Update on NY State’s DSRIP and VBP Programs

Greg Allen
Director, Division of Program Development and Management
State of Quality - Medicaid

- New York has a well-established system to monitor quality of care for Medicaid managed care enrollees. Over time, measures have evolved from preventive care to measures of chronic care and outcomes.
- Since 2001, a managed care pay for performance program has been a driver of improved care and has focused on quality and patient satisfaction measures.
- The rates of Medicaid performance have:
  - Improved over time;
  - 96% of measures exceeded national benchmarks* based on 2013 data; and
  - Seen a reduction in the gap in performance between Medicaid and commercial managed care.
  - Now 34th in the country in avoidable hospital use end cost.

* National benchmarks are based on 2014 State of Healthcare Quality report from the National Committee for Quality Assurance (NCQA).
**DSRIP Objectives**

- **Goal:** Reduce avoidable hospital use – Emergency Department (ED) and Inpatient – by 25% over 5+ years of DSRIP

- **Develop Integrated Delivery Systems**

- **Enhance Primary Care (PC) and Community-based Services**

- **Remove Silos**

- **Integrate BH* and PC**

- DSRIP was built on the Center for Medicare and Medicaid Services’ (CMS) and the State’s goals towards achieving the Triple Aim:
  - Better care
  - Better health outcomes for members
  - Lower costs

- Its holistic and integrated approach to healthcare transformation is set to have a positive effect on healthcare in NYS

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*Within DSRIP, the term “Behavioral Health” also encompasses mental health and substance abuse.*

Source: The New York State DSRIP Program. NYSDOH Website. & New York’s Pathway to Achieving the Triple Aim. NYSDOH DSRIP Website. Published December 18, 2013.
DSRIP Project Implementation

- PPS committed to healthcare reform by choosing a set of Projects best matched to the needs of their unique communities.

- DSRIP Projects are organized into Domains, with Domain 1 focused on overall PPS organization, and Domains 2 - 4 focused on various areas of transformation. All projects contain metrics from Domain 1.
DSRIP Implementation Timeline and Key Benchmarks

Submission/Approval of Project Plan
- PPS Project Plan Valuation
- PPS first DSRIP Payment
- PPS Submission of Implementation Plan and First Quarterly Report

Domain 3: Clinical Improvement P4P Performance Measures begin & MY 3 begins.
Domain 2: Data collection for P4P measures begins

Domain 4: PPS working in collaboration with community and diverse set of service providers to address statewide public health priorities; system improvements and increased quality of care will positively impact health outcomes of total population.

Focus on Infrastructure Development/System Design

Focus on Continued System/Clinical Improvement

Focus on Project Outcomes/Sustainability

We are here
# DSRIP Independent Assessor

The DSRIP Independent Assessor has three primary functions throughout the life of DSRIP: Project Plan Application Reviews, Mid-Point Assessment, and monitoring of PPS progress through the Quarterly Report process to determine semi-annual performance payments.

<table>
<thead>
<tr>
<th>Primary Function</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| **DSRIP Project Plan Applications (COMPLETE)** | - Develop the DSRIP Project Plan Application and Scoring Methodology  
- Review and score the DSRIP Project Plan Applications submitted by the PPS  
- Present the DSRIP Project Plan Application scores to the Project Approval and Oversight Panel |
| **Mid-Point Assessment (IN PROCESS)** | - Develop a Mid-Point Assessment plan and tool  
- Conduct the Mid-Point Assessment  
- Develop Mid-Point Assessment Report and Recommendations  
- Present Mid-Point Assessment Recommendations to the Project Approval and Oversight Panel  
- Review and approve PPS Mid-Point Assessment Action Plans |
| **Monitoring of PPS through Quarterly Reports (ONGOING)** | - Review PPS progress against established milestones through the PPS Quarterly Reports  
- Assign Achievement Values (AVs) for PPS progress against required process milestones and performance metrics  
- Calculate semi-annual performance payments based on PPS Quarterly Report results  
- Conduct annual on-site reviews of each PPS |
DSRIP Mid-Point Assessment

- New York State has already seen a decrease in avoidable admissions
- All 25 PPS found to be on track for success
- Recommendations from the IA ranged from zero (0) to twenty-three (23)
  - Three PPS had zero and three had one
- Most common recommendation among the PPS was not having met original partner engagement targets as stated on project application
  - Particular focus on primary care, MH and SUD, and CBOs
- Many factors on PPS reporting, nonetheless, there are needs and opportunities for further community partner engagement and collaboration to impact the next phase of DSRIP
Behavioral Health & Physical Health Integration in DSRIP

- Performing Provider Systems (PPS) were required to implement at least one behavioral health project from the Domain 3 A (Clinical Improvement Projects) category.

- 3.A -Behavioral Health Projects:
  - 3.a.i: Integration of primary care services and behavioral health
  - 3.a.ii: Behavioral health community crisis stabilization services
  - 3.a.iii: Implementation of evidence-based medication adherence program (MAP) in community-based sites for behavioral health medication compliance.
  - 3.a.iv -Development of withdrawal management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs.
  - 3.a.v -Behavioral Interventions Paradigm (BIP) in Nursing Homes.
# Traditional High Performance Fund Measures

<table>
<thead>
<tr>
<th>Projects</th>
<th>Measure Name</th>
<th>P4P Timing</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.a.i-2.a.v</td>
<td>Potentially Preventable Emergency Department Visits (All Population)</td>
<td>DY3</td>
<td>1</td>
</tr>
<tr>
<td>2.a.i-2.a.v</td>
<td>Potentially Preventable Readmissions (All Population)</td>
<td>DY3</td>
<td>1</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Antidepressant Medication Management - <strong>Effective Acute Phase Treatment</strong></td>
<td>DY2</td>
<td>0.5</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Antidepressant Medication Management - <strong>Effective Continuation Phase Treatment</strong></td>
<td>DY2</td>
<td>0.5</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Cardiovascular Monitoring for People with CVD and Schizophrenia</td>
<td>DY2</td>
<td>1</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Diabetes Monitoring for People with Diabetes and Schizophrenia</td>
<td>DY2</td>
<td>1</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Follow-up after hospitalization for Mental Illness - <strong>within 30 days</strong></td>
<td>DY2</td>
<td>0.5</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Follow-up after hospitalization for Mental Illness - <strong>within 7 days</strong></td>
<td>DY2</td>
<td>0.5</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Potentially Preventable Emergency Department Visits (BH Population)</td>
<td>DY2</td>
<td>1</td>
</tr>
<tr>
<td>3.a.v</td>
<td>Antipsychotic Use in Persons with Dementia (SNF Long Stay Residents)</td>
<td>DY2</td>
<td>1</td>
</tr>
<tr>
<td>3.b.i-3.b.ii</td>
<td>Tobacco Cessation - Discussion of Cessation Strategies</td>
<td>DY4</td>
<td>1</td>
</tr>
<tr>
<td>3.b.i-3.b.ii</td>
<td>Controlling Hypertension</td>
<td>DY4</td>
<td>1</td>
</tr>
</tbody>
</table>

*Indicates measures are combined in the traditional DSRIP High Performance Fund, meaning the measures is worth 0.5 AV.*
AHPP Measures

- AHPP is designed to further incentivize performance target achievement for 9 of the measures in the High Performance Fund (HPF).

<table>
<thead>
<tr>
<th>Projects</th>
<th>Measure Name</th>
<th>Pay For Performance (P4P) Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.a.i-2.a.v</td>
<td>Potentially Preventable Emergency Department Visits (PPV) (All Population)</td>
<td>DY3</td>
</tr>
<tr>
<td>2.a.i-2.a.v</td>
<td>Potentially Preventable Readmissions (PPR) (All Population)</td>
<td>DY3</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Antidepressant Medication Management - Effective Acute Phase Treatment</td>
<td>DY2</td>
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<td>Antidepressant Medication Management - Effective Continuation Phase Treatment</td>
<td>DY2</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Cardiovascular Monitoring for People with Cardiovascular Disease (CVD) and Schizophrenia</td>
<td>DY2</td>
</tr>
<tr>
<td>3.a.i-3.a.iv</td>
<td>Diabetes Monitoring for People with Diabetes and Schizophrenia</td>
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<tr>
<td>3.a.i-3.a.iv</td>
<td>Potentially Preventable Emergency Department Visits (Behavioral Health (BH) Population)</td>
<td>DY2</td>
</tr>
<tr>
<td>3.a.v</td>
<td>Antipsychotic Use in Persons with Dementia (SNF Long Stay Residents) **</td>
<td>DY2</td>
</tr>
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</tr>
</tbody>
</table>

In AHPP, all measures are valued equally. This differs from the HPF program which assigns separate Achievement Values for each measure.

** 3 of the HPF measures are not applicable to all PPS based on their DSRIP project selections, and are therefore not part of the AHPP.
## Other DSRIP Performance Measures with Most Opportunity based on MY2 Results

<table>
<thead>
<tr>
<th>Measure Name</th>
<th># PPS that met AIT</th>
<th>% PPS that met AIT</th>
<th>Turns P4P In:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)</td>
<td>1 / 25</td>
<td>4%</td>
<td>MY2</td>
</tr>
<tr>
<td>Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)</td>
<td>3 / 25</td>
<td>12%</td>
<td>MY2</td>
</tr>
<tr>
<td><strong>HP</strong> Antidepressant Medication Management - Effective Acute Phase Treatment</td>
<td>2 / 25</td>
<td>8%</td>
<td>MY2</td>
</tr>
<tr>
<td><strong>HP</strong> Antidepressant Medication Management - Effective Continuation Phase Treatment</td>
<td>2 / 25</td>
<td>8%</td>
<td>MY2</td>
</tr>
<tr>
<td>PQI 1 Diabetes Mellitus Short Term Complications</td>
<td>2 / 10</td>
<td>20%</td>
<td>MY2</td>
</tr>
</tbody>
</table>

HP: High Performance measure
PPS and CBO Collaborations
Recovery Services in DSRIP
Crisis Stabilization Projects

• Staten Island PPS
  • Community Health Action of Staten Island (CHASI)

• Hudson Valley PPS collaborative (Westchester, Montefiore and Refuah)
  • Dutchess County Stabilization Center
  • Rockland County Behavioral Health Crisis Response Team

• Adirondack Health Institute
  • Citizen Advocates Crisis Stabilization Center
Recovery Services in DSRIP
Crisis Stabilization Projects

• Nassau Queens PPS
  • Creedmoor Crisis De-escalation Team (TSI)
  • Possible expansion of MHANC respite housing

• Central NY PPS
  • Expansion of CPEP programs in 6 counties and peer respite

• Mount Sinai PPS
  • Incorporation of peer services into revamped Harlem MCT
Challenges

• DSRIP funds pay for innovation and transition, not for services traditionally paid for by Medicaid
• Regulations
  • Both state and federal regulations require PPS and partners to approach implementation with creativity and persistence
• Project reporting
  • Requirements can be burdensome and onerous, especially for smaller partners
  • Technical platforms may not exist that would assist reporting
  • Contracting challenges
• VBP readiness a general challenge for many BH partners
• MCO engagement
Success Factors

• Collaboration
  • PPS and partners that formed partnerships earlier are having more success
  • Personal approaches to collaboration more effective than virtual engagement
  • Collaboration with state agencies has yielded creative approaches to project implementation
    • All state agencies want to engage DSRIP networks and support projects
    • Regulatory waivers
  • Community partners that present specific project ideas to PPS are more likely to receive funds—ASK your PPS for $$$
• Utilization of DSRIP dollars as accelerant for early stage projects
• Get involved in DSRIP and other available transformation efforts
• Make friends. Make more friends. You can never have enough DSRIP friends.
Medicaid Accelerated eXchange (MAX) Series

The MAX Series is a Rapid Cycle Continuous Improvement program that operates at the core of DSRIP by bringing front-line clinicians together to redesign the way care is delivered.

- **Interdisciplinary** and **multi-provider teams** of **front-line clinicians** come together to redesign the way care is delivered.
- **Data** is used for problem identification, monitoring and performance measurement.
- In **Rapid Improvement Cycles**, teams drive results to truly impact the lives of Medicaid members.

Case Study: MAX Integrating BH and PC Services

Care Compass Network – Case Study
337 adults 20-50 years with mild-moderate/acute depression scoring 10+ on the PHQ

Patient Success Story: PCP ‘warm hand-off’ and introduction of SW to patient in exam room!

Process Improvements

<table>
<thead>
<tr>
<th>Patient Identification</th>
<th>Care Planning</th>
<th>Management</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implemented referral and warm handoff processes</td>
<td>Implemented full-time SW</td>
<td>Brief intervention and connection facilitated by SW</td>
<td>Implemented ED follow-up process with Lourdes SW</td>
</tr>
<tr>
<td>Implemented waiting room screening processes</td>
<td>Implemented integrated care plan</td>
<td>Collaborative care planning and management (“Mini huddles”)</td>
<td>Implemented HH processes</td>
</tr>
<tr>
<td>Expanded screening to include SBIRT*</td>
<td>Continuous provider education</td>
<td>BH shadowing of PCP to further embed BH into practice</td>
<td></td>
</tr>
<tr>
<td>Data tracking and reporting</td>
<td>Electronic Medical Record referral process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quantitative Results

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ Screening Compliance</td>
<td>0</td>
<td>1,297</td>
</tr>
<tr>
<td>Warm Handoff Count (Patients received brief intervention with SW and attended a follow up session with SW)</td>
<td>0</td>
<td>156</td>
</tr>
<tr>
<td>Number of Patients with a score of 15 or higher who were connected to BH</td>
<td>0</td>
<td>85</td>
</tr>
<tr>
<td>Improvement in Patient Health Questionnaire (PHQ) Score</td>
<td>showed an improvement of between 1-12 reduction in PHQ-9</td>
<td></td>
</tr>
</tbody>
</table>

*SBIRT= Screening, Brief Intervention, and Referral to Treatment
Behavioral Health & Physical Health Integration in DSRIP - Challenges

• DSRIP Project 3.a.i - Model 2 Behavioral Health Integrated Clinics Concerns:
  • 1) MMC Model Contract PCP minimum on-site work hours limitations.
    • Some BH integrated clinics mentioned that they cannot afford to have a PCP work 16 hours/week at their sites.
  • 2) MCO’s PCP network restrictions/limitations
    • Some BH integrated clinics mentioned that some MCOs are not accepting new PCPs or Physical Health providers into their network
  • 3) Credentialing and contracting with MCOs and BHOs
Collaborative Efforts Around the State

St. Barnabas team coordinated with BronxWorks to shuttle homeless persons presenting to the ED, primarily needing food and shelter, to a 24-hour drop-in center. Trained staff connect patients to housing or “Living Rooms.” It has resulted in a 36% reduction of ED visits by the cohort. 3 patients have reduced their visits by 90%, with a projection of 124 annual ED visits avoided.

NY-Presbyterian Queens is working with a Certified Home Health Agency and St. Mary’s Hospital for Children to do home assessments for children and their families to determine and help mitigate potential asthma triggers.

Bassett (Leatherstocking) PPS is working with Intellectually/Developmentally Disabled providers to determine causes and potential solutions to avoidable utilization of the ED by members.

Finger Lakes PPS is implementing a transitional supportive housing program, for short-term housing support for members between acute care settings and longer term housing solutions.

Source: Presentations from “Medicaid in New York: Progressing to Value-Based payment”. United Hospital Fund Website. Published July 2016.
Performance Measurement in DSRIP
Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual

Measurement Year 2

JULY 15, 2016
DSRIP.HEALTH.NY.GOV

Connecting to DSRIP Attributed Population & Rolling Up to a PPS

- Member Level Measures
- Provider Based Measures
- Facility Based Measures

PPS Level Measure Results
Potentially Preventable Readmissions ±

± A lower rate is desirable / * Indicates that MY2 measure result met the annual improvement target.

Moving in right direction

Moving in wrong direction
Potentially Preventable Emergency Room Visits ±

± A lower rate is desirable / * Indicates that MY2 measure result met the annual improvement target.
Potentially Preventable Emergency Room Visits (BH Population) ±

* A lower rate is desirable / * Indicates that MY2 measure result met the annual improvement target

Moving in right direction

Moving in wrong direction
Diabetes Monitoring for People with Diabetes and Schizophrenia

* Indicates that MY2 measure result met the annual improvement target / ^ Rates may not be stable due to small numbers (< 30) in denominator.
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

* Indicates that MY2 measure result met the annual improvement target / ^ Rates may not be stable due to small numbers (< 30) in denominator

Moving in right direction

Moving in wrong direction
Follow Up After Hospitalization for Mental Illness – within 30 Days

* Indicates that MY2 measure result met the annual improvement target
June 2017

Follow Up After Hospitalization for Mental Illness – within 7 Days

* Indicates that MY2 measure result met the annual improvement target

Moving in right direction

Moving in wrong direction
Antidepressant Medication Management – Acute Phase Treatment

* Indicates that MY2 measure result met the annual improvement target

Bronx-Lebanon
Alliance
Central New York
New York and Presbyterian
Advocate Community Providers
Finger Lakes
Albany Medical Center
Stony Brook
Care Compass
SBH
Bassett
Sisters of Charity
Mount Sinai
Adirondack Health Institute
Nassau Queens
Millennium
Westchester
Maimonides
Montefiore
New York City Health and Hospitals
Staten Island
Samaritan
NYU Lutheran Medical Center
Rafuah
New York Presbyterian/Queens
All PPS

Performance Goal = 60.0

Moving in right direction
Moving in wrong direction
Antidepressant Medication Management – Continuation Phase Treatment

* Indicates that MY2 measure result met the annual improvement target
Introduction to VBP
What is VBP?

• VBP is…
  ➢ the new model for administering Medicaid reimbursement,
  ➢ a shift away from the fee-for-service model, and toward a per unit (person or event) payment model,
  ➢ currently underway, and happening right now

• New York State’s model of VBP includes key program elements
  ➢ We will touch on each element throughout this training and call out key elements in the top right corner of the slide
  ➢ If you can walk away understanding these key elements slides, you will have a solid understanding of VBP
New York State Medicaid Transformation Since 2011

2011: Governor Cuomo created the Medicaid Redesign Team (MRT) which developed a series of recommendations to lower immediate spending and propose future reforms.

2014: As part of the MRT plan NYS obtained a 1115 Waiver which would reinvest MRT generated federal savings back into redesigning New York’s health care delivery system known as Delivery System Reform Incentive Payment Program (DSRIP).

2015: As part of DSRIP, NYS undertakes an ambitious payment reform plan working towards 80% value based payments by the end of the waiver period.

June 2015: NYS publishes a multi-year VBP Roadmap, a living document that outlines the State’s payment reform goals and program requirements.
Key Nomenclature—what we mean when we say “Fee for Service”

Before we move further along, we need to clear up the following:

- **Medicaid Managed Care Fee-for-Service (FFS)**
  - Impacted by VBP, intent is to move payment methodology from FFS to value based

- **Medicaid FFS**
  - Not impacted by VBP, FFS business as usual

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**DOH**

Managed Care Organization

**MC Network Provider**

**DOH**

FFS Payment

**FFS Provider**
MCOs are expected to contract with ‘VBP Contractors’ (IPAs, ACOs, larger individual providers) who take on responsibility for total cost and outcomes for four defined VBP populations, or for episodic arrangements within one of those populations:

Total Care for:

**General Population**
- All costs and outcomes for care of members excluding MLTC, HARP, HIV/AIDS, and I/DD subpopulations.
- Inclusive of all costs and outcomes of total care for *Integrated Primary Care* and *Maternity Care* arrangements.

**Integrated Primary Care**
- All members, responsibility for costs and outcomes for preventive care, routine sick care, and a set of chronic conditions selected due to high volume and/or costs.
- A subset of the TCGP, carved out of the TCGP arrangement if both arrangements contracted.

**Maternity Care (Episodic)**
- Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother.
- Carved out of the TCGP arrangement if both arrangements contracted.

**MLTC, HARP, and HIV/AIDS subpopulations**
- Includes costs and outcomes of total care for all members within a subpopulation exclusive of TCGP.

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.*

Source: NYS Department of Health website: VBP Bootcamp – Sessions 1&3
NYS 2014 Medicaid Costs and VBP Arrangement Breakdown

Total Population including Subpopulations

- General Population: 72%
- HARP: 9%
- I/DD: 10%
- HIV/AIDS: 6%
- MLTC: 2%
- HARP & HIV/AIDS: 1%

VBP Arrangements:
Total Care for Subpopulations

- Total Care for HARP Subpopulation
- Total Care for I/DD Subpopulation
- Total Care for HIV/AIDS Subpopulation
- Total Care for MLTC Subpopulation

Disclaimer: The data presented in this deck should not be considered final as the analysis environment continues to mature and validation of data input and analytical output continues. Source: NYS Medicaid Data Warehouse, 2014 Medicaid Claims unless otherwise indicated. Members included are Medicaid-only (duals excluded). Members attributed to NPIs that are also on other potential VBP contractor’s lists will not be in the dataset.
VBP Arrangements

• Arrangement Types*
  - Total Care General Population (TCGP)
  - Integrated Primary Care with Chronic Bundle (IPC-CB)
  - Maternity Bundle
  - Health and Recovery Plans (HARP) for those with Serious Mental Illness or Substance Use Disorders
  - HIV/AIDS
  - Managed Long Term Care (MLTC)

*Arrangements do not yet include Dually Eligible members

• Two VBP implementation subcommittees were created to focus on:
  - Social Determinants of Health (SDH) and CBOs
  - Advocacy and Engagement

The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library: [https://www.health.ny.gov/health_care/medicaid/reform/dsrip/vbp_library/index.htm](https://www.health.ny.gov/health_care/medicaid/reform/dsrip/vbp_library/index.htm)
A Holistic Approach to System Transformation

Tracking quality measurement will occur at all levels of care.

In coordination with key professional organizations, the State developed arrangements for those populations requiring specific and high cost care (such as HIV/AIDS, or those with Intellectual and/or Developmental Disabilities).

The VBP Levels and arrangements, such as the IPC and Chronic Bundle, are structured to incentivize further investment in primary care.

Providers in risk-sharing arrangements will be required to contract with CBOs, to promote successful population health outcomes.

Providers in risk-sharing arrangements will be required to implement at least one SDH intervention, and a compendium of best practices has been created.

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published March 2016.
MCOs and Contractors can choose different levels of Value Based Payments.

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (feasible after experience with Level 2; requires mature contractors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No Risk Sharing</td>
<td>↑ Upside Only</td>
<td>↑↘ Upside &amp; Downside Risk</td>
<td>↑↘ Upside &amp; Downside Risk</td>
</tr>
</tbody>
</table>

Acronym Definition: Fee for Service (FFS); Per Member Per Month (PMPM)

*Level 0 is not considered a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.
VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

**DSRIP Goals**

- **April 2017**
  - Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP

- **April 2018**
  - > 10% of total MCO expenditure in Level 1 VBP or above

- **April 2019**
  - > 50% of total MCO expenditure in Level 1 VBP or above.
  - > 15% of total payments contracted in Level 2 or higher

- **April 2020**
  - 80-90% of total MCO expenditure in Level 1 VBP or above
  - > 35% of total payments contracted in Level 2 or higher
Upside and Down Side Risk Sharing Arrangements

- While VBP encourages efficiency, **quality** is paramount!
- No savings will be earned without meeting minimum quality thresholds.

<table>
<thead>
<tr>
<th>Quality Targets % Met goal</th>
<th>Level 1 VBP Up - and downside when actual costs &lt; budgeted costs</th>
<th>Level 2 VBP Up - and downside when actual costs &gt; budgeted costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 50% of Quality Targets Met</td>
<td>50% of savings returned to VBP contractors</td>
<td>Up to 90% of savings returned to VBP contractors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>VBP contractors are responsible for up to 50% losses</td>
</tr>
<tr>
<td>&lt;50 % of Quality Targets Met</td>
<td>Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)</td>
<td>Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)</td>
</tr>
<tr>
<td>Quality Worsens</td>
<td>No savings returned to VBP contractors</td>
<td>No savings returned to VBP contractors</td>
</tr>
</tbody>
</table>

Role of Quality Measures in VBP

• Quality of all contracted care (whether VBP or not) is rewarded through up- and downward adjustments of premiums received by the MCO from the State following the same guidelines as have been created by the VBP Subcommittees.

• According to the VBP Contracting Guidelines, current quality performance impacts the target budget set by the MCO for the VBP Contractor.
  • High/low quality = higher/lower target budget

• Quality Performance during contract year determines percentages of savings / losses shared with VBP contractor.

Source: NYS Department of Health website: VBP Bootcamp – Session 3
TCGP/IPC Measure Set

- Measures recommended by the Clinical Advisory Groups (CAGs) were aligned with measures included in the NYS DOH portfolio of programs including: the Delivery System Reform Incentive Payment (DSRIP) Program, the Quality Improvement Program (QIP), Quality Assurance Reporting Requirements (QARR), and the Advanced Primary Care (APC) measures.

- TCGP and IPC measure sets were originally separate to allow for additional measures for the TCGP arrangement.
  - No specific TCGP measures in 2017.
- The IPC Measure set is the main list of measures for the IPC arrangement.
  - TCGP/IPC measures are also included in HARP and HIV/AIDS measure sets.

Clinical Care Delivery and Outcomes Addressed by the TCGP / IPC Measure Set

- **Prevention & Routine Sick Care**
  - Chronic Heart Disease
  - Diabetes
  - Pulmonary

- **Physical Health Chronic Conditions**
  - Depression & Anxiety
  - Substance Use Disorder
  - Bipolar Disorder
  - Trauma & Stressor

- **Behavioral Health Chronic Conditions**
Episode-based VBP Arrangements (IPC, Maternity Care)

In episodic arrangements the VBP Contractor assumes responsibility for the care for the *conditions* of its attributed members.

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Integrated Primary Care (IPC)      | • Preventive care  
• Routine sick care  
• Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related) |

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Bundle (care bundle)</td>
<td>Arrangement in which all costs related to the episode across the care continuum are measured</td>
</tr>
</tbody>
</table>
HARP Measure Set

MY 2017 VBP Measure Sets
HARP – Category 1 Measures

The Category 1 HARP Subpopulation measure set table includes measure title, measure steward, the NQF number and/or other measure identifier (where applicable), and State determined classification for measure use.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Steward</th>
<th>Measure Identifier</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of readmission to inpatient mental health treatment within 30 days</td>
<td>OMH / OASAS*</td>
<td>-</td>
<td>P4P</td>
</tr>
<tr>
<td>Percentage of members who receive PROS or HCBS for at least 3 months in reporting year</td>
<td>OMH / OASAS</td>
<td>-</td>
<td>P4R</td>
</tr>
<tr>
<td>Percentage of members with maintenance of stable or improved housing status</td>
<td>OMH / OASAS</td>
<td>-</td>
<td>P4R</td>
</tr>
<tr>
<td>Percentage of members with reduced criminal justice involvement</td>
<td>OMH / OASAS</td>
<td>-</td>
<td>P4R</td>
</tr>
</tbody>
</table>

*Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS)
### HARP – Category 1 Measures (cont.)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Steward</th>
<th>Measure Identifier</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes screening for people with schizophrenia or bipolar disorder using antipsychotic medications</td>
<td>NCQA</td>
<td>-</td>
<td>P4P</td>
</tr>
<tr>
<td>Follow-up after emergency department visit for alcohol and other drug dependence</td>
<td>NCQA</td>
<td>-</td>
<td>P4P</td>
</tr>
<tr>
<td>Follow-up after hospitalization for mental illness (within 7 and 30 days)</td>
<td>NCQA</td>
<td>-</td>
<td>P4P</td>
</tr>
<tr>
<td>Continuity of care within 14 days of discharge from any level of SUD inpatient care</td>
<td>New Measure</td>
<td>-</td>
<td>P4P</td>
</tr>
<tr>
<td>Initiation of pharmacotherapy for opioid dependence within 30 days</td>
<td>New Measure</td>
<td>-</td>
<td>P4P</td>
</tr>
</tbody>
</table>
HARP – Category 1 Measures (cont.)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Steward</th>
<th>Measure Identifier</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of pharmacotherapy for alcohol use disorder within 30 days</td>
<td>New Measure</td>
<td>-</td>
<td>P4R</td>
</tr>
<tr>
<td>Percentage of members enrolled in a Health Home</td>
<td>New Measure</td>
<td>-</td>
<td>P4R</td>
</tr>
<tr>
<td>Percentage of members who maintained/obtained employment or maintained/improved higher education status</td>
<td>New Measure</td>
<td>-</td>
<td>P4R</td>
</tr>
</tbody>
</table>
HARP – Category 2 Measures*

The Category 2 Maternity measure set table includes measure title, measure steward, the NQF number and/or other measure identifier (where applicable).

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Steward</th>
<th>Measure Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing engagement of alcohol and other drug dependence treatment (CET)</td>
<td>OMH / OASAS</td>
<td>-</td>
</tr>
<tr>
<td>Percentage of mental health discharges followed by two or more mental health outpatient visits within 30 days</td>
<td>OMH / OASAS</td>
<td>-</td>
</tr>
<tr>
<td>Utilization of pharmacotherapy for alcohol use disorder</td>
<td>OMH / OASAS</td>
<td>-</td>
</tr>
<tr>
<td>Utilization of pharmacotherapy for opioid dependence</td>
<td>OMH / OASAS</td>
<td>-</td>
</tr>
</tbody>
</table>

*The HARP Subpopulation Clinical Advisory Group reconvened on November 17, 2016 to refine measure recommendations based on feedback from the VBP Pilot providers. The final recommendations to the State are aligned with the measures presented in the Category 1 and Category 2 measure set tables included in this document.
IPC for HARP

A subset of IPC measures are recommended for the HARP arrangement. The final 26 Category 1 and 5 Category 2 IPC measures were assessed for this population*.

The following measures are recommended to not be included in the HARP IPC measure set:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale for removal</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management - Effective Acute Phase Treatment &amp; Effective Continuation Phase Treatment</td>
<td>Not applicable to HARP+</td>
<td>Cat. 1</td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)</td>
<td>Not applicable to HARP+</td>
<td>Cat. 1</td>
</tr>
<tr>
<td>Potentially Avoidable Complications in routine sick care or chronic care</td>
<td>There will be a specific HARP PAC measure assessed for inclusion in 2018</td>
<td>Cat. 1</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Not applicable to HARP+</td>
<td>Cat. 1</td>
</tr>
</tbody>
</table>

*HARP members are, by virtue of their eligibility for HARP, exempted from basic screening and follow-up measures more applicable to primary care.

*The final recommended IPC measure set contains 29 Category 1 and 9 Category 2 measures. Of these measures, 3 Category 1 and 4 Category 2 measures are already included in the HARP measure set.
Thank you!

Questions?

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vbp@health.ny.gov