NEW YORK STATE | Department of Health | Medicaid Redesign Team

Behavioral Health and Primary Care in the DSRIP Program: Integrating Two Worlds

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DSRIP Explained

- Built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health of members
  - Reducing costs
- To transform the system, DSRIP will focus on the provision of high quality, integrated primary, specialty and behavioral health 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 noticeable effect on healthcare in New York

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Performing Provider Systems and Local Partnerships

Each PPS must include providers to form an entire continuum of care:

- ✓ *Hospitals*
- ✓ *Health Departments*
- ✓ *Health Homes*
- ✓ *Social Service Departments & Local Government Units*
- ✓ *Behavioral Health Providers*
- ✓ *Skilled Nursing Facilities*
- ✓ *Clinics & Federally Qualified Health Centers*
- ✓ *Home Care Agencies*
- ✓ *Physicians/Practitioners*
- ✓ *Other Key Stakeholders*

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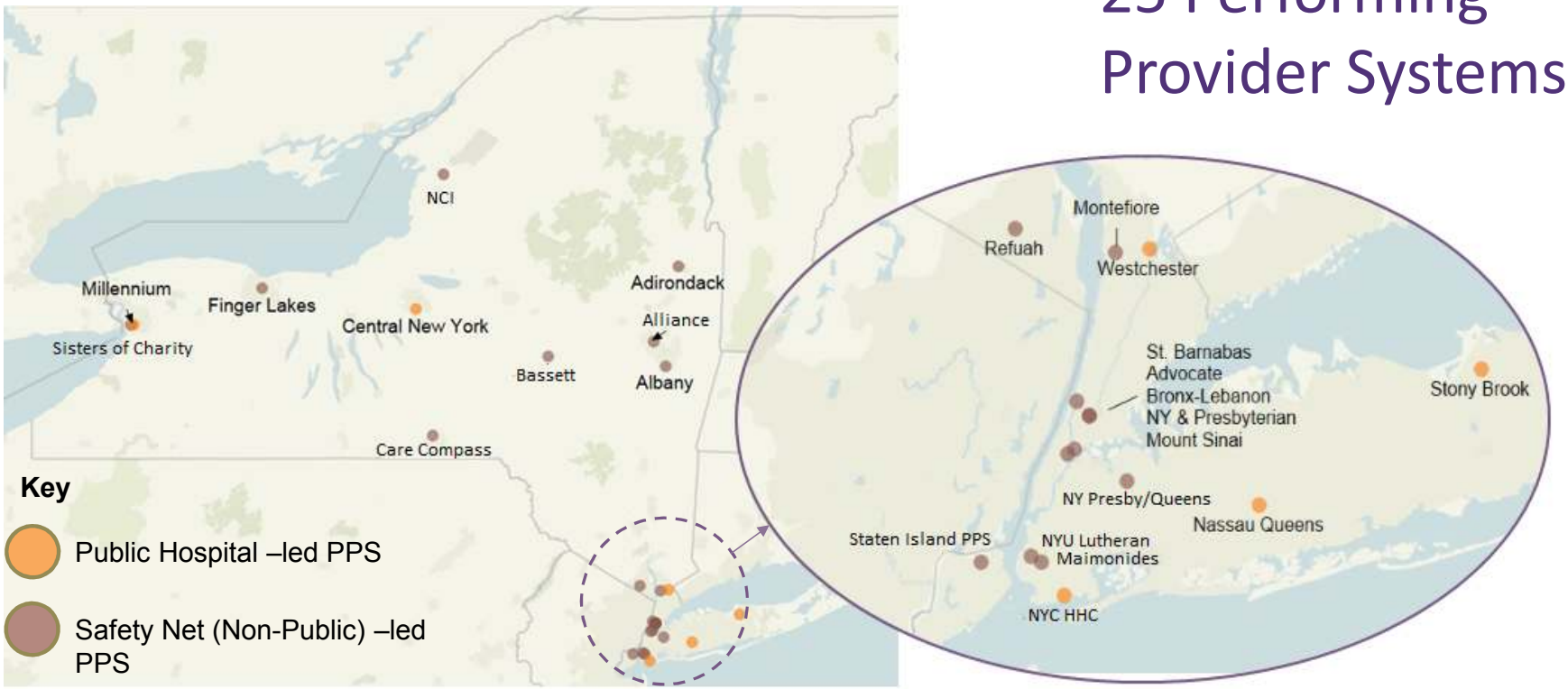
Performing Provider Systems (PPS)

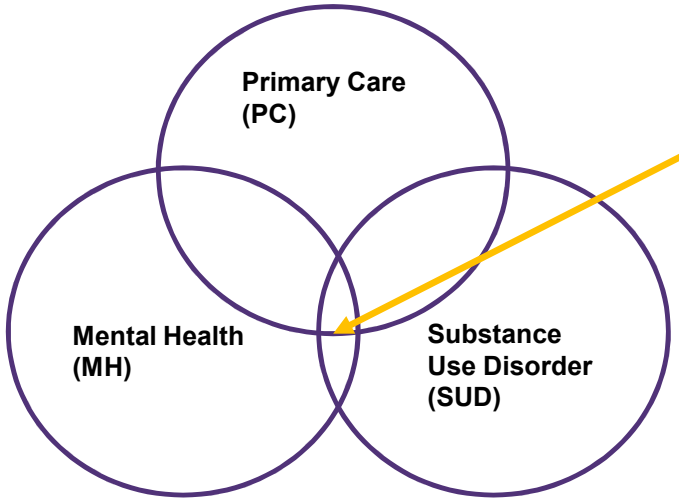
25 Performing Provider Systems



The Need for Service Integration

Healthcare providers recognize that many patients have comorbid physical and behavioral healthcare needs, yet services in New York State have traditionally been provided and billed for separately.

The integration of physical and behavioral health services can help **improve the overall quality of care** for individuals with multiple health conditions by **treating the whole person** in a more comprehensive manner



** Within DSRIP, the term "Behavioral Health" also encompasses mental health and substance use disorders*

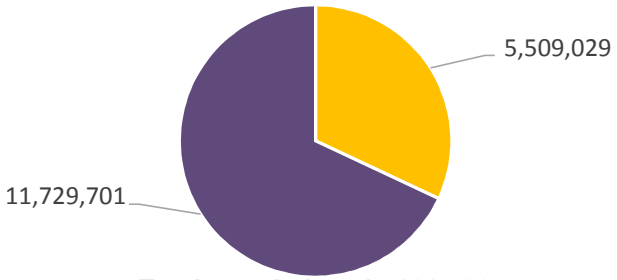
Statewide Summary of Behavioral Health Members

A disproportionate amount of annual total cost of care and hospital visits in New York State can be attributed to the Behavioral Health population.

Overview:

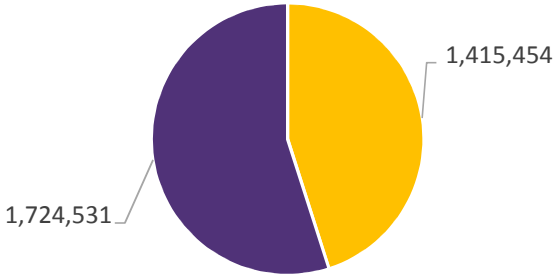
- Medicaid members diagnosed with BH account for **20.9%** of the overall population in New York State
- The average length of stay (LOS) per admission for Behavioral Health users is **30%** longer than the overall population's LOS
- Per Member Per Month (PMPM) costs for Medicaid Members with BH dx is **2.6** times higher

Medicaid members diagnosed with BH account for 32% of PCP visits



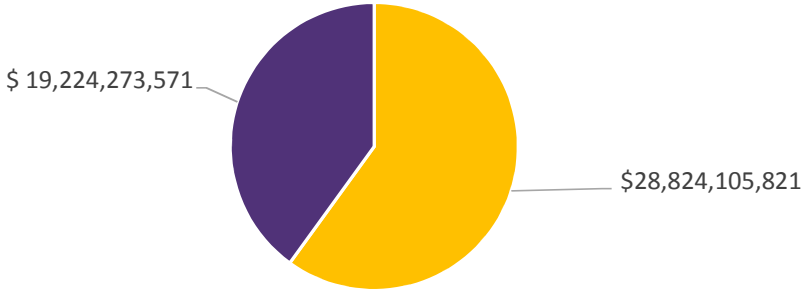
Total population: 17,238,730

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



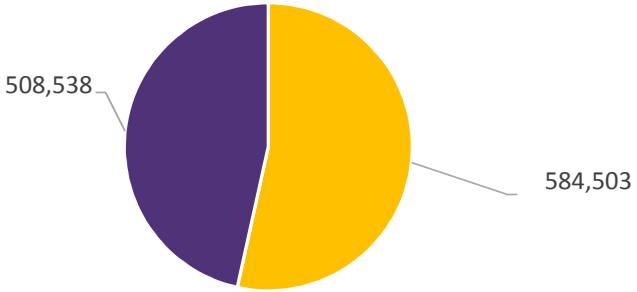
Total ED visits: 3,139,985

Medicaid members diagnosed with BH account for 60% of the total cost of care in New York State



Total cost: $48,048,379,392

Medicaid members diagnosed with BH account for 53.5% of admissions



Total admissions: 1,093,041

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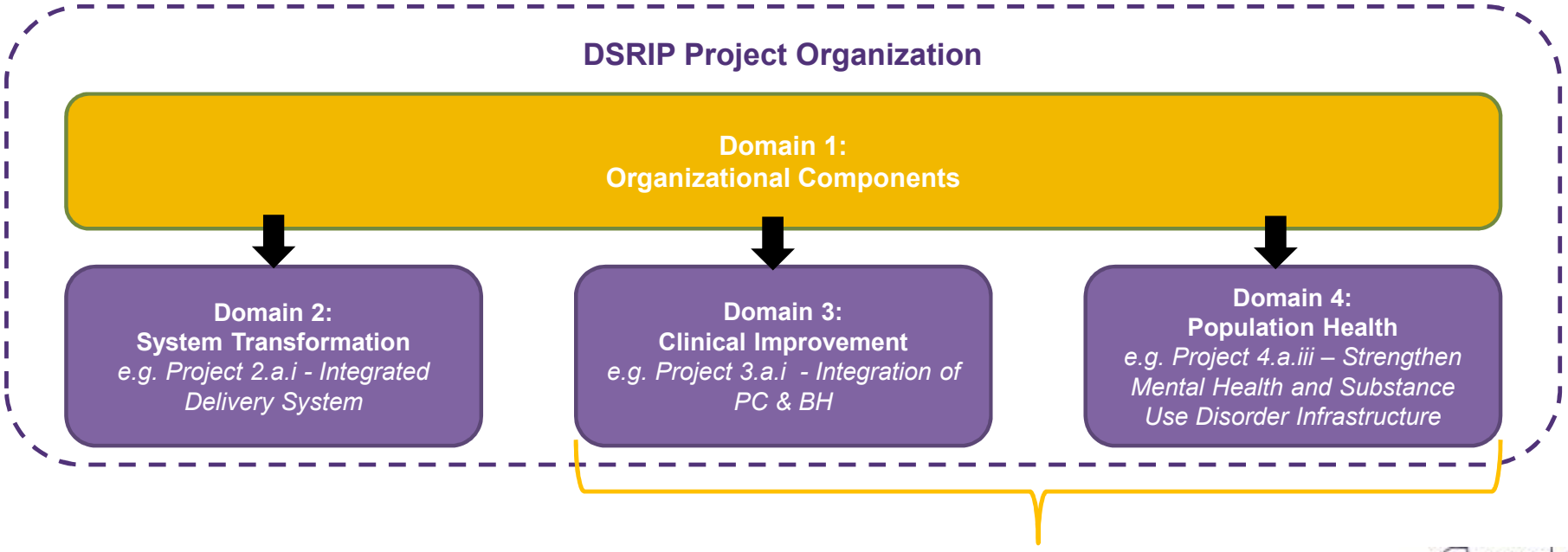
** This data includes Members with 1+ Claims with primary or secondary diagnosis of behavioral health issues*

DSRIP Project Implementation

Performing Provider Systems (PPSs) committed to healthcare reform by choosing a set of Projects best matched to the needs of their unique communities.

DSRIP Projects are organized into Domains, with Domain 1 focused on overall PPS organization, and Domains 2-4 focused on various areas of transformation. All projects contain metrics from Domain 1.



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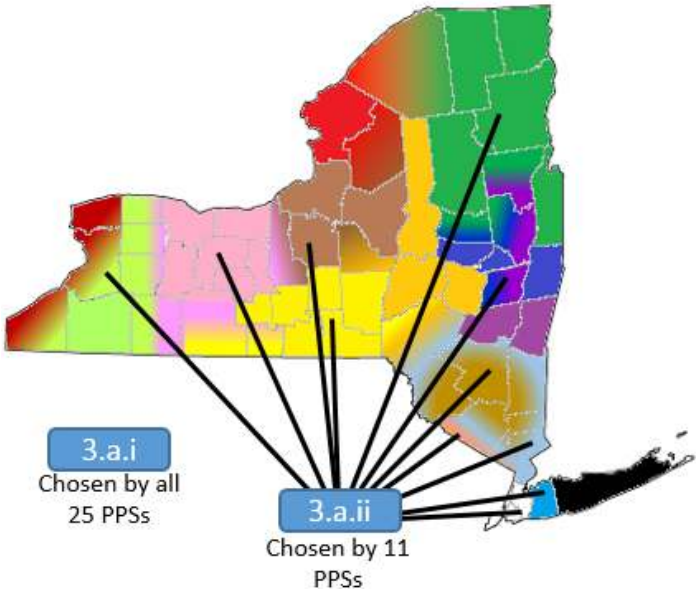
DSRIP Requirements to Achieve Service Integration

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

3.A Projects: Behavioral Health

- 3.a.i - Integration of primary care and behavioral health services
- 3.a.ii - Behavioral health community crisis stabilization services
- 3.a.iii - Implementation of evidence-based medication adherence program (MAP) in community-based sites for behavioral health 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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DSRIP Project 3.a.i: Three Models of Integration

- Model 1) Behavioral Health integrating into a Primary Care site
- Model 2) Primary Care integrating into a Behavioral Health site
- Model 3) IMPACT model of Collaborative Care for Depression
  - IMPACT - **I**mproving **M**ood – **P**romoting **A**ccess to **C**ollaborative **T**reatment for late-life depression

DSRIP Project 3.a.i

All 25 PPSs chose to participate in DSRIP Project 3.a.i; however each PPS chose different models for integration.

PPS	# actively engaged	Model 1	Model 2	Model 3
Adirondack Health Institute PPS	44965	x	x	
Advocate Community Partners	215344	x	x	x
Albany Medical Center Hospital PPS	38269	x		
Bronx-Lebanon Hospital Center PPS	30000	x		x
Community Partners of Western New York	64468	x	x	
Central New York Care Collaborative	67000	x	x	
Alliance for Better Health Care PPS	57533	x	x	
Finger Lakes PPS	109250	x	x	x
NYU Lutheran Medical Center PPS	28192	x		x
Maimonides Medical Center PPS	83000	x	x	x
Millennium Collaborative Care	22700	x	x	
Bassett Medical Center PPS	13009	x	x	
Montefiore Medical Center PPS	133734	x	x	x
Mount Sinai LLC PPS	100000	x	x	x
Nassau University Medical Center	115576	x	x	
New York City Health and Hospital's Corporation, as fiduciary for the HHC-led PPS	106477	x	x	x
Refuah Community Health Collaborative PPS	15000	x	x	
Staten Island PPS	15000	x	x	
Samaritan Medical Center PPS	12000	x	x	x
St. Barnabas Hospital (dba SBH Health System)	91800	x	x	x
Stony Brook University Hospital	45059	x	x	x
The NewYork and Presbyterian Hospital PPS	2258		x	
The NewYork-Presbyterian/Queens PPS	12759	x	x	x
Southern Tier PPS	53970	x	x	
Westchester Medical Center PPS	31000	x		
Total	1508363	24	21	12

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Standard Framework for Integration

With efforts moving towards full collaboration in an integrated practice, there are key elements and steps to achieve this.

Referral		**Co-Located**		**Integrated**	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance	Level 3 Basic Collaboration On-Site	Level 4 Close Collaboration On-Site with some System Integration	Level 5 Close Collaboration Approaching an Integrated Practice	Level 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities	In separate facilities	In same facility not necessarily same offices	In same space within the same facility	In same space within the same facility (some shared space)	In same space within the same facility, sharing all practice space

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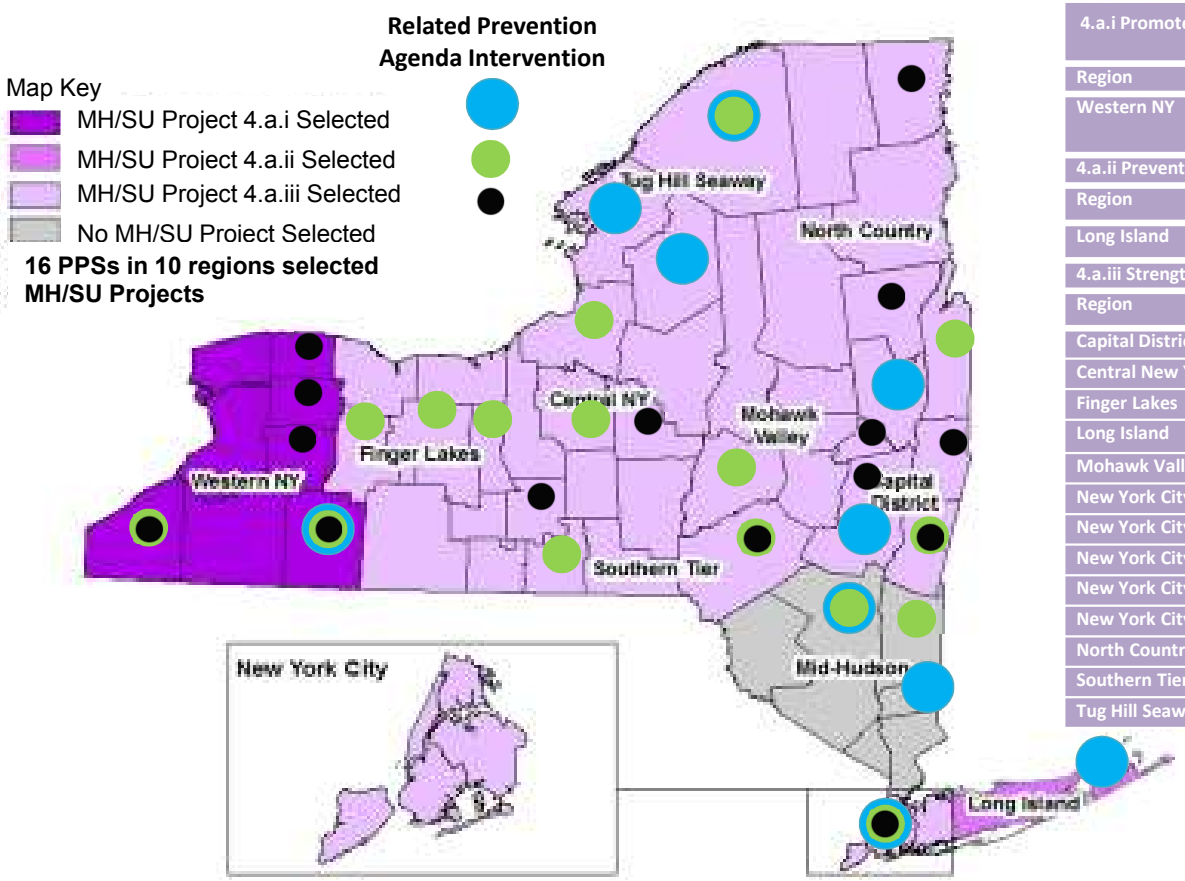
Projects 4.a.i, ii, iii: Mental Health and Substance Use



4.a.i Promote Mental, Emotional and Behavioral Well-being in Communities	
Region	**PPS**
Western NY	Catholic Medical Partners
	Millennium Collaborative Care (ECMC)
4.a.ii Prevent Substance Use and other Mental, Emotional and Behavioral Disorders	
Region	**PPS**
Long Island	Suffolk Collaborative Care (Stony Brook)
4.a.iii Strengthen Mental Health and Substance Use Infrastructure across Systems	
Region	**PPS**
Capital District	Ellis
Central New York	Central New York PPS
Finger Lakes	Finger Lakes PPS
Long Island	Nassau Queens PPS
Mohawk Valley	Leatherstocking (Bassett)
New York City	Bronx-Lebanon Hospital Center
New York City	One City Health PPS (HHC)
New York City	Maimonides
New York City	Staten Island PPS
New York City	St. Barnabas
North Country	Adirondack Health Institute
Southern Tier	Care Compass (UHS Hospitals)
Tug Hill Seaway	North Country Initiative (Samaritan)

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Medicaid Billing for Integrated Services

- Integrated settings that bill via APGs will be able to submit a single claim for both a Behavioral Health visit and a Physical Health visit that occur at the same site on the same day
  - Starting July 2016 – webinar held July 14, 2016 for the Performing Provider Systems (PPS)
  - Will include Behavioral Health (BH) care occurring at a Primary Care (PC) site, and PC occurring at a BH site
  - Need the PPS to identify which provider sites are doing Project 3.a.i., in order to set rate codes
  - Does not apply to FQHCs billing under Prospective Payment System
    - We are working on this issue with Federal partners

Current Challenges to Service Integration

Some of the service integration challenges PPSs are currently facing have stemmed from primarily two categories:

	Challenge	How the State is Assisting
Federal vs. State Regulations	• Barrier to physical co-location • NY State has the authority to waive State level regulations, not Federal regulations	• Developing guidance document on co-location arrangements
Billing for Services Rendered	• Billing rules prevented billing two services from integrated settings in one day	• Will now be allowing same-day billing in all but FQHC settings billing PPS rates, starting July 2016 • Published an Integrated Services FAQ and Billing Matrix (March 2016) • Integrated Services Webinar July 14, 2016

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Expected Benefits of Service Integration

Integration of primary care and behavioral health services improves population health and provides additional benefits:

Improved Process of Care

- Improved communication leading to more coordinated care
- Improved recognition of MH disorders
- Increased Primary Care Providers (PCPs) use of BH intervention
- Decreased stigma of MH conditions

Clinical Outcomes and Service Benefits

- Improved understanding of patient needs
- Improved patient and provider satisfaction
- Improved clinical outcomes

Economic Benefits

- Reduced avoidable hospital utilization
- Increased productive capacity
- Reduced medical costs

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Case Study: Integrating Behavioral Health and Primary Care Services

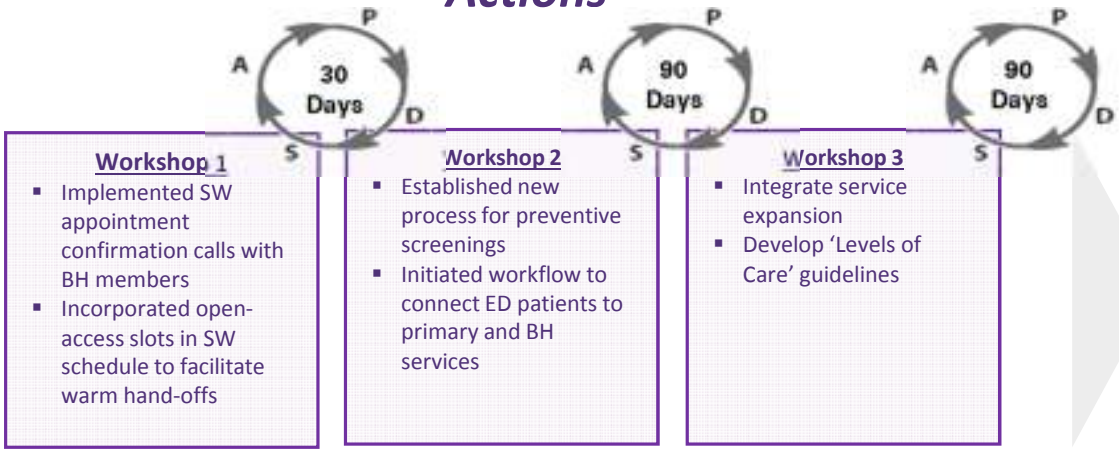
Baseline

(Data reflects Dec '15 – May '16)

The cohort is defined as behavioral health members with a chronic condition of diabetes

Representing approximately 50 patients

Actions



Workshop 1
- Implemented 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

Interim Results

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

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Case Study: Medicaid Accelerated Exchange (MAX) FQHC Action Team – Social Determinants of Health

Problem Statement: Persons who are homeless are presenting to the St. Barnabas Hospital ED in the Bronx with vague complaints, and really only want/need food and shelter.

Goals: 1) Improve patient and staff experience through collaboration, and 2) improve access to care and service delivery through measurable and reportable outcomes.

Actions to address the problem:

1. Identified patients who met Superutilizer definition.
   - 50 patients had 3195 ED visits (2.7% of total) and 270 in-patient admissions (1.1% of total)
2. Trained security staff to help connect patients to housing or "Living Room"
3. Worked with BronxWorks to shuttle patients from ED to 24-hour drop-in center, transporting 81 patients since 3/22/16

Initial results:

- For cohort of 50, have seen a 36% reduction in ED visits
- Have had a 90% reduction in visits by 3 patients connected to Safe Haven beds, with an annualized projection of prevented ED visits of 124 (Yes, from just 3 people!)

Health Homes

- Administration of Care Management services for members
- Oversee outreach, engagement and enrollment into Health Homes of Medicaid members with:
  - 2 or more chronic conditions, or
  - A single qualifying condition of HIV/AIDS or Serious Mental Illness (SMI)
- Each PPS is required to work with the Health Homes
- A vehicle for engagement of members for PPSs doing the 11th Project
  - Low utilizers and non-utilizers of Medicaid, and the uninsured
- Health and Recovery Plans (HARP) members – those with SMI and Substance Use Disorders a priority for Health Home enrollment
  - Home and Community-Based Services (HCBS) available for eligible HARP members
    - Tier I services include employment, education and peer supports services
    - Tier 2 includes the full array of 1915(i)-like services*

Note: 1915(i) allows states to offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit
Source: Medicaid Health Homes. NYSDOH Website. Revised January 2016. & Health Homes for Individuals in HARPs & HARP eligibles in HIV SNPs. NYSDOH Website. Revised May 2016

DSRIP Domain 1 Health Home Measures

Measure Name	Numerator Description	Denominator Description	Performance Goal	Achievement Value	Reporting Responsibility	Payment: DY 1 through 5
Health Home assigned/referred members in outreach or enrollment	Number of referred and assigned HH eligible members with at least one outreach or enrollment segment during the measurement year	Total number of referred and assigned HH eligible members in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home members who were in outreach/enrollment who were enrolled during the measurement year	Number of HH members with at least one enrollment segment in the Health Home Tracking System during the measurement year	Total number HH eligible members with at least one outreach or enrollment segment of in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home enrolled members with a care plan during the measurement year	Number HH with a care plan update indicated in any of the four quarters of the measurement year	Total number HH eligible members with at least one segment of enrollment in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-02-25_measure_specific_rpting_manual.pdf

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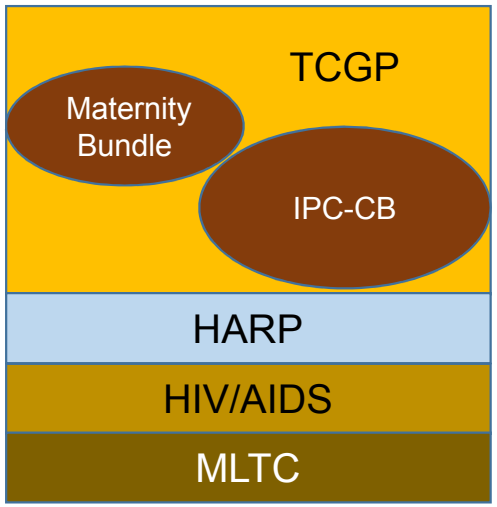
Value Based Payment (VBP) Arrangements

- Arrangement Types*
  - Total Care General Population (TCGP)
  - Integrated Primary Care with Chronic Bundle (IPC-CB)
  - Maternity Bundle
  - Health And Recovery Plans (HARP)
  - HIV/AIDS
  - Managed Long Term Care (MLTC)

**Arrangements do not yet include Dually Eligible members*



- 2 VBP implementation Subcommittees were created to focus on:
  - Social Determinants of Health and Community Based Organizations
  - Advocacy and Engagement
  - The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

NY DSRIP Program's Vision

Today's Care	Care in DSRIP Program
PCP sees person and refers for Behavioral Health care	Member sees PCP at the same place and on same day as Behavioral Health practitioner
Acute care is given as next available, and walk-ins are scheduled for another time	Open access scheduling accommodates ALL appropriate acute care needs and walk-ins, whether for Medical or Behavioral Health care
Care delivered around acute illness, In-patient hospital stays, and ER visits	Annual exams, Medical and Preventive care shift the focus to wellness for Medicaid members in their communities
PCP directs any care coordination	Care Management needs met *a priori*, and all appointments are coordinated around Care Management
Care directed by a single practitioner	Care coordinated by a multidisciplinary team, each member working to the full extent of her/his scope of practice
Medicaid member (or guardian) informs practitioner about what happened when hospitalized in another hospital or city	Integrated electronic network enables the practitioner to see the other providers' labs, imaging studies, medication list and hospital discharge summary

Questions?

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