Health Home Webinar – Q & A Session

New York's MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan

1. **Q: Can Health Homes or care management agencies get paid for performance rather than the current risk adjustment methodology starting in 2015, or will that not change until PPSs are formed?**

   A: For the current time, Health Homes will continue to receive payments based upon services provided. The current payment methodology is in the process of being simplified. The state has committed to work with Medicaid Managed Care Plans to move to outcome based payments for the majority of Medicaid services by the end of DSRIP. Health Homes that are participating in DSRIP can also be eligible for DSRIP incentive payments based upon the Performing Provider Systems' meeting process and outcome goals.

2. **Q: How do vital organizations and network partners of Health Homes who serve a high volume of Medicaid members get designated as a safety net provider?**

   A: Cohort organizations must submit a cost report in order to be evaluated as a safety net provider. Without the cost report, there is no methodology to be approved as a safety net provider. There was an opportunity to appeal the designation, and alternative methodologies have been developed and are under review by CMS for providers who do not submit cost reports. The Vital Access Provider (VAP) Exception process is an additional opportunity that was made available for all Medicaid providers, physicians, and pharmacies for facilities that did not qualify by the Safety Net Definition by calculation or by appeal. If the exception is granted, then the applicant will be qualified and can fully participate in the DSRIP program. Non-qualifying providers are limited; they may only receive up to 5% (as a group) of their PPS' award.

3. **Q: Some MCOs will not work with Health Homes at this time. How does this influence Health Homes in DSRIP?**

   A: MCOs are not mandated to work with all Health Homes. As for all services, MCOs may contract with Health Homes that are sufficient to serve their members. Network adequacy for these services is monitored by the state. It will become more and more important for MCOs to align their work with Health Homes as care management is a key component of DSRIP. Health Homes have an additional opportunity to contract with more Medicaid Managed Care Organizations as part of the Performing Provider System network.

4. **Q: Is the entity/ organization given safety net status or is the program within the organization given the safety net status?**

   A: Safety net status is granted at the NPI level, so it would cover any programs operating under that organization's NPI.

5. **Q: Will you please explain how the DISCOs (Developmentally Disabled Integrated Service Coordination Organizations) will interact with DSRIP?**

   A: It has not been finalized how DISCO, a managed care program for the developmentally disabled, will interact with DSRIP. They will be working with PPSs, with a focus on developmentally disabled populations.

6. **Q: Can primary care physicians with 35% Medicaid patients apply to be a safety net provider instead of applying at the institutional level?**

   A: Yes, and there was a separate practitioner path developed aligned with attestations given by the practitioner related to meaningful use payments.

7. **Q: Children's Health Homes are coming later – can they be added to DSRIP? If so, how?**

   A: Safety net providers should get approved now if they are serving a large number of Medicaid users. Besides a midpoint period in the future, there are no plans to add safety net providers outside of the current process.

8. **Q: Can you say more about what contracts look like for MCOs as they move from their current state to more performance based payments?**

   A: It is likely that several different models will emerge. For example, PPSs are likely to become ACO-like and develop a performance payment strategy with the MCO for services to Medicaid members. These payments to the PPS will need to be shared by provider partners in some manner to ensure support for positive outcomes. There will be payment reform webinars that will explain payment methods in further detail.

9. **Q: What happens with participants attributed to the DSRIP program that are already part of the Health Home tracking system?**

   A: Nothing is changing with the way Health Home services are being delivered; Health Home services will be leveraged to assist PPSs to achieve their project goals. Every Health Home in the state should be participating with the PPS(s) in their region to accomplish this. Please see the DSRIP website for a full explanation.

   Please note that the Health Home tracking system is being upgraded to become part of the Medicaid Analytics Performance Portal. This portal will be used for both the Health Homes and the DSRIP program.

10. Q: Will there be directives to hospitals from the Department to encourage Health Home referrals?

A: Yes. There are existing directives that will be reinforced. Since hospitals are primarily serving as the lead in the PPSs, they will be interested in Health Homes because the PPS performance, in part, will be related to the effectiveness of Health Home care management. Performance of Health Homes will be important to all members of a PPS, including hospitals.

11. Q: How do you recommend lead Health Homes decide which PPS to affiliate with if there is more than one in the geographical area?

A: That should be a clinical decision based on where the Health Home has clinical connectivity. A Health Home may have several network partners that service their members. The network can be split to work with the PPSs that have most of the providers. This may mean affiliating with more than one PPS, which is acceptable.

12. Q: What happens when a DSRIP attributed member is already in a Health Home but not in a PPS network?

A: If a member is enrolled in a Health Home, they will be attributed to the PPS based on their Health Home. If they are not in any PPS, they can get attributed based on their PCP or their clinic. The goal is to ensure that there is no situation where a Health Home is not affiliated with at least one PPS.

13. Q: What sort of communication systems will be needed to make this program run effectively?

A: There will need to be various layers of communication, including at the organizational level to ensure open communication among all partners within the PPS. For clinical, it will be critical to develop an interoperable EHR with HIE connectivity through the local RHIO to ensure clinical record sharing as well as real time alerts for acute events. Efforts will need to be made to ensure those entities such as behavioral health and care management providers have access to resources to develop these capabilities. This level of connectivity will be required for PPSs to meet their process and outcome metrics and to receive their incentive payments.

PPS Project Plans must include provisions for appropriate data sharing arrangements, including connections to RHIOs, that drive towards a high performing PPS while appropriately adhering to all federal and state privacy regulations. The PPS plan must include a process for rapid cycle evaluation (RCE) and indicate how it will tie into the state's requirement to report to DOH and CMS on a rapid cycle basis.

14. **Q: As a residential provider, do we need to be named in the DSRIP project plans? Should we be contracting with DSRIP now or is it too early?**

    A: Community based organizations need to get approved as safety net providers if they quality. If a downstream entity is strictly residential and doing no Medicaid or care management work, then they may not qualify as a safety net providers. PPSs are currently establishing their provider list and it is very important for community based organizations to contact their local PPSs and share their interest in joining before the networks are finalized in early November. One must be part of a network if they wish to be able to participate in incentive payments from DSRIP.

15. **Q: When talking about avoidable hospitalizations are you talking about all usage or in-patient?**

    A: Avoidable hospital use refers to potentially avoidable services in both the emergency department and in patient admission. There are two types of avoidable inpatient services: those initial admissions that could have been avoided with quality community based primary and preventive care and those readmissions that would have been avoided with improved care on the initial admission as well as improved coordination of care after discharge.

16. **Q: Can you explain how ACOs fit into DSRIP?**

    A: ACO regulations will be released. Some PPSs are being built with current ACOs that are servicing Medicare members. In the beginning, PPSs are affiliations pursuing projects together, but many will develop ACO-like payment relationships over time or specifically evolve into ACOs.

17. **Q: Have any DSRIP initiatives looked at moving behavioral health to pediatric care?**

    A: There are projects in the program that would be appropriate for such an initiative, although it is not mentioned specifically.

18. **Q: In a PPS contract with a non-clinical entity to assist with project development, how would the payment work?**

    A: The payment would be based upon the contract established with the non-clinical entity, as any other contract would work.

19. Q: Do you have a plan for care management agencies to grow to meet the demand for care management under DSRIP?

A: Yes, we certainly expect for there to be growing demand for care management services due to the DSRIP program. The overarching DSRIP goal of a 25% reduction in avoidable hospital use (emergency department and admissions) will result in the transformation of the existing health care system - potentially impacting thousands of employees. This system transformation will create significant new and exciting employment opportunities for appropriately prepared workers. PPS Project Plans must identify all impacts on their workforce that are anticipated as a result of the implementation of their chosen projects as well as a workforce plan for repurposing jobs that will free up as we lower avoidable hospitalization. One clear area to repurpose those jobs to will be care management. Training and outreach for care management will be needed. The state is already working with health homes to have them staff up for the demands of DSRIP, HARPs and the community transition activities related to Olmstead.

20. Q: In regions where there are multiple PPSs expected to submit applications, should Health Homes affiliate with multiple PPSs? If not, what if the PPS they affiliate with is not approved?

A: PPSs that received development funding were those that looked promising for approval. There is current consolidation occurring among the PPSs as they are developing. The goal of the DSRIP Support Team is to help each PPS become a successful applicant to DSRIP. If a Health Home has a clinical relationship with multiple PPSs, then it can be affiliated with multiple PPSs.

21. Q: Is attribution based on the Health Home lead or on the downstream care management agency?

A: The billing of either is used. Most of the billing is coming from the downstream care management agency so attribution will be based primarily on the downstream care management agency.

22. Q: Are there restrictions or guidance on what performance payments can be used for?

A: There are no restrictions once the performance payments have been provided. They are PPS revenue and are fundable to anything the PPS thinks it needs to advance DSRIP projects and goals.

23. Q: The relationships between the MCOs and the PPSs is still not clear. Is there a suggested governance structure between the MCO and PPS?

A: The incentive payments come through the State. The service payments come through the MCO. So the flow of funds for DSRIP goes to the lead provider and then to the rest of the PPS. But MCOs will be asked to evolve from their existing fee-for-service payments to more quality based payments. Two of the key relationships between the MCO and PPS are network reform and performance reform.

24. Q: Why not have the PPS become an MCO?

A: There are capabilities of the PPS that begin to look MCO-like over time, but PPSs simply need to support and monitor strong clinical work and project development, while MCOs are already handling insurance risk and other aspects of quality management, which are functions that do not need to be replicated. As the PPSs mature and accept performance based payments, the question of 'when does the PPS look like an ACO which looks like an MCO' comes up, however this is not the focus of this webinar.

25. Q: If the lead Health Home is an entity with the safety net system, does it need to be recognized as a safety net provider?

A: The Health Home will need to be designated as a safety net provider per the STC with CMS. There are pathways that are in process for this. All leads are anticipated to be designated safety net providers. Downstream providers are hoped to be recognized as well, but it is critical that leads are safety net providers.

26. Q: How will TBI populations be attributed?

A: The TBI waiver populations are attributed are based on their TBI providers.

27. Q: Are downstream providers allowed to negotiate their payments with the PPS directly, or do all service negotiators have to go through the lead Health Home?

A: Service payments will still come from the State; they are not bundled with the PPS performance payments. The PPS is responsible for the distribution of DSRIP performance payments.

28. Q: Support services will become essential for individuals to avoid unnecessary hospital usage. How will this service be incorporated into DSRIP?

A: Within DSRIP Toolkit, there are a number of projects that involve community based support services as a key component of the project. Peer support, crisis diversion, and social rehabilitation should all be delivered by community providers as partners in the PPS. PPSs need these community service providers in their network list to meet their DSRIP objectives. The Community Needs Assessment is an excellent vehicle for the PPS to recognize the community service and Health Home resources at hand and on how they will coordinate their activities.

29. Q: Is an organization a safety net provider if one of its programs has been designated as a safety net provider?

A: Safety net provider tests were performed at the organization level. Safety net tests were done based on the cost report for large organizations with many arms, and if a large organization is a safety net provider then all of its affiliates are as well. For Health Homes, the lead and the network partners are anticipated to be approved together; however, some of the agencies that work with Health Homes may wish to become approved as safety net providers in their own right as they may deliver other services.

30. Q: Can and should MCOs sign up on PPS applications? How will it be reimbursed?

A: Yes, Managed Care Organizations can be PPS partners and are important partners in aligning service networks, managing performance, developing value based payment models and other key activities. However, the state does not envision MCOs as eligible entities for DSRIP performance awards but the PPS may choose to contract with MCOs to assist with some administrative functions of the PPS.

31. Q: If a clinic has some kind of cost-based rate, will that be an impediment in the negotiations?

A: Yes, but if a clinic can demonstrate the value of their services, and why it is that the clinics services cost more, then that is an opportunity to be paid more for high quality work.

32. Q: Could you clarify today's meaning of fee-for-service? Are PPS payments to their providers specifically considered fee-for-service?

A: Fee-for-service is used in two ways. Payment reform means moving towards prepaying for population health and receiving encounter quality data while moving away for paying for individual units of care. In other words, paying for quality instead of quantity. Payment will no longer be attached to a unit of service, but rather towards a patient, bundle of care, or population. The other meaning of fee-for-service is being enrolled not in managed care and instead being enrolled in a fee-for-service plan. An APG payment is better than paying per procedure, but paying for quality is the next step. These capabilities will be developed over time.

33. Q: Will you allow DSRIP quality reporting to replace some current clinical reporting?

A: DSRIP was designed to align to the existing measures already collected through claims and encounters. Very few new measures have been added and CMS has been encouraging the State to rely on existing measures. All Health Home clinical reporting is not being leveraged for DSRIP. This will be looked at in the future and the burden will be measured against the benefit.

34. Q: Regarding attribution as a downstream entity in a PPS with no lead Health Home, can our assigned cases be attributed to the PPS?

A: The PPS needs to work to get a lead Health Home in their network. Performing Health Home networks should be aligned with DSRIP – Health Home networks should not need to be reconfigured.

35. Q: Who determines how much downstream providers get paid for performance payments, the PPS or the lead Health Home?

A: The lead PPS will negotiate with the lead Health Home, and the lead Health Home will ensure performance payments reflect the efforts of their downstream providers. This should be an active conversation between the lead Health Home and the downstream providers.

36. Q: How does MLTC fit with DSRIP and Health Homes?

A: The MLTC is an important partner in avoiding unnecessary hospitalization and will play a key role in the PPS, as will Health Homes.

37. **Q: How can a care management agency prepare a budget for 2015 when rates are not finalized? Should a provider set aside funds in the budget for DSRIP?**

    A: The new payment system is designed to prevent major revenue changes to Health Homes. Budgeting based on past rates should serve as an appropriate base position. It is not expected that risks associated with DSRIP performance will accumulate to downstream providers.

38. **Q: Health Home payments to downstream care management providers take nearly three months or more with much of that due to the 60-day window within which MCOs can pay.**

    A: A workgroup has been formed to examine this issue.

39. **Q: Will TBI waiver clients be eligible to enlist in Health Homes, MLTCs, and HARPs, or will they remain separate?**

    A: Waiver transitions are still being examined. Likely, these TBIs will transition into something like HARPs. The capacity in the TBI waiver will be conserved until a transition has been developed to ensure continued access to services.