DSRIP Transition Plan Milestone: Support Further Delivery System Reform

Overview

The Texas Health and Human Services Commission (HHSC) respectfully submits to the Centers for Medicare and Medicaid Services (CMS) this deliverable for the approved Delivery System Reform Incentive Payment (DSRIP) Transition Plan milestone to Support Further Delivery System Reform. The deliverable outlines options that HHSC has assessed for potential new programs for Demonstration Year (DY) 11 (Federal Fiscal Year (FFY) 2022) of the current Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver).

The programs included in the deliverable were developed with the goal of supporting further delivery system reform and sustaining successes of the DSRIP program. HHSC developed the programs based on analysis of performance by participating providers in the current program[1], review of data on the populations currently served by DSRIP, focused input from DSRIP stakeholders in the Best Practices Workgroup, and other stakeholder engagement.

The options integrate DSRIP successes in the Texas Medicaid managed care model primarily through Directed Payment Programs (DPPs). They target participating provider groups of the DSRIP program to continue progress and maintain some funding stability, but also broaden participation opportunities for other Medicaid providers to expand the impact of quality improvement. Participating providers for DY 11 DSRIP Transition options include: physician practices, Community Mental Health Centers (CMHCs), hospitals, Local Health Departments (LHDs), and Rural Health Clinics (RHCs). For LHDs, options include participation in the Uncompensated Care program under the current waiver and a Medicaid cost-reimbursement program, similar to the School Health and Related Services program operated by HHSC.

[1] Includes the data report also submitted December 31, 2020.

The proposals address the Focus Areas identified in the DSRIP Transition Plan:

- Sustain access to critical health care services;
- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for patients with complex conditions that have high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Integration of public health with Medicaid;
- Telemedicine and telehealth; and
- Social drivers of health (SDOH).

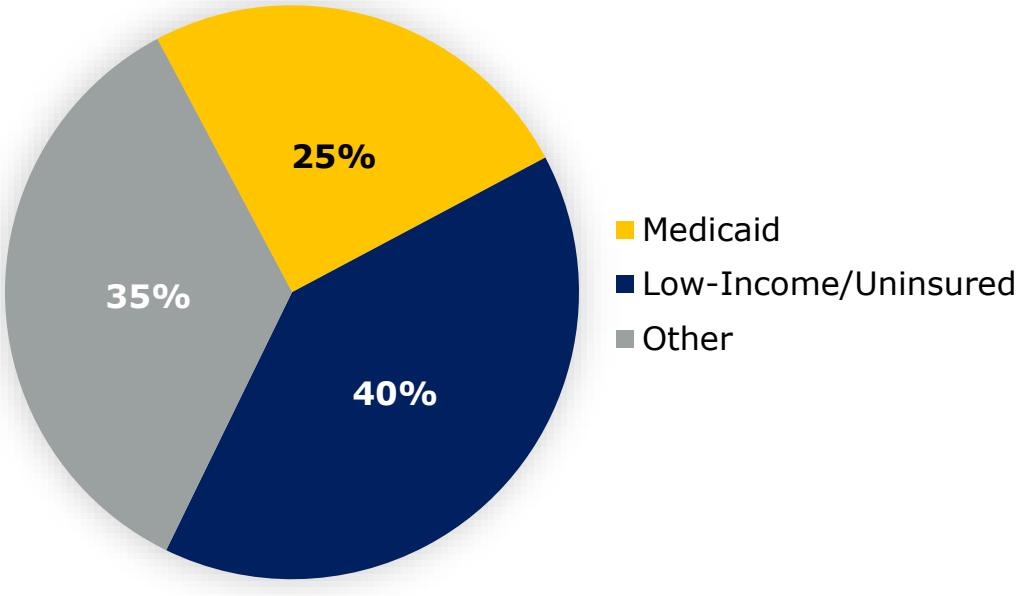
The DY 11 programs provide a foundation for continued innovation and advancement of value-based care in future years. The inclusion of a broader base of providers than has participated in DSRIP quality improvement activities (e.g., community physicians, rural health clinics), in addition to the loss of measurement progress due to the COVID-19 pandemic, inhibits the state from starting new programs exactly where DSRIP providers will end. Per the approved DSRIP Transition Plan, DY 12 programs will be submitted by September 2021. HHSC continues to explore additional program options for individuals who have been served under DSRIP.

Analysis of Current DSRIP Program

HHSC conducted analysis of the current DSRIP interventions and data to inform the development of these programs. This analysis indicates that DSRIP providers have had high success in achieving selected outcome measures and improving quality of care, as demonstrated by improvements in the median performance rate on selected measures.

DSRIP providers earn payments by demonstrating achievement on metrics and selected measures, rather than based directly on service utilization. DSRIP improvements have benefited all Texans, across multiple payer groups. Figure 1 provides an overview of the populations served in the DSRIP 1.0 interventions; DSRIP 2.0 payer data was only collected as data points in denominator populations of selected measures. As such, DSRIP 1.0 provides the best overall picture of the distribution across payer types.

Figure 1. Percentage by Payer Type for DSRIP 1.0



The 297 providers participating in the DSRIP program have earned funding to support their healthcare transformation efforts and improve quality of care for the people they serve. From 2012 through July 2020, providers have earned $19.23 billion in total funding. Intergovernmental Transfers (IGT) from participating providers serve as the non-federal share of the DSRIP program.

Demonstration Year (DY)	Allocation	Payments to Date*
DY1 (October 1, 2011 – September 30, 2012)	$0.50 Billion	$0.48 Billion
DY2 (October 1, 2012 – September 30, 2013)	$2.30 Billion	$1.93 Billion
DY3 (October 1, 2013 – September 30, 2014)	$2.67 Billion	$2.54 Billion
DY4 (October 1, 2014 – September 30, 2015)	$2.85 Billion	$2.68 Billion
DY5 (October 1, 2015 – September 30, 2016)	$3.10 Billion	$2.84 Billion

Demonstration Year (DY)	Allocation	Payments to Date*
DY6 (October 1, 2016 – September 30, 2017)	$3.10 Billion	$2.87 Billion
DY7 (October 1, 2017 – September 30, 2018)	$3.10 Billion	$2.99 Billion
DY8 (October 1, 2018 – September 30, 2019)	$3.10 Billion	$2.62 Billion
DY9 (October 1, 2019 – September 30, 2020)	$2.91 Billion	$0.32 Billion
DY10 (October 1, 2020 – September 30, 2021)	$2.49 Billion	TBD
DY11 (October 1, 2021 – September 30, 2022)	$0	NA

**DY8 payments are eligible to be earned through July 2021. DY9 payments are eligible to be earned through July 2022.*

The proposed programs continue some of the successful interventions that DSRIP providers operationalized to achieve their targeted outcomes. The most frequently selected Core Activities in the DSRIP program, grouped thematically, follow. These Core Activities align with the focus areas of the DSRIP Transition Plan and remain priorities in the new programs.

- Access to Primary Care Services
- Chronic Care Management
- Expansion of Patient Care Navigation and Transition Services
- Behavioral Health Care Services
- Prevention and Wellness

As part of the Transition Plan, HHSC is also updating its Quality Strategy to be submitted to CMS in March 2021. While not yet final, the updated Quality Strategy has provided a guidepost for aligning new programs with overall Medicaid quality goals.

Stakeholder Engagement

HHSC has engaged a broad base of stakeholders throughout the process of program development. The process started in November 2018 with stakeholder submission of ideas for new programs, followed in Summer 2019 with stakeholder meetings to collect providers' input on DSRIP transition.

The proposals included in this submission are based in part on some of those original suggested ideas. For example, the CMHCs developed a proposal to continue quality improvement in behavioral health, particularly by using the Certified Community Behavioral Health Clinic (CCBHC) model. Physician groups also indicated strong preferences for broader provider participation in post-DSRIP programs to expand the impact of successes and lessons learned in DSRIP across Texas.

HHSC also established a Partner Engagement Plan to provide transparency into the Transition Plan work. HHSC held quarterly Partner Engagement meetings to provide updates on Transition Plan status. HHSC also sent monthly newsletters to the Partner Engagement distribution list, which was open to any and all stakeholders. HHSC has maintained its regular engagement with the DSRIP anchors on bi-weekly anchor calls and the Executive Waiver Committee, through quarterly meetings. Through these forums, HHSC has kept the stakeholder community informed of status, new options, and key decisions for DSRIP transition.

HHSC also engaged specific impacted stakeholder groups to determine program details. HHSC convened workgroups for seven weeks in Fall 2020 to develop agreement on quality objectives, measurement, and program structure for The Comprehensive Hospital Increased Reimbursement Program (CHIRP) and the Texas Incentive for Physicians and Professional Services (TIPPS). Similar focused groups of providers met regularly with HHSC staff on the programs for CMHCs, LHDs, and RHCs. HHSC staff also solicited direct input through surveys to a larger group within these provider types.

Best Practices Workgroup

In January 2020, HHSC formed a Best Practices Workgroup consisting of more than 80 DSRIP provider representatives, DSRIP Anchor representatives, and other stakeholders to support the sustainability of delivery system reform best practices and the development of the next phase of delivery system reform in Texas. The Workgroup's first task was to prioritize DSRIP measures identified as key to driving improvements in health status. Workgroup members were surveyed on 41 measures aligned with priority focus areas from HHSC's DSRIP Transition Plan.

Workgroup members prioritized measures as key drivers of improvements in the health status of clients and ranked the priority of key measures. The top 10 key measures are:

1. Diabetes hemoglobin A1c (HbA1c) poor control
2. Diabetes blood pressure control
3. Cancer screening
4. Cardiovascular disease blood pressure control
5. Follow-up after hospitalization for mental illness
6. Age appropriate screening for clinical depression or suicide risk
7. Pediatric and adolescent immunization status
8. Post-partum follow-up and care coordination
9. Medication reconciliation
10. Maternal screening for behavioral health risks

Additionally, members were surveyed to rank the top three key measures by various focus areas. Different key measures were prioritized for each focus area, but across all focus areas, the most frequently ranked key measures were:

- Diabetes HbA1c poor control
- Diabetes blood pressure control
- Cardiovascular disease high blood pressure control

These measures are incorporated into many of the programs included in this submission, as appropriate for the provider group and Medicaid patient populations served.

In addition to prioritizing DSRIP measures, the Best Practices Workgroup also prioritized practices from DSRIP that have been key for driving improvements in health status within focus areas and populations.

Best Practices Workgroup members were surveyed on a total of 40 practices, representing practices that were most commonly implemented by DSRIP providers or associated with measures the workgroup identified as key measures.[2] The top 10 prioritized key practices are:

1. Pre-visit planning and/or standing order protocols

[2] The 40 practices reviewed by the Best Practices Workgroup were taken from Related Strategy reporting submitted in 2019.

2. Care team includes personnel in a care coordination role not requiring clinical licensure
3. Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist
4. Automated reminders/flags within the E.H.R. or other electronic care platform
5. Same-day and/or walk-in appointments in the outpatient setting
6. Integration or co-location of primary care and psychiatric services in the outpatient setting
7. Care team includes personnel in a care coordination role requiring clinical licensure
8. Culturally and linguistically appropriate care planning for patients
9. Integration or co-location of primary care and specialty care (physical health only) services in the outpatient setting
10. Panel management and/or proactive outreach of patients using a gap analysis method

These practices and interventions have also been prioritized for continuation in the programs included in this submission. Some of these are activities that providers will be required to implement in order to participate in DY 11 proposed programs.

Considerations for DY 11 Programs

The state is shifting from the DSRIP program and funding pool to other strategies, such as DPPs, for advancing delivery system reform and supporting providers. Certain key factors impact this transition and the options available for DY 11 and beyond.

- *IGT for state match* – Consistent with the DSRIP program, the DY 11 programs assume the continuation of IGT funding as the non-federal share.

- *Funding amounts and distributions* – With the implementation of new programs, funding amounts and distribution methodologies will likely change. DPPs are tied to Medicaid utilization, whereas DSRIP funding is earned when providers demonstrate achievement on performance measures for serving Medicaid and low-income uninsured individuals. HHSC must also consider the available budget neutrality needed to sustain the programs beyond DY 11. DSRIP participating providers have varying levels of Medicaid utilization to support DPPs. For example, HHSC assessed the potential for a DPP for LHDs, but low Medicaid utilization and managed care claims did not justify the administration of the program.

HHSC has maintained a holistic view of funds that providers are earning through the state's other supplemental or DPPs in the development of new programs to ensure the total reimbursement received by providers is economic and efficient for the services being delivered. For example, instead of developing a separate program for DY 11 for hospitals, HHSC strengthened evaluation criteria for the CHIRP program (an expansion of the current Uniform Hospital Reimbursement Increase Program DPP) based on DSRIP measurement and experience.

- *COVID-19 public health emergency* - The state will continue to monitor the impact the current public health emergency has on provider's ability to invest in healthcare reforms and meet quality metrics. The programs have been designed to phase-in quality requirements as a result of the significant impact the COVID-19 pandemic has had on provider's ability to implement, sustain, and advance quality improvement.

Next Steps

The product of this development process are options for new programs to begin in DY 11 that are summarized in the following pages. HHSC is continuing to finalize its plans for DY 11 and beyond and will separately request CMS approval for any programs HHSC plans to implement. Formal applications for CMS approval of new programs will be submitted to CMS under the standard processes and protocols.

Program	Texas Incentives for Physician and Professional Services (TIPPS)
Model	Directed payment program (DPP)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and possibly STAR Kids
Participating Providers	Physician practice groups
Funding Estimate	$500+ million annually in All Funds at estimated Average Commercial Rate[3]

Intended Quality Outcomes

1. Support access and improve outpatient care for Medicaid managed care members.
2. Expand successful innovations from DSRIP to a broader base of physician practice groups across the state to improve primary care, chronic care, maternal health, behavioral health, and social drivers of health (SDOH).

Program Overview

- The TIPPS program is a new value-based DPP. The program is intended to span 3 years. In Year 1, the program would include the three components described below.
- Three classes of physician practice groups are eligible to participate: 1) physician groups affiliated with a health-related institution (HRI); 2) physician groups affiliated with a hospital receiving the indirect medical education add-on (IME); and 3) other physician practice groups that are not HRI or IME (Other).
- Component 1 would be paid as a per-member-per-month (PMPM) payment tied to requirements to implement quality improvement activities. HRIs and IMEs are eligible for Component 1.
- Component 2 would serve as a uniform rate enhancement based on achievement of quality metrics focused on primary care for adults and children and chronic care. HRIs and IMEs are eligible for Component 2.
- Component 3 would serve as a rate enhancement for certain outpatient services based on achievement of quality metrics focused on maternal health, chronic care, behavioral health, and SDOH. All physician practice groups are eligible for Component 3.
- Physician practice groups would apply to participate in the program and must serve a minimum volume of Medicaid managed care members to be eligible for participation.

Background

- The proposed program aligns with the focus areas identified in the DSRIP transition plan including:
    - Primary Care
    - Pediatric Care
    - Chronic Care Management
    - Maternal health and birth outcomes including in rural areas of the state
    - Behavioral health
    - SDOH
- TIPPS is designed to improve access, quality, and timeliness of outpatient care—providing the right care in the right place at the right time—a focus of physician practices' DSRIP activities.
- The proposed program incorporates best practices identified in DSRIP including:
    - patient-centered medical homes
    - same-day, walk-in, or after-hours appointments

[3] HHSC will request the actual amount of any DPP from CMS under the standard processes and protocols.

- care teams that include personnel in a care coordination role
- pre-visit planning and/or standing order protocols
- self-management classes
- SDOH screening
- participation in local health information exchange
- telehealth

- This program uses measures identified by stakeholders as key for improving the health of clients including:
  - tobacco screening
  - cervical cancer screening
  - immunization status
  - behavioral health screening
  - diabetes hemoglobin A1c testing and control
  - prenatal and post-partum care

Program	Comprehensive Hospital Increased Reimbursement Program (CHIRP)
Model	Directed payment program (DPP)
Target Beneficiaries	Adults and children enrolled in STAR and STAR+PLUS
Participating Providers	Hospitals
Funding Estimate	TBD

Intended Quality Outcomes

1. Advance at least one of the goals and objectives in the managed care quality strategy.
2. Maintain access to care for Medicaid managed care members.
3. Monitor the adoption of successful innovations from DSRIP by a broader base of hospitals across the state.

Program Overview

- CHIRP is a change to the existing Uniform Hospital Rate Increase Program (UHRIP), currently in its fourth year of operation. Beginning in program year 5, the program would include two components.
- Component 1 (UHRIP) would provide a uniform rate enhancement. Component 2 (Average Commercial Incentive Award (ACIA)) would allow participating providers to earn higher reimbursement rates based upon a percentage of the estimated average commercial reimbursement.
- Hospitals apply for participation in the program and can opt into the ACIA component.
- HHSC specifies the performance requirements associated with the designated quality metrics to advance at least one of the goals and objectives in the managed care quality strategy. Achievement of the performance requirements will be used to evaluate the degree to which the program advances at least one of the goals and objectives that are incentivized by the CHIRP payments.

Background

- Redesign of the UHIRP program allows HHSC to monitor progress on focus areas identified in the DSRIP transition plan, which could include:
    - maternal health
    - behavioral health
    - patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization
    - SDOH
- The proposed program is designed to target ongoing needs among Medicaid managed care members.
- This program would use measures identified by HHSC as key for improving the health status of clients.

Program	Directed Payment Program for Behavioral Health Services
Model	Directed payment program (DPP)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
Participating Providers	Community Mental Health Centers (CMHCs). There are 39 CMHCs statewide that all participate in DSRIP.
Funding Estimate	Increasing to 100% of Medicare reimbursements would provide an estimated $43.5 million in All Funds annually[4]. HHSC is also conducting cost modeling of the DPP based on the CMS approved CCBHC cost report rate methodology.

Intended Quality Outcomes

1. Continue successful DSRIP innovations by CMHCs to promote and improve access to behavioral health services, care coordination, and successful care transitions.
2. Incentivize continuation of services provided to Medicaid-enrolled individuals that are aligned with the Certified Community Behavioral Health Clinic (CCBHC) model of care.

Program Overview

- This new value-based DPP continues to support the state's transition to the CCBHC model of care.
- CCBHCs provide a comprehensive range of evidence-based mental health and substance use disorder services, with an emphasis on the provision of 24-hour crisis care, care coordination with local primary care and hospital providers, and integration with physical health care. Federal legislation defined the model and certification criteria for the Medicaid provider type, and Congress has financially supported the model with funding grants.[5]
- Component 1 is a uniform dollar increase issued in monthly payments to all CMHCs participating in the program recognizing progress made toward certification or maintenance of CCBHC status, and focusing on access and quality improvements such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange.
- Component 2 is a uniform percent increase on CCBHC services based on achievement of quality metrics that align with CCBHC measures and goals.
- CMHCs would apply for the program.

Background

- Process measures selected by CMHCs and clinical outcome measures for behavioral health showed the greatest improvement in DY7-8 of DSRIP. These include:
  - Assessment for psychosocial issues of psychiatric patients
  - Independent living skills assessment for individuals with schizophrenia
  - Unhealthy alcohol use screening & brief counseling
  - Counseling for psychosocial and pharmacologic treatment options for opioid addiction
  - Post-partum follow-up and care coordination
  - Depression remission at six months

[4] HHSC will request the actual amount of any DPP from CMS under the standard processes and protocols. To maintain current levels of DSRIP funding for CMHCs, other options may be required.

[5] https://www.thenationalcouncil.org/wp-content/uploads/2019/10/What-is-a-CCBHC-UPDATED-10-25-19.pdf?daf=375ateTbd56

- Follow-up after hospitalization for mental illness
- This new DPP for CMHCs builds directly on DSRIP successes with quality improvement and supports the CCBHC model.
- The proposed program aligns with the focus areas identified in the DSRIP transition plan including:
  - behavioral health
  - patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization
  - sustaining access to critical healthcare services
- The program would also continue to build upon the core activities CMHC providers have been implementing during DSRIP. For example, core activities in the top four groupings for CMHCs included:
  - implementing a provision of care aligned with the CCBHC model
  - utilizing telehealth/telemedicine
  - integration of behavioral and primary care services
  - education and use of self-management programs
  - implementation of community-based crisis stabilization alternatives
- This program would use quality measures identified by stakeholders as key for improving the health of clients. This may include the top three key behavioral health measures identified through the Best Practices Workgroup:
  - follow-up after hospitalization for mental illness
  - age-appropriate screening for clinical depression/suicide risk
  - behavioral health conditions - ED visits rate

Program	Rural Access to Primary and Preventive Services (RAPPS)
Model	Directed payment program (DPP)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
Participating Providers	Rural Health Clinics (RHCs). There are 306 RHCs in Texas.
Funding Estimate	Increasing to 100% of Medicare reimbursements would provide an estimated $18.7 million in All Funds annually[6]

Intended Quality Outcomes

1. Providing the right care, in the right place, at the right time for Medicaid enrollees in rural communities.
2. Improving primary and preventive care access and chronic care management for Medicaid enrollees in rural areas.

Program Overview

- The new value-based DPP for RHCs incentivizes provision of primary and preventive services for Medicaid-enrolled individuals in rural areas of the state. The program also focuses on management of chronic conditions.
- Two classes of RHCs would be eligible for the DPP: (1) hospital-based RHCs, which include non-state government owned and private RHCs, and (2) free-standing RHCs.
- RHCs would apply for the program and must serve a minimum volume of Medicaid managed care members to be eligible for participation.
- There would be two program components:
    - Component 1 would provide a uniform dollar increase in the form of prospective, monthly payments to all participating RHCs to enhance structures that promote better access to primary and preventive services. The amount of the increase would vary by RHC class. The structure measures would include reporting on electronic health record (EHR) use, telemedicine/ telehealth capabilities, and ensuring access to care for Medicaid clients.
    - Component 2 would be a uniform percent rate increase for certain services based on achievement of quality metrics focused on preventive care and screening and management of chronic conditions.

Background

- DSRIP has improved access to care in rural areas through increased primary and specialty care capacity (direct staff or telemedicine). However, access to necessary services in rural areas continues to be a challenge. A prospective payment included in Component 1 of the program provides some budget stability for rural providers.
- RHCs were not performing providers in DSRIP, but as subcontractors to rural hospitals, provided primary and preventive care services measured for improvement.
- RHCs provide access to primary and preventive care and chronic disease management to rural residents and help to avoid potentially preventable emergency departments visits and hospitalizations, which increase Medicaid costs.
- The program's quality requirements are supported by the results from the Best Practices Workgroup that found diabetes control, cancer screening, high blood pressure control, and immunization measures among the top seven measures for driving improvements in the health status of clients.

[6] HHSC will request the actual amount of any DPP from CMS under the standard processes and protocols.

Program	Local Health Department Participation in the Uncompensated Care Program
Model	Uncompensated Care (UC) Program in the 1115 Waiver
Target Beneficiaries	Individuals qualifying for charity care services at Local Health Departments
Participating Providers	Local Health Departments (LHDs)
Funding Estimate	Estimated annual maximum available funding in FFY 2022: $100 million in All Funds

Intended Quality Outcomes

This program aligns with the DSRIP Transition Plan focus areas to sustain access to critical healthcare services and follows the requirements of the current UC program.

Program Overview

- The program adds LHDs as an eligible provider to the Uncompensated Care (UC) program, authorized under Texas' Healthcare Transformation and Quality Improvement Program 1115 Waiver.
- LHDs would earn matching federal funds for eligible charity care expenses from the statewide UC pool that reimburses providers for the cost of care to the uninsured.
- To participate, LHDs would be required to create a Charity Care Policy and produce cost reports.
    - Charity Care policies require assessing clients' insurance status and ability to afford services rendered.
    - LHDs would submit cost reports to HHSC detailing their charity care qualifying expenses to earn matching federal funds.

Background

- The inclusion of LHDs in the UC program would ensure continued access to critical services that have been provided under DSRIP:
    - Immunization services
    - Communicable disease prevention and treatment (HIV/STD)
    - Tuberculosis treatment and prevention services
    - Chronic disease prevention
    - Health and public health education/promotion
    - Disease surveillance and tracking services
- LHDs are safety net providers. Allowing participation in UC would acknowledge the significant role of LHDs in providing services to Medicaid, low-income, and uninsured populations and protecting public health.
- The program would financially support the public health system as it experiences an unprecedented strain because of the global COVID-19 pandemic.

Program	Public Health and Related Services (PHARS)
Model	Cost reimbursement for certain Local Health Departments' Medicaid services
Target Beneficiaries	Individuals receiving Medicaid services at Local Health Departments
Participating Providers	Local Health Departments (LHDs), 65 in Texas, 21 are DSRIP Participating Providers
Funding Estimate	Pending

Intended Quality Outcomes

- This program supports LHDs which are providing important services to individuals enrolled in Medicaid, but not always receiving Medicaid reimbursement for those services. This program would provide Medicaid reimbursements while HHSC continues to address integration of LHDs in Medicaid managed care.

Program Overview

- LHDs would certify expenditures for eligible Medicaid services provided to Medicaid-enrolled individuals.
- LHDs would submit cost reports and fulfill other program requirements based on the parameters developed by HHSC.
- The program would provide LHDs the federal share of the costs related to eligible Medicaid services provided to Medicaid-enrolled individuals.
- Payments under this program would not be made through Medicaid managed care organizations (MCOs).

Background

- LHDs provide numerous services such as chronic disease prevention, immunization services, and communicable disease prevention and treatment. LHDs also perform functions, not limited to Medicaid, that are valuable to the state, especially during the current COVID-19 pandemic.
- LHDs report challenges contracting with MCOs, and those with contracts with MCOs report having limited opportunities for billing for Medicaid services. Billing limitations are a result of LHDs enrolling in Medicaid under different provider types and not all being credentialed or in-network with all MCOs. A contributing factor to this issue is that there is not one LHD provider type in Medicaid. HHSC is working to address these issues by enhancing contract requirements for MCOs to include LHDs in network and exploring other policy solutions.
- As a result, LHDs provide services to Medicaid enrolled-individuals that are currently not billed and/or not reimbursed through fee-for-service or managed care.
- DSRIP has enhanced LHDs' ability to serve Medicaid enrolled-individuals.
- This program prioritizes the DSRIP Transition Plan focus area to better integrate public health and Medicaid.