is an insurance company and “Health Plan” that might have three “Product Lines,” Commercial, Medicaid and Medicare as a result of contracts with employers, individuals or the government.

- There might be four Coverage Plans within the Medicaid Product Line, i.e., Mainstream Managed Care (including Family Health Plus and Child Health Plus), HARP, MLTC and FIDA.

- Each Health Plan will have its own distinct structure and may not provide all product lines or Coverage Plans.
FIDA Key Issues: Covered Services

- FIDA Plans are required to provide medically necessary covered items and services.
- FIDA offers the most robust service package available in New York’s Managed Care Program.
- FIDA coverage includes items and services currently covered by:
  - Medicare
  - Medicaid
  - Long Term Care
  - Behavioral Health
  - Wellness Programs
  - Prescription Drugs
  - Home and Community Based Waiver Services
FIDA Key Issues:
Covered Services

- There are no FIDA-specific costs to Participants, including no Part D or Medicaid drug co-payments, no premiums, and no deductibles for any covered items or services. Balance billing of Participants is prohibited.

- Participating Providers will bill FIDA Plans for services and cannot bill Medicaid, Medicare, or any Participant directly for covered items and services.
**FIDA Key Issues:**

**Enrollment Structure**

- **Region I - NYC and Nassau:**
  - No earlier than April 1, 2015, NYSDOH will passively enroll community based:
    - Eligible Individuals Medicaid Eligibility Authorization that are due for renewal
    - Eligible Individuals who do not undergo annual Medicaid Renewal and have a birthday within the months of January, February, and March 2015.
    - Each month new cohort based on MEA or DOB until August of 2015

- **Region II - Suffolk & Westchester:**
  - All community based eligible individuals will be passively enrolled July 1, 2015.
FIDA:
Enrollment

- **There are two types of enrollment:**
  - **Opt-in Enrollment,** which is initiated by an individual.
    - January 1, 2015, effective date for individuals in Region I (New York City and Nassau County).
    - April 1, 2015, effective date for individuals in Region II (Suffolk and Westchester).
  - **Passive Enrollment,** enrollment by the State, which the individual can decline by opting out.
    - April 1, 2015, effective date for individuals who are Passively Enrolled in Region I. Passive Enrollment will occur over a five-month period.
    - July 1, 2015, effective date for individuals who are Passively Enrolled in Region II.
FIDA:
Enrollment

- All enrollments (Opt-in and Passive) will be through NY Medicaid Choice, which will provide counseling and assistance. Plans cannot perform enrollments into FIDA.
- FIDA eligible individuals enrolled in a Managed Long Term Care (MLTC) plan will “convert” to their Plan’s FIDA product, unless they choose another plan.
- Individuals may disenroll from FIDA at any time.
- The FIDA Program Announcement Letter is the first notification the Participant receives and marks the start of potential Opt-in Enrollments. Participants will also receive a 90-day, a 60-day and a 30-day Passive Enrollment reminder notice.
## FIDA Approved Plans: Government Scope

<table>
<thead>
<tr>
<th>PLAN Name</th>
<th>Approximate Current Enrollment in FIDA Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNS Choice</td>
<td>22,000</td>
</tr>
<tr>
<td>Guildnet, Inc.</td>
<td>15,000</td>
</tr>
<tr>
<td>Managed Health, Inc.</td>
<td>200</td>
</tr>
<tr>
<td>Elderplan, Inc.</td>
<td>11,000</td>
</tr>
<tr>
<td>Elderserve Health, Inc.</td>
<td>10,000</td>
</tr>
<tr>
<td>Centerlight Healthcare, Inc.</td>
<td>3700</td>
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<tr>
<td>NYS Catholic Health Plan, Inc.</td>
<td>490,000</td>
</tr>
<tr>
<td>Wellcare of New York</td>
<td>186,000</td>
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<tr>
<td>Health Insurance of Greater New York</td>
<td>245,000</td>
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<tr>
<td>Independence Care System, Inc.</td>
<td>5200</td>
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<tr>
<td>Agewell New York, LLC</td>
<td>3800</td>
</tr>
<tr>
<td>Amerigro New York, LLC</td>
<td>415,000</td>
</tr>
<tr>
<td>Village Senior Services Corporation</td>
<td>3300</td>
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</table>

<table>
<thead>
<tr>
<th>PLAN Name</th>
<th>Approximate Current Enrollment in FIDA Region</th>
</tr>
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<tbody>
<tr>
<td>Aetna Better Health, Inc.</td>
<td>2800</td>
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<tr>
<td>Catholic Managed Long Term Care, Inc.</td>
<td>400</td>
</tr>
<tr>
<td>Integra, MLTC</td>
<td>1950</td>
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<tr>
<td>Centers Plan for Healthy Living, LLC</td>
<td>2000</td>
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<tr>
<td>North Shore-LIJ Health Plan, Inc.</td>
<td>1200</td>
</tr>
<tr>
<td>Senior Whole Health of New York</td>
<td>1500</td>
</tr>
<tr>
<td>Metroplus Health Plan, Inc.</td>
<td>419,000</td>
</tr>
<tr>
<td>Alphacare of New York, Inc.</td>
<td>1000</td>
</tr>
<tr>
<td>Montefiore HMO, LLC</td>
<td>500</td>
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</table>
FIDA:
IDT

- Each Participant must have an individualized care planning process using the IDT approach.
- The IDT will be person-centered, based on the Participant’s specific preferences and needs, and deliver services with respect to linguistic and cultural competence, and dignity.
- The IDT will use the comprehensive assessment as a basis for care plan development or Person-centered Service Plan (PCSP).
- All services plans developed by the IDT act as authorizations for those items and services contained within.
- Service authorizations may be made by the FIDA Plan through the Utilization Management (UM) process before the initial PCSP is developed by the IDT and in between IDT meetings.
After the PCSP is developed by the IDT, care decisions contain therein act as service authorizations for six months, or the duration of the care plan.

In between IDT meetings, any additional services the Participant needs that are not already addressed by the current PCSP are subject to the Plan's UM process for coverage decisions.
FIDA: IDT

- **Participant** or, in the case of incapacity, an authorized representative;
- Participant’s **designee(s)**, if desired by the Participant;
- **Primary Care Provider** (PCP) or a designee with clinical experience from the PCP’s practice who has knowledge of the Participant’s needs;
- **Behavioral Health Professional**, if there is one, or a designee with clinical experience from the professional’s Behavioral Health practice who has knowledge of the Participant’s needs;
- **FIDA Plan Care Manager**; Participant’s **home care aide(s)**, or a designee with clinical experience from the home care agency who has knowledge of the Participant’s needs;
- Participant’s **Nursing Facility representative**, who is a clinical professional, if receiving Nursing Facility care; and
- **Other providers** either as requested by the Participant or designee, or as recommended by the IDT.

- **The RN** who completed the Participant’s Assessment, if approved by the Participant or designee.
<table>
<thead>
<tr>
<th>Plan Name</th>
<th>County</th>
<th>Total Enrollment</th>
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<tbody>
<tr>
<td>GUILDNET</td>
<td>NASSAU</td>
<td>1557</td>
</tr>
<tr>
<td>GUILDNET</td>
<td>SUFFOLK</td>
<td>1474</td>
</tr>
<tr>
<td>ARCHCARE COMMUNITY LIFE</td>
<td>WESTCHESTER</td>
<td>435</td>
</tr>
<tr>
<td>VNS CHOICE</td>
<td>NEW YORK</td>
<td>15943</td>
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</table>
## MLTC Enrollment

<table>
<thead>
<tr>
<th>Enrollees in MLTC</th>
<th>As of November 1, 2014</th>
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<tbody>
<tr>
<td>New York City</td>
<td>117,785</td>
</tr>
<tr>
<td>Rest of the State</td>
<td>20,455</td>
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<tr>
<td>Total Statewide:</td>
<td>138,240</td>
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<table>
<thead>
<tr>
<th>Types of Plans</th>
<th>Number Actively Enrolling</th>
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<tbody>
<tr>
<td>Partial</td>
<td>32 (25 serve NYC)</td>
</tr>
<tr>
<td>PACE</td>
<td>8 (2 serve NYC)</td>
</tr>
<tr>
<td>MAP</td>
<td>8 (8 serve NYC)</td>
</tr>
<tr>
<td>Total:</td>
<td>48</td>
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FIDA

- Transitions of Care
  - “The FIDA Plan will manage transitions of care and continuity of care for participants moving from an institutional setting to a community living arrangement”

- Health Promotion and Wellness:
  - Plan will offer expansive set of health education
  - Plan will identify regional community health education opportunities; including classes, support groups and workshops related to heart attack and stroke prevention, asthma, etc
  - Includes annual reminders to caregivers
  - Flu Prevention
External:
Conflict-Free Evaluation and Enrollment Center (CFEEC)

- **NY Medicaid Choice is performing the CFEEC activities, which include:**
  - Scheduling initial evaluations
  - Staffing nurse evaluators to perform in-home evaluations (hospitals and nursing homes)
- **The CFEEC will evaluate consumer’s eligibility for one of the four MLTC products:**
  - Partially Capitated Plans
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Medicaid Advantage Plus (MAP)
  - Fully Integrated Duals Advantage (FIDA) (To be implemented January 2015)
### External and Internal: Demographics

- **Track your clients**
  - By age
  - By neighborhood
  - By ethnicity and cultural needs

- **Understand the community demographics**
  - Is population served changing?
  - Where are socio-economic trends going?
  - Opportunity for private pay?
  - Opportunity for special programs?
### External: Relationships and Referrals

- **Track every referral**
  - Review monthly and trend
  - Understand the MC referral process
  - MC network opens new referral opportunity
  - Relationships with Nursing Homes and Assisted Living

- **Understand the community**
  - Review managed care enrollments
  - Opportunities for younger patients; private pay; special program
External Data: Prevention

Department of Health Prevention Agenda Dashboard

Rate of hospitalizations due to falls per 10,000 Aged 65+ years, 2012
Prevention Agenda 2017 Objective: 204.6
## External: Medicare Advantage Enrollment

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>ELIGIBLES</th>
<th>ENROLLED</th>
<th>PENETRATION RATE</th>
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<tbody>
<tr>
<td>ALBANY</td>
<td>54,493</td>
<td>20,956</td>
<td>38.46%</td>
</tr>
<tr>
<td>NASSAU</td>
<td>241,644</td>
<td>124,046</td>
<td>51.33%</td>
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<tr>
<td>SUFFOLK</td>
<td>263,172</td>
<td>142,183</td>
<td>54.03%</td>
</tr>
<tr>
<td>WESTCHESTER</td>
<td>161,135</td>
<td>82,970</td>
<td>51.49%</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>1,181,969</td>
<td>467,890</td>
<td>39.58%</td>
</tr>
<tr>
<td>ERIE</td>
<td>183,758</td>
<td>44,714</td>
<td>24.33%</td>
</tr>
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### Medicaid Enrollment

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<thead>
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<td>NEW YORK</td>
<td>15943</td>
</tr>
<tr>
<td>FIDELIS CARE AT HOME</td>
<td>ERIE</td>
<td>241</td>
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External:
Medicare Advantage Enrollment

- 14 NY Counties have greater than 50% Medicare Advantage Penetration Rates (most are Upstate)
- Participation is expected to grow:
  - baby boomers familiar with managed care
  - lower cost to beneficiary
- Impacts on referrals based on Network partners
- May represent a private pay opportunity
Internal: Contract Review

- **Reviewing contract from all perspectives:**
  - Administration
    - Type of contract; scope of opportunity; network
  - Finance
    - Rates: Can you identify your unit costs? Volume does not make up for below cost rates!
  - Clinical
    - Service definitions; supervision; assessments; training
Internal: Translating Quality

- Best practices
- Outcome measurement
- Electronic communications
- Using technology
- Patient and family involvement
- Training of patient and family
- Staff training, engagement
**Internal:**

**Quality Definitions CMS Style**

- **Effectiveness:** providing care processes and achieving outcomes as supported by scientific evidence.
- **Efficiency:** maximizing the quality of a comparable unit of health care delivered or unit of health benefit achieved for a given unit of health care resources used.
- **Equity:** providing health care of equal quality to those who may differ in personal characteristics other than their clinical condition or preferences for care.
- **Patient Centeredness:** meeting patients' needs and preferences and providing education and support.
- **Safety:** actual or potential bodily harm.
- **Timeliness:** obtaining needed care while minimizing delays.
Internal: Revenue Cycle

- Analyze accounts receivable and denial data
- Review management reports for trends (are they created?)
- Understand work flow - consider shadowing staff throughout the revenue cycle
- Facilitate management and staff to revise processes, brainstorm to adopt approaches that sustain an optimal revenue cycle - each step is critical
- Develop key performance indicators and tracking mechanisms
Internal: Performance Analysis

- Identify the processes, trends & other factors driving performance
  - Intake processes - follow thru to billing
  - Documentation: regulations, accuracy, completeness & timeliness
  - Billing routines, timeliness & completeness
  - Payer mix
  - Software systems
  - Clinical & billing personnel performance
  - Process & personnel accountability
Contracts often are for multiple types of lines:
- MLTC
- Medicaid Advantage Plus
- FIDA
- Medicaid Mainstream Managed Care
- Medicare Advantage

Other Contracts:
- IPAs
- Brokers
Lessons from Home Care

- Share contract internally - clinical review
- Rates have decreased for providers over time
- Lawsuit pending on care plan service reductions
- Home care providers seek support for payments
- Confusion on regulatory requirements vs. MLTC policies
- “Shopping around” by consumers - there is no lock-in
- Requirement of Conflict Free Evaluation
- Importance of Medicaid Broker
Lessons from Nursing Homes

Transition has been delayed multiple times; will allow voluntary enrollment first; transition by County

Individuals may change Plans to access NH of preference (no lock-in)

Network must provide members with a choice of two participating NHs with available beds.

For 3 years Plans will be required to pay either:

- Benchmark Rate (FFS), includes all existing scheduled pricing/transition phase-in adjustments through December 2017; or
- Negotiated Rate, allow other financing arrangements, such as sub-capitation.
Lessons from Physicians

- Physicians know well what it feels like to be out-of-network, versus in-network
- Don’t be afraid to negotiate
- Don’t sign a bad agreement
- Referrals are not guaranteed
- Beware of referring to out-of-network providers if you are in-network
- Beware of referrals from in-network providers if you are out-of-network.
DSRIP Overview

- Delivery System Reform Incentive Payments or DSRIP is the process by which the State of New York and the Centers for Medicaid and Medicare (CMS) have agreed to allow savings generated by the Medicaid Redesign efforts to be used to reform the delivery of health care to Medicaid recipients.
- DSRIP is a demonstration and the State is subject to all the requirements for reporting and evaluation.
- The continuation after the 5 year period will be dependent on the success of the demonstration and any additional requirements negotiated with CMS in the future.
DSRIP Overview

- The goals of DSRIP are:
  - Transformation of the health care safety net at both the system and state level.
  - Reducing avoidable hospital use and improve other health and public health measures at both the system and state level.
  - Ensure delivery system transformation continues beyond the waiver period through leveraging managed care payment reform.
  - Near term financial support for vital safety net providers at immediate risk of closure.
DSRIP Overview

- 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
DSRIP Overview

- 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.
DSRIP Overview

- **Responsibilities of Performing Provider System (PPS) 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.
  - Submit full application by December 22, 2014
DSRIP Overview

- 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 Overview

- 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 90th percentile of statewide performance for a specific measure
DSRIP Overview

- **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.

- **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.**
DSRIP Overview

- **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
Crystal Ball

The DSRIP Vision: 5 Years in the Future - How The Pieces Fit Together: MCO, PPS & HH

MCO*

Other Providers

• Care Management for Health Home Eligibles
• Participation in Alternative Payment Systems

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

• 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

PPSs

PPS Provider

• Role:
  • Care Management for Health Home Eligibles
  • Participation in Alternative Payment Systems
Questions?

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