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THE NEW YORK STATE DSRIP: A COLLABORATIVE APPROACH TO REFORM

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Delivery system reform incentive payment (DSRIP) programs, under Section 1115 Medicaid waivers, have greatly evolved since California implemented the first DSRIP program in 2010. To date, nine states across the U.S. have implemented these programs and each has its own unique model. While DSRIP programs have evolved since 2010, the New York State approach provides an example of the role collaboration between primary care providers and hospitals can play in delivery system transformation efforts.

Between late 2015 and early 2016, the National Partnership for the Health Care Safety Net held conversations with stakeholders that included leaders from hospitals and health centers and their respective associations in New York State. The goal of these conversations was to better understand the elements of collaboration that were part of the implementation of New York State's DSRIP program and how this differs from other DSRIP models. The following is a summary based on these conversations.

THE NEW YORK STATE MODEL

The New York State DSRIP program originated from the broader efforts of the New York State Medicaid Redesign Team (MRT). The MRT brought together stakeholders and experts from throughout the state to work cooperatively to both reform New York State's health care system and reduce costs. As a part of this Medicaid restructuring, the New York State Department of Health negotiated with the Centers for Medicare & Medicaid Services (CMS) to ultimately implement a DSRIP program under a Section 1115 waiver amendment. The program will reinvest savings - roughly $7 billion over five years - resulting from MRT initiatives into delivery system reform, contingent on certain population health and quality achievements.

From the outset, the New York State DSRIP program was designed to incorporate both hospitals and primary care providers. Specifically, in order to participate in the DSRIP, hospitals and health centers, as well as other health and community partners, must be part of a local Performing Provider System (PPS). Each PPS was required to submit its own improvement plan, choosing up to 11 projects from a list preapproved by CMS, and could be led by any of the participating provider organizations. These improvement projects fall into the categories of delivery system reform, clinical improvements such as asthma and perinatal care, and population health/prevention.

In a break from earlier DSRIP models[1], PPSs are not required to have a hospital lead but, partly due to the complexity of the requirements, almost all networks are led by a hospital system. One exception is the Refuah Community Health Collaborative (see below). There are currently 25 PPSs throughout the state. Some providers may be involved in multiple PPSs, creating cross-over in local systems and DSRIP initiatives.

[1] The state of Texas also operates on a slightly different model involving collaboration where Regional Healthcare Partnerships (RHP), larger geographic designations, have a singular improvement plan. However, these plans are managed by an anchor hospital.

FACILITATING COLLABORATION

The development of the PPS approach emerged out of early stages of waiver planning and negotiation, as well as other complementary state-wide initiatives. A number of stakeholder engagement groups were established early on, which brought together different representatives from primary care and hospital systems. It was important to recognize diverse partners that would be critical to meeting the broader DSRIP goals. Specifically, the DSRIP program aimed for the PPS to act as a building block towards moving into a value-based payment environment.

In 2015, providers in communities came together to apply as PPS. Due to requirements to include provider partnerships in order to qualify as a PPS, networks had to be developed well in advance of implementation. PPS funding was allocated based on the number of patient lives served through a layered patient attribution methodology that accounted for the assignment of patients to health homes and primary care providers. Therefore, PPSs tended to have large patient populations with many different types of provider organizations and primary care providers were recognized as having an essential role.

COLLABORATION IN ACTION

As noted above, one of the PPS in New York State is Refuah Community Health Collaborative. This PPS is unique as it was founded by two health centers (Refuah Health Center and Ezras Choilim Health Center) and their local community hospital (Good Samaritan Hospital) and is led by the Refuah Health Center, a federally qualified health center.

Refuah Health Center was well-positioned to lead the Collaborative because they are entrenched in the community, have longstanding relationships with community providers, and include social determinants of health in their model of care. The formation of the PPS has helped solidify the relationship between the health center and their hospital partner as well as increased communication and collaboration with other partners, such as local government, the Department of Health, and substance abuse and behavioral health providers.

WMCHealth PPS, a neighbor and partner of Refuah Health Center, is a network led by Westchester Medical Center. Westchester, an essential hospital, began expanding their partnerships with local primary care and community providers as soon as state discussions for the DSRIP program started. Starting early was a crucial approach for building a network that would be successful for the formal PPS application process and creating partnerships that could be sustained beyond the DRSIP program. There are over 250 separate provider entities participating in the WMC PPS, including many community-based organizations.

In addition to the partners within their PPS, WMC also works with their local PPS partners - Refuah Community Health Collaborative, mentioned above, and the Montefiore Hudson Valley Collaborative, another DSRIP PPS. The formation of these partnerships is a strong example of how collaboration is occurring among PPS. WMCHealth PPS, Refuah Community Health Collaborative, Montefiore Hudson Valley Collaboration communicate and work closely on a regular basis. This resulted in these three partners forming a more formal collaboration – the Hudson Region DSRIP Public Health Council.

Together, they are tackling smoking cessation and other clinical priorities across their larger, shared network.

AN IMPORTANT STEP IN HEALTH REFORM

The New York State DSRIP program has garnered national attention for its inclusion of primary care and hospital partnerships, and may indicate a new trend in DSRIP models. Prior to New York State's waiver, DSRIP programs had predominantly been hospital-focused with limited inclusion of other providers built into the model.

Specifically, the New York State DSRIP program was designed to address a major barrier to many hospital and health center partnerships – misaligned financial incentives. DSRIP program funding in itself can be a critical resource for health care providers in their efforts to transform and integrate care. The New York DSRIP program takes this a step further by also providing financial resources for developing alignment and infrastructure for key partnerships.

Furthermore, the New York State DSRIP demonstrates how the inclusion of stakeholders in envisioning and planning can help shape meaningful system transformation. It is important to note that not only do hospitals and health centers collaborate as part of their PPS, but they are also represented through hospital and primary care groups (e.g. associations like Community Health Care Association of New York State, Greater New York Hospital Association, and the Healthcare Association of New York State) that are continuously engaged in conversations at the state level and coordinated by state agencies.

KEY TAKEAWAYS

Collaboration between hospitals, health centers, and other health care providers is the backbone of the New York State DSRIP program. There are still many lessons to be learned, as the program is in early phases of implementation. However, a collaborative approach may serve as an important first step in breaking down barriers for unconventional partnerships and facilitating a system wide, comprehensive approach to delivery system transformation and improved patient outcomes. Continued monitoring of the experience of providers and their partners in New York State will offer insights into the elements of provider partnerships that can address the needs of shared patient populations and implement health policy initiatives outside DSRIP waivers.