



Value Based Payment

Subcommittee Recommendation Report

February 2016



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Introduction

The Subcommittee Recommendation Process

The Value Based Payment (VBP) Subcommittees (SC) were created to address questions around the design and implementation of Payment Reform as they were documented within the VBP Roadmap. The agenda items reviewed by each of the five Subcommittees were derived from the various sections of the VBP Roadmap that identified the need for key decision making. The five Subcommittees created were the following:

1. Technical Design I;
2. Technical Design II;
3. Regulatory Impact;
4. Advocacy and Engagement; and
5. Social Determinants of Health and Community Based Organizations.

Per each agenda topic, where appropriate, the SC was charged with recommending whether the State should set a statewide **Standard** or **Guideline** for the methodologies employed between MCOs and the providers. In this context, a Standard was a set methodology that must be followed by all MCOs and providers. A Guideline was a suggested statement of advice or instruction that provided flexibility in implementation. A Guideline was recommended when it was useful for providers and MCOs to have a starting point for the discussion, but deviation could occur without harming the overall success of the Payment Reform.

Each SC met on a regular basis from July through December of 2015. The SC members were selected through a nomination process - the members of the VBP Workgroup had the opportunity to nominate individuals who they believed had the knowledge and interest needed for each SC's specific subject matter. Each SC had two co-chairs who were also members of the VBP Work Group¹. The co-chairs assisted in facilitating the SC meetings and provided input on the development of the meeting materials for each session.

The SC's recommendations are compiled in this Recommendation Report and submitted to the VBP Workgroup for further consideration.

¹ Exception: co-chairs of the Technical Design II Subcommittee, who were not inherent members of the VBP Workgroup.



Subcommittee Goals and Recommendations

Technical Design I Subcommittee

Goals

The Technical Design I (TD I) Subcommittee's goal was to address the open financial and methodological policy questions included in the VBP Roadmap and produce recommendations with suggested approaches.

Agenda

The Technical Design I Subcommittee developed recommendations on the below agenda topics:

1. Medicaid Member Attribution Methodology
2. Target Budget Methodology
3. Shared Savings/Losses Methodology
4. Retrieving Overpayment by Plan to Provider
5. Criteria for Hospitals to Receive 50% of Shared Savings in Integrated Primary Care Contracting

The following agenda topics were originally placed on the SC agenda but did not result in the Subcommittee recommendations as a creation of such was not deemed necessary:

6. Lowest Number of Medicaid Members to Contract for VBP
7. Changes in Level 1 Shared Savings % in Year 2, 3 and Further
8. Stop Loss Mechanism and Risk Corridors

Recommendations

1. Medicaid Member Attribution Methodology

Design Question: What should the methodology be for Medicaid Member attribution?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Medicaid Member Attribution determines which members the VBP contractor² will be responsible for and which are attributed to a specific VBP contract. Attribution allows for the calculation of the total costs of care, patient-centered outcomes, and potential shared savings per member or episode of care - measures that are essential for the continual monitoring of VBP arrangements.

Recommendation:

The Subcommittee recommends the following attribution *guidelines* be communicated to stakeholders:

a. *Assignment*

- i. The MCO assigned Primary Care Physician (PCP) drives attribution in Total Care for the General Population (TCGP), Integrated Primary Care (IPC), chronic bundles, and the HIV/AIDS subpopulation.
- ii. For non-chronic bundles, the provider delivering the core services that ‘trigger’ the bundle drives attribution. In maternity care, for example, that provider is the obstetric professional delivering the pregnancy care.
- iii. The MCO assigned health home drives the attribution for the HARP subpopulation.
- iv. The MLTC assigned home care provider or nursing home (depending on the residential status of the member) drives attribution for the MLTC subpopulation.

An MCO and VBP contractor may deviate from this guideline and agree on a different type of provider to drive the attribution on the condition that the State is adequately notified.³ The attribution entity does not need to be the same provider or provider-type as the VBP contractor but must be part of the VBP arrangement (i.e., a hospital system could be the contractor for a TCGP population while its associated PCPs would drive the attribution).

b. *Timing*

- i. Members are prospectively attributed to a provider through assignment (PCP, Health Home)

² VBP contractors include Accountable Care Organizations, Independent Physician Associations, individual providers, or groups of individual providers that are brought together by an MCO (creating a Level 1 or Level 2 VBP arrangement through individual contracts with these providers).

³ For example, in a chronic care episode attribution may be performed by a specialist group rather than a PCP. In this case cardiologists may be the point of attribution for an arrhythmia bundle or a Nursing Home for members that reside there.



or start of care (bundle). If the member switches their assigned PCP/Health Home within the first six months of the year, the member will be attributed to the VBP arrangement of the latter PCP/Health Home. To reduce complexity and to assure predictability for the VBP contractor, the Subcommittee recommends not to attempt retrospective reconciliation of members through an analysis of actual PCP or Health Home use⁴.

Through prospective attribution, the State will be able to monitor quality and costs of care, and provide MCOs and VBP contractors with their risk-adjusted and proxy-priced⁵ costs, real-priced costs, outcomes, target budgets and savings opportunities per VBP arrangement.

The VBP contractor may choose to use a similar approach for downstream contractors joining or leaving at various points of the contract period (joining late or terminating early), as for Medicaid members joining or leaving attribution pool. Entitlement to a full percentage of shared savings, or a portion of it should be based on the amount of time the downstream provider was a part of the contract. Distribution of savings in these situations should be negotiated and defined in the contract language.

Through prospective attribution, the State will be able to monitor quality and costs of care, and provide MCOs and VBP contractors with their risk-adjusted and price-standardized costs, real-priced costs, outcomes, target budgets and savings opportunities per VBP arrangement.

2. Target Budget Methodology

Design Question: What methodology should be used to calculate the target budget?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The target budget is the per member per month (PMPM) or episode budget that a VBP contractor is measured against to determine its shared savings or losses in VBP arrangements. A well designed target budget continuously incentivizes improvement of quality and cost effectiveness for both historically high performing and poor performing VBP contractors.

Caveat: The specific percentages and operational details mentioned below are directional. Following additional modeling the State will exercise flexibility to adjust these in accordance with the integrity of the Medicaid Global Cap.

Recommendation:

⁴ The VBP contractor may choose to use a similar approach for downstream contractors joining or leaving at various points of the contract period (joining late or terminating early), as for Medicaid members joining or leaving the attribution pool.

⁵ Previously called 'price-standardized'. Both mean that price differences between providers for similar services are excluded from the calculations.



The Subcommittee recommends the following target budget *guidelines* be communicated to stakeholders:

a. *Baseline*

- i. The VBP contractor's specific historic claims under the VBP arrangement are aggregated to create the baseline of the target budget and allow for a comparison to prior VBP contractor experience.
- ii. The baseline is to be created on the basis of the previous three years with the latest year weighted at 50% of the baseline and the proceeding years accounting for 35% and 15% respectively.
- iii. To avoid unwarranted rebasing once savings have been made, the historical costs of care of a VBP contractor are calculated including the shared savings reimbursed (or losses reclaimed) to the provider.

b. *Growth Trend*

- i. The growth trend of costs during the performance period is calculated by averaging the regional growth trend (upstate or downstate) and a VBP contractor-specific growth trend.

c. *Risk Adjustment*

- i. The 3M Clinical Risk Grouping (CRG) methodology is utilized for risk adjustment in TCGP. For the subpopulations, the default is to follow the risk adjustment methodology used for setting the plan's rates (the State is currently developing risk adjustment methodologies for both HIV/AIDS and HARP).
- ii. The most recent HCI3 methodology is utilized for risk adjustment of bundles of care⁶.

As adjustment methodologies improve over time (including better sensitivity to pre-existing disparities), the State will adjust accordingly.

d. *Performance Adjustments*

The State may change the suggested percentages for up- and downward adjustment over time, based on lessons learned, the desire to keep Medicaid dollars maximally available for high value care delivery as well as the integrity of the Medicaid Global Cap⁷.

- i. After applying the risk adjustment factors, the performance adjustments are applied based on the efficiency and quality of VBP contractors in the most recent year for which claims are available.
 - a. Efficient VBP Contractors ranked above the 70th percentile⁸ in Efficiency receive a 1% target budget increase:

⁶ <http://www.hci3.org/content/ecrs-and-definitions>

⁷ If, at any time, the State is on track to exceed the appropriated dollar amount within the Medicaid Global Spending Cap, efforts will be taken by the Health Commissioner to rein in spending and ensure total spending does not exceed the cap.

⁸ Efficiency is measured as the risk-adjusted cost of care per VBP arrangement (per member/episode), using 'proxy-priced' data (Proxy-priced data implies that variability in costs due to negotiated prices is excluded from the analysis). The percentile is based on a state-wide ranking of VBP contractors per VBP arrangement. Higher percentiles indicate greater efficiency (lower costs) and higher quality.



- i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 1.5% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 2% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 0.5% target budget increase
 - b. Highly efficient VBP Contractors ranked above the 80th percentile in Efficiency receive a 2% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 3% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 4% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 1% target budget increase
 - c. The most efficient VBP Contractors above the 90th percentile in Efficiency receive a 3% target budget increase:
 - i. If the Quality score is above the 80th percentile: the upward adjustment will be increased by 50% resulting in a 4.5% increase to their target budget
 - ii. If the Quality score is above the 90th percentile: the upward adjustment will be increased by 100% resulting in a 6% increase to their target budget
 - iii. If the Quality score is below the 50th percentile: the upwards adjustment is decreased by 50% resulting in a 1.5% target budget increase
 - d. If Quality is below the 40th percentile: the VBP contractor will be ineligible for any upward adjustments despite their Efficiency ranking

The State will make funds available to MCOs for these adjustments, and will reward the plans as well. The actual percentages that the State will be able to provide to the MCOs will be determined on a yearly basis by the State.

- ii. At the start of 2018, (giving providers two years to improve and potentially begin earning sharing savings), in addition to upward adjustments VBP contractors' efficiency and quality may produce target budget decreases:
 - a. VBP Contractors below the 30th percentile in Efficiency receive a 1% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 1.5% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 2% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 0.5% target budget decrease



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- b. Inefficient VBP Contractors below the 20th percentile in Efficiency receive a 2% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 3% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 4% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 1% target budget decrease
 - c. Highly inefficient VBP Contractors below the 10th percentile in Efficiency receive a 3% decrease to their target budget:
 - i. If the Quality score is below the 30th percentile: the downwards adjustment will be increased by 50% resulting in a 4.5% target budget decrease
 - ii. If the Quality score is below the 15th percentile: the downwards adjustment will be increased by 100% resulting in a 6% target budget decrease
 - iii. If the Quality score is above the 80th percentile: the downwards adjustment will be reduced by 50% resulting in a 1.5% target budget decrease
 - iii. To prevent unwarranted target budget adjustments, the target budget will not be adjusted when the variability between VBP contractors is below a certain (to be determined) threshold.
 - iv. When certain future developments can be foreseen to become relevant in the target year (i.e., pending changes in pharmacy benefits), and of course within the context of the development of MCO rates, MCOs and VBP contractors can adjust the target benchmark accordingly.
 - e. *Stimulation Adjustment*
 - i. To stimulate the progress towards Level 2 and higher VBP arrangements, VBP contractors can receive an upwards adjustment to their target budget (for a duration of two years) when moving into a level 2 VBP arrangement. Similarly, when moving into a Level 3 arrangement, the same adjustment would apply.
 - ii. Arrangements that focus on IPC or care bundles will receive a higher Stimulation Adjustment (1% upward adjustment of VBP contract's target budget) than Total Cost of Care for the General (Sub)Population (0.5% upward adjustment) because: a) infrastructure costs for these former arrangements will be relatively higher compared to the total dollar amount of the VBP contract and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system will be higher when a more differentiated VBP approach is taken. These Stimulation Adjustments will end in 2020.
 - iii. The State will make funds available to MCOs for these adjustments, and will reward the plans as well. The actual percentages that the State will be able to provide to the MCOs will be determined on a yearly basis by the State.



iv. As explicated in Section 3 of this Roadmap Update, from 2018 on, MCOs may receive a penalty when falling behind the goals of the VBP Roadmap (i.e., when the percentage of value based payments to providers is lagging behind the yearly Roadmap targets). In such situations, it is to be expected that MCOs may pass through such downward adjustments to e.g. inefficient providers that resist entering into VBP arrangements or otherwise work towards reaching their goals.

f. *Future adjustments*

i. When the price-standardized and risk-adjusted PMPM or episode costs for a specific VBP arrangement start to converge around the State average, that State average can become the starting point for target setting, and these efficiency modifiers would no longer be used. The quality-based performance adjustments would become bonus- and/or malus-payments.

This target budget setting methodology will be used by the State to calculate and adjust the target budgets for VBP arrangements to be used in the dynamic VBP analytics platform the State will create for providers and MCOs.

3. Shared Savings/Losses Methodology

Design Question: What will be the methodology to calculate shared savings and losses?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Following the performance period, the difference between a VBP contractor’s target budget and actual cost is calculated and a portion of the difference is retained by the VBP contractor as shared savings if the actual performance is better than the target. Conversely, in Level 2 VBP arrangements, if the actual costs are greater than the target, a portion of the difference is returned by the VBP contractor as shared losses.

Recommendation:

The Subcommittee recommends the following shared savings *guidelines* be adopted by the DOH and communicated to stakeholders:

1. *Level 1 VBP Arrangements*
 - i. 50% of shared savings to be retained by the VBP contractor and 50% of the savings to be retained by the MCO in all VBP arrangements.
2. *Level 2 VBP Arrangements*
 - i. 90% of shared savings to be retained by the VBP contractor and 10% of the savings to be retained by the MCO in all VBP arrangements.



- ii. Shared savings and losses percentages may be modified dependent on the type of risk protection mechanisms (such as stop loss or risk corridors) that are implemented to limit total provider risk.

3. *Outcome measures*

- i. 50% of outcomes targets must be met in order for the VBP contractor to be eligible to receive the full amount of shared savings as discussed above. If less than 50% of the outcome measures are achieved, the shared savings are reduced in proportion to the percentage of outcomes targets met. No savings are returned when the outcomes of care deteriorates in comparison with earlier years.

4. *Distribution of Shared Savings/ Losses*

The Subcommittee suggests the following **general guiding principles** for the distribution of shared savings among providers by the VBP contractor:

- i. Funds are to be distributed according to provider effort, provider performance and utilization patterns in realizing the overall efficiencies, outcomes, and savings.
- ii. Required investments and losses of the involved providers can be taken into consideration in calculating and distributing available savings.
- iii. The relative budgets of the providers involved should not be the default mechanism for making the distribution of savings/losses (i.e., distributing the savings among providers by the relative size of each provider’s budget).
- iv. The distribution of shared savings should follow the same principles as the distribution of shared losses.
- v. For shared losses, smaller providers, financially vulnerable providers, or providers with a regulatory limitation on accepting certain losses may be treated differently by the VBP contractor to protect these individual providers from financial harm. It is legitimate that this ‘special treatment’ would weigh in as an additional factor in determining the amount of shared savings that these providers would receive.

Shared savings and losses calculations will not be included in the VBP dynamic analytics platform the State will make available for the providers and the MCOs.

4. Retrieving Overpayment by Plan to Provider

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Frequent incidences of provider overpayments in Level 2 VBP arrangements are possible. Though there are a variety of mechanisms by which overpayments can be mitigated and prevented, the retrieval of overpayments from providers needs to be addressed.

Recommendation:

Upon review, the New York State Department of Financial Services (DFS) already provides requirements

around the retrieval of overpayments. Barring instances of fraud or misconduct, plans have a timeframe in which to request a return of funds. The State regulatory guidance currently in place for the retrieval of provider overpayments will not require any changes at this point. When setting up value-based contracts, plans and providers can continue to build off of the existing regulation and agree upon additional details of overpayment recovery in their contracts.

5. Criteria for Hospitals to Share in Savings

Design Question: What should be the criteria for hospitals to share in savings generated in Integrated Primary Care (IPC) and Total Care for General Population (TCGP) and Total Care for SubPopulation (TCS) arrangements?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

During the October 21, 2015 meeting the Technical Design I Subcommittee reviewed language from the *New York State Roadmap for Medicaid Payment Reform* regarding the equitable split of savings⁹ between professional-led Value-Based Payment contractors¹⁰ and downstream hospitals. This can apply to Integrated Primary Care (IPC) arrangements, but also to professional-led Total Care for General Population and Total Care for SubPopulation VBP arrangements. A professional-led IPC or TCGP/TCS VBP contractor is defined as a contractor that does not include, or has no contractual relations with, a hospital system which operates downstream of this contractor.

The Roadmap states that the downstream hospital only qualifies for a share of the savings if it is working collaboratively with professional-led VBP contractors to better manage their member populations. The Subcommittee discussed criteria to determine what would count as ‘adequate collaboration’.

Recommendation¹¹:

The Subcommittee recommends implementing the three criteria listed below as a statewide **Standard** for adequate collaboration between the professional-led VBP contractors and downstream hospitals. To provide flexibility, hospitals and professional-led VBP contractors may agree to alternative sub-criteria measures and specifics where appropriate (**guideline**), provided the State is notified and the MCO

⁹ Clarification: the amount of savings subject to an equitable split with hospitals does not include the MCO share of the total savings. In addition, a downstream hospital only shares in the savings proportionally to its loss of revenue (i.e., the amount in which savings generated by the professional-led contractor were based on lost revenue to the hospital). For downstream hospitals to share in the savings, no causal relation between the VBP contract and the revenue loss has to be established.

¹⁰ Typically, these ‘professional-led contractors’ are Primary Care Physicians, but they may also include behavioral health providers and other professionals that take responsibility for the comprehensive care of the Medicaid members in IPC and TCGP and TCS arrangements.

¹¹ This is a non-consensus recommendation from the SC.



contracting the Level 1 and/or 2 VBP arrangements agrees. They may also include criteria in addition to what the SC establishes in this recommendation. It is considered to be the responsibility of the contractor to notify downstream hospitals of its intent to negotiate value-based arrangements with an MCO. Subsequently, it is the responsibility of the hospital to initiate conversations with the VBP contractor based on a plan created by the hospital conforming to the statewide Standard.

If Level 1 arrangement is contracted, the hospitals qualify for 50% of the savings realized by the professional-led practice. If Level 2 arrangement is contracted, the hospitals will qualify for 25% of the savings; 75% will remain with the professional-led practice (as the VBP contractor) as it has now accepted downside risk.¹²

The criteria for determining that hospitals are good partners in Level 1 and 2 IPC arrangements are separated into three categories: Data Management and Data Sharing, Innovation and Care Redesign, and Quality and Engagement. If the hospitals meet all of these three criteria and savings are generated in the VBP arrangements, the hospitals will receive 50% or 25% of the savings depending on the arrangement VBP Level. Hospitals must meet all three criteria in order to receive savings. Partially met criteria will not result in savings realization.

a. Data Management and Data Sharing

- i. Provide real time direct data feeds to professional-led VBP contractors for emergency room utilization, admissions, and discharges (including behavioral health and substance use).

b. Innovation and Care Redesign

- i. Fulfill at least one of the three following measures:
 1. Develop standardized care plans based on evidenced-based guidelines and practices to reduce inappropriate variation in the organization for at least one of the following service areas: high cost imaging, emergency room care, oncology treatment, diagnostic testing, behavioral health treatment, substance use treatment, etc.
 2. Enhance care transitions to post-acute settings such as mental health treatment facilities, substance use disorder treatment facilities, Skilled Nursing Facilities, home, etc. to reduce readmission rates and potential complications
 3. Implementation of Palliative Care and collaboration with Hospice.

c. Quality and Engagement

- i. Collaborate with professional-led VBP contractors on DSRIP Domain 2 and 3 metrics quality indicators affecting population health¹³.

¹² Costs for risk-mitigation such as reinsurance to prevent excessive insurance risk may be subtracted from 'VBP contractor's shared savings' before the 25% calculation is applied.

¹³ See Appendix A for the extract of Domain 2 and 3 DSRIP measures from the DSRIP Measure Specification and Reporting Manual.

Disagreement between the hospital and the professional-led VBP contractor does not prevent the MCO and the VBP contractor to pursue with the contract. When disagreement on the interpretation of the criteria persists, or disagreement on whether a hospital has met the criteria persists, the parties may choose to appeal to the Department of Health.

Technical Design II Subcommittee

Goals

The Technical Design II (TD II) Subcommittee's goal was to address the open quality, support and design policy questions included in the VBP Roadmap and produce recommendations with suggested approaches for the VBP Workgroup consideration.

Agenda

The Technical Design II Subcommittee developed recommendations on the following agenda topics:

1. Fee-for-Service as VBP
2. Technical Assistance in VBP Arrangements
3. Exclusions from VBP
4. VBP Innovator Program Design
5. Financially Challenged Provider Status
6. Planned Assessment of Progress in VBP Participation, and Market Dynamics
7. Process for Addressing Impasse Situations during VBP Contract Negotiations

The following topics were originally placed on the SC agenda, however, recommendations were not created for the reasons describes below:

8. Quality and Outcome Measures in Total Cost for General Population Arrangements

There was not significant participation from the SC to reach consensus and develop a recommendation for this topic. The issues was transferred to the VBP Workgroup for further deliberation with the Office of Quality and Patient Safety (OQPS) at DOH. The SC believes that OQPS has the appropriate knowledge and insights for completing the list of Measures for TCGP arrangements. The comments received from the SC members were compiled and distributed to the VBP Workgroup.

9. Defining Workforce Measures

In discussions between DOH and 1199SEIU funds (1199), it has become clear that there are many available workforce measures but their validity, reliability and feasibility vary. For this reason, it was agreed to monitor the development of the DSRIP program and perform further research to refine the workforce measures. DOH and 1199 will share the findings with VBP Workgroup in the future.



Recommendations

1. Fee-for-Service as VBP

Design Question: What activities/services should remain Fee-for-Service (FFS) and be considered VBP?

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

The New York Department of Health recognizes the value of preventive care activities and the need to promote and stimulate preventive care provided to the Medicaid population as it's currently underutilized. The State aims to use Fee-for-Service as a value-based payment mechanism for a limited set of preventive care activities, provided that adequate quality measures are included. Since FFS incentivizes volume, paying FFS for high quality preventive services could arguably be seen as paying for value.

Recommendation:

The Subcommittee suggests that there are two instances in which the argument for Fee-for-Service as a VBP model for preventive care still stands:

1. Preventive activities that require widespread implementation whose impact will be mid- to long term. (The financial return on investment for a Total Care for the General Population arrangement, for example, could be too remote in such a situation.) An example is certain immunizations and vaccinations.
2. Preventive activities that are relatively high cost whose impact may well be felt outside the scope of the VBP contractor. (Similarly, here the financial return on investment may be too uncertain for the VBP contractor to make the investment.) An example is high-cost contraception interventions such as long-acting, reversible contraceptive (LARC).

The Subcommittee suggests developing a limited list of such services and related quality measures for CMS's consideration. The dollars associated with these FFS payments would count towards the statewide goal of 80-90% of payments from MCOs to providers in VBP arrangements. For each suggested preventive service, the State will look at associated quality measures. In the case of LARC, for example, the LARC intervention is not a part of the VBP Maternity Bundle (and thus remains FFS), but the intervention is included in the overall quality measure set for the Maternity Bundle. If approved, the State will review its list on an annual basis with CMS. The intent is to keep abreast of the current state of affairs in NYS health care, assessing, for example, the need for more or new immunizations and vaccinations, etc. Priority will be given to the areas where NYS needs improvement according to the Prevention Agenda 2013-2017: New York State's Health Improvement Plan.

This recommendation issued by the Subcommittee will set a **standard** for all of the parties participating in VBP implementation to adhere to.

2. Technical Assistance in VBP Arrangements

Design Question: How should technical assistance be provided to providers in VBP arrangements who are encountering substantial performance challenges?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The possibility of encountering performance challenges by providers in VBP arrangements is recognized by the Subcommittee. It is important to differentiate two main areas of technical support that have been identified: (1) support for providers *prior* to their entering VBP arrangements, and (2) support for providers who are facing challenges following implementation.

As part of this Subcommittee’s charge, only assistance for those who are already participating in a VBP agreement is being addressed. For those providers who have not yet entered into a VBP arrangement, it will be critical to have an accurate understanding of one’s preparedness, and this area of concern will be covered in the *Social Determinants of Health and Community Based Organizations* Subcommittee. The Technical Design II Subcommittee’s responsibility is to address and recommend solutions for assisting those providers who are already participating in VBP arrangements rather than those who are evaluating the opportunity.

Recommendation:

In New York State, current contracts that are in place between the providers and MCOs provide a strong incentive for the MCOs to offer technical support to the provider, given the potential financial benefit to both parties. In addition to the support that MCOs can provide, healthcare providers participating in DSRIP have the ability to use program funds to employ third party services for further education and technical support on VBP arrangements. Providers may also seek assistance within their PPS. Though the development of a standard or guideline is not recommended at this time, the State, PPSs, MCOs and providers will collectively monitor whether action or additional guidelines may become necessary in the future.

3. Exclusions from VBP

Design Question: Should certain services or providers be excluded from Value-Based Payments?

Implementation Mechanisms that Require Change:

State Legislation Model Contract DOH Policy None

Description:

The NYS VBP Roadmap states that the State does not want to wholly exclude any cost categories from VBP, but is willing to consider the necessity of excluding certain services or providers if these would constitute either a risk or an obstacle to meeting the Roadmap targets.

Recommendation:

The Subcommittee recommends that a narrow list of services and providers be (allowed to be) excluded from VBP arrangements. For high cost specialty drugs, and transplant services the decision to exclude is left to VBP contractors and MCOs (*guideline*). For certain financially challenged providers, and services delivered to Medicaid members that are not attributed to the VBP contractor, the recommendation is to set a *standard* that is to be followed statewide.

High Cost Specialty Drugs

MCOs and providers may wish to exclude high cost specialty drugs from their VBP arrangements if they so choose as specialty drugs may shift too much insurance risk to the provider.

Under Medicare Part D, CMS defines specialty drugs as those costing \$600 or more per month¹⁴, and has maintained this definition since 2008. It is recommended that the \$600 threshold be used for evaluating high cost drugs in Medicaid VBP in order to be aligned with existing CMS definitions. However, should plans and providers decide to include high cost specialty drugs in their VBP arrangements, they are able to do so.

Financially Challenged Providers

To successfully participate in VBP arrangements, particularly those at higher levels of risk sharing, providers need corresponding levels of financial and organizational stability. It is recommended that the DOH exclude specific providers to be (a parent of) a VBP contractor, under the circumstances defined below:

¹⁴ Centers for Medicare & Medicaid. *Medicare Part D Specialty Tier*. Retrieved from <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/CY-2016-Specialty-Tier-Methodology.pdf> on August 20, 2015.



A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding provider, which is evidenced by the following¹⁵:

- less than 15 days cash and equivalents;
- no assets that can be monetized other than those vital to the operation; and
- the provider has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

Such providers should be in the planning process with DOH to:

- Be absorbed under the umbrella of another health care system,
- Be transitioned to another licensure category/service line, or
- Discontinue operations.

Payments to the providers falling in either one of these categories would be excluded from VBP target goal calculations during the planning, restructuring and/or phase-out period.

That said, financially challenged providers (including the broader group of providers with a negative net worth) may enter into VBP agreements as subcontractor to a VBP contractor. As the regulatory workgroup will propose to the State, such providers should not be allowed to accept risk without additional safeguards being put into place.

Services to non-attributed Medicaid members

(Emergency) services performed by a provider for a Medicaid member that is not attributed to a VBP arrangement in which this provider participates will not be seen as costs to that VBP arrangement.

Transplant Services

MCOs and contractors may choose to exclude the cost of organ transplant services from their arrangements.

4. VBP Innovator Program Design

Design Question: What should be the participation criteria and policies for the VBP Innovator Program?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The Value-Based Payment (VBP) Innovator Program was designed as part of the VBP Roadmap as a mechanism to allow for innovators and experienced providers to chart the path into Value Based

¹⁵ Aligned with the Interim Access Assurance Fund (IAAF) program criteria of severe financial distress.



Payments. The Innovator Program is a voluntary program for VBP contractors¹⁶ prepared for participation in high-risk Level 2 and 3 value-based arrangements by Year 2 (2016) of the Delivery System Reform Incentive Payment Program (DSRIP). The State aims to promote Total Care for General Population and Subpopulation value-based arrangements by rewarding the Program's participants with up to 95% of the total dollars which have been traditionally paid from the State to the MCO. Managed Care Organizations are expected to support these arrangements. Such Innovator support will be outlined in the updated Managed Care Model Contract. It is important to note that because Integrated Primary Care and episode-based VBP arrangements cannot readily be translated in a percentage of premium and because these arrangements would not include significant task-shifting between MCOs and VBP contractors, these contracts are not included in the Innovator Program. For these arrangements, pilot support and financial rewards are going to be available in 2016 and 2017. Additionally, VBP Pilots and the Innovator Program are separate and distinct in two ways:

1. While the Innovator Program provides benefits (90-95% premium pass-through) to the providers and is limited to specific types of arrangements, the Pilots do not warrant premium pass-through benefits and are open to all types of arrangements set forth in the VBP Roadmap. Financial incentives are going to be available as well. The goal of the Pilots is to help the state and its participating organizations learn how VBP transformation will work in practice as well as incentivize participants for early adoption of VBP. The goal of the Innovator Program is to recognize those providers that start implementing VBP by contracting high risk, Level 2 or 3 total cost of care for general and subpopulation arrangements.
2. The Innovator Program is a standard component of the VBP program. In contrast, the Pilot Program is only available in State FY 2016. The pilots will run for two years.

The Innovator Program is not intended to limit provider networks or patient choice. The Department of Health (DOH) will administer the Innovator Program, which will be run on an open enrollment basis, taking into account the following design recommendations from the Subcommittee (SC).

Recommendation¹⁷:

The Subcommittee has made recommendations on the following key Innovator Program components, setting **standards for**:

1. Which VBP risk arrangements are eligible for the Innovator Program?
2. What is the review/assessment process for the Innovator Program?
3. What are the additional criteria for participating in the Innovator Program?
4. Is there an appeals process and what should it include?
5. What are the Innovator Program benefits?
6. How is the Innovators' performance measured?

¹⁶ A VBP contractor can be an ACO, IPA, or an individual provider.

¹⁷ This is a non-consensus recommendation from the SC.



7. What is the status maintenance and contract termination/program exit criteria?

The State will be taking all of these recommendations into consideration and for inclusion into a Model Contract for VBP contractors entering into the Innovator Program.

1. Which VBP risk arrangements are eligible for the Innovator Program?

The Subcommittee recommends that VBP contractors that aim to engage in Level 2 and Level 3 TCGP and subpopulation arrangements be eligible to apply for the Innovator Program, provided they pass a contract review process. It is recommended by the SC that Level 2 contracts are only considered eligible if the total risk assumed by the provider (and therefore also the potential savings) is comparable to a Level 3 arrangement level of risk.¹⁸ It should be made possible for a VBP contractor to enroll in the Innovator Program with a Level 2 contract with a somewhat lower risk profile, as long as the contractor demonstrates that it will be ready to transition to the required Level 3 (or high-risk Level 2) the following year.

The contract review process should maximally follow the new tiered review process as being recommended by the Regulatory Subcommittee.

2. What is the review/assessment process for the Innovator Program?

It is recommended that the assessment process for entering into the Innovator Program be aligned with the aforementioned contract review process. This process focuses on ensuring that VBP contractors can safely take on higher levels of risk, and on the alignment of the VBP arrangements with the Roadmap.

3. What are the additional criteria for participating in the Innovator Program?

In order for VBP contractors to participate in the Innovator Program, they should meet the following four criteria (at a minimum):

1. Meet health plan network adequacy requirements based on the appropriate provisions of the NYS laws and regulations;
2. Demonstrate proven success in VBP contracting for TCGP and subpopulations, determined during the review process on a case by case basis;
3. To ensure impact as well as reasonable size to be able to assume significant risk¹⁹, the SC recommends that VBP contractors have a minimum number of 25,000 Medicaid members (excluding dual eligible members) attributed for a TCGP contract, or 5,000 Medicaid members (excluding dual eligible members) attributed for a total care for a subpopulation contract. For

¹⁸ To be counted as a Level 2 VBP agreement, the minimum percentage of potential losses to be allocated to the provider with a low quality score is 40%, with a maximum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on. To be considered a high risk Level 2 arrangement, the minimum percentage of potential losses to be allocated to the provider with a low quality score is 60%, with a minimum cap of 35% of the target budget.

¹⁹ With low numbers of attributed lives, 'chance' determines financial outcomes more than actual performance.



the MLTC subpopulation contract, the minimum number of dually eligible members is recommended to be 10,000. Providers and MCOs should be cognizant of the number of Medicaid members served in the Program – it should be large enough to justify the investments and make substantial positive impact on population health.

4. Be financially solvent and have appropriate net worth as per the DOH analysis.

4. Is there an appeals process and what should it include?

The Subcommittee does not recommend the creation of a process for VBP contractors to appeal their Innovator status. Decisions on acceptance into the Innovator Program will be based on the DOH/DFS review process. The State will monitor whether the need for a comprehensive appeals process becomes necessary in the future.

5. What are the Innovator Program benefits?

The Roadmap highlights rewarding providers with up to 95% of premium pass-through for total risk arrangements in a form of a Program benefit. The pass-through percentage will be determined by analyzing the amount of the risk and administrative tasks taken on by the providers: more delegation results in higher percentage of premium (between 90% and 95%).

Delegable functions as defined by the SC include the following: utilization review, utilization and care management, drug utilization review, appeals and grievances, quality, claims administration, member/customer service, network management, risk adjustment and reinsurance, disease management, member/provider services, provider relations, and credentialing. The SC defined member enrollment/advertising, fraud, waste and abuse, legal, and compliance as functions that are unlikely to be delegated. In addition, some tasks may still require some ‘sign off’ or have other process limitations from MCOs, while the providers can be responsible for the majority of the actual work. The resulting list of administrative functions that can be fully or partially delegated, as well as those that cannot be delegated, is displayed below.

To be eligible for 90% premium pass-through, functions 1, 2 and 10, listed in the table below for reference, should be fully delegated to the provider, while at least half of the tasks listed as ‘shared’ below should be partially delegated, as described above. To be eligible for the 95% premium, tasks 1, 2, 6, 10 and 13 should be fully delegated to the provider, while all the other tasks should be delegated to the maximum amount possible. Percentages may be set between 90 and 95% depending on the exact delegation of tasks negotiated.



Optimum

#	MCO Administrative Functions*	MCO	Provider
1	Utilization Review (UR)		
2	Utilization and Care Management (UM)		
3	Drug Utilization Reviews (DUR)		
4	Appeals and Grievances		
5	Quality		
6	Claims Administration		
7	Member/Customer Service		
8	Network Management		
9	Risk Adjustment & Reinsurance		
10	Disease Management		
11	Provider Services Helpdesk		
12	Provider Relations		
13	Credentialing		
14	Data Sharing		
15	Member Enrollment/Advertising		
16	Fraud, Waste and Abuse		
17	Legal		
18	Compliance		

Legend	
	Sole Responsibility
	Shared Responsibility
	Can't be delegated

It is important to note that this SC recommendation does not imply any changes to the current NYS law and regulations with respect to any licensing or certification requirements.

6. How is the Innovators' performance measured?

The performance measures for the Innovator Program will be aligned with the relevant VBP measures, which are based on the current DSRIP and QARR measures, but may include some additional measures when the respective Clinical Advisory Groups (CAG) have recommended that. No specific Innovator Program measures are going to be created. It is recommended that Innovators report on these measures and cannot perform below average (compared to the performance comparable VBP contractors, or, when not available, to PPSs) in order to maintain their Innovator status. The performance measures of the VBP arrangements that pertain to the Innovator Program will become available as soon as they have been approved by the VBP Workgroup.

7. What is the status maintenance and contract termination/program exit criteria?

If performance measurements are below average, or if the MCOs are concerned about the financial

soundness of the VBP contractor or if it faces operational challenges, the SC suggests that the MCO may consider contacting the State (after having informed the VBP contractor) to assess whether the Innovator should be placed on probation. In case of probation, a 6 – 12 month timeline to improve performance is recommended with no surplus payments to the innovator until the measurements are above average again. In a Level 3 arrangement, the VBP contractor should share in any costs or penalties imposed on the health plan if the contractor’s failure to meet quality standards negatively affects the health plan’s quality scores. Also, if a provider operates at a loss so that the costs exceed the percent of premium paid by a health plan, the provider will not have any recourse against the health plan or any of its members.

Should Innovators need to exit the program (for reasons surrounding mergers and acquisitions, or failure to improve, other reasons), the Subcommittee recommends that a transition period be included in the contract. This will be a set period of time during which the provider and respective MCO ensure a smooth transition out of the Innovator Program.

5. Financially Challenged Provider Status

Design Question: What is Financially Challenged Provider status and how is it defined?

Implementation Mechanisms that Require Change:

State Legislation Model Contract DOH Policy None

Description:

To support stable and effective transitions to VBP while being cognizant of the changes that occur within the health care market, it is recommended that a guideline be created around the role of Financially Challenged Providers (FCPs) in the Value Based Payment system. This guideline is aimed at reducing the likelihood of financially challenged providers taking on downside risk while undergoing significant restructuring, and who may not be in positions to do so. This guideline aligns with the recommendation made to exclude FCPs from VBP calculations while they are undergoing their respective transitions.

Recommendation:

The SC recommends that the following definition be used as a guideline to identify FCPs:

A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding provider, which is evidenced by the following²⁰:

- less than 15 days cash and equivalents;
- no assets that can be monetized other than those vital to the operation; and

²⁰ Aligned with the Interim Access Assurance Fund (IAAF) program criteria of severe financial distress.

- the provider has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

Such providers should be in the planning process with DOH to:

- Be absorbed under the umbrella of another health care system,
- Be transitioned to another licensure category/service line, or
- Discontinue operations.

The SC further recommends that for those providers who are deemed to be financially challenged, the following limitations apply: the providers cannot enter a Level 2 or higher VBP arrangement in a VBP contractor role, though they can be part of a Level 2 or higher VBP arrangements, as long as they are protected from any downside risk.

6. Planned Assessment of Progress in VBP Participation, and Market Dynamics

Design Question: What will be included in the planned assessment of progress made in VBP participation and market dynamics?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The Medicaid Redesign Team Waiver Amendment stipulates that the State is responsible for producing an annual VBP Progress Report for CMS, with participation in VBP contracting and market dynamics being evaluated at the end of DSRIP Year 3. To prepare for timely delivery and robust reporting, the Technical Design II Subcommittee has been charged with recommending an approach for the VBP planned progress assessment that would provide the MCOs, providers, and the State itself with sufficient information and the ability to address any challenges that may arise during the VBP implementation.

Recommendation:

The Technical Design II Subcommittee recommends that the design of the planned assessment be delayed for at least a six month period (ending approximately in June 2016), shifting the decision-making to the broader VBP Workgroup. Given the number of related requirements concurrently being discussed by other Subcommittees, the Technical Design II SC suggests that it would be more effective to plan the assessment process when these decisions have been finalized. The key decision points include but are not limited to: definition of reporting guidelines (to better understand the data already being collected), as well as finalization of the amendments to the Medicaid Model Contract. Also, this time will allow for a obtaining a good understanding of the impact that will help guide the evaluation.

7. Process for Addressing Impasse Situations during VBP Contract Negotiations

Design Question: What should be the process for addressing impasse situations during VBP contract negotiations?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The NYS VBP Roadmap contains language proposing a State-assisted process for supporting contract negotiations when parties have reached an impasse. Historically, the State has not been heavily involved in such negotiations, stepping in only on rare occasions when help was requested. The Technical Design II Subcommittee was asked to deliberate on this topic and make a recommendation as to whether this type of process would be beneficial in the new VBP environment.

Recommendation:

Upon review, the Subcommittee does not feel that the development of a State-supported process is warranted at this time. Though the contracting environment will change, it is difficult to predict what type of challenges might arise and what form of corresponding State support may be needed. The State and the VBP Workgroup will monitor the experiences of the pilot groups for further insight into changes in the VBP contracting process. Though the development of a standard or guideline is not recommended at this time, the State, MCOs and providers will collectively monitor whether action or additional guidelines may become necessary in the future.

Regulatory Impact Subcommittee

Goals

The Regulatory Impact Subcommittee's goal was to address open regulatory policy questions highlighting impediments to successful implementation of the payment reform and produce recommendations with suggested approaches.

Agenda

The Regulatory Impact Subcommittee developed recommendations on the following agenda topics:

1. Provider Risk Sharing
2. Default Risk Reserves
3. PPS as Contracting Entities
4. Provider Contract Review Tiers
5. Changes to the Medicaid Managed Care Model Contract and Provider Contract Guidelines
6. Self-Referral (Stark Law)
7. Anti-Kickback (Fee Splitting)
8. Prompt Payment Regulations
9. Civil Monetary Penalty
10. HIPAA and State Privacy
11. Program Integrity
12. Business Laws and Corporate Practice of Medicine
13. Regulation Reform
14. Physician-Pharmacist Collaboration



Recommendations

1. Provider Risk Sharing

Design Question: Are the regulatory requirements that are in place for providers taking on downside risk appropriate for the transition to VBP or should some alternate regulatory vehicle be developed?

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

During the second Regulatory Impact Subcommittee meeting, the SC discussed Provider Risk Sharing (PRS) in the context of recommending regulatory changes to the State in an effort to help facilitate Value-Based Payments. The State’s objective is to ensure that plans and providers are incentivized to enter into VBP Level 2 & 3 arrangements while maintaining appropriate safeguards that ensure all parties (the State, MCOs, providers, and Medicaid members) are not adversely impacted by other providers who are unable to perform or perform poorly under risk sharing arrangements.

Recommendation:

The SC recommends keeping DFS Regulation 164 as it currently stands and applying it to higher risk VBP Level 3 arrangements. VBP Level 2 arrangements would be excluded from the Regulation 164 definition of financial risk transfer and the “business of insurance” but would require separate DOH approval as described in Provider Contract Review Tier recommendation.

2. Default Risk Reserves

Design Question: Should State laws and regulations be amended to re-structure financial security deposits, escrow accounts, and contingency reserves so that there are adequate safeguards for the delivery system without inefficient cash reserves?

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

During the second Regulatory Impact Subcommittee meeting, the SC discussed Default Risk Reserves (DRR) in the context of recommending regulatory changes to the State in an effort to help facilitate Value-Based Payments. The State’s objective is to ensure that plans and providers are incentivized to enter into VBP Level 2 & 3 arrangements while maintaining appropriate safeguards that ensure all parties (the State, MCOs, providers, and Medicaid members) are not adversely impacted by other providers who are unable to perform or perform poorly under risk sharing arrangements.

Recommendation:

The SC recommends allowing providers to engage in VBP Level 2 arrangements without a financial security deposit under Regulation 164, but they would be subject to additional DOH safeguards to mitigate risk. Such safeguards might include protections against catastrophic events or withholds to mitigate cash flow fluctuations.

3. PPSs as Contracting Entities

Design Question: What regulatory changes and policies should be implemented to establish or govern value-based payment (VBP) contracting entities such as Performing Provider Systems (PPSs)?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

New York State DSRIP program created a number of Performing Provider Systems (PPSs) in various regions of the State. The SC deliberated on the ability of PPSs to contract VBP arrangements as legal entities.

Recommendation:

The SC recommends that no regulatory changes should be implemented to recognize a PPS as a formal legal entity. Existing contracting vehicles (e.g., IPAs and ACOs) should be maintained and are deemed sufficient. The Department of Health expressed interest in preserving the infrastructure created by the investments made as part of DSRIP and suggested the option of having PPSs form an IPA to contract with plans, which the SC supports.

This approach could also be applied to subsets of providers within a PPS that could form an IPA and potentially simplify contract management from the plans' perspective. Additionally, providers will have a better understanding of how the new financial requirements would impact their organization if they establish an IPA and implement appropriate governance structures.

4. Provider Contract Review Tiers

Design Question: What should be the provider contract review process and what type of VBP provider contracts will require review and approval by DOH or DFS?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

A primary goal of the New York State DSRIP waiver is that the state’s Medicaid Managed Care (MMC) program transition to 80-90% VBP by the end of DSRIP Year 5 (2019). To facilitate achievement of this goal, modifications to the contract review process are suggested. The updated process will coordinate the review of the Department of Health and the Department of Financial Services (DFS), and standardize it to the extent possible. In addition, the recommended review process will contain safeguards to protect providers against taking on more risk than financially sustainable.

Recommendation:

The Subcommittee recommends creating three formal review Tiers to reflect the new VBP Levels as per the Roadmap (see Figure A). These Tiers will be used to determine the type of financial review required for all provider contracts.²¹ DOH will collapse the existing five contract review levels per the existing Provider Contract Guidelines into two Tiers while the third Tier will be subject to the existing DFS review and approval process for prepaid capitated arrangements that trigger Regulation 164. DOH will continue to conduct a programmatic review of the contracts in this third Tier. The application of the Tiers should apply uniformly to all types of VBP contractors (IPAs, ACOs, individual providers).

Multi-Agency Review Tier (Tier 3)

The Multi-Agency Review Tier (Tier 3) includes all contractual arrangements which trigger Regulation 164.

DOH Review Tier (Tier 2)

The DOH Review Tier (Tier 2) includes VBP Level 2, VBP Level 3, and all other arrangements that do not trigger Regulation 164, but contain over \$1,000,000 of potential payments at risk AND ANY of the following factors:²² (a) the payments at risk in the contract are above 25% of the value of all Medicaid Managed Care contracts between that provider and that MCO; or (b) the projected Medicaid revenue in this contract is above 15% of the total projected Medicaid revenue for that provider; or (c) the arrangement is Off-Menu.

²¹ Regardless of which Tier a particular agreement falls, the financial and/or programmatic reviews referenced here only apply from the State’s perspective to assess financial risk and programmatic risks to the Medicaid program. The State is not providing legal advice to either plans or providers nor is the State determining whether the contractual arrangement is a fair business deal between the parties.

²² See Figure B for a detailed description of each factor including the formulas for the 25% and 15% calculations.

For contracts that fall into this DOH Review Tier, DOH will continue to develop a framework for determining which type(s), if any, of financial viability will be required. Once developed, this framework will be publicly available. While the framework will be used for guidance and predictability for contracting plans and providers, DOH will review each contract on a case-by-case basis with discretion to require more or less demonstration of financial viability depending on the specific facts and circumstances of the contract.

File and Use Tier (Tier 1)

The File and Use Tier (Tier 1) includes all VBP Level 1 arrangements (upside only arrangements) and all other arrangements that do not meet the minimum review thresholds for a Multi-Agency Review (Tier 3) or DOH Review (Tier 2).

Figure A

The flowchart below illustrates the contract review process:

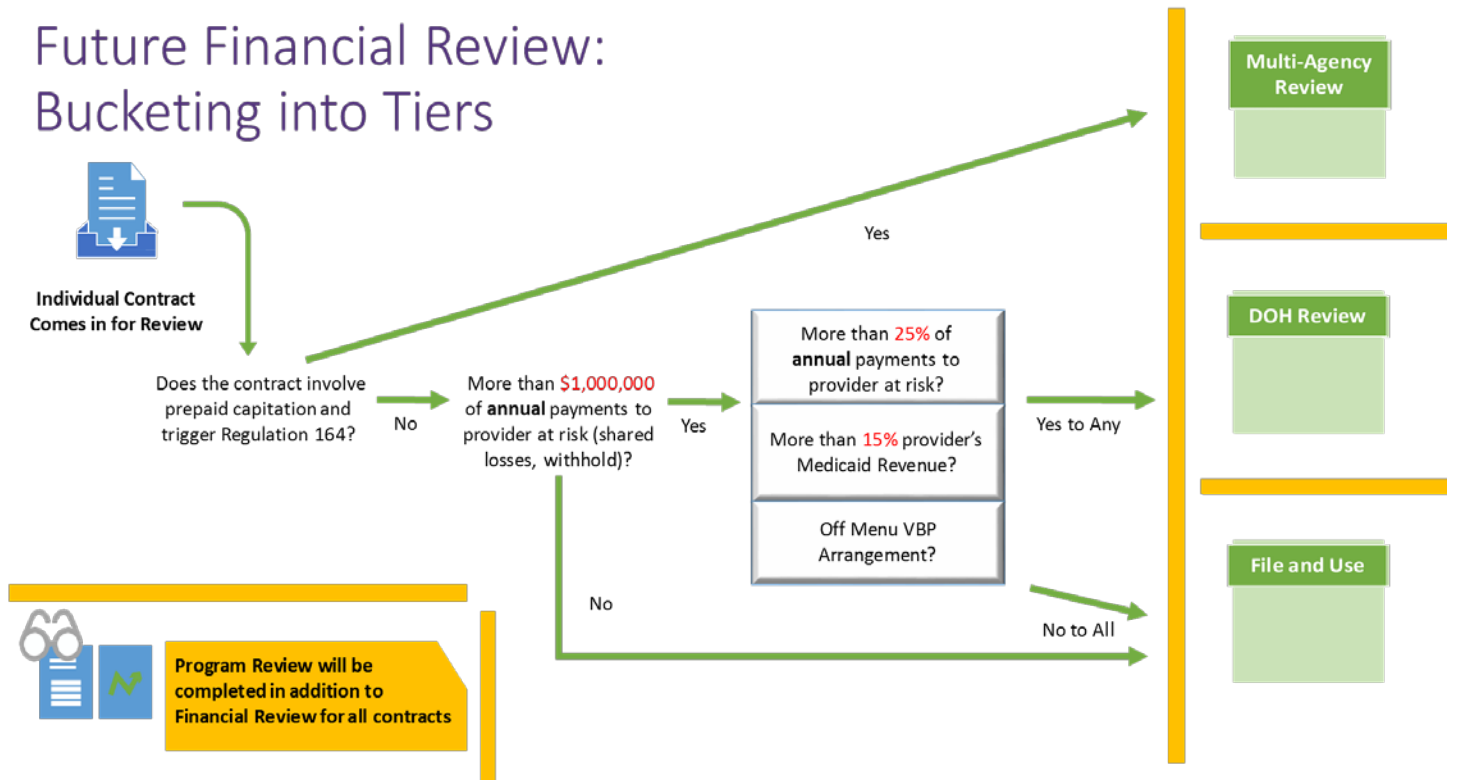




Figure B

- **This \$1,000,000 annual payment threshold is applied to:**
 - Only the individual contract that is coming in for review
 - Medicaid Managed Care components of the contracts only

- **This 25% payment threshold is applied to:**
 - Only the individual contract that is coming in for review
 - Medicaid Managed Care components of the contracts only
- The ratio is expressed as:

$$\frac{\textit{Annual Medicaid Payments at Risk for this Contract}}{\textit{Total Value of All Medicaid Contracts between this MCO and Provider}}$$

- **This 15% revenue threshold is applied to:**
 - All MCOs that contract with the provider
 - All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts
- The ratio is expressed as:

$$\frac{\textit{Value of This Contract's Projected Medicaid Revenue}}{\textit{Total Projected Annual Medicaid Revenue for Provider}}$$



5. Changes to Medicaid Managed Care Model Contract and Provider Contract Guidelines

Design Question: What changes should be made to the Medicaid Managed Care Model Contract and Provider Contract Guidelines to address the implementation of VBP?

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

The Model Contract is the principal document that the Department of Health uses to govern the relationship between the State and Managed Care Organizations. The Provider Contract Guidelines (PCG) is the principal document that DOH uses to govern the relationship between MCOs and providers. PCG contains both guidelines and mandatory provisions. Both documents are primarily drafted for use in a fee-for-service payment environment. With the transition to VBP, the DOH will be amending both the Model Contract and the PCG over the next several years. The SC sought comments and proposed revisions to the PGS for the DOH’s review and consideration. Several comments and proposed revisions were received regarding both documents.

Recommendation:

The SC recommends that the DOH review and consider the SC members’ comments and proposed revisions as the DOH amends the Model Contract and the Provider Contract Guidelines to accommodate VBP. The SC will refrain from providing recommendations on a one-by-one basis as this process should be conducted in a holistic manner by the DOH taking into account the collection of input. The updated Model Contract and Provider Contract Guidelines language will be made available to the public when finalized.

6. Self-Referral (Stark Law)

Design Question: Should New York state law be amended to more fully align (harmonize) with federal Stark law OR should individual state exceptions be expanded (e.g. the Medicaid ACO exceptions)?

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

Federal and state laws prohibit physicians from referring patients for certain designated health services (DHS) which the physician (or immediate family member) has a financial interest. A violation can be triggered through prohibited referral arrangements, splitting of fees, leases of office space, as well as other ownership and compensation arrangements. The federal rules apply to physicians only and allows for several exceptions. New York State’s (NYS) version of the federal law broadens it to different

provider types, all payers, and does not include several exceptions that are in federal law. Therefore, New York law is more restrictive and affords less flexibility for providers.

Recommendation:

The SC recommends amending NYS laws and regulations so that they are fully aligned with federal Stark rules. This change would allow more flexibility for providers to engage in VBP contracting. The SC also recommends that the new state language incorporate future amendments to federal laws and regulations.

Some Relevant NYS Laws and Regulations to Review

- Public Health Law §§ 238 to 238-e; § 4501
- Education Law § 6530
- 10 NYCRR Part 34

7. Anti- Kickback (Fee- Splitting)

Design Question: How can NYS minimize the risks that VBP arrangements violate federal and NYS Anti-kickback laws in a VBP system, and what changes, if any, should be made to NYS laws and regulations to address VBP payment arrangements?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Federal Anti-Kickback statute prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals (including self-referrals) or generate federal health care program business. Unlike Stark law, AKS is intent-based and can carry both civil and criminal penalties. Federal and state AKS laws are largely similar (unlike Stark law). The state law is broader and has a lack of safe harbors (exemptions) or exceptions to the general prohibitions. There are several “safe harbors” that act as exemptions to AKS, but VBP arrangements are not currently included at either the federal or state level.

Recommendation:

The SC recommends amending NYS laws and regulations so that they are fully aligned with federal AKS laws and regulations. This would allow more flexibility for providers to engage in VBP contracting. The SC also recommends that the new state language incorporate future amendments to federal laws and regulations.

Some Relevant NYS Laws and Regulations to Review

- Education Law §§ 6530(18), 6530(19)
- Social Services Law § 366-d
- 18 NYCRR 515.2

8. Prompt Payment Regulations

Design Question: Should any revisions be made to state laws and regulations regarding Prompt Payment to govern bonus reconciliations and payments?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Prompt Payment laws and regulations typically require Managed Care Organizations to pay claims submitted by providers within 30 days (electronic filing) or 45 days (paper filing). However, bonus payments, downside risk reconciliations, and reimbursements of withholds are not specifically addressed in current statute and regulations. The Subcommittee reviewed the current laws to assess the need for modifications to address the changes in payment structure in a value based payment setting.

Recommendation:

The SC recommends no change to New York State laws or regulations for Prompt Payment. The timing of shared savings bonuses, reimbursements of withholds, and related VBP payment structures should be handled contractually between the relevant parties. The Department of Health should consider whether additional guardrails or safeguards should be included in the Model Contract and/or Provider Contract Guidelines to ensure timeliness of payments.

9. Civil Monetary Penalty

Design Question: Should state laws and regulations be changed to enhance violations which may be more prevalent under VBP?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Federal and state laws penalize and sanction plans and providers for violations such as: submitting false claims and false patient health data; offering remuneration to influence a patient to go to a particular provider; payment by a hospital to a physician to artificially reduce services to a Medicaid member; falsification of member applications; and utilization of an excluded provider. Given the change in the payment structure of a value based payment environment, the Subcommittee explored the necessity of any changes in scope to state CMPs to address these differences.

Recommendation:

Upon review, the SC recommends no new changes at this time as federal CMPs and the NYS equivalents already provide comprehensive coverage in the VBP environment.

10. HIPAA and State Privacy

Design Question: Should NYS privacy laws be amended to more fully align (harmonize) with federal HIPAA and the goals of VBP?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Current New York State privacy laws and regulations are more restrictive and provide less flexibility than federal HIPAA laws and regulations. These additional restrictions may prevent providers from sharing information for the purpose of coordinating care and evaluating the outcome of care, both of which are critical to successful VBP arrangements.

In some cases, the recommended method will be to align NYS and federal policies while maintaining sufficient protections to prevent the unnecessary sharing of individuals' Protected Health Information (PHI). Furthermore, there may need to be additional training for providers on any changes to the laws in order to support appropriate information sharing for the purpose of coordinating care while still protecting the confidentiality of this information. In other cases, the recommendation may be to retain NYS laws and regulations due to state policy reasons, yet create specific exceptions or alternative processes to accomplish the purposes of VBP.

Recommendation:

The Subcommittee recommends that a separate workgroup be created to address these privacy law issues on a scenario by scenario basis. The group may be comprised of various NYS departments and stakeholders to follow these scenarios and implement recommendations throughout the development of VBP. While there are many scenarios to consider, five initial Scenarios²³ have been identified to start the process:

Scenario 1 – DSRIP Opt-Out and DEAA Process

Scenario 2 – Care Management

Scenario 3 – RHIO and SHIN-NY Data

Scenario 4 – Scope of Medicaid Consent

Scenario 5 – Vital Statistics

²³ These Scenarios are detailed in the HIPAA and State Privacy issue brief in Appendix B.

11. Program Integrity

Design Question: What changes to Program Integrity are necessary to ensure Medicaid PI compliance for new VBP needs?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Value-based payments will fundamentally change the way Medicaid healthcare services are delivered, paid, and measured. As a result of these changes, the guiding principles underlying New York’s Medicaid Program Integrity strategy (Program Integrity) must also change. Many of the foundational activities and strategies in a fee-for-service environment to ensure that quality healthcare is delivered at a reasonable cost while protecting stakeholders, may not be effective in VBP. VBP will also drive new and innovative patient care strategies which will prompt questions as to whether strategies to deliver more effective and efficient patient care are in compliance with current laws and regulations.

Since the basics of VBP are still in development such as determining patient outcomes metrics, it is difficult to identify immediate current gaps and future needs. Unfortunately, the State cannot wait until all of the details of VBP implementation are finalized before addressing Program Integrity.

Recommendation:

The Subcommittee recommends the creation of a new Program Integrity workgroup comprised of stakeholders including the State, payers, and providers. The new workgroup will be tasked with making recommendations to improve integrity at all levels of healthcare delivery. Specifically, the workgroup should focus on developing actionable recommendations addressing compliance in a VBP environment. These recommendations may come in the form of changes to State laws and regulations, contracting requirements between the State and MCOs or providers, and other contracting guidelines between parties.

12. Business Laws and Corporate Practice of Medicine

Design Question: How should laws surrounding Professional Service Entities be modified to align with VBP?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

Currently, there are some obstacles to collaboration for some clinical groups in New York State. The current Business laws and Corporate Practice of Medicine (CPOM) laws present the following barriers in a value-based payment setting:

- Restrictions regarding which professionals can have ownership interests in professional entities
- Constraints on how medical professionals structure their corporate entities to optimize VBP; implementation; and
- Limitations on which professionals and entities can split fees (e.g., bundled payments for services including physicians and non-physicians).

These limitations may prevent different types of providers from collaborating and integrating in the spirit of the Delivery Service Reform Incentive Payment program, and inhibit the implementation of the NYS Value-based Payment Roadmap. A bill has been introduced (S.5862/A.8153) in June of 2015 that addresses several of the Business Law issues mentioned above. The Bill is currently pending in the Senate Rules Committee and the Assembly Higher Education Committee. Overall, the Regulatory Impact Subcommittee supports the intent of the bill in the spirit of implementing VBP; however, there may need to be changes to the bill to maintain appropriate physician control over certain clinical decisions. The SC also suggests pursuing other approaches to ensure a more expedited consideration by the NYS legislature as listed below.

Recommendation²⁴:

The SC recommends the following approach to supporting the bill on changing the Business laws:

- Include the language of S.5862/A.8153 or other similar language deemed acceptable by the Department of Health (DOH) legal counsel in the Budget Bill.
 - This will require immediate action given the timeline – the Executive Budget Bill is to be introduced by February 1 of next year. Language might be introduced as part of the Executive Budget Bill (Article VII) or through one-house Senate and/or Assembly Budget Bills. Language may need to be amended to preserve physicians' control over clinical decision-making.
- DOH should continue discussions, as needed, to address whether changes should be made to CPOM laws and regulations. These discussions should take into account changes to the Business Laws, as indicated above.

²⁴ This is a non-consensus recommendation from the SC at this point. Medical Society of the State of New York (MSSNY) and a number of specialty physician societies object to the recommendation. They prefer to maintain the current restrictions and explained why they think such restrictions are valid in order to preserve physician control over clinical decision-making. There was also discussion around the scope of management and fee-splitting between physicians and non-physician providers. MSSNY is currently in the process of drafting bill language that would bring all parties to a consensus. Until the language is finalized the State defers to make a final determination regarding this recommendation.

13. Regulation Reform

Design Question: What specific regulations could be eliminated or relaxed to reduce regulatory burden while still protecting patient safety?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Current New York state healthcare regulations (Regulations) were created to protect the State, providers, payers, and especially patients in a fee-for-service environment. Value-based payments and the DSRIP program introduce new methods of collaboration, contracting, and delivery of healthcare services that may be at odds with existing Regulations, despite the goals of VBP.

In order to expedite progress in the DSRIP program, the State’s Department of Health created a formal process where a Performing Provider Systems can submit written requests to the DOH for regulatory waivers specifically for the formation and administration of a PPS during the DSRIP waiver period. DOH will evaluate approved waivers over the DSRIP waiver period and consider the waivers for permanent revision if effective.

Because VBP is evolving and future regulatory roadblocks may not be known until stakeholders begin negotiating, contracting, and operating under VBP. Similar to the DSRIP waiver request program, an ongoing, formal process should exist for stakeholders to request changes to make VBP implementation more effective.

Recommendation:

The SC recommends the creation of a new workgroup that would deliberate on any regulatory hurdles that weren’t reviewed by this Subcommittee, and the new VBP regulatory relief process overseen by the DOH where stakeholders may submit a written request for regulatory relief specific to VBP. Requests for regulatory relief under this new process will focus on regulations that stakeholders see as a significant hindrance to effective VBP implementation.

14. Physician – Pharmacist Collaboration

Design Question: Should NYS laws be amended to improve the level of collaboration between physicians and pharmacists on Comprehensive Medication Management (CMM) for patients with Chronic Diseases?

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

Current New York State (NYS) Public Health laws and regulations allow a certain degree of collaboration between the physicians and pharmacists, however, it doesn't provide for the full spectrum of benefits that the patients (including Medicaid Members) could realize in terms of improving their health and quality of services received. By allowing a higher degree of collaboration²⁵ between physicians and pharmacists on Comprehensive Medication Management (CMM), the State would be able to achieve an enhanced service integration environment that will result in reduction of hospitalization rates in NYS thus helping achieve the goals of the Payment Reform, and the DSRIP program overall.

Recommendation:

The SC has reviewed the current CMM state of affairs in New York and recommends amending the Public Law to create a *voluntary* program for collaboration between qualified pharmacists²⁶ and physicians ruled by a written protocol that would enable physicians to refer certain patients with chronic conditions who (1) have not met the goals of therapy, (2) are at risk for hospitalization or (3) otherwise considered to be in need of CMM services, to qualified pharmacists.

The written protocols would describe the nature and scope of services to be provided; they would be made available to the Department of Health (DOH) for review to ensure compliance with the requirements in the law. Such protocols could cover services including but not limited to the following:

- ongoing evaluation of a patient's condition and medication adherence, including ordering/performing routine patient monitoring functions;
- adjusting or managing a drug regimen of a patient;
- accessing the patient's medical records;
- other.

Further, the pharmacist would be required to notify the treating physician in a timely manner relative to his/her recommendations and any permitted adjustments made to the patient's prescribed medications.

Lastly, the SC recommends an amendment to the current NYS laws with a condition that the pharmacy and physician groups work together and help introduce bill language that they unanimously agree upon.

²⁵ Currently, collaboration is already permitted in all hospitals and limited nursing home settings in New York. This recommendation promotes voluntary collaboration in community practice settings as well.

²⁶ Qualified pharmacists would be pharmacists who hold an unrestricted license and have completed accredited programs in the management of chronic disease(s). Their qualifying credentials would be reviewed by physicians who are interested in CMM programs offered by qualified pharmacists to which they could refer selected patients.

Social Determinants of Health and Community Based Organizations

Goals

The Social Determinants of Health goal was to formulate and provide specific recommendations that drive VBP by addressing social determinants of health. The Community Based Organizations (CBOs) goal is to formulate and address the training needs for CBOs and ensure all pertinent organizations are involved.

- A number of the recommendations have been categorized as “*Recommendation*”, as they are suggestions for consideration for the State, and are not classified as guidelines or standards
- In the following recommendations, a provider/provider network is defined as any Medicaid certified provider or network of providers participating in VBP at any level.

Agenda

The roadmap provided guidance and direction for the subcommittee but it did not define an exact agenda. The agenda below is based off the categories of the recommendations developed during the subcommittee meetings.

The SDH and CBO Subcommittee developed recommendations on the agenda topics below. There are multiple recommendations for each agenda topic, comprising of 31 recommendations in total.

1. Designing and improving SDH by creating guidelines and standards for Providers, MCOs and the State
 - a. Recommendations to Encourage Development of Culturally Competent SD Initiatives and Collaboration with MCOs
 - b. Methods to Measure the Success of the Programs Implemented
2. Methods of addressing and developing an action plan for Medicaid Member housing determinants
3. Determining methods which can be used to capture savings across public spending as related to SDH and CBOs
4. Providing CBOs technical assistance and education for VBP
 - a. Decreasing the knowledge deficit
 - b. Understanding and addressing capacity, monetary and infrastructure deficits
 - c. Overcoming infrastructure challenges
 - d. CBO involvement in the development of VBP networks



Recommendations

1. Designing and improving SDH by creating guidelines and standards for Providers, MCOs and the State.

Description:

The overall wellbeing of individuals, families, and communities should be the driving purpose of a health care system. Viewed from that lens, addressing SDH should come naturally to health care providers. Specific interventions have been shown to improve outcomes for members facing acute and/or chronic health conditions, and even prevent some health conditions before they develop. Since social determinant (SD) interventions are often less costly than medical interventions, which will be necessary as a person’s disease progresses, the benefit of investments to address SDs would seem self-evident. However, these interventions are traditionally seen as being beyond the scope of health care. The VBP effort by NYS provides a unique opportunity to transform this perception and practice. Below are recommendations for providers, provider networks, MCOs, and the State, which are separated into two sub-categories:

- a. Recommendations to Encourage Development of Culturally Competent SD Initiatives and Collaboration with MCOs
- b. Methods to Measure the Success of the Programs Implemented

a. Recommendations to Encourage Development of Culturally Competent SD Initiatives and Collaboration with MCOs

Recommendation #1:

Providers/provider networks and MCOs should implement interventions on a minimum of one SDH.

- **Level 1 Providers²⁷:** Guideline
- **Level 2 Providers and MCOs:** Standard
- **Level 3 Providers:** Standard

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

When the provider/provider network/MCO has identified the SD to be addressed, determining the corresponding intervention needs to be well-thought out considering a single intervention may not address the identified need. For example, someone with diabetes whose condition is

²⁷ Clarification: Level 1, 2, or 3 providers or MCOs are providers and MCOs that are contracting Level 1, 2, or 3 arrangements.



exacerbated by poor nutrition will derive little benefit from nutritional counseling if the person does not have access to fresh fruit and vegetables. Conversely, fresh fruit and vegetables will go to waste if the person does not know how to prepare them or have the motivation to engage in diet modification. In such a case, nutritional counseling and access to healthy foods need to be linked with culturally competent education as well as coaching. In some cases, multiple interventions will need to occur simultaneously, while in others, the interventions will need to be carefully staged to be successful. Refer to Appendix C: SDH Interventions Menu for possible interventions.

MCOs contracting with VBP Level 2 providers/provider networks will share in the costs and responsibilities associated with the investment, development, and implementation of the intervention(s). Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk. Providers/provider networks/MCOs may contract with CBOs to satisfy this recommendation. Contracted CBOs should expect the inclusion of a value-based component in the contract, such as pay for performance, and be held to performance measure standards.

Providers/provider networks should create a report explaining a measureable reason why the SDH was chosen and identify metrics which will be used to measure its success. This could follow a similar process/procedure that the current Vital Access Provider (VAP) program uses where the provider selects what they want to focus on, develops metrics, and reports back to the state. The selection should be based on information such as, but not limited to, the community needs assessment, Prevention Agenda community priorities, results of an SDH screening tool, the attributed member population in specific VBP bundles, and/or other pertinent information with respect to the needs of the community the network serves.

Recommendation #2:

The SD interventions selected by providers/provider networks should be based on the results of an SDH screening of individual members, member health goals, and the impact of SDs on their health outcomes, as well as an assessment of community needs and resources.

- **All Level Providers:** Guideline

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

It is important to recognize that no one SD can necessarily be prioritized over others. Rather, the priorities will vary based on personal circumstances, including health factors. For example, if a person is homeless, housing is likely to be the top priority but not necessarily that person’s only need. Indeed, many SDs are both co-occurring and co-factors in other SDs. It is important to ensure a balance among the goals of payers, providers and members, to achieve a shared purpose. Thus, prioritizing which SDs a VBP network should address should depend upon the



results of an SDH screening of individual members, member health goals, and the impact of SDs on their health outcomes. In addition to the individual member’s screening, there should be an assessment of community needs and resources. The DSRIP community needs assessment could provide a starting point for a more detailed assessment of the community cared for by the providers/provider networks. Further information can be gained by completing a focused needs assessment by the particular providers/provider networks with emphasis on the chronic illness(es) or populations chosen in their VBP agreement. The decision of which SD(s) to address should be based on the members’ goals and community needs/needs of the patient panel. The prioritization must happen with a flexible approach and at a local level, balancing both individual needs with overall population health. Eighteen specific SDs have been identified under five key domains of SDH and are believed to have the greatest impact on health outcomes for Medicaid members (see Appendix C: SDH Interventions Menu).

Recommendation #3:

Providers/provider networks and MCOs should invest in, and the State should provide financial incentives for, ameliorating an SDH at the community level employing a community participatory process.

- **All Level Providers:** Guideline
- **MCOs:** Guideline
- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Providers/provider networks and MCOs should invest in effective interventions that have a meaningful impact on the overall population health and the overall wellbeing of the community in which it serves. The State should develop financial incentives to reward providers/provider networks and MCOs for interventions geared toward the community. Providers participating in total cost of care arrangements are already incentivized to do this so they would not be eligible for this additional financial incentive. The nature of the intervention(s) should be negotiated between the VBP contractor and MCO, taking into account population health and preventive health needs identified by the community. This community participation will lead to a more culturally competent, effective intervention. A participatory approach is one in which everyone who has a stake in the intervention has a voice, either in person or by representation. Providers and MCOs may wish to collaborate with CBOs to support, develop, and broaden their reach in their communities. To that end, networks should consider larger partnerships and advocate for systemic improvements that might not be easily quantified on the individual member level immediately or in the short-term. For example, participating in a campaign to make fresh produce available in a “food desert” would not only have an impact on members with specific nutritional deficits, but would also contribute to



overall population health and community well-being. The same can be said for participation in efforts to improve air quality, housing stock and many other SDs that contribute to overall population health. Ultimately the goal should be to track the impact of interventions, not just on an individual level, but on a population level. The State should revisit this recommendation at a later time to assess the success of implementing SDH at the community level.

Recommendation #4:

MCOs and the State should incentivize and reward providers (including CBOs) for taking on member and community-level SDH.

- **MCOs:** Standard
- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Since providers that successfully address SDH may not see savings in the short term, they should be incentivized upfront to choose identified SDH (as described in Recommendations 2 and 3) and be financially rewarded for addressing them.

- Level 1 providers should get an additional bonus if they address at least 1 SDH
- Level 2 & 3 providers should receive a funding advance (investment or seed money) if they commit to addressing one or more SDs. This funding advance would provide financial assistance to the provider investing in an intervention. The provider could benefit financially from the savings generated if the intervention is successful in lowering the cost of healthcare for those members. If the interventions are successful, the savings generated could encourage further investment.

It is recommended that this be included within the MCO model contract.

Recommendation #5:

Providers/provider networks should maintain a robust catalogue of resources in order to connect individuals to community resources that are expected to address SDH.

- **All Level Providers:** Guideline
- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

By creating a catalogue or living library of resources, providers can quickly and easily refer members to appropriate and effective community based organizations. Members can also take a more active role in their healthcare if they are provided information on community resources to use to better improve their quality of life and health outcomes. The providers/provider networks should maintain an up-to-date, robust catalogue of resources that aligns with the information from the SDH screening tool and the SDH Interventions Menu (Appendix C). In the longer term, the State, together with payers, providers, community-based organizations, and municipalities should create a usable, universal, electronically supported system for assessing individual members’ needs and providing automatic links to vetted resources to address members’ SDH at the individual level.

Recommendation #6:

Providers/provider networks should employ a culturally competent and diverse workforce at all levels that reflects the community served.

- **All Level Providers:** Guideline

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

Cultural competence is a broad term, however there are several widely-accepted definitions that can be used in the VBP context (e.g. National CLAS Standards). Lack of access to culturally competent staff has been identified as a barrier to better health. It is critical for providers/provider networks to understand cultural competence and incorporate accepted cultural competence standards in their practice. To better serve the community and provide the best healthcare, providers/provider networks should use data from demographic reports and hire staff that reflect, and is culturally sensitive to the community served.

The SDH Interventions Menu (Appendix C) includes recommended interventions for this SD. It is recommended that issues relating to health workforce cultural competence and diversity be addressed in a comprehensive manner by the statewide DSRIP/SHIP Workforce Workgroup.

Recommendation #7:

The State should form a taskforce of experts and a process specifically focused on children and adolescents in the context of VBP. This process should be initiated by the State in an inclusive manner.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None



Description:

“A child’s early experiences and the environments in which they spend their time have an important and measurable effect on their later life path of health and well-being.”²⁸ The primary emphasis within DSRIP and VBP is achieving immediate or short-term cost savings/outcomes. Children are not, generally, high cost users of health services today, though inattention to their developmental health could lead to future needs and costs. With regard to the SDH, evidence suggests that one of the most important things that can be done in the early years for positive health outcomes later is strengthening the stability, safety and nurturing in the home environment. The task force should advise on how this can be accomplished in the context of VBP.

b. Methods to measure the success of the programs implemented

Recommendation #8:

The State should create a data system and dashboard that displays providers/provider networks' and MCOs' success in addressing health disparities and should measure and report on outcomes based on race, ethnicity, disability, sexual orientation, etc. Providers/provider networks and MCOs should be encouraged to use this information to inform negotiations regarding performance metrics.

- **All Level Providers:** Guideline
- **MCOs:** Guideline
- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Performance metrics and dashboards can be used to define and communicate strategic objectives tailored to individuals and the organizations where they receive services. Establishing goals, measuring progress, rewarding achievement and displaying results in a way that is accessible and transparent can accelerate change and drive positive outcomes.

The State should create an integrated data system and dashboard that encapsulates key performance metrics in a layered and visual information delivery system, allowing users to identify disparities in health and health care and to measure the effectiveness of interventions and strategies aimed at achieving equitable outcome for the population being served. The data and analytics collected should be readily available to inform real time activity. Steps could include:

- Use available Medicaid data to construct performance metrics where appropriate, including the ability to view metric by race, ethnicity, disability, sexual orientation, etc.

²⁸The Human Early Learning Partnership. University of British Columbia, Web. <<http://earlylearning.ubc.ca/research-overview/>>.



- Work with the Office of Minority Health and community stakeholders to further define performance goals and identify performance measures to be tracked
- Join multiple data sources, where feasible, to better describe populations and understand outcomes
- Use measures to track disparities in a dashboard format, such as web-based provider report stratified by demographic variables
- Track performance, examine trends, make comparisons, and identify strong performers
- DOH will incentivize providers based on improved cultural competence performance

Recommendation #9:

Providers/provider networks and MCOs should utilize an SDH screening tool to measure and report on SDs that affect their individual members, which include elements of each of the five key domains of SDH identified. The SDH screening tool will be used with each individual member at least annually.

- **All Level Providers:** Guideline
- **MCOs:** Guideline
- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The healthcare organization must ensure providers/care teams have access to SDH information for their members. The SDH domains that the SDH screening tool must identify are: Economic Stability; Education; Health and Healthcare; Social, Family, and Community; Neighborhood and Environment. The SDH screening tool will assist in determining the SDs that affect providers’ members. In the short-term, the State should develop a plan to systematize this screening tool and then explore the potential to use a uniform tool in the long term. Recognizing that SDHs are as important as clinical data, providers/provider networks and MCOs should ensure clinicians and care teams have access to SDH information on each member. Recognizing this data does not currently fit into the traditional clinical data record, providers should find ways to add or append it to the EHR/Medical Record. The recent implementation of ICD-10 codes (primarily Z55-65 and Z69-76²⁹) allows more granularity to better reflect the socioeconomic status of members and therefore more accurately reflects the members’ true health status. Reporting tools within EMR systems should be leveraged to track members and provide data on health outcomes for specific populations with one or more of these diagnoses.

²⁹ “Factors influencing health status and contact with health services Z00-Z99.” *ICD10Data.com*. Web. 08 Oct 2015. <<http://www.icd10data.com/ICD10CM/Codes/Z00-Z99>>.



The menu (Appendix C) identifies standard measures of SDs where they exist. There are a variety of tools that include at least some of these measures. For example, the Health and Recovery Plans (HARP) assessment tool measures seven of the eighteen SDs identified on the menu that are believed to have the greatest impact on health outcomes for Medicaid members. This provides a strong foundation for development of a common instrument that can measure all of the recommended SDs. Even if imperfect, a standardized instrument, or at least one with uniform elements, would allow for the development of a common understanding of the breadth of SDs, consistency in the type of data collected, and new evidence on the impact of SDs on health outcomes. This can lay the foundation for a better understanding of the cost and impact of interventions.

Recommendation #10:

The State should design and implement a system that aims to track the success of interventions and how they are measured. This should include, but not be limited to, systematically collecting and publicly reporting on member experience with any service, whether from a CBO, hospital, behavioral health provider or primary care practice. Members need this information to inform their own decisions and payment reform needs this level of transparency in order to drive change and inform future contracting.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

While the SDH Interventions Menu (Appendix C) suggests several evidence-based interventions, there are several other potential interventions for which there is not strong evidence. The State should leverage its role in the implementation of VBP to create a statewide living laboratory for addressing SDH. First, the State should both incentivize and require VBP providers and provider networks to collect data on SDs and to test, track and report on interventions and share findings (this is stated in recommendation 1, listed above). Second, the State should support the development of standardized tools, nomenclature and/or domains that allow state-wide sharing of information and analysis in order to advance collective knowledge and create an accessible library of best practices, including best practice in the selection methodology of SD investments. Third, the State with the support of VBP networks should publish the results of these efforts so as to advance these initiatives. Finally, the State should lead the way in convening conversations with other parts of government on collaboration among health, social services, housing, criminal justice, education, and other sectors with the goal of collectively contributing to the health of communities. Many of these potential partners are identified in the SDH Intervention Menu which is found in Appendix C.

Recommendation #11:

Providers/provider networks and MCOs are expected to track and report discrete outcomes of the interventions and are encouraged to use a continuous quality improvement (CQI) model for enhancing the intervention.

- **All Level Providers:** Guideline
- **MCOs:** Guideline

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

A basic SDH screening, conducted periodically, would indicate whether an individual member’s life circumstances are improving, but VBP networks will also want to track the impact of these interventions on the specific health outcomes sought. For this reason, interventions, much like in medicine, should be viewed as experimental and carefully measured, evaluated, and reported to the State by the MCOs on an ongoing basis. This should occur both with respect to individual members as well as looking at the larger cohort of persons who are participating in the intervention(s) through a meaningful CQI process.

The tracked outcomes of the intervention(s) coupled with a CQI model should promote identification of best practices and lessons learned. While the SDH Interventions Menu (Appendix C) suggests several evidence-based interventions, there are many other potential interventions for which there is not strong evidence at this time. Providers/provider networks and MCOs are encouraged to experiment and track and report on the intervention outcomes to create an evidence base. MCOs should consider owning the tracking and reporting processes to show if interventions are lowering costs of care and improving specified metrics. In the longer term, the State will collect the data from the MCOs and publicize best practices and lessons learned obtained from a centralized analysis process.

Recommendation #12:

The State should incorporate SDH into Quality Assurance Reporting Requirements (QARR) measures.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None



Description:

QARR is a set of performance measures on which health plans must report annually, to NYSDOH under Medicaid, amongst other coverages. QARR currently measures: 1) Effectiveness of Care 2) Access to/Availability of Care 3) Satisfaction with the Experience of Care 4) Use of Services 5) Health Plan Descriptive Information 6) NYS-specific measures (Adolescent Preventive Care, HIV/AIDS Comprehensive Care, and Prenatal Care measures from the Live Birth file). SDH measures should be incorporated in this measurement tool.

Recommendation #13:

The State should form a taskforce to identify standard data sources and points that can be utilized to provide a consistent and reliable SD adjustment to the member acuity calculation prior to attribution, and establish an adjusted acuity calculation which takes SDs into consideration when establishing member acuity.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Given the central role of member acuity to VBP arrangements, and the fact that acuity calculations by the State are limited to claims data and do not include a screening of non-clinical SDs, a taskforce should be established to identify standard data sources and points that can be utilized to provide a consistent and reliable SD adjustment to the member acuity calculation prior to attribution. Data may include history of incarceration (Corrections), housing status, and other SES indicators that can be collected by the State. Following the establishment of standard collectable data points, the acuity calculation should be adjusted. This process should be transparent throughout and include multiple opportunities for community discussion and review.

Recommendation #14:

The State should develop a standard set of measures for SDH and well-being that can be added to existing data collection and electronic health record systems.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

A standard set of measures for SDH and well-being is important for reporting baseline data and outcomes, recognizing trends, and identifying best practices in care. The State could leverage existing systems that measure SDH and well-being, such as the Statewide Planning and Research Cooperative System (SPARCS) Health Data Query System. The All Payer Database along with data from Medicaid claims, electronic records, and the census could also be used in the development of the standard measures.

2. Methods of addressing and developing an action plan for Medicaid Member housing determinants.

Description:

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. Housing is recognized by Healthy People 2020 as a key Social Determinant of Health³⁰ and is referenced specifically within the VBP Roadmap, “Offering a stable, safe, and accessible housing environment can be a highly efficient and improve outcomes for vulnerable, homeless Medicaid members.” In international studies and in studies in the United States, safe, stable housing is recognized as one of the most powerful correlates with physical and mental quality of life. People who experience homelessness experience shorter life spans, increased incidence and higher prevalence rates of almost every disease and condition than their domiciled counterparts.

Every medical condition becomes more difficult to treat if the member does not have stable and adequate housing. Housing status affects the ability of the member to follow the medical professional’s directions, and lack of stable housing has been found to have a stronger independent effect on health outcomes than age, mental health issues, substance use, or other individual member characteristics associated with poor outcomes. Numerous studies have also demonstrated that interventions to improve housing status significantly reduce avoidable crisis and inpatient health care utilization, generating savings in health spending that offset the cost of housing supports. Housing status should therefore modify a clinician’s overall treatment plan, especially for persons with chronic conditions. Currently, housing status is not routinely collected or recorded in a formal way during medical encounters. Lack of uniform collection of this data adversely affects the ability to care for high-need members, and to evaluate the care and health of homeless and unstably housed persons.

Given the importance of housing on health outcomes and spending, it must be accounted for properly in a VBP system. Without ability to uniformly document and account for housing instability, providers will be penalized for poor health outcomes. As a result, some providers may seek to avoid serving people who are facing housing instability. Conversely, appropriate payment will provide the resources to care for members experiencing housing instability and to support measures and partnerships that will help secure and maintain housing, which will yield health benefits to the

³⁰ *HealthyPeople.gov*. U.S. Department of Health and Human Services. Web. 26 Aug 2015.



members and cost benefits to the health system. This should drive policy decisions around societal allocation of resources for stable housing.

Recommendation #15:

Medicaid providers, MCOs, and the State should collect standardized housing stability data. The State should explore options and determine the best mechanism for capturing this data.

- **All Level Providers:** Guideline
- **MCOs:** Guideline
- **The State:** Standard

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Medicaid providers, MCOs, and the State should routinely collect and update standardized housing data. This information should be maintained in a shared database, such as the Regional Health Information Organization (RHIO), Salient, or other accessible system, for purposes of rate setting and appropriate intervention research and analysis. The State should determine a standardized mechanism for housing stability data collection and consider requiring providers and MCOs to capture this data in the future.

Recommendation #16:

Provider/provider networks and MCOs should coordinate with Continuum of Care (COC) entities, where they exist, when considering investments to expand housing resources. This could ensure that resources are aligned with documented community needs and priorities, and coordinated with other resources and the many stakeholders seeking to serve this at-risk population.

- **All Level Providers:** Guideline
- **MCOs:** Guideline

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Providers/provider networks and MCOs should work in collaboration with established multi-stakeholder COC coalitions, which already identify housing gaps and needs, and establish priorities for spending McKinney-Vento (Homeless Assistance Act) dollars on an annual basis. These networks are longstanding and have a wealth of information on how to address the gaps and needs, as well as, what resources have already been established. VBP providers, networks, and MCOs are encouraged to collaborate with COCs to improve coordination to help at-risk population access



affordable housing, something that has not previously been considered a part of traditional medicine practice.

Recommendation #17:

New York City, the State, and other involved localities should update the NY/NY Agreements to give priority to homeless persons who meet Health and Recovery Plan (HARP) eligibility criteria or have other serious supportive housing needs without regard for specific diagnoses or other criteria. The definition of “homeless” should be modified (for units that do not receive US Department of Housing and Urban Development (HUD) capital or operating dollars) to include persons who are presently in institutional or confined settings.

- **The State:** Recommendation

Implementation Mechanisms that Require Change: (State Policy)

- State Legislation Model Contract DOH Policy None

Description:

Currently, the NY/NY Agreements attach units to specific agencies, such as OMH, OASIS and HASA, and attach additional criteria such as length of homelessness, creating an “obstacle course” for persons seeking housing. Because NY/NY uses the HUD definition of homelessness, persons leaving incarceration and other institutional settings are completely precluded from this program. New York City, the State, and other involved localities should amend the NY/NY Agreements so that those members who also have chronic conditions that require supportive housing who are facing homelessness are given priority for supportive housing regardless of type of condition or other criteria. Additionally, the definition of “homeless” used in the NY/NY Agreements should be expanded to include those persons leaving institutional settings so they can be considered for housing prior to discharge.

Recommendation #18:

The State should submit a New York State waiver application to the Center for Medicare and Medicaid Services (CMS) that tracks the June 26, 2015 *CMCS Information Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*³¹.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

³¹ Wachino, Vikki. *CMCS Information Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. Department of Health and Human Services. 26 June 2015. Web. 07 Oct. 2015. <<http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>>.



Description:

The State should submit a waiver application to CMS to track the guidance on the statements made in the bulletin in regards to CMS paying for programs related to housing. This is a good way to ensure that the State can leverage the maximum amount of housing money as it is entitled from the federal government. The money could be used to fund housing-related case management, tenant education and coaching, housing transition services, and crisis/respite services, amongst other programs. It would also be beneficial to the State, VBP networks, and community housing facilities if CMS could pay for a portion of what is already being provided.

Recommendation #19:

The State should leverage Medicaid Reform Team (MRT) housing work group money to advance a VBP-focused action plan.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

There is an existing housing workgroup that makes recommendations to the MRT every year on how to use shared savings that have been allocated for housing. \$250 million were set aside last year (2014) to be used for housing over the next two years. It is recommended that the MRT Housing Workgroup align its work and investments with VBP.

Recommendation #20:

The State should submit a waiver application that challenges the restrictions on rent and home modifications in the context of VBP.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The State should submit a waiver application to encourage CMS to view housing interventions as “healthcare” for people with chronic conditions.



3. Determining methods which can be used to capture savings across public spending as related to SDH and CBOs.

Description:

As described in *The American Health Care Paradox*, the total cost of health and wellbeing for any population cannot be calculated using health care cost alone. Rather, it is the aggregate of spending on both health and social welfare. Insufficient spending or inappropriate targeting of social welfare spending results in higher health care costs. (The converse is also true; inadequate spending or inappropriate targeting of health care dollars will result in higher social welfare costs. VBP arrangements aim to address this in as much as its whole purpose is to better focus health expenditures.) However, lack of adequate social services spending not only impacts health care, but also contributes to the inefficiency of social welfare costs such that increased social welfare spending may not right-set the equation. For example, if lack of adequate social welfare spending increases homelessness, the available social welfare resources may get directed at homeless services rather than homelessness prevention, since it is usually the less costly investment. Moreover, inadequate or inappropriate health and social welfare spending also contributes to costs that are carried by other public sectors such as the criminal justice system³².

To the extent that lack of social welfare spending increases health care costs, it is rational from a financial perspective for the health care system to invest in social welfare activities as a means of reducing its own cost. But these investments are likely to accrue savings in social welfare as well as other public sectors. Moreover, investment beyond the health care savings may not only further drive down costs to these other sectors, while also improving health outcomes on both the individual and population level. This is the rationale for leveraging investment across the social welfare and other public sectors into interventions that improve health outcomes – going beyond a coordinated seamless health care system to a community-integrated healthcare system.

The SDH and CBO SC has identified mechanisms by which resources can be leveraged in the context of VBP arrangements to capture savings across the public sector. Below, the terms are defined, recognizing that all have elements in common as well as their own benefits and challenges. For each mechanism, there is an evaluation of risk, potential barriers and mitigation strategies. The mechanisms should not be viewed as an exhaustive list, but as guidance for consideration. There is a need for further experimentation and development to occur before more detailed guidance can be produced.

Recommendation #21:

Provider networks could participate in a co-investing model.

- **All Level Providers:** Guideline

³² Bradley, Elizabeth H., and Lauren A. Taylor. *The American Health Care Paradox: Why Spending More is Getting Us Less*. New York: Public Affairs, 2013. Print.



Implementation Mechanisms that Require Change:

- State Legislation
- Model Contract
- DOH Policy
- None

Description:

Co-investing is a model in which the VBP network identifies a provider of services that could better achieve its mission at the same time as improving health outcomes if the VBP network were to invest with the provider to align and achieve the desired outcomes.

Risk:

Risk is relatively low for the VBP network in this model. The level of investment is also low in relation to the potential yield. Thus, this model lends itself to strategies where there is little concrete evidence to support the interventions. There may be significant barriers to successful implementation of this model. One barrier would be the culture of the partner organization, whose staff would possibly need intensive training not only in the desired interventions, but also on the outcome-driven health care model. The same barrier might exist on the VBP network side, where providers would need to be oriented toward “writing a prescription” for interventions provided by a system with which they are unfamiliar. A second barrier would be failure to clearly articulate the same outcomes. This can be addressed by mutually clarifying in advance the metrics by which success will be measured. A rigorous evaluation component would be important to ensure that the missions of both organizations are being satisfied synergistically.

Please refer to Appendix D: Capturing Savings Across Public Spending for an example of co-investing.

Recommendation #22:

Provider networks could participate in innovative contracting.

- **All Level Providers:** Guideline

Implementation Mechanisms that Require Change:

- State Legislation
- Model Contract
- DOH Policy
- None

Description:

Innovative contracting is a term used to describe situations in which a VBP network negotiates to provide a service that the public sector is already providing, either at a cheaper cost or at the same cost, but aligning that service to maximize health outcomes. Payment in this model might be cost-based reimbursement, input-based, or performance-based.

Risk:

Risk in this model is moderate for the VBP network. The contracting model is standard for many types of service provision and the financial risk is limited by the terms of the contract. One barrier in

this model is political inertia that militates against innovation. A second barrier in this model is that the health care system is taking on delivery of a service to which is may not be accustomed. Rigorous evaluation is an important component.

Please refer to Appendix D for an example of innovative contracting.

Recommendation #23:

Provider networks could invest in one or more social impact bonds.

- **All Level Providers:** Guideline

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

Social Impact Bonds are an innovative financial tool that enables government agencies to pay for programs that deliver or have the potential to improve results, overcome barriers to innovation, and encourage investments in cost-saving preventive services. Generally, investors provide working capital to an intermediary who hires the entity to perform the intervention. A third party evaluator determines whether or not the performance objective has been achieved, and then the government pays the intermediary, who repays the investor with a return for the upfront risk. The third party evaluator should propose analytic strategies that do not require limited access to the proposed intervention for any eligible individual or populations. In the case of VBP, the VBP contractor could serve as the investor or co-investor, contract with a service provider(s) within its network to provide the intervention, and, if successful, share in the return paid by the government entity based on a third party evaluation.

Risk:

Risk in this model is high. The VBP network is investing in an intervention with full risk if the intervention does not yield the targeted results. However, it also has the opportunity to profit, paid by a part of the public sector not involved in health care, for having taken that risk, even while using an intervention proven to improve health outcomes.

Please refer to Appendix D for examples of social impact bonds.

Recommendation #24:

The State should assess economic development investments.

- **The State:** Recommendation

Implementation Mechanisms that Require Change: (State Policy)

- State Legislation
 Model Contract
 DOH Policy
 None



Description:

Community conditions' impact on residents' health is well documented. The State should assess economic development investments for their impact on SDH and require that Regional Economic Development Councils undertake the same assessment. The Rochester-Monroe County Anti-Poverty Initiative is a current example of how this type of assessment may lead to investments that directly target poverty, poor housing stock, and other drivers of SDH. The State of New York is significantly investing in improving the economic development climate in specific regions and across the state. The Upstate Revitalization Initiative³³, for example, identifies Medicaid Redesign as a State initiative that can be leveraged to enhance economic development investments.

4. Providing CBOs technical assistance and education for VBP

Description:

The SC discussed how to incorporate technical assistance and education for CBOs to support integration into the VBP initiative. The recommendations are categorized into four sections: (a) Decreasing the Knowledge Deficit; (b) Understanding and addressing capacity, monetary, and infrastructure deficits; (c) Overcoming infrastructure challenges; and (d) CBO involvement in the development of VBP networks.

The expectation is that VBP networks should work with all types of CBOs that address SDH, particularly non-profit organizations that have not traditionally billed Medicaid (Tier 1, below). The purpose of the categories below was to guide the discussion on the support and technical needs of CBOs in VBP. CBOs may, in some cases, include county-operated organizations and may fit into more than one of the tiers listed below.

- Tier 1 - Non-profit, Non-Medicaid billing, community-based social and human service organizations (e.g. housing, social services, religious organizations, food banks).
- Tier 2 - Non-profit, Medicaid billing, non-clinical service providers (e.g. transportation, care coordination).
- Tier 3 - Non-profit, Medicaid billing, clinical and clinical support service providers licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office with Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

a. Decreasing the knowledge deficit

Recommendation #25:

The State and/or a third party should develop educational materials on VBP that focus on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks and MCOs. Additionally, the State and/or a

³³ Regional Economic Development Councils. *New York Upstate Revitalization Initiative*. Apr 2015. Web. <https://www.ny.gov/sites/ny.gov/files/atoms/files/2015UpstateRevitalizationInitiative_FINAL1.pdf>



third party should provide technical assistance for the providers/provider networks and MCOs (non-CBO) contracting entities on how to work effectively with CBOs.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

This recommendation aims to achieve several objectives. First, it will explain the changes that CBOs can expect to see from VBP and managed care (e.g. healthcare delivery changes, payment structure changes, more focus on preventive medicine). Second, it should provide guidance on how an organization could self-assess its readiness to overcome potential challenges. Third, educational materials should outline interventions (program initiatives) a CBO could consider as part of its “value proposition” to potential payers (e.g. fees for the CBOs services, outcome measurements, possible savings) as well as methods to assess contracting opportunities. Basic educational information could be communicated over several mediums (e.g. webinars, forums, a VBP CBO page on the DOH website, frequently asked questions, readiness checklist). Fourth, providers/provider networks, and MCOs should be educated about potential CBO partners, how to work with CBOs and what benefits they offer.

Recommendation #26:

The State should create a workgroup to determine the possibility of, or options for, developing a user-friendly, bidirectional system that enhances communication and streamlines the referrals process between providers/provider networks and CBOs to better address members’ SDH needs. Once the system has been developed, the State should ensure providers/provider networks implement the system within their networks. The providers/provider networks should collaborate with CBOs to ensure the correct and relevant SDH information is collected.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The workgroup should not only research what is needed in this new system but also determine if there are systems currently available that could provide some of the needed information in the interim. Consideration should be given to a system that meets some of the criteria and has the ability to be implemented at low cost within a short timeframe, while an ideal system is being created.

Linking members to the proper resources, primarily local CBOs, is necessary to better address SDH.



This proposed system should interface with existing EMRs and provide data on a member’s SDH screening and a corresponding list of CBOs that address the identified needs. Additionally, the system should be created to support and streamline the referrals process between providers and CBOs. The provider’s success of linking the member to an organization that meets the member’s needs could be reported as a metric. CBOs will need to be heavily involved in the linking of SDH to CBOs to ensure the system covers all of the services necessary.

The State could explore the use of the Regional Health Information Organizations (RHIO) and State Health Information Network of New York (SHIN-NY) as the data repository for CBOs to share data where SDH can be measured against DSRIP goals. The local Offices for the Aging could be consulted about the data they collect through their various CBO agencies and how that data can be shared to determine their impact on SDH and DSRIP goals.

Recommendation #27:

The State should create a “design and consultation team” of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support in a way that is affordable to CBOs who are either involved or considering involvement in VBP.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The goal of the “design and consultation team” should be to prepare CBOs with the information and support needed to create effective partnerships with health care entities (e.g. health plans, providers, provider networks). The team of experts should include individuals knowledgeable in VBP, finance, operations, legal, and contracting, to provide the appropriate support to CBOs through structured management, education, and technical assistance.

b. Understanding and addressing capacity, monetary and infrastructure deficits

Recommendation #28:

The State or a third party should develop criteria for CBOs to self-assess their readiness to enter into VBP arrangements. This will provide information to assist the CBO with areas where further development may be necessary before entering a VBP contract.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

CBOs are essential to the success of DSRIP and VBP transformation efforts. A structured approach should be taken with CBOs that wish to be involved in or are considered fundamental to the success of VBP. Based on the criteria identified by the State or a third party, the CBO’s self-assessment should consist of an analysis of strengths, weaknesses, opportunities, and threats (SWOT analysis). Areas to consider in this evaluation might include assessing technology needs in order to perform at the required level; the ability to effectively set pricing, understand volume capacity, and report service costs; and the ability to measure the effectiveness of the services provided. The evaluation should assist the CBOs with identifying and understanding the areas needing improvement or development before attempting to contract with providers/provider networks.

c. Overcoming infrastructure challenges

Recommendation #29:

State funding should be made available to CBOs to facilitate their participation in specific VBP arrangements.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

CBOs will need funding for infrastructure development, including IT systems (e.g. ability to measure and collect data to demonstrate their value), contracted services (e.g. fiscal and legal expertise), and other areas needing assistance. In addition, the State should explore mechanisms for how it could assist and support CBOs if payment or cash flow issues arise.

Recommendation #30:

The State should encourage integration of community-based care teams into the clinical care setting, and similarly, the collaboration of clinical care teams into the community-based care setting.

- **The State:** Recommendation

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Given the vast array of community based services, clinical Case Managers may not fully understand the ever-changing services and admission criteria of CBOs. Likewise, CBO Case Managers may not fully understand the clinical side. Integrating community-based care teams from CBOs into the



clinical care setting and encouraging collaboration of clinical-based care teams into the community-based setting will improve efficiency in finding and transferring members to lower levels of care where they can receive the treatment needed. This may ultimately decrease costs. The care teams from the CBOs and clinical settings should provide training to one another to strengthen care coordination and the Case Management Department.

d. CBO involvement in the development of VBP networks

Recommendation #31:

Every level two or three VBP arrangement will include a minimum of one Tier 1 CBO (definition of CBO Tiers on pg. 58) starting January 2018. The State will, however, make financial incentives available immediately for plans and providers who contract with Tier 1 CBOs.

- **All Level Providers:** Standard
- **Level 2 MCOs:** Standard
- **The State:** Standard

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Many CBOs have years of experience improving SDH. This expert understanding of community needs, coupled with support and clinical expertise of a provider network, could make a significant positive impact on population health and generate savings for the entities involved.

Providers/Provider networks and MCOs should partner with organizations that have objectives aligning with their own, the community needs, and member goals. The CBO should work with the providers/provider networks and MCOs to deliver interventions that support SDH and advance DSRIP goals.

After a period of two to three years, the State should create a process, which would include an independent retrospective review of the role of the CBO, to determine if the VBP providers are adequately leveraging community based resources. The review should also identify best practices and determine if further guidance or technical assistance is needed to maximize utilization of community resources.

The State recognizes that CBOs may not exist (within a reasonable distance to providers) in some regions of New York State, thus making collaboration (with the goal of serving the local Medicaid population) between the providers and CBOs inefficient and ineffective. In this case, the providers/provider networks would be exempt from this Standard but only until the time when CBOs are present in the community. These providers should apply to the State for rural exception.



Advocacy and Engagement

Goals

The goal of the Advocacy and Engagement Subcommittee was to: design a program that incentivizes patients to make lifestyle choices proven to improve health and reduce downstream costs (i.e. reduce Emergency Room visits); focus on patients' rights to know the incentives that affect their care and how to communicate to patients and providers; and develop strategies around what and when information related to VBP and DSRIP will be communicated to members, working in close collaboration with consumer advocates.

Agenda

The Advocacy and Engagement Subcommittee developed recommendations on the agenda topics below. **There are multiple recommendations for each agenda topic, comprising of 16 recommendations in total.**

1. Creating a member incentive program
2. Development of Patient Reported Outcomes (PRO)
3. Defining what the Medicaid Member has a right to know about VBP

Recommendations

1. **Creating a Medicaid Member incentive program.**

Description:

Currently, many Managed Care Organizations (MCOs) throughout the State have member incentive programs. The recommendations for incentives will assist providers and MCOs in improving current and/or adding new incentives to offer in the future.

In the context of VBP arrangements in Medicaid, both the providers and payers are interested in using member incentives to improve outcomes and reduce costs. Incentives offered by providers create a different dynamic than incentives by MCOs, but the two can be smartly combined. As savings are realized, providers and MCOs could consider increasing and/or offering new incentive programs to continue to drive value in the healthcare system.

Member incentives should assist and encourage members to make effective choices and address:

- **Member Activation** (e.g. selecting/contracting a Primary Care Provider, engaging with a patient navigator)
- **Proper System Utilization** (e.g. use of "in-network" high-value providers)
- **Preventive Care** (e.g. setting health goals, attending workshops and information sessions)
- **Healthy Lifestyles** (e.g. proper nutrition, smoking cessation)
- **Disease Management** (e.g. taking ownership of care, including mental health, palliative/end of life care and transition care)

Overall, the well-being of individuals, families, and communities should be the driving purpose of a

health care system and incentive programs.

Recommendation #1:

Develop a Member Incentive Program.

- **All:** Guideline
- **The State:** Recommendation

All MCO and providers should offer member incentives in the VBP environment. The State should offer financial incentives to reward MCOs and providers who implement member incentives.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Member incentives are currently being offered by several MCOs. Since a provider and MCO could potentially offer incentives to the same member, there needs to be good communication to eliminate incentivizing the member for the same program. The entity (provider or MCO) that provides and will benefit from the member incentive program should be the one responsible for funding that incentive. Providers will have the flexibility to experiment/test various incentive programs across different member populations and have the ability to request a waiver, from the Department of Health, to opt out of the incentive program. The State should make available specific financial incentives to reward MCOs and providers for developing and offering a member incentive program.

Recommendation #2:

Guidelines for Acceptable Practices When Developing Member Incentive Programs.

- **All:** Guideline

The State should create guidelines to inform and educate Providers and MCOs about anti-kickback and fraudulent claims laws in order to ensure that incentive programs do not violate regulations associated with incentivizing and influencing members to select particular providers.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

Federal and State regulations prohibit incentivizing members to seek care from a particular provider. However, given the broad language and lack of specificity within these regulations, the State should develop guidelines to better inform providers and MCOs about the scope of acceptable practices as they develop member incentive programs.

Recommendation #3:

Guiding Principles for Member Incentive Programs.

- **All:** Guideline

Incentive programs take into account a set of guiding principles in their design and implementation.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

The following guiding principles should be the building blocks of all member incentives. These principles are:

- Provide information about the program* – Providers will provided detailed information to members concerning any incentive program they implement
- Culturally sensitive* -- Ensuring cultural sensitivity is necessary to provide successful outcomes as cultural norms differ and may need to be incentivized differently
- Unbiased* -- Creating unbiased incentives is necessary to comply with federal laws. Incentives must not leave out any groups (e.g. ethnicity, education, race, social class)
- Possess equity* -- Equality is not enough when providing incentives, rather maintaining equity should also be considered. (e.g. equality would be providing a pair of size 10 shoes to everyone; equity is providing a pair of the correct size shoes to everyone)
- Does not promote negative behavior* -- Incentives should not promote behaviors that could harm or have the possibility of producing poor outcomes. (e.g. incentivizing members not to use the ED could have negative outcomes if the member has a medical emergency when the ED would be a proper choice for treatment)
- Provide reward as promised in a timely manner from when it is earned* -- Members should not have to wait lengthy amounts of time to receive their incentive. Timely reward redemption is critical to success
- Communicated appropriately in a timely manner* -- Incorporate the most appropriate and farthest-reaching vehicle to communicate the incentive so as not to exclude members. (e.g. lack of literacy and technology should be considered). Appropriate messaging should capture high quality outcomes.



- h) *Be relevant* -- If barriers exist that prevent the members from using the incentive, the incentive will not hold much value. (e.g. a members is given a gym membership as an incentive but has no transportation to get to the gym)
- i) *Measurable* -- Creating an incentive which is measurable provides metrics which provide outcome information and proving efficacy

Recommendation #4:

Creation of an Expert Group for Achieving Cultural Competence in Incentive Programs.

- **All:** Guideline

The State should convene a group of experts and consumers to create more detailed guidance (e.g a “checklist”) for the development of incentive programs. The more detailed guidance should track the guiding principles in Recommendation #3 with a particular focus on creating more specific suggestions for achieving cultural competency in program design.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Programs that support the member’s role in promoting positive health outcomes should be evidence- based and should focus on increasing access to strategies for prevention and treatment of disease. In addition, programs need to incorporate respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors (e.g. race, ethnicity, language, urban/rural, LGBT). Further, incentives that promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people and recommends consumers be involved in the group that the State convenes.

Recommendation #5:

Elimination of the \$125 Incentive Cap for Preventive Care.

- **All:** Standard

The State to eliminate the \$125 incentive cap for preventative care services in the current New York State (NYS) Medicaid managed care model contract.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

Currently the NYS Medicaid managed care model contract sets a maximum reward of \$125 annually in fair market value per Enrollee for completion of a health goal (e.g. finishing prenatal visits, participating in smoking cessation, etc.). This reward is limiting and could decrease the efficacy of an incentive program, and/or have no positive effect at all. The State should remove the cap and allow providers and MCOs to establish fair market values that will result in successful health outcomes.

Recommendation #6:

Implementation of Pilot Incentive Programs

- **All:** Guideline

Established VBP Pilot Programs currently in development for early adopters should be considered as a vehicle for piloting incentive programs.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Developing an incentive program can be a challenging but rewarding. Design and implementation will require careful thought and consideration about the types of incentive, the target member population and the measurement of outcomes. Early adopter of VBP will be piloting specific clinical bundle(s) and could also consider piloting member incentives as part of the bundle to improve health incomes. An example of this could be a pilot program for members in the maternity bundle that would encourage postpartum moms to breast feed by giving them a free breast pump, or free diapers attending baby checkups. However, design and implementation of incentive programs do not necessarily need to be limited to the bundle(s) chosen by the pilot or even to those participating in pilot programs altogether.

Recommendation #7:

Incentive Program Outcome Measurement

- **All:** Guideline

The State should provide or contract a third party to evaluate outcomes of incentive programs implemented for Medicaid.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None



Description:

Any well-thought out incentive program requires close, unbiased attention to details, evaluation and measurement to ensure a program is a success for improving health outcomes. Given the potential variations of incentive programs and the large number of members in a program, providers could be given some flexibility to identify a subset of relative outcomes to report on. The State and/or third party evaluator should review and evaluate if the metric measures the incentive goals, and provide assistance in redesigning the metrics if necessary. When a third party is contracted to evaluate outcomes, the activities that include a behavioral health component will be overseen by a cross-agency group (e.g. representatives from OMH, OASAS and other NYS agencies). The State should analyze the data minimally on an annual basis and identify best practices. The reports from the evaluation should be compiled and included in a public library of knowledge (see Recommendation #8 below).

Recommendation #8:

Development of a Library of Knowledge on Incentive Programs.

- **All:** Guideline

The State should develop a library of knowledge where all providers, payers and members will have access to information on current incentive programs as well as past programs and their efficacy.

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

Developing a centralized library of knowledge for incentive programs across the state for, provider/provider networks, MCOs and Medicaid members will lead to state-wide collaboration and best practice on member incentives. The State should consider leveraging the DSRIP Digital Library for this recommendation.

2. Development of Patient Reported Outcomes (PRO)

Description:

The Advocacy and Engagement SC discussed the importance of providers incorporating the member’s perspective in quality measurement and improvement, through the use of PRO measures. PRO measures are a key instrument in activating the member, putting them central in the evaluation process, enabling them to be better informed about their treatment and outcomes, and making an informed selection of providers. PRO measures can stimulate providers to become oriented towards member goals rather than their own goals, and create a powerful instrument for



constant self-improvement. Although utilizing the PRO measures may seem like an additional burden to providers, they can be incorporated into a provider’s current assessment tool.

Recommendation #9:

Providers should utilize PRO measures in their practice.

- **All:** Guideline

Providers are encouraged to utilize PRO measures in order to assess members’ well-being, feeling and functioning over time, engage members in developing their treatment plans, and facilitate shared decision-making between members and providers. Providers should have the flexibility to choose the mechanism they deem most appropriate for utilizing PRO measures, including introducing selected PRO measures in a brief independent survey or incorporating relevant PRO measure questions into existing assessment tools. Consideration should be given to gathering PRO measures during member visits. This will help providers understand how members are progressing, address any concerns real-time, and track their progress over time.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Incorporating the member’s voice and perspective through the use of PRO measures is a crucial element for clinical care, quality performance management, and clinical research. PRO measures are any report coming directly from a member regarding their health condition and treatment. This may include symptoms as well as functional status and health-related quality of life, allowing physicians to gain a better understanding of less tangible symptoms, such as emotional health and/or fatigue. Some PRO measures are generic and appropriate for use in a wide range of conditions, while others focus on the specific symptoms and side effects of a given disease, condition or treatment.³⁴ Certain providers may be unfamiliar with designing and utilizing PROs. To assist providers the State could consider providing consultative services to providers who are seeking to design PRO measures.

Recommendation #10:

Providers should incentivize members to complete PRO measure questionnaires.

- **All:** Guideline

³⁴ Advances in the Use of Patient Reported Outcome Measures in Electronic Health Records, November 7, 2013. Albert W. Wu, MD, MPH, Roxanne E. Jensen, PhD, Claudia Salzberg, MS, Claire Snyder, PhD

PRO measures helps to facilitate communications around quality of life issues and allows the member to feel supported and included in their care. Providers must receive responses from members in order for care to be improved. To increase survey rates, providers should consider incentivizing members to complete questionnaires.

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

It can be difficult to predict the level of survey participation, as response rates vary widely and a number of factors can impact the return rate. Studies show that offering respondents an incentive can greatly increase response rate.³⁵ Providers choosing to utilize a separate questionnaire for PRO measures as opposed to incorporating them as part of their clinical assessment tool should consider giving incentives to members to encourage participation and completion of the questionnaire. All members who complete the questionnaire, regardless of where (e.g. at home or in the provider’s office) should be eligible for the incentive.

Recommendation #11:

Implementation of pilot PROs program.

- **All:** Guideline

The VBP Pilot Programs, currently in development for early adopters, be considered as a vehicle for piloting the use of PRO measures in an assessment tool.

Implementation Mechanisms that Require Change:

- State Legislation
 Model Contract
 DOH Policy
 None

Description:

Early adopters of VBP will be piloting specific episodic and chronic care bundle(s) and may also consider piloting the use of PRO measures in their assessment tools to improve health outcomes. However, the design and implementation of PROs do not necessarily need to be limited to the bundle(s) chosen by the pilot or even to those participating in pilot programs altogether. In fact, all providers are encouraged to look for opportunities to incorporate PRO measures into their clinical practice, regardless of where they are in their path to VBP. By increasing member engagement, PROs will be an effective tool for improving members’ health outcomes and for provider self-improvement.

³⁵ The Use and Effects of Incentives in Surveys. E. Singer, Survey Research Center, University of Michigan



3. Defining what the Medicaid Member has a right to know about VBP

Description:

The New York State VBP Roadmap states that, “Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to members.” One goal of the Advocacy and Engagement SC is to ensure Medicaid members are well-informed as to what it means to be a member of an MCO, a PPS, and a provider that is participating in VBP.

Recommendation #12:

As a key component of member engagement, Medicaid Members Have a Right to Know about VBP and Fee for Service (FFS).

- **All:** Guideline

The State should ensure that information concerning VBP and how it varies from FFS is communicated effectively to Medicaid members. The State should communicate general information about new structures and incentives under VBP. MCOs or ACOs should communicate more specific information about VBP and FFS programs their members are enrolled in.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

Communication about VBP should include the impact on patient-centered care, payment structure changes influencing provider decision-making, clinical and quality data-sharing, and plan denials.

The following is a list of suggested, general information the State should communicate to members:

- VBP differs from the existing fee for service payment model in that it strives to reward value over volume by improving outcomes and decreasing unnecessary services/tests which drive up costs
- Providers’ and MCOs’ performance on outcome measures as well as their share in both savings and costs
- Current Medicaid Managed Care rights and protections in place for members will not change with the transition to VBP
- The member always has the right to seek a second opinion or change providers. This includes the right to information on how to seek a second opinion or change providers
- Members have the right to be informed of the availability of specific advocacy programs, including Ombuds programs and the right to seek assistance from such programs if they feel they need assistance accessing care and services
- Information about plan denials and members not being held responsible for tests and/or services when payment for the treatment is denied



- The benefits of data sharing while recognizing the member’s right to confidentiality of their personal health information

MCOs should communicate the following, more specific information to their members, tailored to the program they are enrolled in:

- Plan for how providers will create a holistic approach to care. It is expected that providers will collaborate with Community Based Organizations and address Social Determinants of Health to best serve their members. Moreover, providers will effectively coordinate care with specialty providers and others in their member’s care team.
- Information concerning the quality outcomes providers will be measured against and the way in which providers will be rewarded when members’ health outcomes improve.
- Any incentive programs offered by provider that will assist with improving overall health outcomes.
- Information about the benefits of data sharing as well as information on how and with whom confidential information may be shared and the right to not have information shared.

Recommendation #13:

Update the current Managed Care Patient Bill of Rights.

- **All:** Guideline

The State should convene a workgroup to update the current Managed Care Patient Bill of Rights to include information relevant to the VBP context.

Implementation Mechanisms that Require Change:

- State Legislation Model Contract DOH Policy None

Description:

To complement the State’s VBP efforts, it is an opportune time to commission an updated Patient Bill of Rights that clearly states that member’s rights, under Medicaid Managed Care, remain the same and includes reference to new entities which will operate under VBP. The updated Patient Bill of Rights should minimally include the key points referenced in Recommendation #1. Once complete, the State should make this available to MCOs for distribution to their membership.

Recommendation #14:

Publish Easy to Understand Information.

- **All:** Guideline

The State should publish easy to understand information, for Medicaid members assigned to a VBP bundle, about their provider’s performance.

Implementation Mechanisms that Require Change:

State Legislation
 Model Contract
 DOH Policy
 None

Description:

It is in the best interest of members to select providers and plans who deliver high quality care and have the best outcomes. The State should publish information on provider’s and plan performance within VBP bundles that is relevant, user-friendly, and easy to understand for the member including provider-specific utilization trends that compare historical and current service delivery and referrals. This information will assist members in making appropriate and well-informed choices about where they seek their care.

Recommendation #15:

Develop a plan on how to best provide information.

- **All:** Guideline

The State should create a workgroup to develop a plan on how to best provide the information about VBP referenced in these recommendations to Medicaid members.

Implementation Mechanisms that Require Change:

State Legislation
 Model Contract
 DOH Policy
 None

Description:

There are many vehicles in which to provide information to consumers, therefore a workgroup should create guidelines on how and when the State, MCOs and providers ought to distribute VBP information to members. The following are examples of how and when to communicate information that may be considered by the workgroup.

Examples of how to communicate:	Examples of when to communicate:
Public messaging (TV, radio, social media)	During system-wide shift
Websites	Continuously
Mailed letters	Upon enrollment
MCO Handbook	Yearly
Videos	When VBP changes occur within a members’ network
Call centers	When a member requests information
Patient Bill of Rights	Upon enrollment and upon request
Explanation of Benefits	

Recommendation #16:

Expand the Ombuds program.



• **All:** Guideline

The State should expand the Ombuds Program for people with Medicaid long-term care services to include Medicaid members enrolled in VBP. Ombuds staff should have expertise in issues related to VBP, the potential for a less comprehensive array of treatment options, and members’ right to second opinions and provider changes.

Implementation Mechanisms that Require Change:

- State Legislation
- Model Contract
- DOH Policy
- None

Description:

The State currently funds an Ombuds program for Medicaid members receiving long-term care services. The program provides counseling about health insurance and helps Medicaid members solve problems related to their managed care plans or providers. The State’s Ombuds program is currently limited to members receiving long-term care, and although it is still evolving, the State should expand the program to include all Medicaid members enrolled under VBP and ombudsman staff should have expertise in VBP. Since the change to VBP may be complex and confusing to members, an ombudsman could be a valuable resource if issues arise and the member needs assistance with accessing coverage or services. Because VBP will be applicable to the vast majority of Medicaid members and the transition may be complex, the State should consider expanding the Ombuds program to all Medicaid members.

Appendix A: DSRIP Domain 2 and 3 Measures

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP): MEASURE SPECIFICATION AND REPORTING MANUAL

Table 5. Domain 2 Measures

Measure Name	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 Avoidable 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	15.15 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 Avoidable 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	167.94 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 4.4	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 as of June 30 of measurement year	330.79 per 100,000 Medicaid Enrollees # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

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Measure Name	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
PDI 90– Composite of all measures ±	AHRQ 4.4	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 pediatric prevention quality indicators	Number of people 6 to 17 years as of June 30 of measurement year	40.94 per 100,000 Medicaid Enrollees # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	NA	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Dollars paid by MCO under value based arrangements	Total Dollars paid by MCOs	NA – Pay for Reporting measure only	1	NYS DOH	P4R	P4R
Percent of eligible providers meeting Meaningful Use criteria, who have participating agreements with qualified entities (RHIOs) and are able to participate in bidirectional exchange	NA	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of eligible providers meeting meaningful use criteria, who have at least one participating agreement with a qualified entity (RHIO), and are able to participate in bidirectional exchange	Number of eligible providers meeting meaningful use criteria in the PPS network	NA – Pay for Reporting measure only # SW measure	1	NYS DOH	P4R	P4R
Percent of PCP providers meeting PCMH (NCQA) or Advance Primary Care (SHIP) standards	NA	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of PCP providers meeting PCMH or Advance Primary Care Standards	Number of PCP providers in the PPS network	NA – Pay for Reporting measure only # SW measure	1	NYS DOH	P4R	P4R

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Measure Name	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
Primary Care - Usual Source of Care - Q2	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Percent of Responses 'Yes'	All Responses	100%^ # SW measure	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Primary Care – Length of Relationship – Q3	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Percent of Responses at least '1 year' or longer	All Responses	100%^ # SW measure	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Adult Access to Preventive or Ambulatory Care – 20 to 44 years	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 20 to 44 as of June 30 of the measurement year	91.1% # SW measure	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Adult Access to Preventive or Ambulatory Care – 45 to 64 years	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 45 to 64 as of June 30 of the measurement year	94.4% # SW measure	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

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Measure Name	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
Adult Access to Preventive or Ambulatory Care – 65 and older	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 65 and older as of June 30 of the measurement year	94.4% # SW measure	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children’s Access to Primary Care – 12 to 24 months	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement period	Number of children ages 12 to 24 months as of June 30 of the measurement year	100.0% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children’s Access to Primary Care – 25 months to 6 years	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement period	Number of children ages 25 months to 6 years as of June 30 of the measurement year	98.4% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children’s Access to Primary Care – 7 to 11 years	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement period or year prior	Number of children ages 7 to 11 years as of June 30 of the measurement year	100.0% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children’s Access to Primary Care – 12 to 19 years	HEDIS 2015	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the	Number of children ages 12 to 19 years as	98.8% # SW measure	0.25 if annual improvement target or	NYS DOH	P4R	P4P

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Measure Name	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
				measurement period or year prior	of June 30 of the measurement year		performance goal met or exceeded			
Getting Timely Appointments, Care and information (Q6, 8, and 10)	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number responses ‘Usually’ or ‘Always’ got apt for urgent care or routine care as soon as needed , and got answers the same day if called during the day	Number who answered they called for appointments or called for information	100%^ # SW measure	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Helpful, Courteous, and Respectful Office Staff (Q21 and 22)	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number responses ‘Usually’ or ‘Always’ that clerks and receptionists were helpful and courteous and respectful	All responses	100%^ # SW measure	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Medicaid Spending on ER and Inpatient Services ±		NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Total spending on ER and IP services	Per member per month of members attributed to the PPS as of June of the measurement year	NA – Pay for Reporting measure only	1	NYS DOH	P4R	P4R
Medicaid spending on Primary Care and community based behavioral health care		NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Total spending on Primary Care and Community Behavioral Health care as defined by MMCOR categories	Per member per month of members attributed to the PPS as of June of the measurement year	NA – Pay for Reporting measure only	1	NYS DOH	P4R	P4R

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Measure Name	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
H-CAHPS – Care Transition Metrics (Q23, 24, and 25)	V9.0	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Average of hospital specific results for the Care Transition composite	Hospitals with H-CAHPS participating in the PPS network	100%^	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Care Coordination (Q13, 17 and 20)	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number responses ‘Usually’ or ‘Always’ that provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines	All responses	100%^ # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
PAM Level	NA	NA	2.d.i	Interval measure of % of members of total with Level 3 or 4 on PAM	Baseline measure of % of members of total with Level 3 or 4 on PAM	Ratio greater than 1	1 if ratio greater than 1	PPS	P4R	P4P
Use of primary and preventive care services- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU	NA	NA	2.d.i	The percentage of NU and LU Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code.	Baseline percentage of NU and LU Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code.	Ratio lower than 1	1 if ratio lower than 1	NYS DOH	P4R	P4P

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Measure Name	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
and LU Medicaid Members)										
ED use by uninsured	NA	NA	2.d.i	Annual measure of # Emergency Medicaid ED visits/1000 Emergency Medicaid Recipients	Baseline measure of # Emergency Medicaid ED visits/1000 Emergency Medicaid Recipients	Ratio less than 1	1 if ratio less than 1	NYS DOH	P4R	P4P
C&G CAHPS by PPS for uninsured	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.d.i	Using the C&G CAHPS Survey, Annual measure of four composite measures.	Using the C&G CAHPS Survey, three composite measures and one rating measure: 1) Getting timely appointments, care, and information 2) How well providers (or doctors) communicate with patients 3) Helpful, courteous, and respectful office staff 4) Patients' rating of the provider (or doctor)	NA – Pay for reporting only	0.25 for each composite/rating result	PPS	P4R	P4R

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Table 6. Domain 3 Measures

Measure Name	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
Domain 3 - Clinical Improvement Projects										
Potentially Preventable Emergency Room Visits (for persons with BH diagnosis) ±	3M	NA	3.a.i – 3.a.iv	Number of preventable emergency room visits as defined by revenue and CPT codes	Number of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year	47.55 per 100 Medicaid enrollees with Behavioral Health Qualifying Service *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Antidepressant Medication Management – Effective Acute Phase Treatment	HEDIS 2015	0105	3.a.i – 3.a.iv	Number of people who remained on antidepressant medication during the entire 12-week acute treatment phase	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication	60.0% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Antidepressant Medication Management – Effective Continuation Phase Treatment	HEDIS 2015	0105	3.a.i – 3.a.iv	Number of people who remained on antidepressant medication for at least six months	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication	43.5% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

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Measure Name	Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment:	Payment: DY 4 and 5
Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS 2015	1934	3.a.i – 3.a.iv	Number of people who had both an LDL-C test and an HbA1c test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and diabetes	89.8% *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DO H	P4 P	P4P
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	HEDIS 2015	1932	3.a.i – 3.a.iv	Number of people who had a diabetes screening test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic	89.0%	1 if annual improvement target or performance goal met or exceeded	NYS DO H	P4 P	P4P
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS 2015	1933	3.a.i – 3.a.iv	Number of people who had an LDL-C test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease	92.2% (health plan data) *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DO H	P4 P	P4P
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase	HEDIS 2015	0108	3.a.i – 3.a.iv	Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication	Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication	72.3%	0.5 if annual improvement target or performance goal met or exceeded	NYS DO H	P4 R	P4P
Follow-up care for Children Prescribed ADHD	HEDIS 2015	0108	3.a.i – 3.a.iv	Number of children who, in addition to the visit in the Initiation	Number of children, ages 6 to 12 years, who were newly	78.7% (health plan data)	0.5 if annual improvement target or	NY S DO	P4 R	P4P

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Measure Name	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
Medications – Continuation Phase				Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended	prescribed ADHD medication and remained on the medication for 7 months		performance goal met or exceeded			
Follow-up after hospitalization for Mental Illness – within 7 days	HEDIS 2015	0576	3.a.i – 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge	Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders	74.2% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Follow-up after hospitalization for Mental Illness – within 30 days	HEDIS 2015	0576	3.a.i – 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 30 days of discharge	Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected	88.2% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP): MEASURE SPECIFICATION AND REPORTING MANUAL

Measure Name	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
					mental health disorders					
Screening for Clinical Depression and follow-up	NYS DOH	NA	3.a.i – 3.a.iv	Number of people screened for clinical depression using a standardized depression screening tool, and if positive, with follow up within 30 days	Number of people with a qualifying outpatient visit who are age 18 and older	100%^	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Adherence to Antipsychotic Medications for People with Schizophrenia	HEDIS 2015	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 2015	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	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	86.0%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

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Measure Name	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
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	HEDIS 2015	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	31.4%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Potentially Preventable Readmissions for SNF patients ±	3M, using SPARCS and MDS data	NA	3.a.v	Number of at risk admissions followed by a clinically related readmission within 30 days of discharge for long stay nursing home residents (greater than 100 days)	Number of at risk admissions (excludes malignancies, trauma, burns, obstetrical, newborn, left against advice and transfers)	0.0% [^] *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Percent of Long Stay Residents who have Depressive Symptoms	MDS 3.0 Measure #0690	NA	3.a.v	Residents with an assessment with either 1) the resident expressing little interest or pleasure, or feeling down or depressed or hopeless in half or more of the days over the last 2 weeks and a resident interview total severity score indicates the presence of depression;	Long stay residents (101+ days) with an assessment	0.16%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

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				resident demonstrates little interest or pleasure, or feeling down or depressed or hopeless in half or more of the days over the last 2 weeks and a staff assessment interview total severity score indicates the presence of depression						
Prevention Quality Indicator # 7 (Hypertension) ±	AHRQ 4.4	0276	3.b.i – 3.b.ii	Number of admissions with a principal diagnosis of hypertension	Number of people 18 years and older as of June 30 of measurement year	11.71 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Prevention Quality Indicator # 13 (Angina without procedure) ±	AHRQ 4.4	0282	3.b.i – 3.b.ii	Number of admissions with a principal diagnosis of angina without a cardiac procedure	Number of people 18 years and older as of June 30 of measurement year	0.00 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Cholesterol Management for Patients with CV Conditions retired. NYS DOH may introduce a	TBD	TBD	3.b.i – 3.b.ii							

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cholesterol management measure in future										
Controlling High Blood Pressure	HEDIS 2015	0018	3.b.i – 3.b.ii, 3.h.i	Number of people whose blood pressure was adequately controlled as follows: <ul style="list-style-type: none"> • below 140/90 if ages 18-59; • below 140/90 for ages 60 to 85 with diabetes diagnosis; or • below 150/90 ages 60 to 85 without a diagnosis of diabetes 	Number of people, ages 18 to 85 years, who have hypertension	73.3% (2012 Data) *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Aspirin Use	HEDIS 2015	NA	3.b.i – 3.b.ii	Number of respondents who are currently taking aspirin daily or every other day	Number of respondents who are men, ages 46 to 65 years, with at least one cardiovascular risk factor; men, ages 66 to 79 years, regardless of risk factors; and women, ages 56 to 79 years, with at least two cardiovascular risk factors	100%^	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

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Discussion of Risks and Benefits of Aspirin Use	HEDIS 2015	NA	3.b.i – 3.b.ii	Number of respondents who discussed the risks and benefits of using aspirin with a doctor or health provider	Number of respondents who are men, ages 46 to 79 years, and women, ages 56 to 79 years	100%^	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit	HEDIS 2015	0027	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.e.i, 3.h.i	Number of responses ‘Usually’ or ‘Always’ were advised to quit	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	100%^	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication	HEDIS 2015	0027	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.e.i, 3.h.i	Number of responses ‘Usually’ or ‘Always’ discussed cessation medications	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	100%^	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies	HEDIS 2015	0027	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.e.i, 3.h.i	Number of responses ‘Usually’ or ‘Always’ discussed cessation methods or strategies	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	100%^ *High Perf Elig	0.33 if annual improvement target or performance	NYS DOH	P4R	P4P

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Measure Name	Specification Version	NQF #	Projects Associate d 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
							goal met or exceeded			
Flu Shots for Adults Ages 18 – 64	HEDIS 2015	0039	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.h.i	Number of respondents who have had a flu shot	Number of respondents, ages 18 to 64 years	100%^	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Health Literacy (QHL13, 14, and 16)	2357a_C&G CAHPS Adult Supplement	NA	3.b.i – 3.b.ii, 3.c.i – 3.c.ii	Number responses ‘Usually’ or ‘Always’ that instructions for caring for condition were easy to understand, described how the instruction would be followed and were told what to do if illness/condition got worse or came back	Number who answered they saw provider for an illness or condition and were given instructions	100%^	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Prevention Quality Indicator # 1 (DM Short term complication) ±	AHRQ 4.4	0272	3.c.i – 3.c.ii	Number of admissions with a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma)	Number of people 18 years and older as of June 30 of measurement year	3.98 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

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Measure Name	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
Comprehensive Diabetes screening – All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	HEDIS 2015	0055, 0062, 0057	3.c.i – 3.c.ii, 3.h.i	Number of people who received at least one of each of the following tests: HbA1c test, , diabetes eye exam, and medical attention for nephropathy	Number of people ages 18 to 75 with diabetes	62.5%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS	P4R	P4P
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±	HEDIS 2015	0059	3.c.i – 3.c.ii, 3.h.i	Number of people whose most recent HbA1c level indicated poor control (>9.0 percent), was missing or did not have a HbA1c test	Number of people ages 18 to 75 with diabetes	23.2%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS	P4R	P4P
Prevention Quality Indicator # 15 Younger Adult Asthma ±	AHRQ 4.4	0283	3.d.i – 3.d.iii	Number of admissions with a principal diagnosis of asthma	Number of people ages 18 to 39 as of June 30 of the measurement year	12.63 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Pediatric Quality Indicator # 14 Pediatric Asthma ±	AHRQ 4.4	0728	3.d.i – 3.d.iii	Number of admissions with a principal diagnosis of asthma	Number of people ages 2 to 17 as of June 30 of the measurement year	46.56 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Asthma Medication Ratio (5 – 64 Years)	HEDIS 2015	1800	3.d.i – 3.d.iii	Number of people with a ratio of controller	Number of people, ages 5 to 64 years,	76.0%	1 if annual improvement	NYS DOH	P4P	P4P

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				medications to total asthma medications of 0.50 or greater during the measurement year	who were identified as having persistent asthma		target or performance goal met or exceeded			
Medication Management for People with Asthma (5 – 64 Years) – 50% of Treatment Days Covered	HEDIS 2015	1799	3.d.i – 3.d.iii	Number of people who filled prescriptions for asthma controller medications during at least 50% of their treatment period	Number of people, ages 5 to 64 years, who were identified as having persistent asthma, and who received at least one controller medication	68.6%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered	HEDIS 2015	1799	3.d.i – 3.d.iii	Number of people who filled prescriptions for asthma controller medications during at least 75% of their treatment period	Number of people, ages 5 to 64 years, who were identified as having persistent asthma, and who received at least one controller medication	44.9%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
HIV/AIDS Comprehensive Care : Engaged in Care	QARR 2015	NA	3.e.i	Number of people who had two visits for primary care or HIV related care with at least one visit during each half of the past year	Number of people living with HIV/AIDS, ages 2 years and older	91.8%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
HIV/AIDS Comprehensive Care : Viral Load Monitoring	QARR 2015	NA	3.e.i	Number of people who had two viral load tests	Number of people living with HIV/AIDS,	82.7%	1 if annual improvement target or	NYS DOH	P4P	P4P

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				one test during each half of the past year			goal met or exceeded			
HIV/AIDS Comprehensive Care : Syphilis Screening	QARR 2015	NA	3.e.i	Number of people who were screened for syphilis in the past year	Number of people living with HIV/AIDS, ages 19 years and older	85.4%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Cervical Cancer Screening	HEDIS 2015	0032	3.e.i	Number of women who had cervical cytology performed every 3 years or women, ages 30 to 64 years, who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	Number of women, ages 24 to 64 years	83.9%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Chlamydia Screening (16 – 24 Years)	HEDIS 2015	0033	3.e.i	Number of women who had at least one test for Chlamydia during the measurement year	Number of sexually active women, ages 16 to 24	80.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Viral Load Suppression	NYS DOH	NA	3.e.i	Number of people whose most recent viral load result was below 200 copies	Number of people living with HIV/AIDS	100%^	1 if annual improvement target or performance	PPS and NYS DOH	P4R	P4P

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							goal met or exceeded			
Prevention Quality Indicator #9 Low Birth Weight ±	AHRQ 4.4	0278	3.f.i	Number of low birth weight (< 2,500 grams) newborn admissions	Number of members born during the measurement year	31.25 per 1,000 newborns	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Prenatal and Postpartum Care—Timeliness of Prenatal Care	HEDIS 2015	1517	3.f.i	Number of women who had a prenatal care visit in their first trimester or within 42 days of enrollment in Medicaid	Number of women who gave birth in the last year	93.9%	0.5 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Prenatal and Postpartum Care—Postpartum Visits	HEDIS 2015	1517	3.f.i	Number of women who had a postpartum care visit between 21 and 56 days after they gave birth	Number of women who gave birth in the last year	81.6%	0.5 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Frequency of Ongoing Prenatal Care (81% or more)	HEDIS 2015	1391	3.f.i	Number of women who received 81 percent or more of the expected number of prenatal care visits, adjusted for gestational age and month the member enrolled in Medicaid	Number of women who gave birth in the last year	81.4%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P

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Well Care Visits in the first 15 months (5 or more Visits)	HEDIS 2015	1392	3.f.i	Number of children who had five or more well-child visits with a primary care provider in their first 15 months of life	Number of children turning 15 months in the measurement period	93.3%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Childhood Immunization Status (Combination 3 – 4313314)	HEDIS 2015	0038	3.f.i	Number of children who were fully immunized (4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B, 1 Varicella, and 4 pneumococca1)	Number of children turning age 2 in the measurement period	88.4%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Lead Screening for Children	HEDIS 2015	NA	3.f.i	Number of children who had their blood tested for lead poisoning at least once by their 2nd birthday	Number of children turning age 2 in the measurement period	95.3%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Early Elective Deliveries (All inductions and cesarean sections that occur prior to onset of labor, occurring at or after 36 0/7 weeks and before 38 6/7 weeks	NYS Perinatal Quality Collaborative	NA	3.f.i	Number of scheduled deliveries (i.e. All inductions and cesarean sections that occur prior to onset of labor) occurring at or after 36 0/7 weeks and before 38 6/7 weeks	Number of scheduled deliveries (i.e. All inductions and cesarean sections that occur prior to onset of labor) occurring at or after 36 0/7 weeks	NA – Pay for Reporting measure only	1	PPS	P4R	P4R

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documentation of listed maternal or fetal reason) ±				without documentation of listed maternal or fetal reason						
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain	UAS-NY	NA	3.g.i – 3.g.ii	Number of people whose current assessment indicates the same or better response to pain than prior assessment	Number of people with a valid response for the question in both assessment periods	100%^	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Risk-Adjusted percentage of members who had severe or more intense daily pain ±	UAS-NY	NA	3.g.i – 3.g.ii	Number of people with an assessment response indicating pain in the last three days and a pain intensity response of severe or worse	Number of people with valid responses for the questions	0.0% (unadjusted)	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Risk-adjusted percentage of members whose pain was not controlled ±	UAS-NY	NA	3.g.i – 3.g.ii	Number of people with an assessment response indicating pain and a pain control response indicating not controlled	Number of people with valid responses for the questions	0.0% (unadjusted)	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Advanced Directives – Talked about Appointing for Health Decisions	UAS-NY	NA	3.g.i – 3.g.ii	Number of people with a response of yes or no to one or more of the following three: legal guardian, health care proxy or family member responsible	Number of people with an assessment	100%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

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Depressive feelings - percentage of members who experienced some depression feeling ±	UAS-NY	NA	3.g.i – 3.g.ii	Number of people who respond that they experienced some feelings related to depression	Number of people with an assessment	0.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Annual Monitoring for Patients on Persistent Medications – ACE/ARB	HEDIS 2015	NA	3.h.i	Number of people who had at least one blood test for potassium and a monitoring test for kidney function in the measurement year	Number of people, ages 18 and older, who received at least a 180-day supply of ACE inhibitors and/or ARBs	95.4%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P



Appendix B: HIPAA and State Privacy Scenarios

Scenario 1 – DSRIP Opt Out and DEAA Processes:

The DSRIP Opt Out and DEAA processes are limited to NYS provided data. The DEAA process only applies to downstream transactions and does not apply to non-state provided data. There is currently uncertainty on upstream sharing of data and data sharing from provider-to-provider for purposes of VBP.

Example: PPSs, IPAs, and ACOs may need to compare the quality of different providers to evaluate performance. This may require use of PHI (upstream or provider-to-provider) to determine shared savings and losses. Requiring distinct opt out processes per PPS or provider or requiring additional consents for each transaction would be burdensome and may cause delays in review processes and timing of payments.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Clarify that the data sharing for purposes of VBP constitutes health care operations consistent with HIPAA and NYS law.	This may eliminate the need for additional opt outs and consents specific to data sharing for purposes of DSRIP and related VBP transactions.
2. Create Exceptions to NYS Law	Create specific exceptions/state interpretation to allow for both upstream and provider-to-provider sharing of data for purposes of VBP.	Relatively efficient solution, but would not necessarily eliminate the need for all DEAAs and opt outs for purposes of DSRIP and VBP.
3. Replace existing NYS law	Replace/rewrite existing law to allow for both upstream and provider-to-provider sharing of data for purposes of VBP.	Would require a great amount of legal work to rewrite NYS law, but would allow for an updated law taking into account VBP with relevant policy considerations built into the law.

Scenario 2 – Care Management:

There is lack of clarity in the application of state confidentiality laws related to the disclosure of PHI for the purposes of care management organizations. Care management organizations may be neither covered entities nor providers, but may require access to PHI. There is also a lot of confusion about the appropriate sharing of information with and by care management agencies (including health homes) which leads to burdensome and unnecessarily complex consent processes that are not clearly communicated to consumers. If care management facilities such as Health Homes are one of the potential points of attribution in a VBP environment, these issues need to be clarified and addressed.

Example: Care Management organizations and health homes may need access to PHI to gather all necessary information to create a care management plan to better coordinate patient care. Currently, specific patient consent (in addition to current opt-out or treatment consent) may be needed for providers to disclose PHI to each entity or vendor. The consent process may delay, or in some cases deny, the care management entity’s access to patient information.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Align the application of state confidentiality laws related to disclosure of PHI for purposes of care management organizations to the goals of VBP (health care operations).	Also add more resources to support training, tools, development of standardized consents and clearer guidelines for care management agencies and providers.
2. Create Exceptions to NYS Law	Draft exceptions to the relevant Public Health Law, Mental Hygiene, and related laws on a case by case basis.	This would require consideration and cross reference of multiple laws and regulations.
3. Replace existing NYS law	Draft specific laws or regulations to govern the access and security of PHI for care management organizations.	Would require a new NYS law or regulation, but would allow for an updated law taking into account VBP with relevant policy considerations built into the law.

Scenario 3 – RHIO and SHIN-NY Data:

The RHIO and SHIN-NY data may be incomplete due to NYS patient confidentiality laws (e.g., Public Health Law §2782) which limit provider-to-provider data access. If data access is for non-treatment purposes, it is not clear what would constitute “minimally necessary” standard for health care operations. Other issues include minor consent laws, which may create a gap for 12-17 year old patient info; HIV/AIDS; mental health; and maternity and reproductive health confidentiality laws which are more restrictive than HIPAA.

Example: When a minor provides the consent for treatment, only that minor may provide consent to release the medical records or other PHI related to that visit. The RHIO opt-out and SHIN-NY opt-in do not necessarily include the consent of minor patients. Providers are therefore reluctant to provide access to minor patients’ data through the RHIOs and SHIN-NY.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Allow data sharing consistent with HIPAA (e.g., health care operations).	Does not fully solve the issue. Certain state restrictions (e.g., minor consent laws) are important to the State’s policy interests. HIPAA does not account for minor confidentiality, maternity, HIV/AIDS, and related NYS policy considerations.
2. Create Exceptions to NYS Law	Create exceptions to allow for providers to disclose and access PHI through the RHIOs and SHIN-NY to accommodate VBP.	Exceptions can be made to all or some of the following restrictions to: minor consent, HIV, mental health, and maternity confidentiality laws. This requires analysis and evaluation including an update on how the RHIOs are functioning and what protections are currently in place. This requires further discussion and a deeper understanding of the RHIO and SHIN-NY networks and scope of data access.
3. Replace existing NYS law	Replace existing NYS law to allow for providers to disclose and access PHI through the RHIOs and SHIN-NY to accommodate VBP.	This approach will require a great deal of legal work and time. However, replacing existing, pre-HIPAA law would provide the State with an opportunity to customize laws and regulations to accommodate VBP while maintaining critical policy interests.

Scenario 4 – Scope and Medicaid Consent:

The Medicaid consent form seems to allow disclosure for health care operations, but DOH legal takes a strict view of the scope of this consent. There is uncertainty among providers regarding the scope of the Medicaid consent which may lead to missing data and delays in data reporting.

Example: There is a lack of guidance on when opt-in/outs are necessary in light of the exception for health care operations contained in the Medicaid consent form. Some PPSs fear they need their own opt-out or alternative consent process to receive data from downstream providers.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	Clarify that the exception for health care operations is consistent with definition and scope contained in HIPAA.	Does not solve issue if the more restrictive NYS laws and regulations remain in place.
2. Create Exceptions to NYS Law	Clarify the scope of the Medicaid consent form and create legal exceptions, as needed, to allow alternative means of data sharing for purposes of VBP.	Would require case by case analysis of each use of Medicaid member PHI to determine whether the Medicaid consent is sufficient in scope and what exceptions to specific NYS law and regulations is required.
3. Replace existing NYS law	Replace/amend existing law to add law or regulation that addresses the scope of the Medicaid consent form to allow alternative means of data sharing for purposes of VBP.	Could require a great amount of legal work as option 2 above, but would allow for an opportunity to customize the laws and regulations to accommodate VBP while maintaining critical policy interests.

Scenario 5 – Vital Statistics (VS):

Vital Statistics have unique restrictions which render them unusable with Medicaid members. New York state regulation 10 NYCRR 400.22 suggests that only state employees may access VS. There are no exceptions or consent processes available to providers, PPSs, and NYS contractors (there are limited exceptions for non-Medicaid members).

Example: When a baby is born, it is not immediately assigned a Medicaid ID, and costs related to the birth are attributed to the mother. Once the baby receives a Medicaid ID, costs are then attributed to the baby. In some cases, the identity of the mother may be unknown (e.g., homelessness) and it is not possible to create this link. Access to VS records (collection of blood records, SSN, etc.) would help to create the mom-baby link and supplement the medical record.

	Potential Solution	Notes
1. Align NYS Law With HIPAA	N/A. There is no HIPAA equivalent.	This is a NYS specific regulation that is analyzed separately from other data privacy categories.
2. Create Exceptions to NYS Law	Create an exception to allow for access to mom-baby VS data with a DEAA or related consent process (similar to HIV, and other PHI) for limited purposes.	This may be the easiest solution, but would require additional analysis on the policy reasons behind the Medicaid restriction in the current regulation.
3. Replace existing NYS law	Replace/rewrite the existing regulation.	VS data is state collected information; this option would require coordination of multiple departments to determine the policy considerations and may be beyond what is necessary to effectuate purpose of this scenario.

Other Considerations

In addition to the scenarios and options presented above, the Subcommittee should also consider:

- (1) Other potential scenarios and options regarding patient data privacy and security; and
- (2) Whether it would be prudent for the DOH to establish a data privacy and security work group comprised of various NYS departments and stakeholders to follow these issues and implement recommendations throughout the development of VBP on a case by case basis.

Appendix C: Social Determinants of Health Intervention Menu



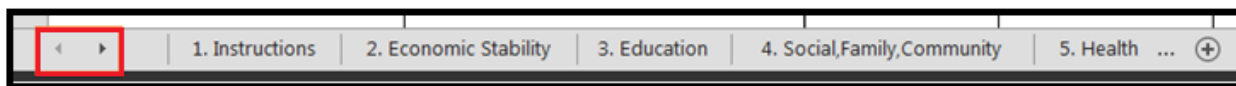
SDH Intervention
Menu.xlsx

Overview:

The subcommittee created the Intervention Menu (the Menu) to supply providers with examples of evidence based interventions that aim to improve certain SDH. There are five key areas of SDH that are addressed in the Menu: (1) Economic Stability; (2) Education; (3) Health and Healthcare; (4) Neighborhood and Environment; and (5) Social, Family, and Community Context. For each key area, the subcommittee identified specific SD and provided relevant evidence-based and promising interventions to address those key issues. Other information, such as expected health outcomes, measurement metrics, resources, references, population health objectives, and social impact, are included for each intervention where available. This menu is a starting point for providers and the State to pave the way to positively affect the SDs that have a significant negative impact on Medicaid members in the state of New York. The Menu is not a comprehensive list of allowable interventions, but rather, a sample of programs that can be used for identifying appropriate interventions to implement. Providers are encouraged, but are not required, to make selections from one or several intervention options listed in the Menu.

How to Use the SDH Intervention Menu:

The Menu is the attached Excel file located at the beginning of this appendix. The Menu consists of six worksheets. Each tab, or worksheet, is titled with a different key area of SDH, with the exception of the first tab (which includes the instructions for use). If not all six worksheets are visible, use the arrow pointing to the right to scroll to see the remaining tabs. Please see the screenshot below for reference.



To see the SDs identified for a key area of SDH, click on the appropriate tab. For example, the second tab in the Excel document is titled “Economic Stability”, and the SDs identified for economic stability along with information about the corresponding interventions are found on that tab. The information is provided in a table format, with headers at the top of each column to explain the contents of each cell. A gray line separates each SD. Please see the screenshot on the next page for reference.

1. Worksheet Tab – click on the tab to access the worksheet for the key area of SDH
2. Title – a title at the top of each worksheet shows the key area of SDH
3. Column A: Social Determinant – Each SD identified under a key area of SDH is listed in Column A. For example, there are four SDs listed for Economic Stability (all four are not pictured in the screenshot below)
4. Social Determinant(s) – In the screenshot below, the first SD group for Economic Stability is shown
5. Column B: VBP Funded Intervention Option(s) – The interventions suggested for improving the SD are listed in this column. Please note that several interventions may be listed for one SD, as pictured below.
6. The remaining columns on the spreadsheet provide additional information on the interventions, where the information exists. Note that all columns are not picture below. When in the Excel document, scroll to the right or use the arrows on your keyboard to move across the page.

Key Area of SDH: Economic Stability		
A	B	C
Social Determinant	VBP Funded Intervention Option(s)	Health Outcome(s)
Economic Instability, Poverty, and Lack of Employment	Case management/entitlement assistance with disability benefits/public assistance/other subsistence benefits/Referral to vocational rehabilitation services/Referral to child care	Improved physical and mental health quality of life
	Financial incentives for medication adherence and/or other health behaviors (ex: cash transfers, vouchers, reduction in insurance premium)	Improved medication adherence; reduction in avoidable inpatient and ER health utilization
	Provision of child care	Greater economic well-being, leading to improved health
	Provision of benefits counseling for persons moving from entitlement programs to employment	Greater economic well-being, leading to improved health
	Provide training and employment opportunities through the use of supportive employment or through the use of credentialing programs for peer specialist community health workers in OASAS, Office of Mental Health, DOH and other Medicaid funded programs to provide one avenue for returning to work	Improved physical and mental health quality of life
	Respite care	Reduced readmission/ER visits; Provide more stable environment for delivery of healthcare services; Reduction of stress and its adverse

Worksheet Tab: 2. Economic Stability | 3. Education | 4. Social, Family, Community | 5. Health and Healthcare

Appendix D: Capturing Savings Across Public Spending

Co-Investing Example: Addressing lack of adequate nutrition and isolation and lack of family/community support

Many frail elderly people live in isolation without community support. Both lack of access and the impact of isolation on mental health may then become a barrier to good nutrition. There are certainly models of health care services that could address these issues, but they can be quite costly and at least partially duplicative of services provided in the community. Senior centers provide nutritious meals and socialization, relying most often on a combination of Federal and local dollars. Generally they have few resources to deliver more than that. If, however, the VBP network were to invest in the neighborhood senior center, improving technology, providing case management or other professional staff, the program would be able to deliver outcomes for its participants that are aligned with the outcomes desired by the VBP network. By investing with the Senior Center, the VBP network would be leveraging Federal and local dollars directed toward the elderly and use them to achieve its goals.

Innovative Contracting Example: Criminal justice involvement and behavioral health

In NYS, public inebriation is treated as a criminal justice matter. People found inebriated in public are arrested by the police, taken to a local jail, and charged with a low level offense such as public intoxication, disturbing the peace, public urination or ordinary trespass. Typically, following arrest, the individual is held overnight and taken before a judge before being released after negotiated plea for time served or with a future court appearance. All of these costs are borne by the local government, and can add up to a significant sum. An innovative contract that might appeal to a local government would be for a behavioral health VBP to establish a diversionary “24-hour sobering up station” paid for by the locality at a cost lower than the current system. The locality would benefit from lower cost as well as freeing up overcrowded jail cells and court systems. Meanwhile, the VBP network would benefit from having the opportunity to begin interventions that engage the consumer in care and an array of services might be offered.

Social Impact Bonds Example One: Employment for persons with HIV

Due to advances in medical treatment, persons who start on ARV’s before a decline in their immune system are unlikely to advance to an AIDS diagnosis. Yet many people living with HIV, particularly those on Medicaid, subsist on public assistance, and often have little work history. Vocational activity correlates strongly with treatment adherence and viral suppression, which is key to living well with HIV and to averting new infections. Thus, a VBP network organized around HIV should have a strong interest in vocational opportunities. The State Office of Temporary and Disability Assistance (ODTA)

and local social service district also have a financial interest in as much as they are paying the costs of entitlements and benefits for these persons. The VBP arrangement could include investment in the development of an employment training and placement program, which has a goal of removing these individuals living with HIV from public assistance through gainful employment. The VBP network would invest a portion of its savings in a program, which might be run by one or more of its affiliated community-based organizations with expertise in job training and placement. OTDA and the local social service district would then pay on the bond if a target number of persons came off of public assistance and remained off of public assistance for at least two years.

Social Impact Bonds Example Two: Isolation and lack of family/ community support

Category: Social, Family, Community

Social Determinant: Isolation and lack of family/ community support

VBP Funded Intervention/ Social Impact Bond: Home-based perinatal interventions including models such as Nurse Family Partnership³⁶ and Healthy Families America

SIB would be appropriate to support this type of intervention, particularly Nurse Family Partnership (NFP). The success and value of NFP are supported by a significant body of evidence, and the demand for these types of services is greater than capacity of the program/funding.

NFP has been found to reduce tobacco use, preterm births and other complications during pregnancy, infant deaths, and more. It positively impacts rates of child maltreatment and injuries, youth criminal offenses and substance abuse, and immunization rates. NFP has shown a reduction in TANF payments, food stamp payments, and Medicaid costs, among others. These outcomes clearly benefit multiple stakeholders, and the health of the broader population.

The intervention's impact can be measured, and evidence demonstrates that the savings are greater than the costs, with a \$2.37 benefit to cost ratio. With success, this is an opportunity for shared savings. The investor in this case is New York State, relying on general revenue set aside for a social impact bond initiative. Because this example leverages state general revenue, it would be an ideal project, if the State were willing to continue with its general revenue investment in the context of VBP.

³⁶ "The Nurse Family Partnership for Low-Income Families." *Washington State Institute for Public Policy*. Washington State Institute for Public Policy, April 2012. Web. <<http://www.wsipp.wa.gov/ReportFile/1485>>.

"Social Impact Bonds." *Nurse-Family Partnership*. Nurse Family Partnership, May 2014. Web. <<http://www.nursefamilypartnership.org/assets/PDF/Policy/NSO-SIBS-Overview.aspx>>.

Social Impact Bonds Example Three: Chronic Individual Homelessness Pay for Success Initiative

The Commonwealth of Massachusetts launched a Pay for Success program in partnership with the Corporation for Supportive Housing, Massachusetts Housing and Shelter Alliance, the United Way of Massachusetts Bay and Merrimack Valley, and Santander Bank with technical assistance for the project coming from the Harvard Kennedy School Social Impact Bond Lab. The six-year program will provide 500 units of stable supportive housing for up to 800 chronically homeless individuals. The project is funded by a \$1 million philanthropic investment and a \$2.5 million private capital investment from the United Way, CSH, and Santander. Root Cause will serve as the independent evaluator and the outcomes payments will be determined by their evaluation. Success will be based on the stable housing for at least one year of chronically homeless individuals participating in the initiative. The maximum possible return to investors is 5.33%. Community support is provided by the state's Medicaid program MassHealth. MassHealth Coordinating Entities (MCEs) fund Medicaid programs in the shelters. If the target of this project were homeless adults with chronic conditions who are enrolled in a VBP network, it would be rationale for the VBP network to be a co-investor so that it realizes a return on its investment in the participants' health³⁷.

³⁷ Gustafsson-Wright, Emily et al. "The Potential and Limitations of Impact Bonds: Lessons from the First Five Years of Experience Worldwide." Brookings. July 2015. Web.

<<http://www.brookings.edu/~media/Research/Files/Reports/2015/07/social-impact-bonds-potential-limitations/Impact-Bondsweb.pdf?la=en>>.

"Massachusetts Launches the Chronic Individual Homelessness Pay for Success Initiative." Pay for Success Learning Hub. Nonprofit Finance Fund. Web. <<http://www.payforsuccess.org/resources/massachusetts-launches-chronic-individual-homelessness-pay-success-initiative>>.