DSRIP: NEW YORK'S AMBITIOUS PLAN TO TRANSFORM THE HEALTHCARE DELIVERY SYSTEM

WHITE PAPER

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New York State's $6.4 billion Medicaid Waiver program, which aims to reduce unnecessary hospitalizations by 25%, has major implications not only for the Empire State, but providers nationwide.

In 2013, New York State experienced a significant milestone. It wasn't the kind that came with accolades, however. Rather, the state spent $54.5 billion on Medicaid, making it one of the highest Medicaid spenders in the country. Between 2010 and 2013 New York's Medicaid enrollment reached 5.3 million, representing a 12.3 percent growth and more than one in four New Yorkers on its rolls, according to a report from New York's Comptroller (2015). In fact, New York's Medicaid spending grew more than 100 percent between 2000 and 2013.

Reversing this spending trend requires a large dose of innovation, system change, and a steady infusion of cash. That is just what is happening now in New York. State and federal legislators, along with healthcare stakeholders, took monumental action in launching the Delivery System Reform Incentive Payment (DSRIP) program, which seeks to reduce Medicaid spending in New York by overhauling the state's healthcare delivery system and redirecting patients to appropriate providers and care settings. The New York State DSRIP is an ambitious plan to integrate services, collaborate on patient care, improve regional healthcare quality, and lower costs of care over a five-year period.

Ambitious Goals: New York's Quest for Transformation

In 2014, New York passed the Medicaid Redesign Team Waiver Amendment, which had been in the works for several years as healthcare stakeholders in New York came together to look for ways to reduce costs and improve care quality. This $8 billion Medicaid Section 1115 Waiver gives the Secretary of Health and Human Services the authority to approve demonstration projects or pilots that promote Medicaid objectives.

It addresses critical issues throughout the state and allows for comprehensive reform through the DSRIP program, which promotes collaboration among healthcare providers at the community level. The waiver provides $6.4 billion in incentives to New York healthcare providers over five years. The state of New York has kicked in another $1.1 billion. The program began April 1, 2015 and will end March 31, 2020.

DSRIP's primary goal is to reduce avoidable hospital use for New York Medicaid enrollees by 25% within five years. Under DSRIP, avoidable hospitalizations include inappropriate admissions and readmissions. The program also mandates that participating healthcare organizations reduce preventable emergency room use. "It's about managing the Medicaid population in New York State and helping Medicaid patients receive care in appropriate care settings to avoid inappropriate hospital use," says Greg DeWitt, director of data analytics and workforce initiatives at the Iroquois Healthcare Association, which represents 54 hospitals and health systems in 32 counties in Upstate New York.

"A lot of Medicaid patients present at the hospital because there is a lack of primary care in many rural parts of Upstate New York," he says. In some cases, patients may have to travel as far as 50 miles to see a physician, explains DeWitt. "This drives patients to the hospital, and that creates a very expensive Medicaid program." According to Debbie Newsholme, senior content director at HCCS, A HealthStream Company, Medicaid is the largest payer in New York. "Downstate hospitals receive 50% of their reimbursements from Medicaid," she says. In addition to a lack of primary care resources, Newsholme also says, "poverty issues Upstate have led to high Medicaid spending."

DSRIP seeks to achieve what the federal government and the healthcare industry are already trying to do through value-based care, population health management, and other quality initiatives: Transform the state's safety net system and ensure sustainability for years to come. Participating organizations are expected to meet goals around system transformation, clinical management, and population health.

They will do this by creating an integrated delivery system, comprised primarily of major public hospitals and safety net providers. They will initiate population

health management strategies that involve cooperation across all care systems. They will also retrain and redeploy the workforce, focusing closely on cultural competency and healthcare literacy. Moreover, DSRIP providers will create targeted financial management systems and sophisticated data analytics programs.

These are aggressive goals, to be sure. Currently, six other states have DSRIP waivers from Medicaid, including Texas, which is in year five of its DSRIP program. In Texas, DSRIP is structured very differently than in New York and has experienced mixed results. Therefore, all eyes will be watching New York, which if successful could serve as a national prototype. "The need for transformation in the healthcare delivery system is imperative," says DeWitt. "The Medicaid program is a significant part of the New York state budget, so getting it done right and getting the providers to work differently to transform the system is a tremendous effort."

"Yet, each PPS is being asked essentially to redesign a care delivery system while the original delivery system is still going on and even competing with its other members."

Launching a Sustainable Program

New York's DSRIP program is comprised of 25 Performing Provider Systems (PPS) located in 11 geographic regions across New York. PPSs are made up of organizations that have joined together to form a collaborative care network. DSRIP has a major stipulation that each PPS cannot be a sole entity. Therefore, they must partner with other organizations, some of which may be competitors. Each PPS began with an anchor hospital that brought together other providers of all types, including other hospitals, long-term care organizations, physician practices, clinics, behavioral health, home health, ACOs, community-based organizations, and more.

Tight Governance

Each PPS is required to form a governing structure that will oversee three key areas:

- Financial
- Clinical
- IT and data

Governing bodies will decide how money is spent, establish and report on clinical metrics, oversee provider participation and accountability, and execute on specific DSRIP projects. New York's DSRIP program has been divided into three phases over the course of five years. Phase 1 is considered DSRIP year 0 and was the planning stage in which every PPS submitted project plans, which were either approved or disapproved.

Phase 2 began April 1, 2015 and includes years 1-5. These are the critical years in which the PPSs develop and implement the projects they submitted for approval. "The first two years are all about building the program and doing the workforce development and training," says Newsholme. "It's a crucial time that will determine the future success of each PPS. They must have the right infrastructure and a highly trained and competent workforce to meet their goals and receive payments.

Phase 3 is all about results. While each PPS has different projects, ideally all will be working as a coordinated and integrated delivery system that operates based on value-based care and population health management principles.

Transitioning From Provider to Community System

DSRIP supports providers down a path towards innovation, enabling them to play a key role in changing the healthcare system. "It can be a great opportunity for them to form a tighter bond with other community providers, physicians and non-physicians alike," says Newsholme. "Now, they have to work together as a team, create a new communication system with their team, and create goals for the entire PPS. They have to do a lot more outreach to other providers in the system, and think of themselves as a community system, and not just a hospital," she adds.

DSRIP seeks to transform the healthcare system through projects that focus on delivering "high quality, integrated primary, specialty, and behavioral healthcare in the community setting with hospitals used primarily for emergent and tertiary level of services."

–New York State Department of Health, 2014

Overall Project Process

Organizational milestones that focus on building the PPS infrastructure

System Transformation Projects

Create Integrated Delivery Systems

Implement Care Coordination and Transitional Care Programs

Connect Settings

Use Patient Activation to Expand Access to Community Based Care for Special Populations

Clinical Improvement Projects

Behavioral Health

Cardiovascular Health—Implementation of Million Hearts Campaign

Diabetes Care

Asthma

HIV/AIDS

Perinatal Care

Palliative Care

Renal Care

Population-wide Projects: New York's Prevention Agenda

Promote Mental Health and Prevent Substance Abuse (MHSA)

Prevent Chronic Diseases

Prevent HIV and STDs

Promote Healthy Women, Infants and Children

New York PPSs selected between a minimum of five and a maximum of 11 DSRIP projects in three domains:

- System Transformation Projects
- Clinical Improvement Projects
- Population-Wide Projects

Each PPS was allowed to choose from a menu of 54 projects based on community needs assessments. New York has over 250 projects spread out among its 25 PPSs. All projects, to a certain extent, work to address high-risk disease processes and behaviors. DSRIP projects focus on numerous areas, including population health, integrated delivery systems, behavioral health, and reducing ER admissions. "It's an opportunity to receive funding for critical projects that can improve care and reduce care costs, such as updating technology systems and performing workforce development," says Newsholme. Some of the more critical projects are being done by nearly all of the PPSs, says DeWitt. "For example, about 22 out of 25 PPSs are doing a project that asks them to create an integrated delivery system." Also, Integration of Primary Care and Behavioral Health Services is a project that every PPS must take on, he adds.

About 50 percent of PPSs have selected a DSRIP project that includes implementation of "patient activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community-based care." Those PPSs must conduct the Clinician & Group Consumer Assessment of Healthcare Providers and Systems® Survey among their uninsured patients to gain an understanding of these patients' experiences with their providers.

"The theme here is integration, and it is a huge part of DSRIP and the Medicaid population. It is important to get patients into the right care settings," says DeWitt. Another project many PPSs are undertaking centers on integrating the uninsured and low and non-utilizing Medicaid enrollees into community-based care, says DeWitt. He notes that PPSs were asked to select projects in their communities that they were not doing before. "The state wants PPSs to address issues in their communities that needed tackling and not just perform the same services." Also, says DeWitt, DSRIP is pushing hard for providers to transform the payment model from fee-for-service to a value-based model. "Medicare's been doing that for a number of years now through the Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing, the Physician Quality Reporting System, and a number of other quality reporting requirements. DSRIP is following on the heels of those initiatives on the state level."

DSRIP Payments

Under DSRIP, PPSs will receive payments based on meeting a list of criteria, including process milestones and metrics, submitting quarterly reports and other required reporting, successfully completing pay for reporting requirements, and pay for performance metrics. Milestones and metrics revolve around four main categories: workforce, cultural competency, governance, and financial sustainability.

The domain under which each project falls also affects payment structure. This is because the domains are weighted differently. "PPSs have the potential to earn a larger award for doing projects that the state says are more difficult to accomplish or those that create a bigger impact for changing the delivery system," says DeWitt. For example, areas such as cultural competency and coordinated care will rank higher than a project focused on creating an IT infrastructure.

It's important to also note that payments are given to the PPS, which is its own legal entity. The PPS then distributes the money to the other organizations. Each PPS has its own distribution formula that it has developed. PPSs earn their payments every six months by meeting specific metrics, says DeWitt. "Over the first two and a half years, PPS payments are based on meeting organizational milestones." In the final three years, those wane and PPSs start to be paid for performance, he adds. "They can earn up to their max award amount. However, if they don't meet their metrics, they don't get paid."

How does DSRIP's payment plan differ from other government programs? "Unlike Medicare's Hospital Readmissions Reduction Program, for example, DSRIP takes more of the carrot and less of a stick approach," says Newsholme. "This gives PPSs and their members a jumpstart toward building a program that will ensure they earn 100% of their awards. Plus, they're paying you up front to do so."

DSRIP is a five-year program that will require participating healthcare organizations and their workforces to become part of a high functioning integrated delivery system. Here are six critical steps to success:

1. Infrastructure Is Everything

PPSs must zero in on creating a solid infrastructure from the start. DSRIP payments are based on the performance of the PPS, not on the individual providers' meeting project milestones. Therefore, it is important to have a strong framework in place that establishes how the PPS will operate. In the first few years, PPSs will be paid more for meeting infrastructure, governance, and workforce goals. During the latter half of the program, payments are based more on clinical performance and reducing unnecessary hospitalizations.

2. Modify Competitive Behaviors

Competition has always been part of the U.S. healthcare system. DSRIP, however, mandates that healthcare organizations and providers set aside some competitive differences in order to create an efficient integrated delivery system. Each PPS should identify and address competitive hotspots that could interfere with this overarching goal.

3. Integrate Cultural Competency into Everything You Do

DSRIP mandates that PPSs build a framework of cultural competency, addressing such things as gender identity and disability issues. Cultural competency is embedded into the core components of most DSRIP projects, including those focused on everything from creating an integrated delivery system to rolling out transitional care and chronic care programs.

4. Create a Strong Post-Acute Care Strategy

Anchor hospitals may oversee each PPS, but it is the post-acute care workers who will be making the majority of avoidable hospital use decisions. DSRIP is designed to take those organizations that behaved as silos in the past and make them integrated and collaborative. Therefore, it is essential that PPSs build plans and processes for transitioning patients from inpatient facilities to and across post-acute environments.

5. Put the Spotlight on Health Literacy

Improving the health literacy of both providers and patients is a significant aspect of the DSRIP program. Health literacy issues influence patient non-compliance with care provider instruction and medication adherence. Additionally, low health literacy is a contributing cause of avoidable readmissions and lack of engagement with the healthcare system. Projects focused on system transformation will need to include ways to identify and address health literacy barriers.

6. Make Training a Priority

DSRIP emphasizes the importance of workforce development, which is part of each PPS's milestones. Having a centralized training platform will mitigate many of the challenges that come with developing workforce strategies for integrated delivery systems with thousands of employees who are geographically dispersed and working within competing organizations.

Preparing the Workforce for DSRIP

Each PPS is a brand-new entity in the process of determining how its healthcare delivery system will take shape. "The PPSs are redefining how they're delivering care with these projects and then deciding how they're going to actually implement them," says DeWitt. "They have to agree on how they will meet all these goals; and therefore, how they will train their staff." As such, they will require comprehensive tools, resources, support and training.

DSRIP has committed $300 million in spending on the workforce. "PPSs have a minimum spending requirement that they committed to in their application," says DeWitt. PPSs must complete their workforce milestones between mid and late 2016. According to DeWitt and others, DSRIP's workforce milestones and metrics are aggressive from the start, in part because of their timing. "It has been a little bit of putting the cart before the horse. You can't do a lot of workforce activities until you have built some of your other infrastructure, such as your fund flow model and the governance structure of the PPS," says DeWitt. "Yet, each PPS is being asked essentially to redesign a care delivery system while the original delivery system is still going on and even competing with its other members."

Re-engineering for Success

Each PPS is expected to form a workforce project team to take a broad look at how their projects will impact staff. They will be looking at training, retraining, redeployment and wages, and benefits. Another important aspect of workforce development is assessing the need for new hires. Each PPS will need to evaluate its current staffing numbers and abilities. DeWitt and others point out that there will likely be more emphasis on hiring new staff and retraining and redeploying current staff as opposed to reducing the workforce. "In Upstate [New York], we have workforce shortages. We've already done a lot of work in creating additional outpatient care settings in Upstate," says DeWitt. "We need more doctors, especially those who are in primary care."

Cultural competency and health literacy training will be central to any workforce plan, notes DeWitt. Staff will be evaluated on competency, how well they engage with their work and patients, and their ability to communicate with a diverse patient population. It will be important for each PPS to know the level of staff competency for each employee and be able to give the right assessments to accurately determine workforce needs.

Creating a Training Platform That Works

As part of their workforce goals, PPSs are charged with developing a rigorous training and development plan that will accommodate a large integrated delivery system. It is critical that each PPS's workforce have a clear understanding of DSRIP goals, projects and payments. The challenge will be to develop a learning system for organizations—with hundreds to thousands of employees—that are not related, yet working together to meet objectives to earn performance payments. It will take innovative planning to bring together under one training hub these groups who were likely competitors before DSRIP. While an average PPS has 1,000 providers, DeWitt notes that there are Downstate PPSs that have as many as 10,000 providers. "Delivering a unified message to 10,000 providers in New York City will take strong organization and planning," DeWitt says.

Depending on how many projects they have committed to, each PPS will want to consider its learning program very carefully. For example, says Newsholme, "each employee must take a DSRIP 101 course. Hospital administrators know about DSRIP, but frontline workers haven't heard about it." Training will cover numerous areas, including behavioral and cultural competencies, age-specific requirements, patient communication, clinical topics, health literacy, care transitions, and more.

Newsholme suggests offering training on a neutral, central learning platform, especially when there are multiple, competing entities involved. "PPSs may think they can do this internally through classroom training or develop their own content, but it will be a challenge due to the logistics of merging employees from

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multiple organizations, as well as different learning systems." Also, DSRIP projects, in many cases, will require developing a library of materials, including hundreds of courses over a short period of time. Working with an outside learning partner may save the PPS time and costs over the long run.

Learning from New York

Government and commercial payers have been pushing healthcare providers into a value-based world for some time now through value-based payments and pay-for-performance programs. In New York State, however, providers have a major incentive because they are being funded before they begin meeting performance metrics. DSRIP will have a significant impact on all healthcare providers in the state and nationwide over the next decade, predicts Newsholme. "Other organizations can learn a lot from New York's DSRIP program," she says. "Whether your state is a low cost region or not, pay-for-performance is a reality."

DeWitt shares similar sentiments. "Obviously the healthcare system is focused on Medicaid, but providers aren't going to be building new care systems just to manage the Medicaid population. They're looking to build systems that are sustainable after DSRIP and that can transform healthcare for all payers, be it Medicare or private payers." New York already has some good news to share, says DeWitt. "We no longer have the highest Medicaid costs. You're starting to see those costs going the other way."

New York Medicaid and DSRIP Program Facts

2010: New York Medicaid spending was between $7,944 and $9,310 per Medicaid beneficiary in fiscal year 2010, one of the highest levels in the nation. (Young, Rudowitz, Rouhani, & Garfield, 2015)

In 2013, New York State spent $54.5 billion on Medicaid, making it one of the highest Medicaid spenders in the country.

2014: New York passed the Medicaid Redesign Team Waiver Amendment to transform the healthcare system. The waiver provides $6.4 billion in incentives to New York healthcare providers over five years. Additionally, the state of New York has kicked in another $1.1 billion."

In April 1, 2015, the DSRIP program began with the goal of reducing avoidable hospital use by 25% among New York Medicaid enrollees.

How HealthStream Can Help

HealthStream Learning Center Solutions for NY DSRIP Program

HealthStream has partnered with Iroquois Health Association (IHA) to provide solutions for PPS leaders in the DSRIP program. HealthStream and IHA analyzed grant proposals and developed a tailored approach to meet each PPS's project plan for workforce development. HealthStream partners with PPSs by offering a centralized training platform, a library with hundreds of courses, and a leading-edge data and analytics platform to measure results.

HealthStream Learning Center (HLC). HealthStream is pleased to offer a centralized learning platform. This is the leading healthcare learning management system, which is used to register learners, distribute on-line courseware, track classroom training activities, run completion reports, and much more.

Control Center. Quarterly reporting and analytics are key to recouping DSRIP funding. HealthStream has designed a unique Control Center for DSRIP reporting. HealthStream's powerful data center allows PPSs to perform targeted data analytics and gap analysis to monitor learners' performance over time. The Control Center also pulls in CMS readmission data to track PPS and site performance. In addition, the Control Center will provide each PPS visibility into how their partners in the PPS are performing on everything from training to tests.

DSRIP PPS-Specific Online Courses.
HealthStream provides access to 500 DSRIP courses, including DSRIP 101 and Health Literacy. Because each PPS has great leeway in designing their program, HealthStream's library can be tailored to meet the specific needs of each PPS. Topics include the following:

- Behavioral Health and Primary Care
- Business Skills
- Care Coordination
- Collaborative Care & Mental Health/IMPACT Model
- Compliance
- Cultural Competency
- Home Health
- Patient Navigation
- Physician Leadership
- Population Health
- Process Improvement
- Transitional Care

Defining Unavoidable Hospital Use

One of the chief goals of New York's DSRIP program is to reduce hospital use by 25%. According to the DSRIP program, this includes both avoidable hospital readmissions and inpatient admissions.

The following measures will be considered when evaluating how well each PPS reduces avoidable hospital use:

1. Potentially Preventable Emergency Room Visits
2. Potentially Preventable Readmissions
3. Prevention Quality Indicators-Adult
4. Prevention Quality Indicators-Pediatric

(New York State DOH, 2015)

Virtual Administration. HealthStream assigns an optional full-time administrator to help run the HealthStream Learning Center for each PPS. Services include loading content, content assignment, collecting registration lists from all facilities, physician offices, etc., and adding learners into the system, as well as monthly and quarterly reporting.

HealthStream Patient Activation Services for NY DSRIP Program

In addition to offering PPSs a solution to manage workforce development, HealthStream has been approved by CMS to administer multiple CAHPS surveys. For PPSs that select the Patient Activation (2di) project, HealthStream offers CG-CAHPS (version 3.0). HealthStream offers a turn-key solution that includes the following:

Survey Administration. HealthStream manages all aspects of survey administration from sampling eligible patients, performing deduplication to ensure patients are only surveyed once, mailing two survey packets to ensure high response rates, and submitting completed survey data back to New York for scoring.

Reporting & Analytics. HealthStream's Insights Online, an interactive on-line reporting website, permits PPSs to review and analyze vital patient experience data quickly and easily. It offers a robust data warehouse that provides dashboards, advanced analytic capabilities, an online Best Practices Library, links to customer communities, advanced filtering and exporting capabilities, and the ability to schedule automatic delivery of specified reports. HealthStream also provides each PPS and practice site a comprehensive report with comparisons to national benchmarks, percentile ranks and identification of priorities for improvement.

Improvement Tools and Resources. PPSs have access to our complete library of Best Practices and a detailed report review with a senior member of their dedicated project team. We also help organizations to improve the patient experience and CAHPS survey results through online and on-site assessments, coaching and educational tools. We focus on strategies that have the greatest potential impact for rapid CAHPS improvement.

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Mr. DeWitt is the Director of Data Analytics and Workforce Initiatives for Iroquois Healthcare Association, representing 54 hospitals and health systems in 32 counties of Upstate New York. Mr. DeWitt has over 30 years of diverse management experience in the service and healthcare industries, with considerable expertise in human resource administration. Mr. DeWitt was responsible for the creation of Iroquois' Survey Solutions, an internet-based data entry and reporting tool for compensation and benefits information provided to participating member organizations. Mr. DeWitt has also been instrumental in implementing several workforce programs including successful grant programs through the New York State Health Workforce Retraining Initiative across Upstate New York. In his 17 years at Iroquois, Mr. DeWitt has created strong working relationships with hospital CEOs, CFOs, Human Resource Executives, and other senior level healthcare executives. He is a graduate of Cornell University.

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