NHS New Care Models – New York DSRIP Compare and Contrast

Outcomes-based Measurement and Payment

New York State Perspective

Peggy Chan – DSRIP Program Director
Melissa Lurie - Office of Patient Safety and Quality
New York State Department of Health

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New York State DSRIP Payments and Performance Measurement

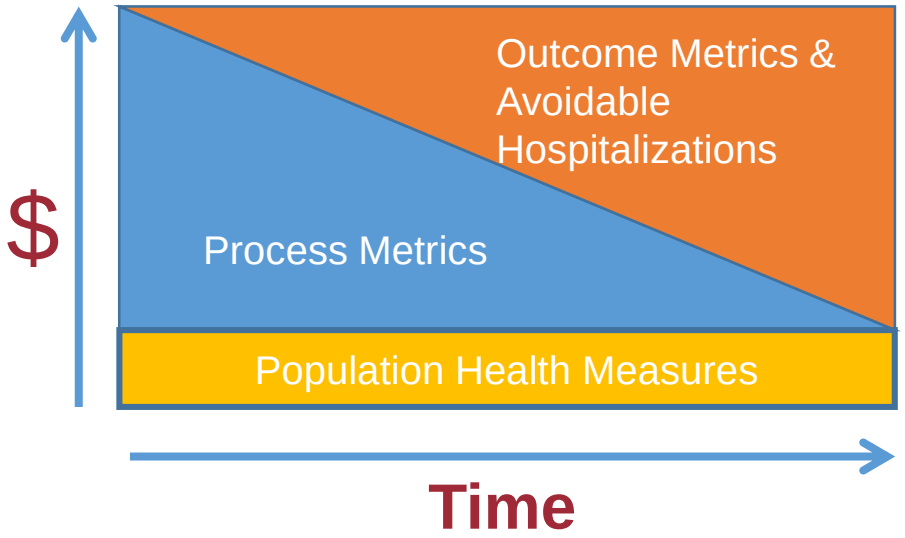
- Calculation of Payments to Performing Provider Systems (PPS)
- Domains to Projects
- Projects to Measures
- Quality Measures
- Performance Measurement

Calculation of PPS Payments

- PPS Project Valuation Award is the total dollars that may be earned based on application commitments and project selection
- PPS payments were initially pay for reporting (P4R) calculated based on progress of milestones and metrics
  - Domain 1 Process – Organizational milestones (e.g. Governance, Workforce, IT, Cultural Competency,)
  - Domain 2 Project Implementation Milestones including provider and patient target numbers for engagement
- As projects progress, there is less payment for reporting and more funds for performance (P4P)
  - Claims and non-claims based performance measures based on annual improvement targets of 10% or more to close gap to goal

Outcomes/Performance Measurement Approach

- Annual improvement targets a methodology of reducing the gap to the goal by 10%.
- Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.
- Performing Provider Systems may receive ***less than their maximum allocation*** if they do not meet metrics and/or if DSRIP funding is reduced because of the statewide penalty).



Project Valuation from DSRIP Program

Fee for Service and "Pay for Reporting" (P4R) → Pay for Performance (P4P)

	Performance Payment*	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
Project progress milestones (Domain 1)	P4R	80%	60%	40%	20%	0%
System Transformation and Financial Stability Milestones (Domain 2)	P4P	0%	0%	20%	35%	50%
	P4R	10%	10%	5%	5%	5%
Clinical Improvement Milestones (Domain 3)	P4P	0%	15%	25%	30%	35%
	P4R	5%	10%	5%	5%	5%
Population Health Outcome Milestones (Domain 4)	P4R	5%	5%	5%	5%	5%
PPS Infrastructure Development	P4R	100%	85%	55%	35%	15%
Clinical Improvement and Health Outcomes	P4P	0%	15%	45%	65%	85%

Statewide Accountability

- PPS funds received may be reduced for missed milestones statewide
  - The reduction is applied proportionately to all PPSs

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DSRIP Pay for Performance

- **75 Pay for Performance (P4P) Measures in DSRIP**
  - **25 measures became P4P** in June 30, 2017 reporting/payment cycle for Measurement Year 2 (July 2015-June 2016)

- **Annual Improvement Target (AIT)**
  - Gap to Goal – 10% improvement over previous measurement year
  - Unearned AIT funds roll over to High Performance Fund (HPF)

- **High Performance Fund (HPF)**
  - Ten (10) eligible HPF measures to further enhance DSRIP focus on key areas
    - Preventable Emergency Room and Readmissions
    - Behavioral Health measures
  - Tier 1 - Based on 20% gap to goal achievement
  - Tier 2 – Meets or exceeds state-wide performance target

DSRIP POWERBALL

~$54M seed funding + ~$7M forfeited DY1

High Performance Fund

~$61M split evenly

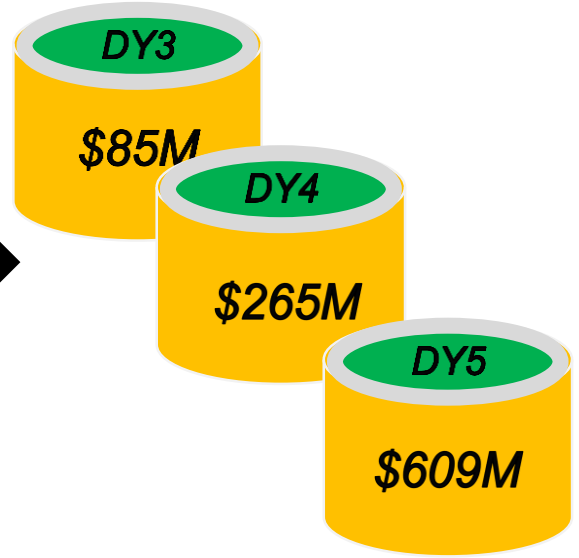
Tier I

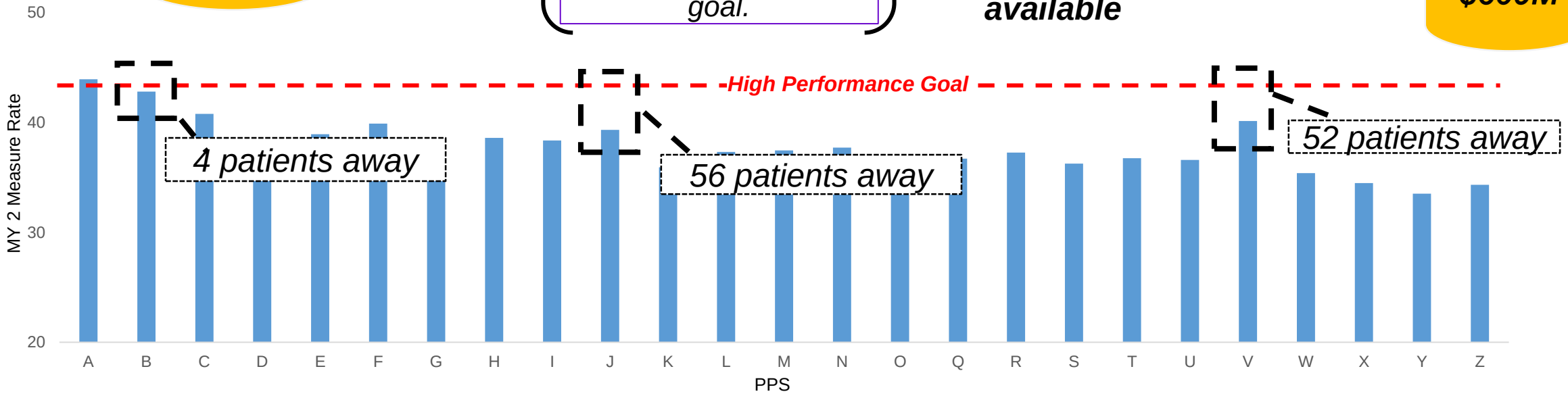
20% improvement: baseline to statewide performance goal

Tier II

Meeting or exceeding statewide performance goal.

MY2: Tier I dollars earned, but ***only 5%*** of Tier II dollars earned leaving: ***$29M available***





Domains to Projects

Domain 2: System Transformation Projects
- **Create Integrated Delivery Systems** focused on Evidence-Based Medicine and Population Health Management
- Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

→ Applicants chose Minimum 2, Maximum 4 Projects

Domain 3: Clinical Improvement Projects
- **Integration of primary care and behavioral health** services
- Evidence-based strategies for disease management in high risk/affected populations

→ Applicants chose Minimum 2, Maximum 4 Projects

Domain 4: Population-Wide Projects
- **Strengthen Mental Health and Substance Abuse Infrastructure** across Systems
- Promote tobacco use cessation, especially among low SES populations and those with poor mental health

→ Applicants chose Minimum 1, Maximum 2 Projects

→ **Applicants chose between 5 and 11 Projects**

*Project 2.d.i is described as **"Implementation of patient and community activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care,"** which PPSs could select as their 11th project.

PPS Project Selection: Domain 2

DSRIP Performing Provider System Project Selections

	Project	Index Score	Short Description	Adv Comm Ptnrs - AW Med (NYC)	Bronx-Lebanon (NYC)	HHC Facilities (NYC)	Lutheran Med Ctr (NYC)	Maimonides Med Ctr (NYC)	Mt Sinai (NYC)	NY Hosp Med Ctr Queens (NYC)	NY-Presbyterian (NYC)	Staten Isl & Richmond Univs (NYC)	St. Barnabas Hosp (NYC)	Nassau County (LI)	Stony Brook Univ Hosp (LI)	Montefiore Med Ctr (Mid-Hudson)	Refuah Health Ctr (Mid-Hudson)	Westchester Med Ctr (Mid-Hudson)	Albany Med Ctr (Capital)	Ellis Hospital (Capital)	Erie Co Med Ctr (Western)	Catholic Med Ptnrs (Western)	CNY PPS (Central)	FLPPS (Finger Lakes)	Mary Imogene Bassett (Mohawk)	Adirondack Health Inst (N Country)	United Hospitals (Southern Tier)	Samaritan Med Ctr (Tug Hill)	TOTAL PPSs Selecting Project
Domain 2: System Transformation. Required to choose two to five projects (at least one from subdomain 2.a and one from 2.b or 2.c). See Footnote 4 in this brief for special rules regarding project 2.d.i ("the 11th project").																													
A. Create Integrated Delivery Systems	2.a.i.	0.93	Integrated Delivery Systems	✓	✓	✓*	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓		22
	2.a.ii	0.62	Patient-Centered Medical Home / Advanced Primary Care						✓							✓								✓	✓			✓		5
	2.a.iii	0.77	Health Home At-Risk	✓	✓	✓*		✓			✓	✓			✓		✓	✓				✓								10
	2.a.iv	0.90	Medical Village—Hospital												✓		✓									✓			✓	4
	2.a.v	0.70	Medical Village—Nursing Home															✓												1
B. Implementation of Care Coordination and Transitional Care Programs	2.b.i	0.60	Ambulatory ICUs		✓					✓																				2
	2.b.ii	0.67	Primary Care in ED										✓																	1
	2.b.iii	0.72	ED Care Triage	✓		✓	✓	✓			✓				✓			✓	✓*	✓	✓	✓	✓							13
	2.b.iv	0.72	Transitions—Chronic Disease	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓			✓	✓*		✓	✓	✓					✓*	✓*	17
	2.b.v	0.68	Transitions—Nursing Facility						✓																					1
	2.b.vi	0.78	Transitional Supportive Housing																				✓							1
	2.b.vii	0.68	Inpatient Transfer Avoidance for SNF						✓		✓		✓	✓*						✓				✓			✓			7
	2.b.viii	0.75	Hospital-Home Care Collaboration					✓	✓		✓								✓*	✓				✓	✓					7
	2.b.ix	0.60	Hospital Observational Programs				✓							✓																2
C. Connecting Settings	2.c.i	0.62	Community-Based Health Navigation				✓	✓								✓								✓*			✓*			5
	2.c.ii	0.52	Telemedicine in Underserved Areas																			✓								1
D. Access for Special Populations	2.d.i	0.93	Patient Activation Activities Toward Community-Based Care			✓					✓			✓	✓			✓	✓*	✓			✓	✓	✓*	✓*	✓*	✓*	✓*	14

For full descriptions of each project, see New York State Delivery System Reform Incentive Payment Program Project Toolkit at https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

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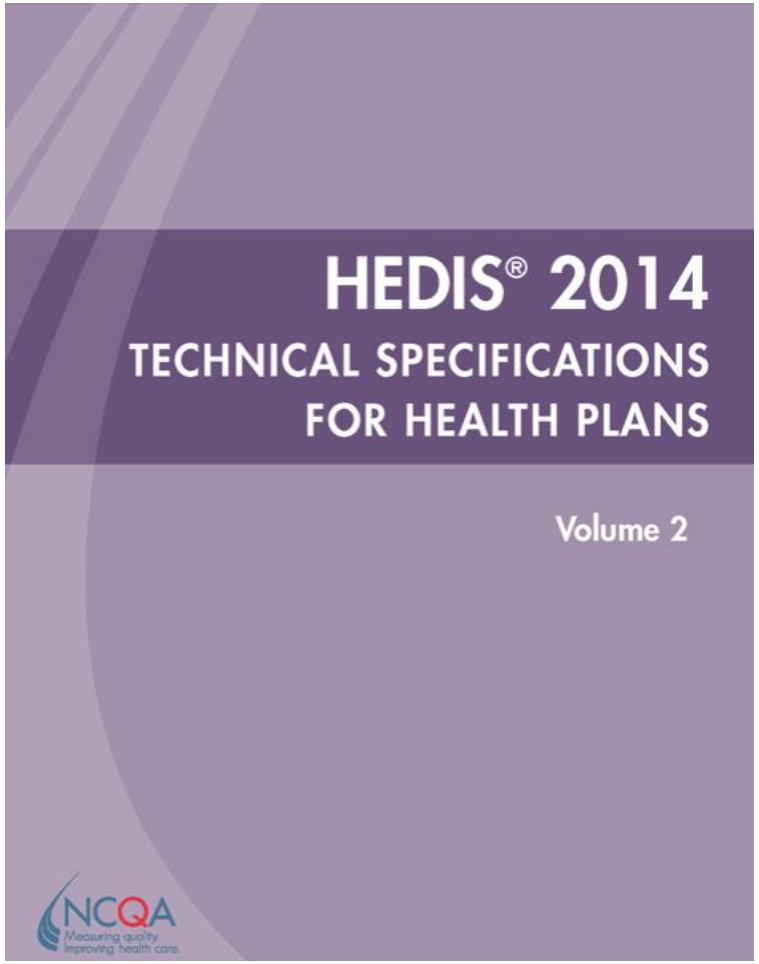
Project to Measures - Example

Project 2.a.i: Create Integrated Delivery Systems that are focused on Evidence-Based Medicine & Population Health Management	
Project Measure	Data Source
Getting Timely Appointments, Care and information	C&G CAHPS Survey
Care Coordination with Provider	
Potentially Avoidable Emergency Room Visits (PPV)	NYSDOH Medicaid Data Warehouse
Potentially Avoidable Readmissions (PPR)	
Prevention Quality Indicator - Composite of all measures (PQI90)	
Pediatric Quality Indicator - Composite of all measures (PDI90)	
Adult Access to Preventive or Ambulatory Care	
Children's Access to Primary Care	
Medicaid Spending on ER and Inpatient Services	SPARCS (hospital discharge & ED visit data)

Claims-Based Measures



AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

Prevention Quality Indicators (PQIs)
Pediatric Quality Indicators (PDIs)

3M Health Care

Potentially Preventable Readmissions (PPR)
Pediatric Preventable ED Visits (PPV)

Non-Claims Measures: PPS Level

cahps® Surveys and Tools to Advance Patient-Centered Care

CAHPS Clinician & Group Surveys — Adult 12-Month Questionnaire 2.0

Your Provider

1. Our records show that you got care from the provider named below in the last 12 months.

   Name of provider label goes here

   Is that right?

   [1] ☐ Yes
   [2] ☐ No → **If No, go to #26 on page 4**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

   [1] ☐ Yes
   [2] ☐ No

3. How long have you been going to this provider?

   [1] ☐ Less than 6 months
   [2] ☐ At least 6 months but less than 1 year
   [3] ☐ At least 1 year but less than 3 years
   [4] ☐ At least 3 years but less than 5 years
   [5] ☐ 5 years or more

Your Care From This Provider in the Last 12 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

4. In the last 12 months, how many times did you visit this provider to get care for yourself?

   ☐ None → **If None, go to #26 on page 4**
   ☐ 1 time
   ☐ 2
   ☐ 3
   ☐ 4
   ☐ 5 to 9
   ☐ 10 or more times

5. In the last 12 months, did you phone this provider's office to get an appointment for an illness, injury, or condition that **needed care right away**?

   [1] ☐ Yes
   [2] ☐ No → **If No, go to #7**

6. In the last 12 months, when you phoned this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?

   [1] ☐ Never
   [2] ☐ Sometimes
   [3] ☐ Usually
   [4] ☐ Always

Medical Record Review

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual

Measurement Year 3

JULY 10, 2017

DSRIP@HEALTH.NY.GOV

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https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-07-25_measure_specific_rpting_manual.pdf

DSRIP Quality Measures

Table 5. Domain 2 Measures

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
Domain 2 – System Transformation										
Potentially Preventable Emergency Room Visits ±	3M	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people (excludes those born during the measurement year) as of June 30 of measurement year	6.10 per 100 Medicaid enrollees *High Perf Elig # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Potentially Preventable Readmissions ±	3M	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of readmission chains (at risk admissions followed by one or more clinically related readmissions within 30 days of discharge)	Number of people as of June 30 of the measurement year	180.66 per 100,000 Medicaid Enrollees *High Perf Elig # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
PQI 90 – Composite of all measures ±	AHRQ 6.0	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of admissions which were in the numerator of one of the adult prevention quality indicators	Number of people 18 years and older who were enrolled in Medicaid for at least one month as of June 30 of measurement year	245.40 per 100,000 Medicaid Enrollees # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

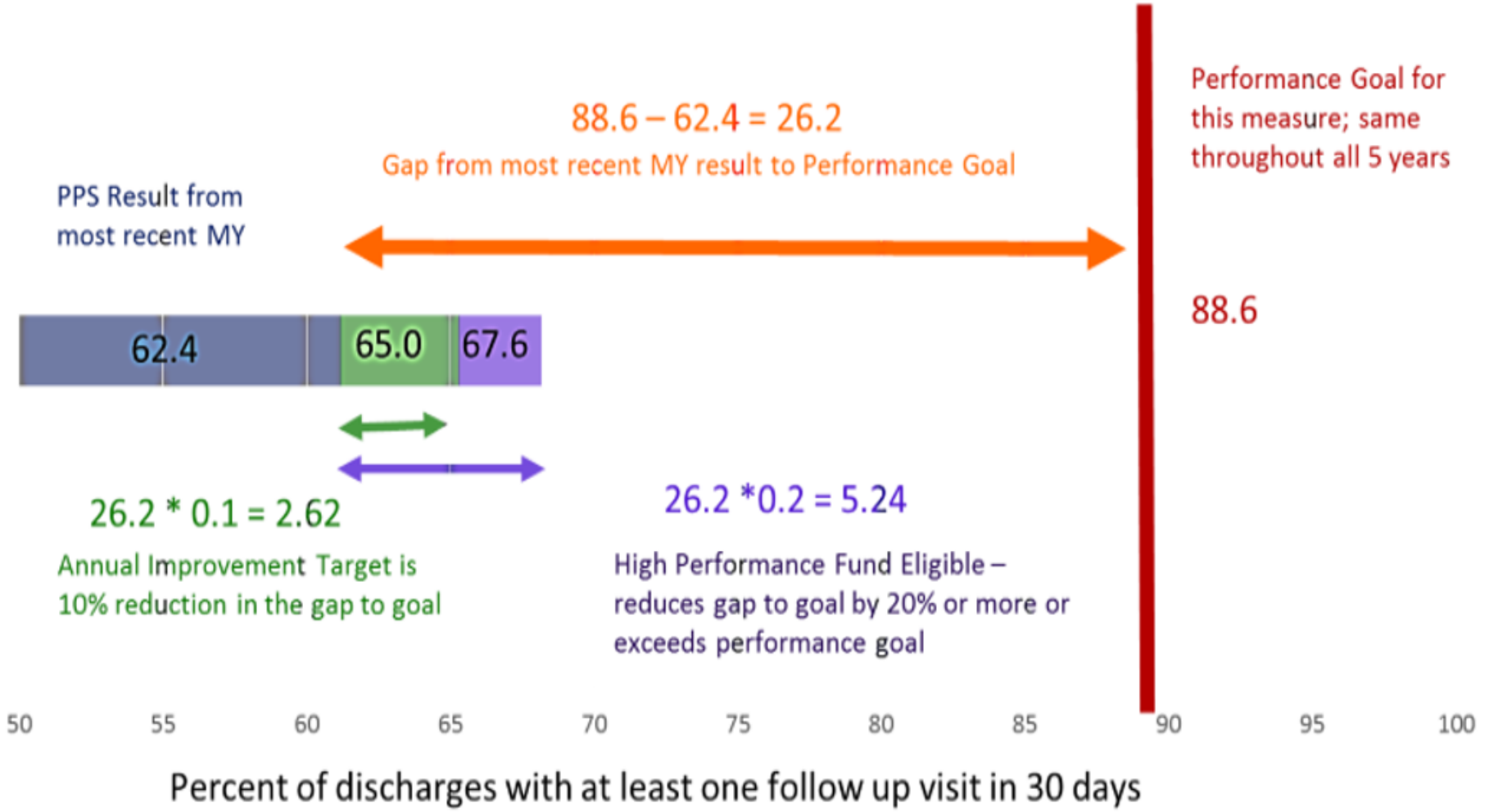
DSRIP Quality Measures (Domain 3)

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Adherence to Antipsychotic Medications for People with Schizophrenia	HEDIS® 2017	1879	3.a.i – 3.a.iv	Number of people who remained on an antipsychotic medication for at least 80% of their treatment period	Number of people, ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications during the measurement year	76.5%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	HEDIS® 2017	0004	3.a.i – 3.a.iv	Number of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	57.1%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	HEDIS® 2017	0004	3.a.i – 3.a.iv	Number of people who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	28.3%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

Setting the Annual Improvement Targets & High Performance Targets

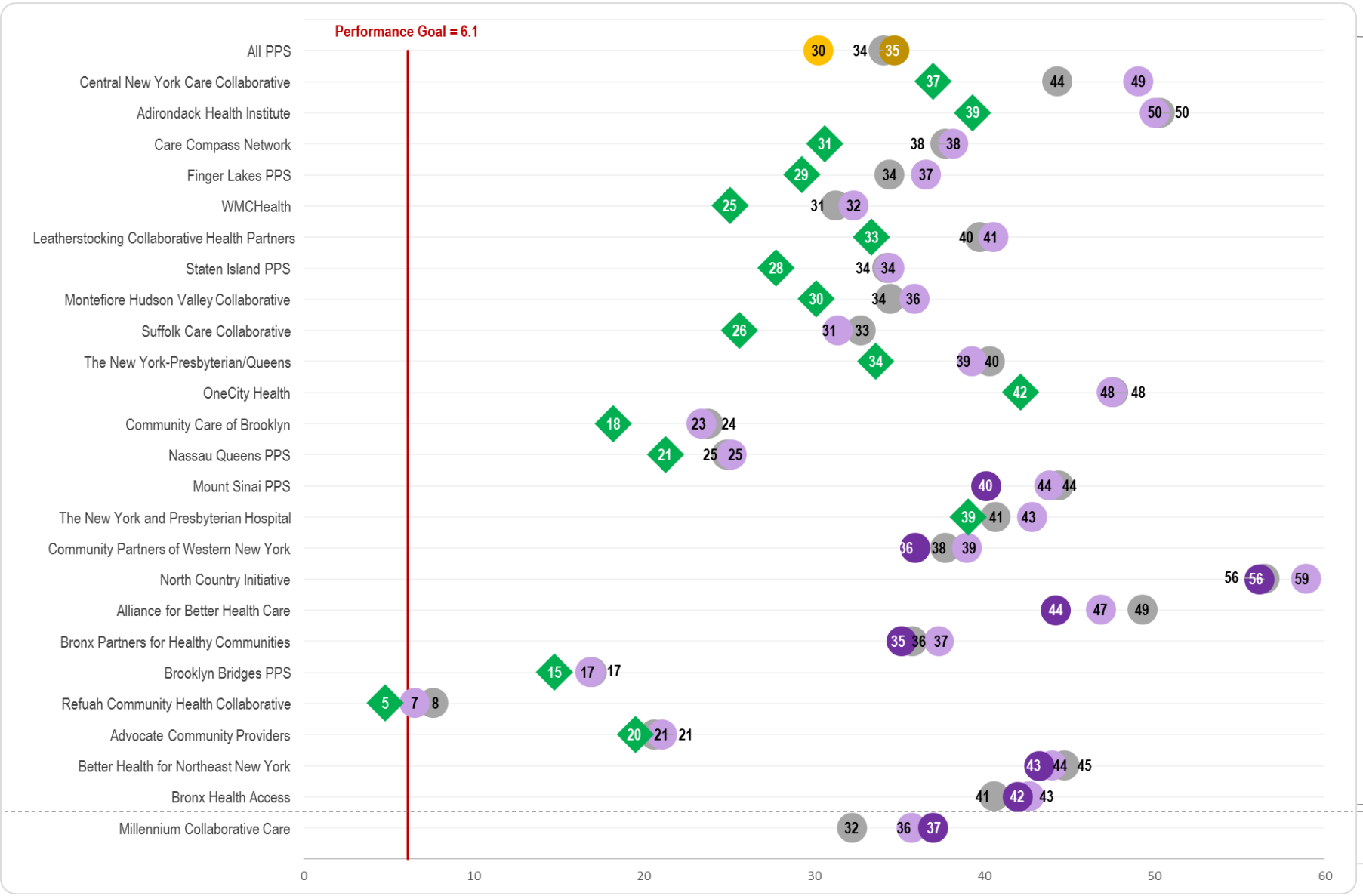
Setting the Annual Improvement Targets & High Performance Targets

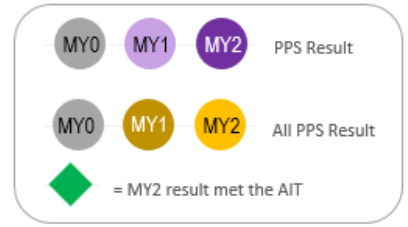
Setting the Annual Improvement Targets & High Performance Targets



Potentially Preventable Emergency Room Visits ±

± A lower rate is desirable





Improving

Not Improving

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Thank You!