NEW YORK STATE | Department of Health | Medicaid Redesign Team

Measurement Year 3 Performance Improvement Series: Using data for workflow development

Webinar 2

November 2016

MY3 Performance Improvement Series introduction

Description:

This webinar is the second in a series with the purpose of assisting Performing Provider Systems (PPSs) in achieving performance measurement targets in Measurement Year 3 (MY3) and beyond. The first webinar provided PPS-led examples of process improvement through Rapid Cycle Evaluation (RCE) with an emphasis on data and analytics.

This second webinar will build upon these topics and provide examples of how a PPS and RHIO are collaborating to use regional health data to improve project workflows.

Webinar Schedule:

1. Webinar 1 September 8, 2016 [link]
2. Webinar 2 November 18, 2016

Webinar #2 agenda

Introduction

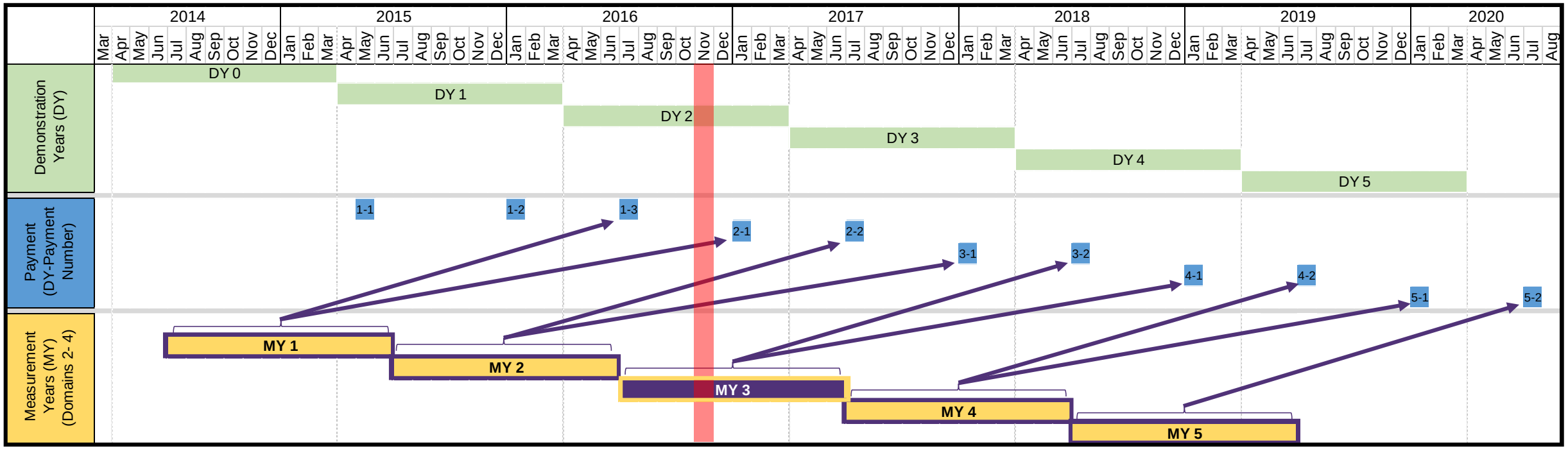
- Current state
- MY2 preliminary data review

PPS Presenters

- Bronx Health Access / Bronx RHIO partnership

Current state: DSRIP is in Demonstration Year 2 and Measurement Year 3.

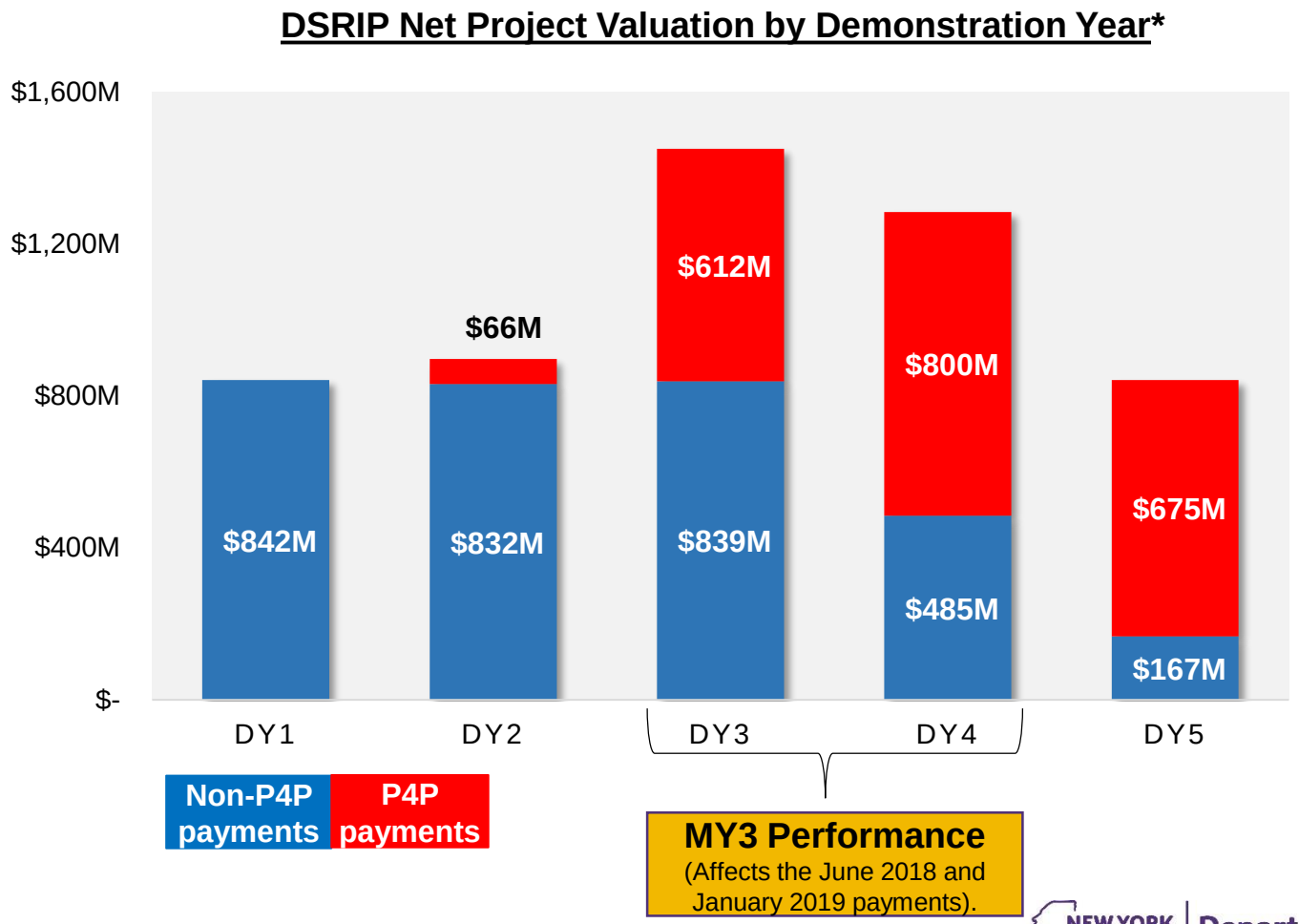
- Performance is measured during the MY and affects future Pay for Performance (P4P) payments in subsequent Demonstration Years (DY).



Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm

42% of available P4P dollars are tied to performance in MY3.

- Performance results collected in MY3 affect $902M in net project valuation.
  - MY3 P4P payments are split between payments in DY3 (payment 2 - $502M) and DY4 (payment 1 - $400M).
- All unearned dollars tied to MY3 performance results will roll in to the High Performance Fund (HPF) available to be earned in MY4.
  - Unearned dollars will be available to all PPSs who meet HP targets.



*Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm

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Data is available for the first three months of MY2 (July - September 2015).

- MY2 targets are established by:
  - Regular Performance: using 10% improvement over baseline (MY1 result) towards the statewide goal.
  - High Performance (HP): using 20% improvement over baseline or met/exceeded the statewide goal.

Measure type	Total performance measures*	Total targets on track for achievement	Total measures improved but not on track
Regular Performance	705	225 (32%)	145 (21%)
High Performance	225	66 (29%)	89 (40%)

- **$176 million in P4P funds are tied to measures in MY2. MY2 performance sets the MY3 targets.**
- Full MY2 (July 2015 – June 2016) official year-end results are scheduled to be finalized at the end of January 2017.
- Potential penalties related to performance of statewide milestones could reduce the overall funding beginning in DY3.

*Includes all measures that will be P4P at any point throughout DSRIP. Data source: DSRIP Performance Dashboards

Most improving high value claims based P4P measures in the first three months of MY2.

- 21 measures were identified with the highest P4P Net Project Valuation.
  - At least two thirds of PPSs improved on 7 of the 21 high value claims based measures.

Measure	Applicable PPSs	PPSs improving	Percent Improving↓	Total P4P $ available*
Children's Access to Primary Care –7 to 11 years	25	20	80%	$28M
Children's Access to Primary Care – 12 to 19 years	25	20	80%	$28M
Children's Access to Primary Care – 25 months to 6 years	25	18	72%	$28M
Prevention Quality Indicator # 15 Younger Adult Asthma	13	9	69%	$29M
Potentially Preventable Emergency Room Visits	25	17	68%	$113M
Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)	25	17	68%	$45M
Diabetes Monitoring for People with Diabetes and Schizophrenia	25	16	68%	$45M

Measure is P4P in MY2

*Includes all P4P dollars available throughout the five years of DSRIP.
Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm and DSRIP Performance Dashboards

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Least improving high value claims based P4P measures in the first three months of MY2.

- Less than one third of PPSs are improving on 5 of the 21 high value claims based measures.

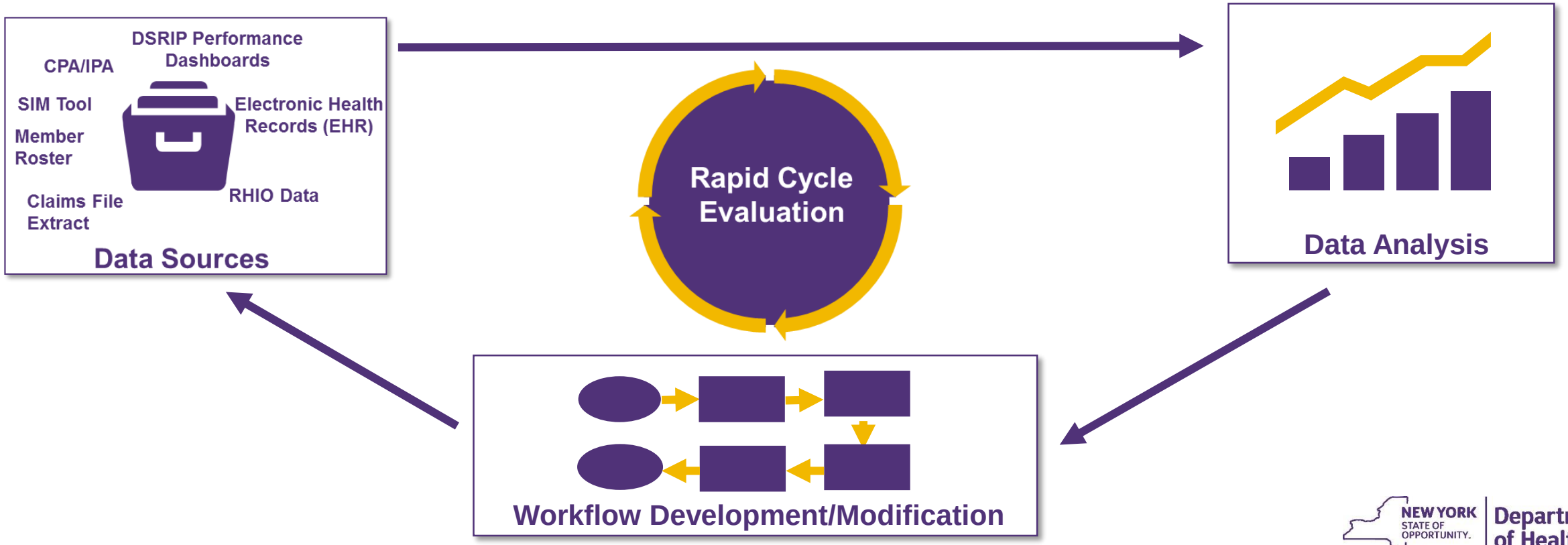
Measure	Applicable PPSs	PPSs improving	Percent Improving↑	Total P4P $ available*
Adherence to Antipsychotic Medications for People with Schizophrenia	25	1	4%	$45M
Children's Access to Primary Care – 12 to 24 months	25	1	4%	$28M
Adult Access to Preventive or Ambulatory Care – 45 to 64 years	25	2	8%	$37M
Adult Access to Preventive or Ambulatory Care – 20 to 44 years	25	2	8%	$37M
Asthma Medication Ratio (5 – 64 Years)	13	4	31%	$29M

Measure is P4P in MY2

*Includes all P4P dollars available throughout the five years of DSRIP.
Source: Achievement Value Guide for PPSs: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm and DSRIP Performance Dashboards

Data alone does not lead to improved performance.

- Workflow development/modification drives changes in patient outcomes.
- Incorporating DOH data sources with local data will deliver additional insight into attributed populations demographics and clinical states.



BRONX HEALTH ACCESS

BronxRHIO
Connecting for Better Health

Steve Maggio, Bronx Health Access
and Keela Rose Shatzkin, Bronx RHIO

Agenda

- Lifecycle of Partnership
- Overview of RHIO's Core Technology
- Overview of Care Coordination Clearinghouse Initiative
- Lessons Learned and Challenges

Lifecycle of Partnership

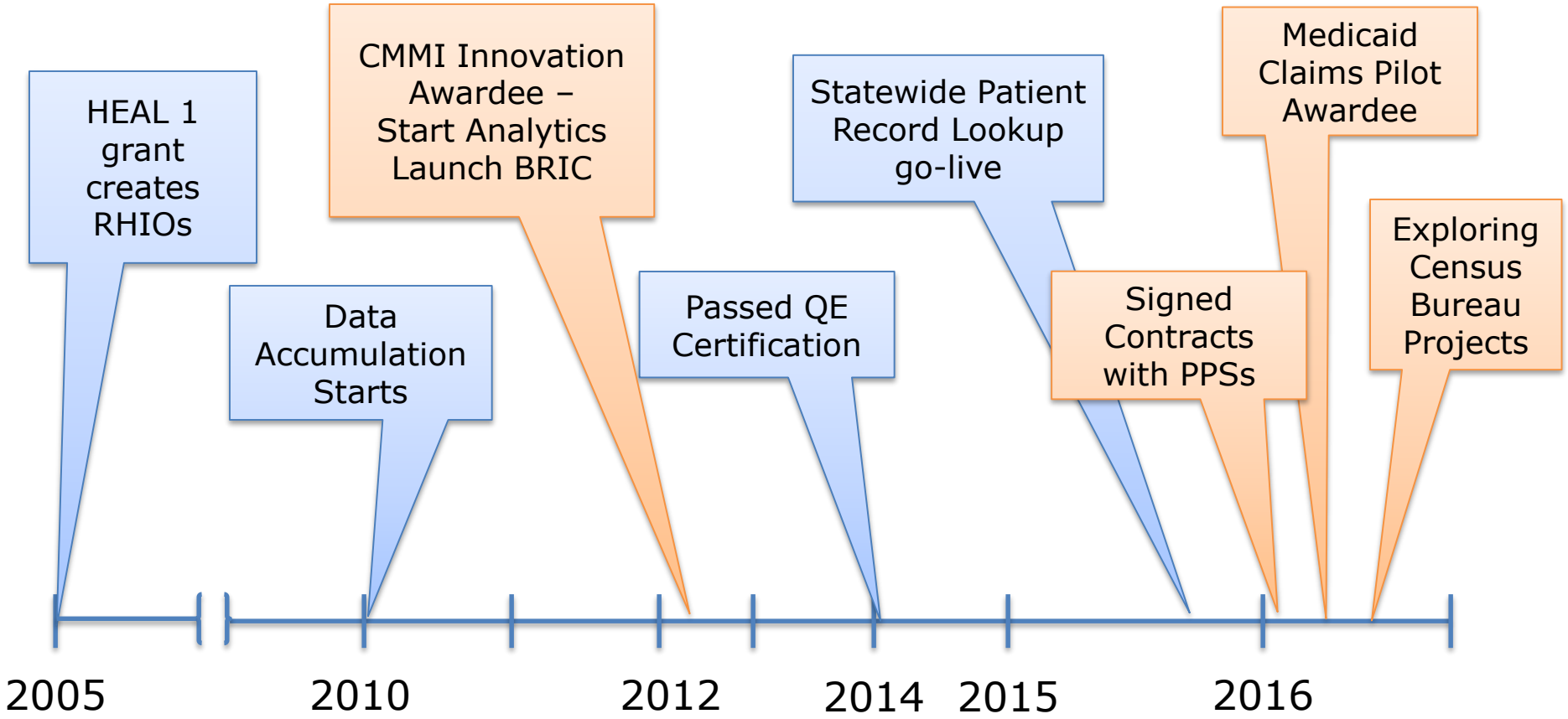
- Initial question for PPS: Invest in BxRHIO or procure technology?
  - RFI and demo day for interface engines and analytics platforms
    - Vendor's sales pitches vs. RHIO experience
      - Implementation vs. Ongoing operations
    - Data aggregation vs. Added functionality
  - Relationships within the PPS
  - State's guidance on RHIOs

Lifecycle of Partnership

- Decision: Invest in BxRHIO
  - BxRHIO shifts into role of vendor:
    - Included in all PPS IT Committee and Clinical Committee meetings
    - Monthly/Quarterly reports
  - Negotiated contract provisions:
    - Funding tied to onboarding of partners
    - Milestone based budget for Analytics

BRONX RHIO TECHNOLOGY OVERVIEW

Bronx RHIO History



Key: Analytics

Health Information Exchange

Overview of BxRHIO Technology: Where we are today

- Traditional HIE:
  - Provider Portal
  - Alerts/Subscriptions
  - Partner data integrations
  - Statewide Patient Record Look-up (sPRL)
- Analytics
  - Dashboards
  - Actively Engaged Counting
  - Reporting from BxRHIO data (patient utilization)
  - Routing eligible patients to programs

Overview of BxRHIO Technology: Future PPS Support

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- Additional dashboards
  - Intersection of Clinical and Claims for Reporting
- Expanded access to Care Plans
  - Health Homes in the PPS
  - Additional Partners in the PPS
- Expanded Clinical Dataset
  - PHQ-2/9, Spirometry, Peak Flow, Self Mgmt Goals
- Integration of non-clinical data
  - Social determinants, 270/271, MCO Members' Gaps in Care, Recertification Dates etc.

Question: How can we leverage these tools to drive clinical outcomes?

CARE COORDINATION CLEARINGHOUSE: PHASE 1

Operationalize Available Technology
&
Inject Information into Clinician's Workflow

What is the Care Coordination Clearinghouse?

- Use all existing data and add technology to support:
  - Linking Patients to Care Coordinators
  - Alerting PCP's of Specific Events
  - Injecting the MCO Gaps in Care (i.e. HEDIS Measures) into the PCP and Care Coordinators Workflow
  - Accountability Reporting
  - Submitting Historical Clinical Utilization Data to MCOs (pseudo claims)

Care Coordination Clearinghouse Step 1

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Bronx RHIO | **BHA PPS** | **MCO PCP** | **Health Home/CMA**

Care Coordination Clearinghouse Step 1

Patient Presents

Risk Stratification & Program Eligibility

Data elements:
- HHTS Eligibility & Enrollment Data
- Clinical Diagnosis and Conditions

Connect Patient to Care Coordination

Analysis:
- Does clinical data indicate eligibility for HH or HH@R?
- Does HHTS data indicate the patient is engaged?
- If NOT, automate bottom-up referral to Care Coordination

Integration with Care Management Platforms

HHTS = Health Home Tracking System
HH = Health Home
HH@R = Health Home at Risk

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Care Coordination Clearinghouse Step 2

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Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Alert to HH

Disseminate to CMAs & CMs

Alert to MCO PCP

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Care Coordination Clearinghouse Step 2

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Patient Presents

Risk Stratification & Program Eligibility

Analysis:
- Is MCO PCP known to PPS?
- Is Health Home known to PPS?

Data Elements:
- HHTS Enrollment
- 270/271 Medicaid PCP
- ADT Admission/Discharge

Alert to MCO PCP

Alert to HH

Disseminate to CMAs & CMs

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Care Coordination Clearinghouse Step 3

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

Generate Patient Snapshot

Deliver to HH System

Deliver to PCP System

Deliver Patient Care

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Care Coordination Clearinghouse Step 3

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Connecting for Better Health

Patient Snapshot:
- MCO PCP
- HHTS Eligibility & Enrollment data
- Gaps in Care Data
- Last 5 PCP visits
- Last 5 BH visits
- PCP misalignment flag (to address auto-assignment issues)

Analysis:
- MCO Gaps in Care vs RHIO Clinical Gaps in Care to compile accurate list

Connect Patient to Care Coordination

Generate Patient Snapshot

Deliver to HH System

Deliver to PCP System

Deliver Patient Care

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Care Coordination Clearinghouse Step 4

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Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Alert to HH

Alert to MCO PCP

Disseminate to CMAs & CMs

Generate Patient Snapshot

Deliver to HH System

Deliver to PCP System

Pseudo Claims

Accountability Reporting

Performance Review and Oversight

Deliver Patient Care

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Care Coordination Clearinghouse Step 4

BRONX HEALTH ACCESS

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Connecting for Better Health

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

Pseudo Claims:
- Notification to MCO based on Clinical evidence of care delivery

Alert to HH

lert to
CO PCP

Disseminate to
CMs

Generate
Snaps

Accountability Reporting:
- Information to PPS for partnership analysis
- Potentially tied to PPS funds flow

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PCP System

Pseudo Claims

Deliver Patient Care

Accountability Reporting

Performance Review and Oversight

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Care Coordination Clearinghouse Challenges

Patient Presents

Risk Stratification & Program Eligibility

Connect Patient to Care Coordination

On what Basis/ Consent?

Alert to MCO PCP

Alert to HH

Disseminate to CMAs & CMs

Generate Patient Snapshot

MCO Gaps in Care?

Deliver to PCP System

Deliver to HH System

Pseudo Claims

Accountability Reporting

Performance Review and Oversight

Deliver Patient Care

Bronx RHIO | **BHA PPS** | **MCO PCP** | **Health Home/CMA**

Solution Architecture

State MDW
- No MCO Gaps in Care

DTA Data Transfer Agreement
Existing Contracts
Data Exchange enabled by DTA
Data Exchange Only

Challenges to Success

- State support for MCOs to release data to RHIOs and PPSs
  - Priority Data: MCO Gaps in Care
  - MCOs in holding pattern until State guidance is issued

- State support for MCO participation in Data Transfer Agreements
  - BxRHIO cannot alert on Health Home Patients who are assigned (not yet enrolled)

Lessons Learned

- Importance of integrating non-traditional datasets
  - Member Gaps in Care
  - 270/271 Medicaid Eligibility data
  - HHTS data
  - Social determinants data
- Narrow meeting scope for successful outcomes
- Start negotiations with Plans immediately
- Involve consent and privacy Subject Matter Experts (SMEs) from the start
  - Allocate legal expenses in your IT budgets

QUESTIONS?

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Thank You!

If you have any questions, please reach out to dsrip@health.ny.gov.