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Jason Helgeson
Deputy Commissioner, Office of Health Insurance Programs/Medicaid Director
New York State Department of Health
Empire State Plaza Corning Tower Building, 14th Floor
Albany, NY 12237

Dear Mr. Helgeson:

The Healthcare Association of New York State (HANYS), on behalf of our 500 non-profit and public hospital, nursing home, home health agency, and other healthcare provider members, welcomes the opportunity to comment on the draft Delivery System Reform Incentive Payment (DSRIP) Evaluation Design, as outlined in a June 23 webconference with staff from the Department of Health (DOH) Office of Quality and Patient Safety.

General Comments

HANYS appreciates that DOH is committed to meeting prevailing standards of scientific and academic rigor with regard to evaluating DSRIP. We also applaud DOH for engaging the public in the development of the Evaluation Design.

Given the limited amount of information provided in the June 23 webconference, HANYS urges DOH to clarify several important pieces of the Evaluation Design:

- What will be the performance period included in the Mid-Term Evaluation?
- What approach will DOH use to reconcile time lags that may occur in the data used for evaluation? HANYS encourages DOH to balance the need for the most current data with the data that have already been submitted to DOH. HANYS strongly urges DOH not to impose additional data reporting burdens on Performing Provider Systems (PPSs) and their participating providers without full discussion and consensus with the PPSs.
- How will DOH work with the other state agencies involved in DSRIP to collect and manage the relevant data for evaluation purposes?
- What methodology is envisioned for developing comparative PPS performance reports?

In addition to the above general remarks, HANYS offers the following specific comments on the draft Evaluation Design.

Methodology

Interrupted Time Series Design

DOH will employ an Interrupted Time Series strategy to evaluate DSRIP. Under this approach, DOH will calculate a summary measure of the outcome variable at equal time intervals prior to DSRIP's implementation, followed by a series of the same summary measure after DSRIP is implemented. DOH will then evaluate whether there was a change in the pattern of the outcome measure at the time of implementation.

HANYS' Comment: HANYS requests that DOH describe how the width of the time intervals will be determined, particularly with regard to statistical power and bias. Bayesian and non-parametric methodologies should also be considered, which could further be used to check model fit and specification.

Segmented Regression Analysis

DOH will use segmented regression analysis to evaluate changes in level and trend of an outcome before and after DSRIP implementation. DOH notes that since the unit of analysis is a summary measure (e.g., average per person pharmacy costs), individual-level predictors (e.g., sex) cannot be included in the model.

HANYS' Comment: While individual-level predictors could not be included in the model, population-level predictors (e.g., average age) can, and should, be included. It may also be appropriate to adjust for other policy changes in subsequent years, such as enrollment eligibility.

Control Group

DOH will add a control group to this design, if available and appropriate. Segmented regression analysis will be used to evaluate changes in level and trend of the outcome before and after DSRIP.

HANYS' Comment: While use of a control group is ideal for scientific rigor, HANYS is concerned about DOH's ability to identify a control group once DSRIP has been implemented. If the goal of DSRIP is to transform the way care is delivered to Medicaid patients by enrolling all Medicaid providers in a PPS, few providers and patients will be available for a comparison group that did not participate in or indirectly benefit from DSRIP reform.

Measurement and Data Sources

DOH will use Domain 2, 3, and 4 measures from the incentive payment process for the evaluation, to the extent possible. Most of the measures are used in Medicaid quality improvement (Quality Assurance Reporting Requirements/Health Plan Employer Data and Information Set) and/or were developed by known measure stewards such as National Committee for Quality Assurance (NCQA) and Agency for Healthcare Research and Quality (AHRQ). DOH collects many of these measures administratively through claims data.

HANYS' Comment: HANYS appreciates that DOH is planning to use the same Domain incentive measures for evaluation purposes. This approach makes the goals specific, measurable, and directly tied to DSRIP objectives. This approach also prevents the imposition of additional data collection and reporting, which would be burdensome for PPSs, participating facilities, and DOH.

Evaluation Objectives

DOH outlines seven distinct Evaluation Objectives:

- Evaluate the extent to which PPSs achieve healthcare system transformation (Domain 2).
- Evaluate the extent to which healthcare quality is improved on a statewide level through clinical improvement (Domain 3) in the treatment of selected diseases and conditions.
- Evaluate the extent to which population health (Domain 4) is improved as a result of the implementation of the DSRIP initiative.
- Assess the extent to which avoidable hospital use is reduced as a result of DSRIP using four measures (potentially preventable emergency room visits, potentially preventable hospital readmissions, prevention quality indicators for adults, and prevention quality indicators for pediatrics).
- Evaluate the impact of DSRIP on healthcare costs.
- Assess the degree of improvement in care quality for specific diseases and conditions under Domain 3.
- Compare major program outcomes across PPSs.

HANYS' Comments: HANYS urges DOH to exercise caution in selecting an aggregate measure or a key measure for each of the Domains for evaluation purposes, as indicated in the Evaluation Design. DOH must ensure that these measures are most representative of the goal of the Domain and have robust statewide data to allow for a thorough evaluation.

The expected changes for Evaluation Objective #1 include increased Medicaid spending on primary care services and decreased Medicaid spending on emergency room and inpatient services. Evaluation of Medicaid spending patterns over time will be complicated by other non-DSRIP changes that will affect Medicaid spending, such as the continued expansion of Medicaid managed care enrollment and expansion of managed long-term care programs. DOH should consider evaluating changes in Medicaid utilization rather than changes in Medicaid spending.

For Evaluation Objective #6, HANYS cautions that valid comparisons of care quality for particular diseases/conditions (with or without project selection) will require proper adjustments for catchment differences (i.e., age, severity of illness).

HANYS requests that DOH provide clarification for the methodology and the reports that will be generated for Evaluation Objective #7, which will compare the performance of PPSs against

each other. Is DOH planning to rank PPSs by performance, or merely provide a report of each individual PPS's progress to goal for each measure?

It appears that Evaluation Objective #7 is not necessary, given that the state's performance on DSRIP will be evaluated as a whole by the Centers for Medicare and Medicaid Services. In addition, given the number and diversity of PPSs, it may not be possible for DOH to group PPSs on similar characteristics (number of projects, diseases/conditions chosen, etc.), resulting in unfair comparisons.

Grouping PPSs by the number of projects selected does not take into account differences in size and resources across PPSs—a large PPS might be able to effectively implement ten projects, while a smaller PPS might struggle to implement more than five projects. Grouping PPSs by the diseases/conditions chosen would also not differentiate between the various specific projects that PPSs may select to address these conditions.

Moreover, we believe that the characteristics specified for Objective #7 may not be useful for the stated purpose of identifying which strategies tend to be more effective. As an alternative, HANYS recommends that DOH make use of the Learning Collaboratives as a means of identifying the most effective strategies.

As stated in our earlier comments on Attachments I and J, HANYS supports the use of Learning Collaboratives to encourage the sharing of evidence-based best practices. Learning Collaboratives can also provide valuable on-site technical assistance, as well as access to state and national content and process experts in the field of healthcare quality improvement. Such collaboratives should also focus on sharing innovative and advanced implementation practices to help hospitals reach their goals.

The Learning Collaboratives should encourage local innovations that advance current knowledge and development of new practices that can serve as models for providers in New York State and throughout the country.

Given the concerns outlined above, HANYS recommends that Objective #7 be eliminated or substantially revised to achieve an accurate and meaningful evaluation.

Qualitative Component

DOH plans to collect data to obtain stakeholders' experience and perceptions regarding DSRIP both at implementation and operational stages of the program. Questions that may be addressed include:

- What difficulties were encountered in developing a PPS?
- How was rapid-cycle evaluation used in developing PPS projects?
- How did the learning collaboratives support system change?
- How was DSRIP received by the community?

- What care improvements have been most notable?

HANYS' Comment: HANYS supports ongoing stakeholder engagement and feedback for DSRIP. However, some of these questions will be difficult to address in a meaningful way. HANYS encourages DOH to work with key stakeholders in developing a more robust set of questions and a strategy for collecting detailed feedback from communities.

In addition, DOH should more thoroughly define "stakeholders." Does DOH intend to survey PPSs, participating providers, non-participating providers, patients, and/or families? Has DOH identified an ideal response rate for each of these groups of stakeholders?

DSRIP Evaluation Timeline

The June 23 presentation included a DSRIP Evaluation Timeline that began in August 2014 and ended in December 2020, with a prolonged procurement process from November 2014 to fall 2016.

HANYS' Comment: HANYS urges DOH to include additional detail about when the contract award will be finalized and the work that will be done between November 2014 and the fall of 2016.

Again, thank you for the opportunity to comment on the draft Evaluation Design. HANYS and our members look forward to continuing our dialogue with DOH about the DSRIP program.

Sincerely,



Dennis P. Whalen
President

DW:as

cc: Tom Melnick
Patrick Roohan
Mark Sharp



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of New York State**

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Dennis Whalen, President

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Jason Helgerson
Deputy Commissioner, Office of Health Insurance Programs/Medicaid Director
New York State Department of Health
Empire State Plaza Corning Tower Building, 14th Floor
Albany, NY 12237

Re: Draft DSRIP Evaluation Plan

Dear Mr. Helgerson:

The Healthcare Association of New York State (HANYS), on behalf of our 500 non-profit and public hospital, nursing home, home health agency, and other healthcare provider members, welcomes the opportunity to comment on the Draft Delivery System Reform Incentive Payment (DSRIP) Evaluation Plan.

HANYS appreciates that the Department of Health (DOH) addressed many of HANYS' earlier questions and comments about the DSRIP Evaluation Plan design as outlined in our July 1 letter. The Draft Evaluation Plan and the Questions and Answers document provide valuable clarifications about DOH's methodology for determining the statewide success of DSRIP. We offer the following additional comments and questions to help DOH evaluate DSRIP success.

Approach

Control Groups

DOH states, "If available and appropriate in terms of comparability to DSRIP participants, the statewide design will be augmented by the use of a control group on which measurements would be taken over the same period in the absence of the program." DOH also outlines a process for creating control groups by clinical conditions selected by the Performing Provider System (PPS).

HANYS' Comment: HANYS appreciates that DOH responded to our earlier comment by acknowledging that control groups may not be available or appropriate for DSRIP. However, we continue to have reservations about the likelihood of appropriate control groups to compare performance for clinical conditions. The goal

of DSRIP is to transform the way care is delivered to Medicaid patients, and if the state is successful in encouraging robust participation of Medicaid providers, few providers and patients would be available for a comparison group that did not participate in or indirectly benefit from DSRIP reform.

In addition, PPSs that focus on one condition may find improvements in outcomes for patients with other conditions that were not chosen as a focus area for DSRIP, merely because the overall process and quality of care has improved. Similar synergic effects can be observed in patients with multiple chronic conditions—when, for instance, the behavioral health issue is resolved, other conditions may improve as a result. These effects will result in unfairly understating the achievement made by the intervention group, compared to the control group.

Stratification

DOH notes that stratification, or inclusion of population level covariates in the model, will be used where program outcomes may differ by recipient subgroups (e.g., sex, race).

HANYS' Comment: We recommend that DOH consider examining additional recipient subgroups with regard to the following stratification and population level covariates: severity of illness, co-morbidities such as mental health, socio-demographic factors, and community issues such as housing status.

Composite Measure

When there is a group of measures that all relate to the same broad concept, DOH is considering the creation of composite measures as a means of reducing the number of individual outcome measures, and in turn, reducing the number of hypotheses to be tested. Adopting the methodology used to create Prevention Quality Indicator composite measures would involve summing the numerators across a set of measures where the same population denominator can be applied.

HANYS' Comment: HANYS is concerned about the use of composite measures for evaluation, particularly those that are comprised of data drawn from different sources and timeframes. Accurate evaluation cannot occur when numerators vary in terms of intensity. Under those scenarios, we recommend that weighting schemes be carefully considered.

Evaluation Objectives

DOH outlines six distinct evaluation objectives:

- 1) Evaluate the extent to which PPSs achieve healthcare system transformation.

- 2) Evaluate the extent to which healthcare quality is improved through clinical improvement in the treatment of selected diseases and conditions.
- 3) Evaluate the extent to which population health is improved as a result of implementation of DSRIP.
- 4) Assess the extent to which avoidable hospital use is reduced as a result of DSRIP.
- 5) Evaluate the impact of DSRIP on healthcare costs.
- 6) Obtain detailed information on the strengths and weaknesses of the DSRIP initiative at the implementation and operational stages from stakeholders' perspectives.

HANYS' Comments: HANYS is pleased that DOH deleted Evaluation Objective 7 from the draft. We continue to believe that evaluating relative performance of the PPSs is not necessary, given that the state's performance on DSRIP will be evaluated as a whole. We reiterate our support for the role of Learning Collaboratives to identify and encourage the sharing of best practices.

HANYS offers the following specific comments on the evaluation objectives.

Evaluation Objective 1: Evaluate the Extent to Which PPSs Achieve Healthcare System Transformation

In an attempt to measure the integration of service delivery, DOH plans to measure:

- percent of eligible providers who have participating agreements with Regional Health Information Organizations (RHIOs);
- percent of eligible providers meeting "meaningful use" (MU) criteria; and
- percent of eligible providers able to participate in a bi-directional exchange.

HANYS' Comment: As noted in HANYS' comments on the DSRIP *Project Toolkit*, HANYS urges DOH to eliminate references to meaningful use standards because we believe they would increase the complexity of DSRIP and add a degree of uncertainty.

MU requirements are one component of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Payment Program. This program does not apply to all providers (for example, hospital-based physicians are not eligible to participate). MU standards also change over time, with the result that a provider may qualify in one year but not meet the new standards when they change. CMS recently released a proposal that would revise selected MU requirements for 2014 in recognition of the challenges that eligible hospitals and physicians are having in meeting program requirements.

Evaluation Objective 2: Evaluate the Extent to Which Healthcare Quality is Improved Through Clinical Improvement in the Treatment of Selected Diseases and Conditions

DOH lists a number of clinical improvement outcomes variables and measures that will be pulled from the "Medical Record," including:

- Behavioral Health—Screening for Clinical Depression and Follow-Up;
- Cardiovascular Disease—Cholesterol Management;
- Cardiovascular Disease—Controlling High Blood Pressure (provider responsible for medical record reporting);
- Diabetes—Comprehensive Diabetes Screening;
- Diabetes—Comprehensive Diabetes Care—Hemoglobin A1c Poor Control;
- Diabetes—Comprehensive Diabetes Care—LDL-c Control;
- HIV/AIDS Viral Load Suppression;
- Prenatal and Postpartum Care—Timeliness and Postpartum Visits;
- Frequency of Ongoing Prenatal Care;
- Childhood Immunization Status;
- Lead Screening in Children;
- Renal Care Comprehensive Diabetes Screening;
- Renal Care Comprehensive Diabetes Care—Hemoglobin A1c Poor Control;
- Renal Care Comprehensive Diabetes Care—LDL-c Control; and
- Renal Care: Controlling High Blood Pressure.

HANYS' Comment: It is HANYS' understanding that these measures are currently being collected through the Healthcare Effectiveness Data and Information Set (HEDIS). HANYS requests clarification as to whether these measures will be collected through HEDIS for the purposes of DSRIP Evaluation. HEDIS is not listed as a data source (pages 15-17) in the Draft Evaluation Plan.

Evaluation Objective 4: Assess the Extent to Which Avoidable Hospital Use is Reduced as a Result of DSRIP

DOH plans to measure reduction in avoidable hospital use with four measures:

- Potentially preventable emergency room visits.
- Potentially preventable hospital re-admissions.

- Potentially preventable hospitalizations for ambulatory care sensitive conditions (Prevention Quality Indicator composite measure).
- Potentially preventable hospitalizations for ambulatory care sensitive conditions—Pediatric (Pediatric Quality Indicator composite measure).

DOH notes that it anticipates that DSRIP effects on avoidable hospital use would be delayed, and plans to omit three-month observation and take the first post-DSRIP per member per month (PMPM) measurement of avoidable hospital use on each of the four measures nine months following the implementation of DSRIP (capturing avoidable hospital usage over the previous three months). PMPM avoidable hospital visits would continue to be measured in three-month intervals from that point forward.

HANYS' Comment: HANYS appreciates DOH's recognition that the measurable improvements in health status and utilization of services as a result of DSRIP will take time to become apparent. Reduction in avoidable admissions and readmissions is one such example where we would expect a prolonged time interval due to both the complex nature of hospital readmissions and dependency on changes in the primary care and ambulatory services infrastructures, as well as the need to wait a period of time to determine if a patient will return to the hospital. We encourage DOH to extend the timeframe for measuring changes in these events.

Again, thank you for the opportunity to comment on the Draft Evaluation Plan. HANYS and our members look forward to continuing our dialogue with DOH about the DSRIP program.

Sincerely,



Dennis P. Whalen
President

cc: Tom Melnick
Patrick Roohan
Mark Sharp

DPW: cf

**HINMAN
STRAUB** 
ATTORNEYS AT LAW

121 STATE STREET
ALBANY, NEW YORK 12207-1693
TEL: 518-436-0751
FAX: 518-436-4751

MEGHAN K. MCNAMARA
E-MAIL: MMCNAMARA@HINMANSTRAUB.COM

July 21, 2014

Mark Sharp
New York State Department of Health
Office of Quality and Patient Safety
mark.sharp@health.ny.gov

Re: New York State DSRIP Evaluation Plan

Dear Mr. Sharp:

Thank you for the opportunity to provide comment on the draft DSRIP Evaluation Plan.

In light of the broad scope of providers participating in DSRIP statewide as well as the contemplated critical role of managed care payment reform through DSRIP, we offer the following suggested revisions to ensure key stakeholders' perspectives are considered in the qualitative analysis of the success of the DSRIP program.

1. Additional Involvement of DSRIP PPS Providers and Medicaid Managed Care Plans in Objective #6

With respect to "Objective #6: Obtain detailed information on DSRIP implementation, successes, and challenges from stakeholders' perspectives," the following is suggested:

- On page 14, paragraph 4, we suggest modifying the language to include the additional underlined language:

Key informant interviews will be conducted with members of PPS leadership, including the PPS Project Advisory Committee ("PAC"), a representative from each Medicaid Managed Care Plan serving the PPS region, as well as NYSDOH staff involved in the development and implementation of DSRIP.

- On page 15, paragraph 7, we suggest modifying the language to include the additional underlined language:

Key informant interviews will be conducted with members of PPS leadership, including the PPS Project Advisory Committee ("PAC"), as well as PPS clinical, administrative,

and financial staff, a representative from each Medicaid Managed Care Plan serving the PPS region, and NYSDOH staff involved in the operation of DSRIP.

2. Request for Additional Objective #7: Assess the Success and Sustainability of Medicaid Managed Care Payment Reform

In light of the required DSRIP goal of managed care payment reform, as well as the CMS requirement that the Evaluation Plan address “efforts to ensure sustainability of transformation of/in the managed care environment at the state level” (See DSRIP STC 22), we request that the following additional objective be included in the Evaluation Plan.

Objective #7: Assess the Success and Sustainability of Managed Care Payment Reform

Qualitative methods will be used to obtain managed care stakeholder perceptions of the DSRIP initiative at both the development and implementation stage of DSRIP, and at the operational stage of the initiative.

For qualitative analysis at both the implementation and operational phases of DSRIP, the Independent Evaluator shall conduct key informant interviews with managed care stakeholders, including but not limited to representatives from both Medicaid and commercial managed care plans serving the state (at least one MMC and one commercial managed care plan per PPS region), health plan associations representing all of the plans in the state, New York State Department of Financial Services, and New York State Department of Health staff, to assess success and barriers towards achieving long term cost savings and sustainability of managed care payment reform.

During the developmental stage of the DSRIP initiative, managed care stakeholder feedback will be gathered regarding the following questions:

- What positive outcomes are expected as the result of DSRIP and managed care payment reform?
- What difficulties were encountered in the involvement of the managed care industry in the development of PPSs?
- With respect to the involvement of managed care plans, what additional information would have been helpful in the DSRIP application process?
- What were some of the obstacles to managed care involvement in the DSRIP process?
- What are the potential savings to consumers of each of the elements of the DSRIP?

Qualitative analysis for the operational stage of the DSRIP initiative will emphasize program functioning and outcomes as perceived by managed care stakeholders. The questions to be addressed include:

- What managed care payment reforms have resulted in the most notable improvement to member/patient populations?
- What difficulties were encountered in the implementation of managed care payment reform?

- Were there any negative impacts of managed care payment reform, including impact on the commercial market? Explain.
- What are suggestions for improvement and sustainability of managed care payment reform?

Interviews will be semi-structured such that questions to be asked will be uniform across participants while at the same time allowing for follow-up questions to probe for more in depth responses. Responses will be reviewed and coded independently by at least two evaluation staff members to identify major themes. Modifications in the interview questions will be made as necessary based on responses obtained on early interviews. Responses will be included in the Evaluation Reports submitted to CMS.

Thank you for your consideration of this request.

Very truly yours,



Meghan K. McNamara

GREATER NEW YORK HOSPITAL ASSOCIATION

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July
Twenty-One
2014

Mark Sharp
New York State Department of Health
Office of Quality and Patient Safety
Corning Tower
Albany, NY 12237

Dear Mr. Sharp:

Thank you for the opportunity to comment on the Department of Health's (DOH) proposed evaluation plan for the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP represents a substantial investment of critically needed resources and a major commitment by the State and the provider community to delivery system transformation. GNYHA strongly supports a comprehensive evaluation of the program in order to objectively assess the effectiveness of this significant investment. We believe the evaluation plan outlined by DOH is thoughtful, well developed and designed to determine the effectiveness of DSRIP in meeting its goals. The following comments reflect areas in which we have concern or that we believe require clarification.

1. In general, we believe the plan would benefit from a timeline that identifies the three years to be used for the pre-DSRIP period as well as the three post-intervention years. Will these time periods be fixed or will they vary based on the measure? It also might make sense to revise the Logic Model to reflect the three DSRIP stages described under Objective 6: development, implementation, and operational.
2. Objective 5 for the evaluation is "Evaluate the impact of DSRIP on health care costs." We believe this objective should really be to evaluate the impact on Medicaid expenditures (both fee for service and managed care) rather than total health care costs. In addition, we suggest that you include the impact on the volume and mix of Medicaid services. There are many factors that will influence Medicaid expenditures and examining how service utilization changes during this period will provide a more complete picture of DSRIP's impact.
3. The plan specifies the desire to utilize a control group for comparison purposes. We are somewhat skeptical that an appropriate control group can be identified. It appears that



GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

most Medicaid beneficiaries will be attributed to a Performing Provider System (PPS). If the intent is to select different control groups based on project selection (comparing beneficiaries in PPS's that selects particular projects to beneficiaries in PPS's that do not select those projects), we would be concerned about the comparability of the populations since characteristics of a PPS population will determine their project selection.

4. In evaluating changes in the level and trends of outcome variables, we are concerned about the potential impact of the large influx of Medicaid beneficiaries that is occurring as a result of ACA implementation, particularly the new Medicaid enrollees who were previously eligible but not enrolled. In addition, the State is considering implementation of a Basic Health Plan (BHP) in 2015 that would potentially move a number of Medicaid enrollees out of Medicaid and into BHP. With respect to Medicaid expansion, our concerns are twofold:
 - a. Many of these enrollees are not new to the system. In other words, they might have had a previous period of Medicaid coverage but were not enrolled as the ACA was rolled out. Many Medicaid beneficiaries become enrolled as a result of an episodic need for health care services, such as a hospitalization, but lapse in coverage when they do not need to use services. It is therefore possible that Medicaid claims history includes the service utilization of this population that cycles on and off and that having them enrolled during periods of non-use will increase the denominator (member months) but not the numerator in terms of utilization rates.
 - b. For the new Medicaid enrollees who were never previously enrolled in Medicaid, it is possible, perhaps probable, that they are generally healthier than the already enrolled Medicaid population. An influx of healthier Medicaid enrollees would also likely impact utilization rates as well as other measures that will be assessed under DSRIP.

Is DOH considering adjustments to account for utilization changes attributable to differences in the Medicaid population pre- and post- ACA and BHP implementation?

5. Under Domain 2 system transformation outcome variables and measures, DOH has proposed measuring Medicaid spending on emergency department (ED) and inpatient services as well as on primary care and behavioral health care, hypothesizing that ED and inpatient spending will decrease and primary care and behavioral health spending will increase. We also think it important to assess whether the ACA is resulting in changes in utilization of these services. A question that is unknown at this point is whether the influx of newly insured individuals will increase appointment wait times for primary care, behavioral health and other health care services, resulting in a reduction in access and a potential increase in ED utilization. With the significant overlap in Medicaid managed care and Exchange plan networks and the overlap in ACA and DSRIP implementation, we believe there is the potential for this to confound outcomes.

GNYHA

6. Under Objective 3, DOH has hypothesized that DSRIP implementation will result in an increased percentage of adults with health insurance. While we believe this is likely to occur due to ACA implementation, we do not believe DSRIP will contribute to this, nor do we believe it is one of DSRIP's goals. We recommend deleting this as a DSRIP measure.

Again, thank you for the opportunity to share our thoughts. We look forward to continuing to work with DOH on DSRIP implementation.

Sincerely,



Kathleen Shure
Senior Vice President

DRAFT

New York State DSRIP Evaluation Plan

The Delivery System Reform Incentive Program (DSRIP), a component of the New York State Medicaid Redesign Team (MRT) Waiver Amendment, seeks to achieve the goals of transforming the health care safety net, improving health care quality, improving population health, reducing avoidable hospital use, and lowering health care costs. This Evaluation Plan, prepared as required by the Special Terms and Conditions (STC) and subject to CMS approval, describes the methods that will be used by the Independent Evaluator to assess the extent to which the New York State DSRIP achieved the intended goals and objectives of the program.¹

Figure 1 shows a logic model depicting the New York State DSRIP program, identifying the major program outcomes and providing a framework for the development of the evaluation. DSRIP is designed to achieve its goals and objectives through collaborations of health care providers termed Performing Provider Systems (PPS) that will create integrated systems to coordinate and provide care across the spectrum of settings to promote health and better outcomes while managing costs. Each PPS will be required to conduct a community assessment and will assume responsibility for a defined population to be served under DSRIP.

The DSRIP Strategies Menu and Metrics document, Attachment J, provides details regarding the specific delivery system improvement projects and associated metrics.² All DSRIP Performing Provider Systems will be responsible for achieving a set of core project progress metrics pertaining to overall program implementation (Domain 1). In addition, each PPS will be responsible for conducting a minimum of 5 and up to 10 projects chosen from a menu of options to address the needs of the population to be served. These projects are designed to facilitate the attainment of program goals and fall into 3 domains with associated metrics: system transformation projects (Domain 2); clinical improvement projects (Domain 3); and population-wide projects (Domain 4).

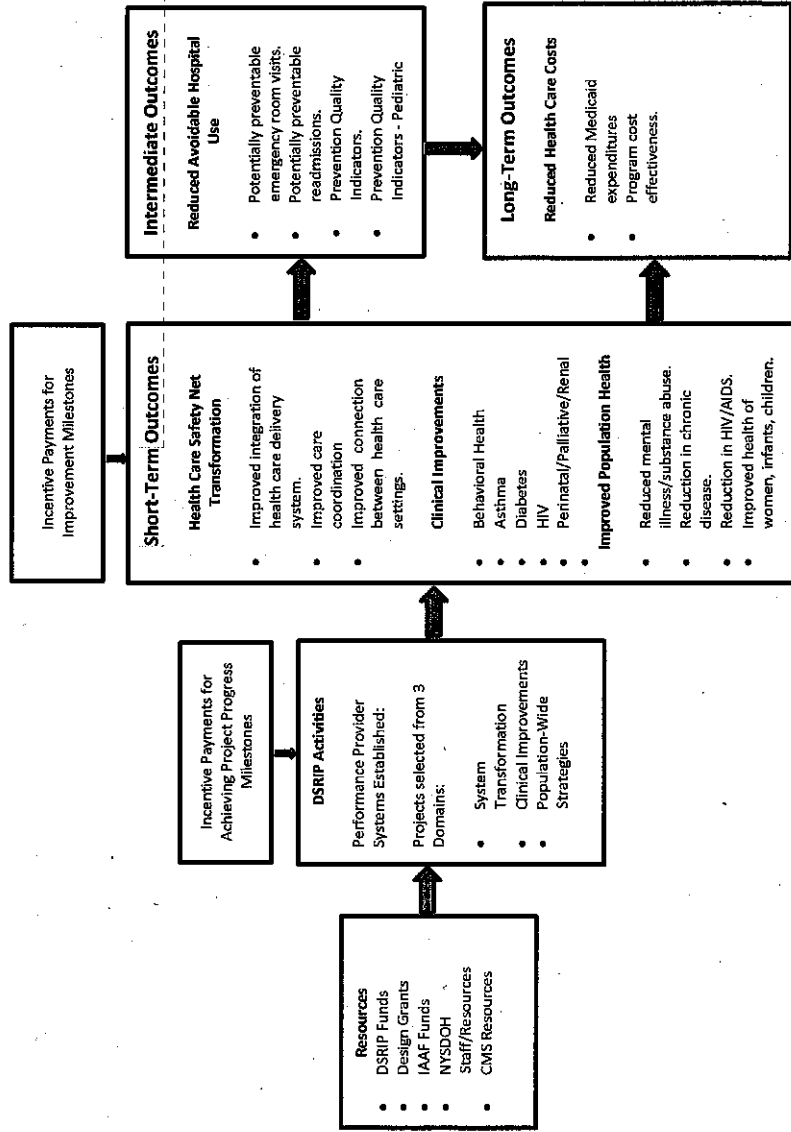
The broad goals of the New York State DSRIP evaluation are to 1) assess program effectiveness on a statewide level with respect to the MRT triple aim of improved care, better health, and reduced cost, and 2) obtain stakeholder feedback regarding the DSRIP program and the services provided. Toward these goals, the following objectives will be achieved:

1. Evaluate the extent to which Performing Provider Systems achieve health care system transformation.
2. Evaluate the extent to which health care quality is improved through clinical improvement in the treatment of selected diseases and conditions.
3. Evaluate the extent to which population health is improved as a result of implementation of the DSRIP initiative.
4. Assess the extent to which avoidable hospital use is reduced as a result of DSRIP.
5. Evaluate the impact of DSRIP on health care costs.
6. Obtain detailed information on the strengths and weaknesses of the DSRIP initiative at the implementation and operational stages from stakeholders' perspectives.

Commented [NYC1]: The way some of these objectives are written, it is unclear if the impact is just among Medicaid patients or costs overall.

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Figure 1. Delivery System Reform Incentive Payment Program (DSRIP) Logic Model



Commented [NYC2]: Some of the Improved Population Health measures are distally or not directly related to the PPS intervention. For example, how will adults with health insurance and adults with a regular health care provider increase as a result of DSRIP? None of the interventions address assisting uninsured with gaining insurance. Rather, the focus of the evaluation plan is on avoidable hospitalizations or clinical-specific metrics. Are population-wide projects (domain 4) measured at the PPS level or as an indicator of the success of PPSs as a whole by county? The logic model indicates there will be incentive payments for achieving project progress milestones and included in the activities are population-wide strategies; it is unclear how PPSs will be paid for metrics that are not directly attributed to them. We request clarification as to the methodology for attributing PPS performance for incentive payments as compared with the methodology for tracking population-level changes in overall health.

Commented [NYC3]: Short-term, Intermediate, and Long-Term are not defined. For some (all?) of the population health outcomes it may be difficult to achieve significant changes in any kind of quick way. This is especially true for something like mental illness.

Method

Approach

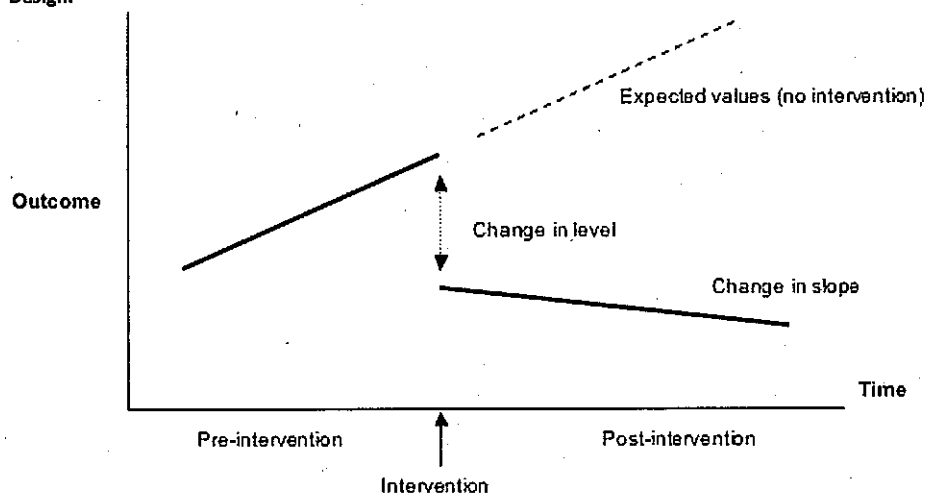
Pre- and post-DSRIP comparisons will be made to assess change in health care system transformation, implementation of clinical improvements, population health, avoidable hospital use, and health care costs. For consistency in the use of metrics, as well as for their appropriateness for use in assessing the statewide impact of DSRIP, the evaluation will primarily employ the measures described in the DSRIP Strategies Menu and Metrics, Attachment J, in testing the hypotheses under each objective. Existing data available within the New York State Department of Health, described in a section to follow, will be used to calculate the measures.

An interrupted time series design³ will be used in making pre-and post-DSRIP comparisons. This is a quasi-experimental design in which summary measures of the outcome variable are taken at equal time intervals over a period prior to program implementation (independent variable), followed by a series of measurements at the same intervals over a period following program implementation, as illustrated in Figure 2. This design has the advantage of minimizing the potential of maturational factors confounding the effects of the intervention by allowing the observation of trends prior to, and after, the intervention. Potential confounding due to historical effects are also minimized by this design in that such effects would be unlikely to occur contemporaneously with the intervention. If available and appropriate in terms of comparability to DSRIP participants, the state wide design will be augmented by the use of a control group on which measurements would be taken over the same time period in the absence of the program.

Commented [NYC4]:
 1. Does NYS DOH plan to construct a bidirectional portal in to which providers will be expected to input needed data?
 2. We request clarification as to the data reporting requirements for the evaluation process; will each PPS be required to report data for all metrics to ensure the availability of a full data set for evaluation purposes? We note that, given the plan to evaluate PPS impact on a specific project by creating control groups of PPS who did not select that measure, data on that project will need to be reported by each PPS, whether or not they have selected that project. Is the intention to require all PPS to report on all metrics in order?

Commented [NYC5]: Having a control group is extremely important though one will be hard to identify.

Figure 2. Pre- and Post-Intervention Comparison of Outcome Variable using Interrupted Time Series Design.



The proposed method to identify a control group may result in a null finding. This may happen in the following situation: PPS A chooses to implement activities under CV health (3.b.i and 3.b.ii., p. 45-47 of the toolkit) whereas PPS B chooses to implement activities under Diabetes Care (3.c.i and 3.c.ii, p. 48-49 of the toolkit). Since some of the activities are similar (patient centered care with multi-specialty team with pharmacists, CHWs, etc.), the difference between the two patient populations with regards to the outcomes may be diminished because 1) the activities are similar to one another and/or 2) the activities may result in improvement in care not just for the specified patient population (those with CV risk/disease or diabetes) but for all patients of a given practice. While this is likely the only way to create control groups, it may be better to only look at this type of control group where there is little to no overlap in the type of activity, or give the results of this type of comparison when there is significant overlap a lower "weight" when determining success.

Commented [NYC6]: Who is going to do the analysis? NYS?

Segmented regression⁴ will be used as the primary analytic strategy in the analysis of data under the interrupted time series design. This analysis enables the evaluation of changes in the level and trend in

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the outcome variable, while controlling, as necessary, for such biases as secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. As the unit of analysis in segmented regression is a summary measure (e.g., average quarterly per patient pharmacy cost), individual-level variables cannot be included in a segmented regression model. Stratification, or inclusion of population-level covariates in the model, will be approaches used where program outcomes may differ by recipient subgroups (e.g., sex, race).

For segmented regression analysis, it has been recommended that there be a minimum of 8 observation points both pre- and post-intervention for sufficient power to detect changes in level and trend.⁵ Therefore, the majority of outcome measures will be calculated in three month intervals over three years prior to the implantation of DSRIP, and again in the same manner following the implementation of DSRIP, for a total of 12 observation points both pre-and post-intervention. Some of the data sources to be used, however, will not be collected with sufficient frequency to allow quarterly measurement of the outcome variables derived from those sources. In such cases where the number of time points may be not be optimal, the use of alternative data sources containing the necessary information will be considered, as will the inclusion of additional pre-intervention data points to increase power to detect secular trends.

A set of measures described in the DSRIP Strategies Menu and Metrics, Attachment J, will be used to quantify facets of system transformation (Domain 2), quality of care through clinical improvements (Domain 3), and population health (Domain 4). To the extent possible and using existing data sources, these measures will be used for purposes of the DSRIP evaluation in assessing statewide outcomes, in addition to the program monitoring activity of determining incentive payments. The majority of these measures are well established with known measurement stewards (e.g., 3M, AHRQ), and are commonly used in health care quality improvement activities.

That the evaluation of the NYS DSRIP evaluation will involve the testing of a large number of hypotheses poses the problem of inflated type I error rate. The method to be adopted to address this issue will be the control of the false discovery rate (FDR),⁶ defined as the expected proportion of errors (i.e., null hypotheses that are actually true) among a set of null hypotheses that have been rejected. In contrast to traditional Bonferroni methods, which adjust significance levels based on the number of tests, control of FDR makes adjustments in significance levels based on the number of null hypotheses expected to be true among a set of tests. Control of the FDR has been demonstrated to preserve more power to detect real effects than do traditional Bonferroni-type adjustments, as well as overcoming other interpretational problems associated with Bonferroni procedures.⁷

Though control of false discovery rate will be used as a means of statistically controlling the increased risk of type I error associated with conducting multiple test, the creation of composite measures will be considered as a means of reducing the number of individual outcome measures, and in turn, reducing the number of hypotheses to be tested. This would potentially be appropriate with a group of measures that relate to the same broad concept. Adopting the methodology used to create Prevention Quality Indicator composite measures, this would involve summing the numerators across a set of measures where the same population denominator can be applied.⁸

Commented [NYC7]: For a lot of the population-level data the evaluator will have trouble getting quarterly numbers and even if they are available we would worry that they are not reliable estimates.

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Objective 1: Evaluate the extent to which performing provider systems achieve health care system transformation.

All Performing Provider Systems will be required to select two projects under Domain 2, which focus on health care system transformation. Given the efforts under DSRIP to improve health care structure and delivery, it is hypothesized that, following the implementation of DSRIP:

- Integration of service delivery will increase.
- Increased care coordination will be demonstrated.
- Availability and use of primary care will increase.
- Access to health care will improve.
- Medicaid spending on ER and inpatient services will be reduced.
- Medicaid spending on primary care services will increase.

Pre- and post-DSRIP comparisons, on both the statewide and PPS levels, will be made on these outcome measures using the interrupted time series approach described above. The measures and associated data sources that will be used to test these hypotheses are shown in Table 1.

Table 1. System Transformation Outcome Variables and Measures		
Outcome	Measure	Data Source
Integration of Service Delivery	Percent of eligible providers with participating agreements with RHIO's; meeting MU criteria and able to participate in bidirectional exchange	PPS Reporting
Care Coordination	CAHPS Measures – Care coordination with provider up-to-date about care received from other providers	CAHPS Survey Data
Availability and Use of Primary Care	Percent of PCP meeting PCMH (NCQA)/ Advanced Primary Care (SHIP)	PPS Reporting
	CAHPS measures including usual source of care patient loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)	CAHPS Survey Data
Access to Care	HEDIS Access/Availability of Care; Use of Services	Medicaid/Medicare Claims
	CAHPS Measures: <ul style="list-style-type: none"> - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours Wait Time (days between call for appointment and getting appoint for urgent care)	CAHPS Survey Data

Commented [NYC8]: We request clarity on the relationship between the system transformation metrics (Domain 2) and clinical improvement metrics (Domain 3). For example, if a diabetic patient only has an A1c test once with the PPS and it is >9.0% (poor control), this might be more of a reflection of the PPS not being able to retain the patient (loyalty) or something about the types of patients attending that facility. If the PPS did not have the chance to get that patient's A1c level under control, the outcome would be due to poor system transformation outcomes rather than poor clinical outcomes.

Commented [NYC9]: For measures using CAHPS as the data source, it will be difficult to associate the change in outcomes with specific PPS. System transformation metrics (domain 2) relies heavily on CAHPS, however it is supposed to be a random sample to allow for valid comparisons across hospitals. Furthermore, the sample size in NYC sample size has been small in the past, and would not be sufficiently large to enable attribution to specific PPS. How will this be addressed?

Commented [NYC10]: The system transformation metrics do not address expansion of PPS' capacity to provide primary care. This has been noted as a critical need for system transformation; however the current set of system transformation metrics does not incorporate measures of enhanced primary care access. Inclusion of access measures would enable evaluation and crediting of PPS focusing on this critical need. This complements the overall focus on improving the quality of primary care included in the baseline for PPS.

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Medicaid Spending	Medicaid spending on ER and inpatient services	Medicaid Claims
	Medicaid spending on PC and community based behavioral health care	Medicaid Claims
Care Transitions	H-CAHPS – Care transition metrics	H-CAHPS Hospital Care Survey

Objective 2: Evaluate the extent to which health care quality is improved through clinical improvement in the treatment of selected diseases and conditions.

All PPS's will be required to implement at least two projects from Domain 3 to achieve clinical improvements, one of which must be in the area of behavioral health, plus one of the following seven diseases or conditions: cardiovascular disease, diabetes, asthma, HIV, perinatal care, palliative care, and renal disease. Under this objective it is hypothesized that, through clinical improvements, health care quality for these conditions will show greater improvement on a state wide level over a three year period following the implementation of DSRIP as compared to a three year period prior to the implantation of DSRIP.

As all PPS's are required to develop a project to address behavioral health, the availability of a control group for inclusion in the interrupted time series design is not anticipated. Pre- and post-DSRIP comparisons in behavioral health care quality will, therefore, be conducted only on the state wide level. For all other diseases/conditions identified for clinical improvement under the DSRIP initiative, variation among PPS's is anticipated with respect to the diseases/conditions that will be addressed. Where appropriate, PPS's will be grouped according to whether or not a particular Domain 3 condition was selected, creating treatment and control groups. Segmented regression analysis will be used to test the hypothesis that, compared to PPS's not implementing a project to make clinical improvements for a particular condition (e.g., diabetes), PPS's that do select that condition will show a greater degree of improvement, following the implementation of DSRIP, in the quality of care for that condition. Such analyses would control for differences in PPS catchment populations and resources, as well as other interventions that may be ongoing in a PPS catchment area (e.g., NYSDOH Prevention Agenda activities). Comparisons to be made on the PPS level are contingent upon final selection of PPS's. Table 2 shows the measures and data sources to be used to test the predicted changes in care quality.

Outcome	Measure Name	Source
Behavioral Health	Antidepressant Medication Management	Claims
	Diabetes Monitoring for People with Diabetes and Schizophrenia	Claims
	Diabetes Screening for People with Schizophrenia/BPD Using Antipsychotic Med.	Claims
	Cardiovascular Monitoring for People with CVD and Schizophrenia	Claims
	Follow-up care for Children Prescribed ADHD Medications	Claims
	Follow-up after Hospitalization for Mental Illness	Claims
	Screening for Clinical Depression and Follow-up	Medical Record

Commented [NYC11]: Do these outcomes apply to all patients they serve and not just those covered by Medicaid?

Are these measures defined in detail somewhere? They are not in attachment J.

For each outcome will all the measures be used or only if they pick a project that addresses that issue specifically?

Commented [NYC12]: Additional metric recommendations listed below this table.

Commented [NYC13]: Of the measures included in table 2, the data source for 15 measures is listed as Medical Record. Medical Records should be included under 'data sources' and the methods by which data will be extracted/transmitted/processed should be detailed, as providers, practices, and PPS will vary widely in terms of the technology that is available in care settings and used to manage, process, and transmit data. The importance of data derived from Medical Records highlights the need for technical assistance to PPS around EHR adoption, meaningful use, patient-centered medical home, connecting to/using the RHIO or other health information exchange, and billing, coding, and documentation. PPS will include providers and practices that are not using electronic health records (EHRs) and this will create a particular challenge in the case of non-employed, independent providers who are part of a PPS. Data collection and reporting represent a significant time burden; the experiences of Accountable Care Organizations and Health Homes highlight the burden created by the need to report significant amounts of data in the absence of functional, effective technological solutions. In order to ensure availability of comprehensive data for evaluation purposes, we suggest that the evaluation plan incorporate alternative data sources for measures based on Medical Record data. In order to assess the quality and representativeness of medical record data, evaluators may wish to note whether PPS have incorporated budget and/or resources to provide technical assistance for adoption and utilization of EHRs.

As RHIO participation is included as an outcome measure for PPS, NYS can further drive participation and routine use of the RHIOs by incorporating RHIOs as a data source and ensuring that PPS can use RHIO data for reporting purposes as appropriate.

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	Adherence to Antipsychotic Medications for People with Schizophrenia	Claims
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Claims
	PPR for SNF patients	Claims
	Percent of Long Stay Residents who have Depressive Symptoms	MDS 3.0
	PQI # 7 (Hypertension)	Claims
Cardiovascular Disease	PQI # 13 (Angina without procedure)	Claims
	Cholesterol Management for Patients with CV Conditions	Medical Record
	Controlling High Blood Pressure (Provider responsible for medical record reporting)	Medical Record
	Aspirin Discussion and Use	BRFSS
	Medical Assistance with Smoking Cessation	BRFSS
	Flu Shots for Adults Ages 50 – 64	BRFSS
	Health Literacy Items (Includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	BRFSS
Diabetes	PQI # 3 (DM long term complications)	Claims
	Comprehensive Diabetes Screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	Medical Record
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medical Record
	Comprehensive Diabetes Care - LDL-c Control (<100mg/dL)	Medical Record
	Flu Shots for Adults Ages 50 – 64	BRFSS
	Health Literacy Items (Includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	BRFSS
Asthma	PQI # 15 Adult Asthma	Claims
	PDI # 14 Pediatric Asthma	Claims
	Asthma Medication Ratio	Claims
	Medication Management for People with Asthma	Claims
HIV/AIDS	HIV/AIDS Comprehensive Care : Engaged in Care	Claims
	HIV/AIDS Comprehensive Care : Viral Load Monitoring	Claims

Commented [NYC14]: PQI#7 should be listed in the CV Disease section to match Attachment J

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	HIV/AIDS Comprehensive Care : Syphilis Screening	Claims
	Cervical Cancer Screening	Claims
	Chlamydia Screening	Claims
	Medical Assistance with Smoking Cessation	BRFSS
	Viral Load Suppression	Medical Record
Perinatal Care	PQI # 9 Low Birth Weight	Claims
	Prenatal and Postpartum Care—Timeliness and Postpartum Visits	Medical Record
	Frequency of Ongoing Prenatal Care	Medical Record
	Well Care Visits in the first 15 months	Claims
	Childhood Immunization Status	Medical Record
	Lead Screening in Children	Medical Record
	PC-01 Early Elective Deliveries	Vital Records
Palliative Care	Risk-adjusted percentage of members who remained stable or demonstrated improvement in pain.	UAS
	Risk-adjusted percentage of members who had severe or more intense daily pain	UAS
	Risk-adjusted percentage of members whose pain was not controlled.	UAS
	Advanced Directives – Talked about Appointing for Health Decisions	UAS
	Depressive Feelings - percentage of members who experienced some depression feeling	UAS
Renal Care	Comprehensive Diabetes Screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	Medical Record
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medical Record
	Comprehensive Diabetes Care - LDL-c control (<100mg/dL)	Medical Record
	Annual Monitoring for Patients on Persistent Medications – ACE/ARB	Claims
	Controlling High Blood Pressure	Medical Record
	Flu Vaccine 18-64	
	Medical Assistance with Smoking and Tobacco Use Cessation	

Commented [NYC15]: The measure for tobacco under renal care is NQF 0027; we recommend this be changed to NQF 0028 (ACO and MU aligned). Alternatively, CAPHS data could be used for tobacco cessation efforts.

NYC DOHMH Behavioral Health Outcomes Recommendations

Recommendation: Obesity (measured by BMI) for Individuals on Psychotropic Medications

- The use of antipsychotic medications is associated with reports of dramatic weight gain, diabetes and increased LDL cholesterol levels.¹ All adults should be screened for obesity (BMI of 30 or higher according to the United States Preventive Services Task Force recommendation (2012)).
- We propose that the National Quality Forum (NQF) measure for BMI² (defined below) be included in this list of metrics.
 - Measure name: Adult Weight Screening and Follow-Up
Description: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.
Reference: Meaningful Use Core Measure: PQRI 128 NQF 0421
- In addition to emergency department visit and re-hospitalizations, we recommend that rates of incarceration and/or arrest be considered an avoidable event or negative outcome that should be used to measure system transformation and project assessment.

Recommendation: Smoking Cessation for Individuals with Behavioral Health Diagnoses

- We propose implementing NQF #0028. Measure #0028 has actually been collapsed into one single measure titled "Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention," by the National Quality Forum. This metric measures the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.³
- Additionally, measure #0028 asks about intervention, which includes medication.

Recommendation: Connectivity to Primary Care for Individuals with Behavioral Health Diagnoses

- People with serious mental illness die significantly younger, with leading cause of death concentrated on medical concerns such as heart disease. There are high levels of co-morbidity between physical and mental health. Connectivity to a primary care physician among high users of behavioral health services may help improve their overall health outcomes.
- We propose that the following metric adapted from New York State PSYCKES be included in this list of metrics:
 - Measure name: Outpatient Medical Visit (<1 Year)
 - Description: Enrollees of all ages with an outpatient medical visit (non-behavioral health office visits, home services, preventive services, medical exams, ob/gyn or prostate screenings) in the past 12 months.
 - Reference: Adapted from the following NYS PSYCKES metric:
 - No Outpatient Medical Visit (No Outpatient Medical Visit >1 Yr): Medicaid enrollees of all ages without any outpatient medical visit (non-behavioral health office visits, home services, preventive services, medical exams, ob/gyn or prostate screenings) in the past 12 months.

¹ "Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes." *Diabetes Care*, Volume 27, 2004.

² <https://www.qualityforum.org/QPS/0421>

³ <https://www.qualityforum.org/QPS/0028>

Objective 3: Evaluate the extent to which population health is improved as a result of implementation of the DSRIP initiative.

Population wide measures (Domain 4) are shown in Table 3. With respect to impact on population health, it is hypothesized that, on a state wide level, DSRIP implementation will result in:

- Lower percentage of premature deaths.
- Increased percentage of adults aged 18-64 years with health insurance.
- Increased age-adjusted percentage of adults aged 18 years and older who have a regular health care provider.

Commented [NYC16]: Is this DSRIP or ACA?

Additionally, all PPS's must select one project under Domain 4 dedicated to improving population-wide health (Domain 4) in one of four areas:

- Preventing chronic disease.
- Preventing HIV and STD's.
- Promoting healthy women, infants, and children.
- Promoting mental health and preventing substance abuse.

On a state wide level, improvements in the above four areas will again be observed following the implementation of DSRIP as compared to pre-implementation of DSRIP. Given expected variation among PPS's in the population-wide projects that will be selected, PPS level analyses will also be conducted. As described previously, and if appropriate, PPS's will be grouped on the basis of having selected a particular population-wide project (e.g., chronic disease prevention), creating a treatment and control group. For each of these 4 areas, it is hypothesized that (compared to PPS's that did not select that particular population health area) PPS's that selected a project to address that area will show a greater degree of improvement in that area over a three year period following the implementation of DSRIP.

Commented [NYC17]: PPSs with overlapping geographic areas will probably cause issues with the evaluation.

Commented [NYC18]: While population prevalence of conditions is a critical end point of interest, there may be a need to conduct more geographically specific analyses to determine impact if the population reach of the PPSs that are conducting activities for a certain goal (e.g., activities related to coordinating behavioral health) is smaller than that of a group of PPSs conducting activities for another goal (e.g., tobacco cessation). Alternatively, it may be more reasonable to look at meaningful use measures.

Also shown in Table 3, racial and ethnic disparities will also be addressed with respect to premature deaths, newly diagnosed cases of HIV, preterm births, and infants exclusively breastfed while in the hospital. Disparities will be measured as ratios on these outcome measures by race/ethnicity. These ratios will be treated as additional outcome at the state wide levels with the prediction that these ratios will show improvement (i.e., will be reduced) as a result of DSRIP implementation.

Table 3. Population-Wide Variables and Measures

Outcome	Measure Name	Data Source
Improve Health Status and Reduce Health Disparities	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics

Commented [NYC19]: We appreciate that racial and ethnic disparities will be measured and note that provider participation in Meaningful Use will support the availability and quality for this analysis due to requirements to document demographics.

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(required for all projects)		
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	Percentage of adults with health insurance - Aged 18-64 years	US Census
	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	BRFSS
Prevent Chronic Diseases	Percentage of adults who are obese	BRFSS
	Percentage of children and adolescents who are obese	BRFSS
	Percentage of cigarette smoking among adults	BRFSS
	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	BRFSS
	Asthma emergency department visit rate per 10,000	SPARCS
	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS
	Age-adjusted heart attack hospitalization rate per 10,000	SPARCS
	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS
	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	SPARCS

Commented [NYC20]: While promoting obesity interventions is critical, the suggested interventions in the toolkit under Domain 4 Chronic Disease Prevention will likely not impact these prevalence estimates. It is possible that with the implementation of food standards combined with improved self-management for people with CV or diabetes (items in the Domain 3), particularly those related to lifestyle and diabetes prevention, the adult obesity prevalence measure may decrease. Thus, we suggest that the adult obesity prevalence measure be moved to Domain 3. Related to this, it is not clear how obesity prevalence among children will be significantly impacted by these proposed activities.

Commented [NYC21]: BRFSS is just among adults. Also, it is only done annually so not sure how the evaluator is going to get quarterly estimates.

Commented [NYC22]: Stated above is the expectation for measurable results on population health indicators 3 years after the implementation of DSRIP yet there is currently a 2 year delay in SPARCS data so we estimate it would take 5 years to document improvement to population health due to DSRIP implementation, unless the State speeds up the SPARCS data release.

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Prevent HIV/STDs	Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System
	<i>Difference in rates (Black and White) of new HIV diagnoses</i>	
	<i>Difference in rates (Hispanic and White) of new HIV diagnoses</i>	
	Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System
	Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System
	Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System
	Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance System
	Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System
Promote Healthy Women, Infants, and Children	Percentage of preterm births	NYS NYSDOH Vital Statistics
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	<i>Ratio of Medicaid births to non-Medicaid births</i>	
	Percentage of infants exclusively breastfed in the hospital	NYS NYSDOH Vital Statistics
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	<i>Ratio of Medicaid births to non-Medicaid births</i>	
	Maternal mortality rate per 100,000 births	NYS NYSDOH Vital Statistics
	Percentage of children with any kind of health insurance - Aged under 19 years	U.S. Census Bureau, Small Area Health Insurance Estimates

Commented [NYC23]: Additional outcome recommendations below.

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	Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	NYS NYSDOH Vital Statistics
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	Percentage of unintended pregnancy among live births	Pregnancy Risk Assessment Monitoring System
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	<i>Ratio of Medicaid births to non-Medicaid births</i>	
	Percentage of women with health coverage - Aged 18-64 years	U.S. Census Bureau Small Area Health Insurance Estimates
	Percentage of live births that occur within 24 months of a previous pregnancy	NYS NYSDOH Vital Statistics
Promote Mental Health and Prevention Substance Abuse	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS
	Age-adjusted percentage of adult binge drinking during the past month	BRFSS
	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics

Commented [NYC24]: Additional recommendation below.

NYC DOHMH Recommendation: Metrics listed under: "Promote Healthy Women, Infants and Children"

- We propose including the following three additional metrics:
 - Percentage of mothers exposed to intimate partner violence.
 - Rates of tobacco use at the end of pregnancy and rates of tobacco use three months postpartum based on results from the NYC Pregnancy Risk Assessment Monitoring System (PRAMS) 2009-2011 survey.

NYC DOHMH Recommendation: Metrics listed under: "Promote Mental Health and Prevention Substance Abuse"

- We propose including a metric to measure the percent of people reporting 'poor mental health' that received outpatient treatment or medication for mental health in the past 12 months.

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Objective 4: Assess the extent to which avoidable hospital use is reduced as a result of DSRIP.

The goal of reducing avoidable hospital use is central to the DSRIP initiative, and is an expected result of implementing the DSRIP components of health care system transformation, clinical improvements, and population-wide health improvement strategies. It is hypothesized that, compared to pre-DSRIP implementation, avoidable hospital use will be reduced following the implementation of DSRIP on four established measures:

- Potentially preventable ER visits.
- Potentially preventable hospital re-admissions.
- Potentially preventable hospitalizations for ambulatory care sensitive conditions (PQI composite measure).
- Potentially preventable hospitalizations for ambulatory care sensitive conditions-Pediatric (PDI composite measure).

Using Medicaid and Medicare (in the case of those dually eligible), measures will be calculated as the number of events on a per member per month basis (PMPM) in three month intervals over three years prior to the implementation of DSRIP. Given that reduced hospital use is in large part dependent on the shorter term DSRIP achievement of health care system transformation, clinical improvements, and improvements in population health, it is anticipated that DSRIP effects on avoidable hospital use would be delayed, i.e., some amount of time would pass following the implementation of DSRIP before reductions in avoidable hospital use would be observed. One way to account for lagged effects in segmented regression analysis is to exclude outcome measurement points during the expected delay period.⁹ Adopting this approach, and estimating six months of DSRIP implementation before reductions in avoidable hospital use would be observed, the three-month observation would be omitted and the first post-DSRIP PMPM measurement of avoidable hospital use on each of the four measures would be taken nine months following the implementation of DSRIP (capturing avoidable hospital usage over the previous three months). PMPM avoidable hospital visits will continue to be measured in three months intervals from that point forward.

Commented [NYC25]: 6 month is optimistic, is this based on any scientific evidence?

Commented [NYC26]: While the evaluation plan did take into account that PPS won't see improvements in avoidable hospitalizations immediately (measuring those nine months following DSRIP implementation), we are not confident this is enough time and request clarity which PQIs can be realistically measured at 9 months.

Objective 5: Evaluate the impact of DSRIP on health care costs.

Consistent with the MRT triple aim of better care, better health, and at lower cost, a goal of the DSRIP initiative is to reduce Medicaid expenditures as a result of DSRIP implementation through payment reform based on positive health outcomes, as opposed to services delivered. It is therefore predicted that slowed growth or reduction of Medicaid expenditures will be observed on a state wide level in the three years following the implementation of DSRIP compared to three years prior to DSRIP.

Using Medicaid claims data, total Medicaid expenditures, including both capitation and fee for service, will be calculated on a PMPM basis in six month intervals over three years prior to the implementation of DSRIP. Like avoidable hospital use described above, reduction in Medicaid costs are a longer-term outcome, dependent upon shorter term DSRIP health care improvements, including the achievement of reduced avoidable hospital use. Given the expected lag in the effect of DSRIP on Medicaid expenditures, post-DSRIP measurement points will be handled in the same manner as for avoidable hospital use, with the first post-DSRIP PMPM calculation of Medicaid expenditures taken one year following the implementation of DSRIP, capturing the expenditures over the previous 6 months. Even though the expected reduction in avoidable hospital use would precede reduction in cost (Figure 1), the lag in DSRIP effect on cost is not expected to be longer than that expected for avoidable hospital use. This is because reductions in avoidable hospital use would likely have an immediate impact on Medicaid expenditures. As with the avoidable hospital use measures, PMPM Medicaid expenditures will continue to be

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measured in six months intervals for three years from that point forward.

Assessment of the effect of DSRIP on health care cost will also include an analysis of cost effectiveness^{10, 11} with respect to avoidable hospital use, as this outcome is central to the DSRIP initiative. The intention of these analyses is to assess value for the money by weighing additional expenditures incurred in the operation of DSRIP against reduction in avoidable hospital use, in a comparison of avoidable hospital use and cost before and after the implantation of DSRIP. Cost-effectiveness ratios, or CER's (change in cost divided by the change in outcome) will be used to express the dollar amount per unit reduction in avoidable hospital use. This information will then be compared to the average cost of an avoidable hospital use event (e.g., an avoidable hospital admission) to determine if additional expenditures incurred under DSRIP (e.g., incentive payments) are offset by savings through avoidable hospital use. This analysis will be conducted on all four measures of avoidable hospital use. Other analyses around cost effectiveness that may be useful would be to compare DSRIP cost effectiveness among subgroups, e.g., cost effectiveness comparisons across Medicaid recipients' health status.

Objective 6: Obtain detailed information on DSRIP implementation, successes, and challenges from stakeholders' perspectives.

Qualitative methods will be used to obtain stakeholders' perceptions of the DSRIP initiative at both the development and implementation stage of DSRIP, and at the operational stage of the initiative.

For qualitative analysis at both the implementation and operational phases of DSRIP, key informant interviews, focus groups, Web-based surveys, and analysis of planning documents and program materials will be methods used to obtain feedback from DSRIP stakeholders, along with appropriate background information. Survey and interview protocols will be approved by New York State Department of Health IRB, and all evaluation staff involved in data collection will receive training on the handling and storage of confidential information.

During the developmental stage of DSRIP initiative, stakeholder feedback will be gathered regarding the following questions:

- What positive outcomes are expected as the result of DSRIP?
- What difficulties were encountered in getting a PPS approved?
- What additional information would have been helpful in the application process?
- What were some obstacles in forming partnerships between providers participating in a PPS?
- What difficulties were encountered in developing and implementing a PPS?
- How was rapid-cycle evaluation used in developing PPS projects?
- How did the learning collaboratives support system change?
- What were some of the earliest improvements in health care delivery that were made as a result of DSRIP?
- What difficulties were encountered in gathering the necessary data about the PPS?
- How was DSRIP initially received by the community?

Key informant interviews will be conducted with members of PPS leadership, as well as NYSDOH staff involved in the development and implementation of DSRIP. Interviews will be semi-structured such that questions to be asked will be uniform across participants, while at the same time allowing for follow-up questions to probe for more in-depth responses. Responses will be reviewed and coded independently by at least two evaluation staff members to identify major themes. Modifications in the interview questions will be made as necessary based on responses obtained on early interviews. Survey data will

Commented [NYC27]:

Objective 6 should include provisions for soliciting feedback from Medicaid beneficiaries, from non-service providing community groups, and from local health departments. It will be important to understand the impact of the program on beneficiaries, to gauge whether community groups were engaged in an ongoing and meaningful way, and to learn whether local health departments believe the PPS projects have had the intended impact without unintended consequences.

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be analyzed using statistical software in the case of closed-ended questions, or for open-ended questions that can be coded into categories. Open-ended questions that may elicit more complex responses will be analyzed in the same manner as the key informant data.

Commented [NYC28]: This paragraph seems to be erroneously re-pasted from above. Additionally, the focus groups methods aren't described - maybe that should be here?

To obtain information from a broader group of PPS staff, a web-based survey will be constructed and administered to selected individuals involved in the administrative, clinical, and financial operations of the PPS's contracted under DSRIP. Informed in part by the key informant interviews, the Web-based surveys will obtain detailed information on collaboration with other providers within a PPS, patient enrollment, financial arrangements between providers participating in a PPS, patient receptivity to PPS care configuration, and recommendations for program modification.

Commented [NYC29]: What about other stakeholders - Medicaid enrollees, LHDs?

Qualitative analysis for the operational stage of the DSRIP initiative will emphasize program functioning and outcomes as perceived by program stakeholders. The questions to be addressed include:

- What care improvements have been most notable?
- Which sub-populations saw the most improvement?
- What difficulties were encountered in operating a PPS?
- What were the notable partnerships that were formed in implementing a PPS?
- How was the PPS received by the community?
- What are the reactions of Medicaid enrollees to DSRIP?
- What intended PPS goals were not achieved, and why?

Key informant interviews will be conducted with members of PPS leadership, NYSDOH staff involved in the operation of DSRIP, as well as PPS clinical, administrative, and financial staff. A Web-based survey will also be developed to obtain additional information on DSRIP outcomes from stakeholder perspectives. Again, the content of this survey will be based on, in part, by the information obtained from the key informant interviews. Analysis of these data will be conducted in the same manner as described above.

Data Sources

Evaluation objectives 1-5 will involve the use of a number of existing data sources that are maintained by the New York State Department of Health. These data will be available for use by the Independent Evaluator as an agent of the Department, in accordance with public health law and/or under the appropriate data use agreements.

Medicaid Claims

This database contains billing records for health care services, including pharmacy, for approximately 5.7 million individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid claims database is updated on a monthly basis to include additional claims and modifications to existing claims.

Medicare Claims

For the approximately 15% of Medicaid enrollees who are dually eligible for Medicare, Medicare claims will be used to ensure data completeness, as many of the services received by this group will be paid by Medicare and thus not appear in the Medicaid database. Medicare claims contains billing records for health care services, including pharmacy services, along with data on diagnoses and provider information. Medicare data are received by the New York State Department of Health on an annual basis, under a care coordination data use agreement with CMS. Medicare Part D data are received on a monthly basis.

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Statewide Planning and Research Cooperative System (SPARCS)

The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects, on a monthly basis, patient level detail on patient characteristics, diagnoses and treatments, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State.

Minimum Data Set (MDS)

MDS 2.0 and 3.0 data consist of federally mandated assessments collected at regular intervals on all nursing home residents in New York State. Assessment data collected include diseases and conditions, nutritional status, resident physical and cognitive functioning (e.g., activities of daily living), medications received, and nursing home admission source and discharge disposition. These data have been shown to be adequately reliable and are widely used in research, and are available to the New York State Department of Health under data use agreement with CMS.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The Clinician & Group version of the CAHPS® survey will be administered annually during the DSRIP demonstration period and will serve as the data source for selected outcome measures. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and office staff. This includes information on patient experience over the last twelve months including most recent visit to provider, ease of getting an appointment, and wait times while in the office.

New York State Vital Statistics

Birth and death certificate data are maintained by New York State, with New York City Department of Health and Mental Hygiene and the New York State Department of Health comprising two separate jurisdictions in the reporting of birth and death records. NYSDOH has the responsibility for annual statewide reporting of vital statistics governed by the terms of a memorandum of understanding between the two jurisdictions. Birth records contain information such as maternal medical risk factors, prenatal care received, infant birth date, birth weight, and infant diseases/conditions including congenital malformations. Death certificate data include date of death, underlying and multiple cause of death, decedent demographics, county of residence, and county of death.

Extended Behavioral Risk Factor Surveillance System (eBRFSS)

The Expanded Risk Factor Surveillance System (Expanded BRFSS) augments the CDC Behavioral Risk Factor Surveillance System (BRFSS), which is conducted annually in New York State. Expanded BRFSS is a random-digit-dialed telephone survey among adults 18 years of age and older representative of the non-institutionalized civilian population with landline telephones or cell phones living in New York State. The goal of Expanded BRFSS is to collect county-specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. Topics assessed by the Expanded BRFSS include tobacco use, physical inactivity, diet, use of cancer screening services, and other factors linked to the leading causes of morbidity and mortality. The 2013-2014 eBRFSS survey will be used as the baseline for DSRIP for measures derived from these data, and contains a question to identify Medicaid respondents. Repeat eBRFSS surveys to be used in support of the DSRIP evaluation will be conducted in 2016-2017, and again in 2019-2020.

Commented [NYC30]: Are they going to come up with enough sample for NYC or should we add questions to the CHS? Probably worth a NYS/NYC discussion.

Also, no mention of children here but above says the evaluator will use this for childhood obesity data.

New York State HIV/AIDS Case Surveillance Registry

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The New York State HIV/AIDS Case Surveillance Registry contains information on new cases of HIV and AIDS, as well as persons living with HIV or AIDS. Data include date of diagnosis, HIV exposure category, county of residence at diagnosis, and whether or not diagnosis was made while individual was incarcerated.

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Uniform Assessment System (UAS)

The Uniform Assessment System contains assessment data on individuals receiving home or community-based long term care (e.g., adult day health care, long term home health care). Data include patient functional status, health status, cognitive functioning, and care preferences.

US Census

US census data are publicly available from the US Census Bureau, and contain estimates of population size, and data on population characteristics. The latter include housing status, income, employment status, educational level, and health insurance coverage. US census data are gathered on an ongoing basis from a number of surveys including the Decennial Census, the American Community Survey, and the Economic Census.

Selection of Independent Evaluator

The procurement process to contract with an independent entity to conduct the evaluation is anticipated to begin in November 2014. In a competitive bidding process, a Request for Proposals (RFP) will be developed and issued by NYSDOH. This RFP will describe the scope of work, the major tasks, and contract deliverables, with a bidder's conference to be held to address questions from potential bidders. Proposals received will undergo review by a panel of NYSDOH staff, using a scoring system developed for this RFP. Applicants will be evaluated on the basis of related work experience, staffing level and expertise, environment and resources, and data analytic capacity. It is expected that a contract will be finalized and work to begin by September 2016.

Evaluation Timeline

- Aug. 14, 2014: Submit draft of evaluation plan to CMS.
- Sept. 14, 2014: Receive feedback from CMS on evaluation plan.
- Oct. 14, 2014: Submit revised evaluation plan to CMS.
- November 2014: Begin procurement process for independent evaluator.
- Fall 2016: Independent evaluator begins work.
- March 31, 2019: Interim evaluation report due to CMS.
- June 30, 2020: Preliminary summative evaluation report due to CMS.
- December 28, 2020: Final summative evaluation report due to CMS.

Comments on the Draft New York State DSRIP Evaluation Plan and Recommendations for Measuring and Assessing Primary Care in DSRIP PPSs

July 18, 2014

A stated goal of DSRIP is the expansion of quality primary care. PCDC makes the following recommendations on the Draft New York State DSRIP Evaluation Plan which we hope will assist New York State in meeting this goal. Our comments focus on Table 1 of the Plan, with particular emphasis on Integration of Service Delivery, Care Coordination, Availability and Use of Primary Care, and Access to Care. In summary, we believe the measures and data sources must be significantly supplemented to adequately measure true system transformation.

Integration of Service Delivery and Care Coordination should be considered together. Providers should be required to demonstrate Meaningful Use Stage 2. Primary care practices that achieve PCMH 2014 Level 3 (which requires MU Stage 2) should have the ability to achieve integration and care coordination-related objectives.

Availability and Use of Primary Care: While the number of providers achieving PCMH Level 3 (2014) or Advanced Primary Care Standards is indeed an important factor in assessing whether a primary practice is operating as a true medical home, it is insufficient for determining availability and use of primary care. *(See primary care recommendations below)*

Access to Care: Access to care cannot be measured solely with HEDIS and CAHPS data. *(See "Measuring Primary Care Capacity and Access" recommendations below, some of which apply to Access to Care)*

Use of CAHPS survey data: CAHPS can be important for assessing patient's subjective impressions of care delivery, but it is not an adequate substitute for measuring how well the health care delivery system is functioning. The plan highlights that the Clinician and Group version of CAHPS will be administered annually. This product is lengthy (34 questions), and because it can be administered anytime within 12 months of the office visit, the accuracy of the data is questionable. New York State should consider using the CAHPS Clinician and Group Visit Survey, which can give a more accurate picture of the office visit and more actionable information for the provider.

PCDC Recommendations for Measuring and Assessing Primary Care in DSRIP PPSs

PCDC makes the following recommendations to help New York State measure primary care capacity, access and readiness for transformation.

1. **Require all PPS project plans to have a primary care plan:** PPSs should specify how they will ensure primary care access to the target population. Those plans should include:
 - a. The desired ratio of patients to primary care providers
 - b. How the PPS would build, acquire, redesign or collaborate to expand primary care capacity;
 - c. How primary care would be integrated into the delivery system, including the PPS governance structure;
 - d. How the PPS will support practice redesign and transformation to achieve the DSRIP goals, including how clinical and support staff in the primary care setting would be trained in patient-centered models of care; and
 - e. How managed care contracts will be modified to support an expanded role for primary care in achieving quality outcomes and reducing total cost of care.

2. **Focus on NCQA Must-Pass Elements and Critical Factors as a baseline:** There are over 26 elements comprised of 160 factors in the NCQA 2014 PCMH standards. However, there are 6 must-pass elements and 9 “critical factors” (central to the concept being assessed within particular elements). PCDC recommends using these factors and elements as a baseline, along with other elements deemed important to achieving DSRIP goals. ([Download PCDC’s PCMH 2014 Self-Assessment Tool](#), and see the attached list of Must Pass Elements and Critical Factors)

3. **Measure Primary Care Capacity and Access:** While the NCQA PCMH 2014 process captures a great deal of valuable information, additional data should be collected to more specifically measure primary care capacity and access:
 - a. Number of patients served by the practice (Medicaid and uninsured) and number of FTE primary care providers;
 - b. Average number of attributed lives per primary care provider;
 - c. Number of primary care exam rooms;
 - d. Physical address of provider (to map geographic distribution);
 - e. Whether the provider is accepting new patients (including Medicaid and uninsured); and
 - f. Third next available appointment (TNAA): Widely used measures such as “Third Next Available Appointment” are useful in this context. TNAA is a more sensitive reflection of true appointment availability. Using TNAA eliminates chance occurrences (cancellations, unexpected events) from the measure of availability. The goal for TNAA is to have zero days wait for an appointment, which indicates sufficient access to care.

4. **Determine Practice Transformation Readiness:** Practices may be compliant with a number of PCMH factors, but struggle to achieve compliance with even a few more. In PCDC's experience, this is often attributable to organizational characteristics of the practices, such as the lacking previous quality improvement experience, executive buy-in, a dedicated and accountable team, or health information technology resources.
 - a. **Indicate current PCMH status or participation in other transformation or alternative payment initiatives:** Practices that have achieved PCMH Level 2 or 3 (2011) have most likely undertaken at least some organizational and system changes (2008 standards and 2011 Level 1 should not be used as an indicator of readiness). Practices with managed care contracts that reward quality (HEDIS/QARR) or offer shared savings based on total cost of care are more likely to be able to adopt reforms that further align payment with quality and cost savings.
 - b. **Conduct transformation readiness assessment:** A complete readiness assessment at the outset is helpful in surfacing issues in the earliest stages of the project so they can be accounted for in the project planning and implementation phases. (See attached: AHRQ Practice Facilitation Handbook – Module 12: Assessing Practice Readiness for Change). More information on primary care readiness at the [AHRQ website](#).
5. **Seek Graduated Responses:** The PCMH recognition or accreditation process requires a straightforward “yes/no” assessment of whether a practice performs a given PCMH factor or not. While this can be helpful, it often fails to yield insight into the complexities of achieving true transformation at a practice. Such an assessment, for example, does not reveal the extent to which a practice is compliant with a given factor, nor does it reveal the practice's *readiness to change* to become compliant. Accordingly, PCDC recommends that assessments include graduated responses (e.g., Likert scale).
6. **All data should be aggregated and shared:** All data collected through this process should be standardized and compiled by the PPS. This will help the PPS make informed decisions about deployment of resources. Data should also be aggregated to give a PPS-wide picture of primary care status, which will help both the PPS and New York State address gaps and gain a clearer picture of the primary care landscape.

Achieving a True Medical Home: About the Standards

NCQA 2014 Level 3 Standards – More Rigorous than 2011: One of the key initiatives embedded throughout the DSRIP domains and projects is that primary care practices must achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards. We note that NCQA 2014 standards are markedly more rigorous. It will be more difficult for practices to submit required documentation without going through the necessary transformation to operate as a true medical home. That said, there is a significant amount of documentation required of practices. [See NCQA PCMH 2014 Recognition Home Page](#)

Joint Commission Primary Care Medical Home – Site Surveys instead of Documentation: While NCQA PCMH recognition has clear benefits, New York State should consider allowing practices to pursue Joint Commission Primary Care Medical Home Accreditation. The Joint Commission does not require significant documentation when submitting, relying instead on on-site surveys to ensure that practices are in compliance (on-site surveys are unannounced, except for first-time accreditation). Joint Commission PCMH Accreditation also applies to the entire organization (NCQA requires separate submission for each site). Joint Commission PCMH Accreditation must be conducted as an add-on to Joint Commission accreditation of the organization itself. [See Joint Commission Primary Care Medical Home Accreditation page.](#)

About PCDC

Since 1993 the Primary Care Development Corporation (PCDC) has helped more than 900 healthcare organizations build and sustain high-quality primary care, including helping over 150 practices become NCQA recognized medical homes - mostly at Level 3. PCDC has led large-scale projects organized to address “clinically important” condition(s) in a variety of communities, assisting in project governance structures, project design, measurement, assessment, implementation, training and process improvement to help providers meet their goals. We work with all types of primary care safety net providers, including hospitals, community health centers, private practices and special needs providers.

Prepared by Dan Lowenstein, Senior Director of Public Affairs; Alan Mitchell, Director, Center for Primary Care Transformation; Deborah Johnson Ingram, Senior Program Manager; Julie Peskoe, Senior Project Manager; Maia Bhirud, Project Manager.

For more information, contact Dan Lowenstein at 212-437-3942; dlowenstein@pcdc.org

TO: Mark Sharp (mark.sharp@health.ny.gov.)

FROM: Janet (Jessie) Sullivan, MD (sullivanjanet@wcmc.com)
Medical Director, Regional Center for Healthcare Innovation, Westchester Medical Center

RE: Comments on DSRIP Evaluation Plan

Thank you for the opportunity to submit comments.

RE: The diagrammed model

As shown on page 2 of the proposed DSRIP evaluation, the model suggests that incentive payments will be based only on DSRIP milestones and short term outcomes, not on the intermediate and long term outcomes of reduced PPV, PPR, PQI, PDI, Medicaid cost and program cost effectiveness. It would be consistent with the project goals to base some portion of the incentive payments on also achieving desired outcomes. This could be important because the work required to score well on the short term and intermediate metrics (mostly HEDIS and CG-CAHPS measures) is not the same as the work required to improve on the long term goals. Placing too much emphasis on the intermediate metrics could channel resources away from achieving the overarching goals.

RE: APPROACH (interrupted time series methodology):

Over the course of DSRIP implementation new populations will be moving into Medicaid Managed Care from FFS Medicaid. The new populations are more complex. This will have some impact on validity of HEDIS and CAHPS measures as baseline, assuming these measure we're not available from the FFS population during the baseline period. This will be mitigated to the extent NYS DOH has collected HEDIS or CAHPS applicable to FFS. The proposal will use CG-CAHPS to evaluate PPS-DSRIP which may not be a valid comparison with baseline data from CAHPS conducted at the level of health plan enrollment.

RE: OBJECTIVE 1 EVALUTION-- the extent to which PPS achieve system transformation

A group of proposed measures look at "% of providers who...." (enroll with RHIO, meet MU, achieve PCMH.) For these measures NYS will need to specify precise criteria for both the numerators and the denominators and AUDIT the results, especially if self-reported. Rates are easily manipulated by varying denominator inclusion criteria. For example, some PQRS measures that were self-reported to CMS resulted in exceedingly high compliance rates based on denominator selection bias.

CG-CAHPS: The document does not state how patients will be attributed to PPS and how the survey will be conducted, by PPS or by NYS. NYS should conduct the CG-CAHPS survey to ensure that the methodology for sampling and collecting is consistent across PPS.

CAHPS questions assume that the patient surveyed is being queried about their usual source of care (PCP). Because in NYS all MCO enrollees are assigned a PCP, it is relatively easy to pull a sample based on people who have visited their PCP. If CG-CAHPS is based on the same assumption, how will the sample be pulled? One approach, after attributing patients to respective PPS, would be to draw the sample as it is drawn for health plan

CAHPS, based on assigned PCP for MCO enrolled patients and based on an attributed PCP for Medicaid recipients not enrolled in managed care. This approach has several advantages:

1-It most closely mirrors the CAHPS survey method;

2-it is consistent with the value placed on a usual source of advanced primary care for all patients;

3-coordinating care with a patient's PCP is an explicit requirement for many projects and is a reasonable requirement of PPS across the board;

4-this approach will foster collaboration across competing PPS to deliver better care for pts.

An additional survey focused on patient experience of BH care would also be reasonable to consider--for all PPS--the applicability of CG-CAHPS for that purpose would need to be evaluated.

However the sample is drawn, adding a measure of patients with no usual source of primary care to the measure set is needed to balance the CG-CAHPS focus on experience with primary care for those who have had a primary care visit. This measure would apply to all Medicaid recipients attributed to a PPS, even if the primary care provider was not a PPS participating provider.

A previously submitted comment on the DSRIP website suggested measuring changes in Medicaid utilization in lieu of cost. Because cost and utilization are related but not the same, measuring both changes in utilization and changes in spending would allow the evaluation to more thoroughly assess the shift from inpatient and emergency room care to primary care and outpatient behavioral health care. When calculating either use or cost of primary care, some attention should be paid to how professional services are attributed. For example: Internal Medicine professional services provided in an inpatient setting could be attributed to primary care if attention is not paid to place of service. Conversely, as services now commonly provided in a hospital setting are moved to the community under DSRIP, attention is required to assure that coding for reimbursement is able to reflect the change in setting if the DSRIP evaluation is to accurately reflect these desired changes.

An example pertains to the NYS plan to use the 3M PPV measure for DSRIP evaluation. DOH staff have said that this measure, as currently used in NYS, includes codes for urgent care in the definition of an emergency room visit. Several FQHCs have implemented on-site walk-in urgent care in an attempt to wean patients away from a near-by emergency rooms. These primary care based urgent care visits are delivered in a more appropriate setting at lower cost than emergency room care, but these visits would continue to count as emergency room care in the PPV measure.

RE: OBJECTIVE 2 EVALUTION-- the extent to which healthcare quality is improved

NYS DOH and CMS should remain open to some revision of measures over the 5 year course of DSRIP. The measures currently available are better in some clinical areas than others. It is to be hoped that the measures available will continue to evolve and improve and we should not be locked into using only what is possible now.

QARR/HEDIS measures are the bulk of what will be used for evaluation. Issues/concerns include:

1-Baseline values for HEDIS measures will be based primarily on measures submitted by health plans prior to DSRIP and may not include results for populations previously excluded from managed care but included under DSRIP.

2-Sampling for health plan HEDIS measures is based on plan enrollment. Health plans being measured are able to identify included patients and do outreach to improve care. Assuming that attribution to PPS will be retrospective, PPS will not be able to do gaps in care outreach unless DOH finds a way to share prospective information on attribution and gaps in care with PPS.

3- HEDIS measures depend on accurate coding. Health plans receive claims and are able to prospectively monitor the coding necessary for measure compliance is accurate. Informed by prospective monitoring of HEDIS measures, plans can and should intervene when providers in the plan network are not coding appropriately. To achieve the level of accuracy expected of plans, PPS will need to monitor coding after measure calculation which will mean DOH must make code level information available to PPS for members attributed to the PPS and allow the PPS to challenge and correct inaccurate results after the initial calculation of rates.

4-The selected perinatal care measure "Timeliness of prenatal care" is linked to plan enrollment. For PPS the measure "prenatal care in the first trimester" might be more appropriate.

Measure based on vital records are problematic if not audited. Even if audited, if used to compare PPS, the measures are not transparent to those being measured as NYS has determined that the records are so highly confidential identification of patients included in the measure cannot be released to the entity being measured.

RE: OBJECTIVE 3 EVALUTION-- the extent to which population health is improved

Our DSRIP collaboration has selected Improving cancer screening and follow-up under the Preventing Chronic Disease. Would the full set of chronic disease metrics addressing asthma, obesity, and hospitalization for short term complications of diabetes also be applicable?

RE: OBJECTIVE 4 EVALUTION-- the extent to which a hospital use is reduced

For the evaluation NYS has proposed defining "avoidable hospitalization" by the four measures: PDI, PQI, PPR, PPV. These are good measures to include in the evaluation but limiting the evaluation to only the admissions defined by these measures will limit the ability of PPS to innovate around ways to bring the delivery of care closer to patients. It must be the case that with new ways of delivering care there are other potentially avoidable admissions missed by these measures. This shortcoming could be addressed by also adding a measure of risk adjusted all cause admissions/10,000 enrollees.

RE: OBJECTIVE 5 EVALUTION-- the impact of DSRIP on health care costs

See above. Measuring risk adjusted all-cause admission/10,000 would foster broader innovation and collaboration about ways to reduce cost for NYS Medicaid while improving care for patients. This is also a better measure for calculating cost effectiveness.

RE: OBJECTIVE 6 EVALUTION—Obtain detailed information on DSRIP implementation, successes and challenges from stakeholder's perspectives

Consider adding the following points:

What additional information was needed to support implementation and operation?

What additional regulatory relief was needed to address implementation and operation barriers?

What adverse unattended consequences were found? How were these addressed?

Again, thank you for the opportunity to comment

**Comments on the DSRIP Evaluation Plan from OMH and OASAS Perspectives
July 21, 2014**

Incentive payments based on Short-term outcomes:

Health Care Safety Net Transformation

Just as we hope to make it clear to the PPS's that behavioral health (BH) needs to be embedded in these areas if the PPS is to be successful so should the BH population be provided focus/attention when creating reports in this area. Improved integration of health care delivery system, care coordination and connection between health care settings cannot be sustained without a concentration on outcomes for people with BH conditions.

Clinical improvements:

BH indicators included are limited:

- 1) 7 and 30 day ambulatory follow-up,
- 2) Adherence to Schizophrenia medication for individuals diagnosed with Schizophrenia
- 3) Antidepressant Medication metrics
- 4) Substance Abuse – AOD treatment initiation and engagement
- 5) ADHD follow-up visit and follow-up prescription

We also know that the BH population will be well represented when targeting for example asthma, diabetes and HIV. We would like to monitor the intersection of the BH population in terms of the health related clinical metrics such as asthma, diabetes, HIV, ambulatory care and cardiovascular care. In addition, monitoring the seriously and persistently mentally ill population should be a priority. The HARP designation could be a proxy for identification of this population. The metrics could then be examined for trends in the general population, the HARP and BH overall.

Improved Population Health: There is no specific category for reducing mental illness/substance use disorders (SUDs) (i.e., prevention reduces incidence or reduced use of ER and I/P). Also, in the absence of intermediate outcomes for BH related to potentially preventable ER/IP visits we need to add ER/IP surveillance metrics to the population level outcomes being monitored.

Suggested metrics to monitor include:

Trends in IP Admissions for:

- BH overall, HARP and for Schizophrenia, Major Depression, Bipolar, SUD Detox and SUD Rehab

Trends in ER Visits for:

- BH overall, HARP and for Schizophrenia, Major Depression, Bipolar, SUD Detox and SUD Rehab

Long term Outcomes Reduced Health Care Costs:

This area is the one the most needs to ID BH influence on outcomes. Because of the effects on costs and health outcomes for PH people have co-morbid BH conditions we will need to monitor the potentially preventable and prevention quality indicators for the BH population and HARP population as subsets of the overall population.

Data Sources: Here as in HH acuity scoring there is a dearth of information on issues like incarceration, homelessness and other quality of life indicators that OMH and OASAS believe are important life circumstances that if addressed can reduce health care costs.

Qualitative component: Concentrates, as it should, on the experience of developing and implementing a PPS. We should be certain that when the community is addressed for this component of the evaluation that OMH and OASAS community-based providers, recipients and family members are included in the process.

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New York State DSRIP Evaluation Plan

The Delivery System Reform Incentive Program (DSRIP), a component of the New York State Medicaid Redesign Team (MRT) Waiver Amendment, seeks to achieve the goals of transforming the health care safety net, improving health care quality, improving population health, reducing avoidable hospital use, and lowering health care costs. This Evaluation Plan, prepared as required by the Special Terms and Conditions (STC) and subject to CMS approval, describes the methods that will be used by the Independent Evaluator to assess the extent to which the New York State DSRIP achieved the intended goals and objectives of the program.¹

Figure 1 shows a logic model depicting the New York State DSRIP program, identifying the major program outcomes and providing a framework for the development of the evaluation. DSRIP is designed to achieve its goals and objectives through collaborations of health care providers termed Performing Provider Systems (PPS) that will create integrated systems to coordinate and provide care across the spectrum of settings to promote health and better outcomes while managing costs. Each PPS will be required to conduct a community assessment and will assume responsibility for a defined population to be served under DSRIP.

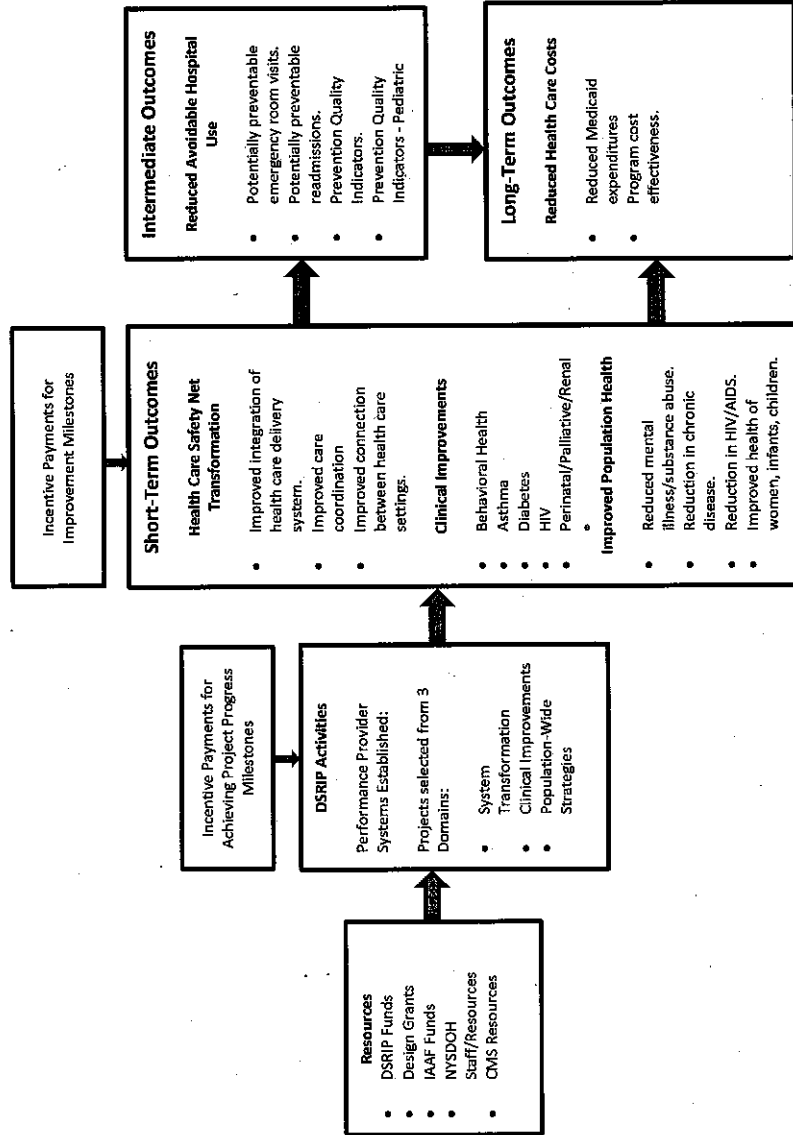
The DSRIP Strategies Menu and Metrics document, Attachment J, provides details regarding the specific delivery system improvement projects and associated metrics.² All DSRIP Performing Provider Systems will be responsible for achieving a set of core project progress metrics pertaining to overall program implementation (Domain 1). In addition, each PPS will be responsible for conducting a minimum of 5 and up to 10 projects chosen from a menu of options to address the needs of the population to be served. These projects are designed to facilitate the attainment of program goals and fall into 3 domains with associated metrics: system transformation projects (Domain 2); clinical improvement projects (Domain 3); and population-wide projects (Domain 4).

The broad goals of the New York State DSRIP evaluation are to 1) assess program effectiveness on a statewide level with respect to the MRT triple aim of improved care, better health, and reduced cost, and 2) obtain stakeholder feedback regarding the DSRIP program and the services provided. Toward these goals, the following objectives will be achieved:

1. Evaluate the extent to which Performing Provider Systems achieve health care system transformation.
2. Evaluate the extent to which health care quality is improved through clinical improvement in the treatment of selected diseases and conditions.
3. Evaluate the extent to which population health is improved as a result of implementation of the DSRIP initiative.
4. Assess the extent to which avoidable hospital use is reduced as a result of DSRIP.
5. Evaluate the impact of DSRIP on health care costs.
6. Obtain detailed information on the strengths and weaknesses of the DSRIP initiative at the implementation and operational stages from stakeholders' perspectives.

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Figure 1. Delivery System Reform Incentive Payment Program (DSRIP) Logic Model



Commented [A1]: This logic model is good for summarizing the program structure and purpose.

For evaluation purpose, there may be a need for a more detailed logic model to provide information on the expected PPS activities, outputs and linkages with the intended short-term, intermediate, and long term outcomes. This is to make sure the completion of the evaluation plan with regard to measures/indicators, especially measures on activity implementation.

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Method

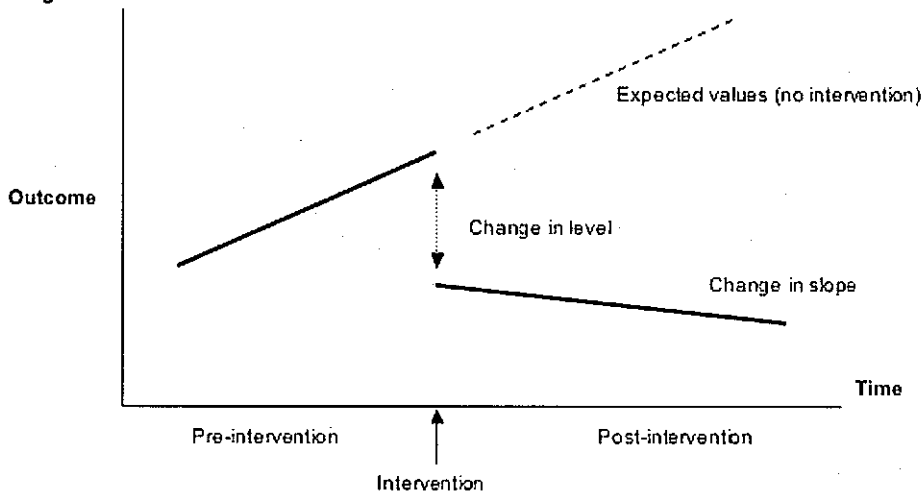
Approach

Pre- and post-DSRIP comparisons will be made to assess change in health care system transformation, implementation of clinical improvements, population health, avoidable hospital use, and health care costs. For consistency in the use of metrics, as well as for their appropriateness for use in assessing the statewide impact of DSRIP, the evaluation will primarily employ the measures described in the DSRIP Strategies Menu and Metrics, Attachment J, in testing the hypotheses under each objective. Existing data available within the New York State Department of Health, described in a section to follow, will be used to calculate the measures.

An interrupted time series design³ will be used in making pre-and post-DSRIP comparisons. This is a quasi-experimental design in which summary measures of the outcome variable are taken at equal time intervals over a period prior to program implementation (independent variable), followed by a series of measurements at the same intervals over a period following program implementation, as illustrated in Figure 2. This design has the advantage of minimizing the potential of maturational factors confounding the effects of the intervention by allowing the observation of trends prior to, and after, the intervention. Potential confounding due to historical effects are also minimized by this design in that such effects would be unlikely to occur contemporaneously with the intervention. If available and appropriate in terms of comparability to DSRIP participants, the state wide design will be augmented by the use of a control group on which measurements would be taken over the same time period in the absence of the program.

Commented [A2]: When there are no appropriate/comparable control group, what statistical methods will be used?

Figure 2. Pre- and Post-Intervention Comparison of Outcome Variable using Interrupted Time Series Design.



Segmented regression⁴ will be used as the primary analytic strategy in the analysis of data under the interrupted time series design. This analysis enables the evaluation of changes in the level and trend in

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the outcome variable, while controlling, as necessary, for such biases as secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. As the unit of analysis in segmented regression is a summary measure (e.g., average quarterly per patient pharmacy cost), individual-level variables cannot be included in a segmented regression model. Stratification, or inclusion of population-level covariates in the model, will be approaches used where program outcomes may differ by recipient subgroups (e.g., sex, race).

For segmented regression analysis, it has been recommended that there be a minimum of 8 observation points both pre- and post-intervention for sufficient power to detect changes in level and trend.⁵ Therefore, the majority of outcome measures will be calculated in three month intervals over three years prior to the implantation of DSRIP, and again in the same manner following the implementation of DSRIP, for a total of 12 observation points both pre- and post-intervention. Some of the data sources to be used, however, will not be collected with sufficient frequency to allow quarterly measurement of the outcome variables derived from those sources. In such cases where the number of time points may not be optimal, the use of alternative data sources containing the necessary information will be considered, as will the inclusion of additional pre-intervention data points to increase power to detect secular trends.

A set of measures described in the DSRIP Strategies Menu and Metrics, Attachment J, will be used to quantify facets of system transformation (Domain 2), quality of care through clinical improvements (Domain 3), and population health (Domain 4). To the extent possible and using existing data sources, these measures will be used for purposes of the DSRIP evaluation in assessing statewide outcomes, in addition to the program monitoring activity of determining incentive payments. The majority of these measures are well established with known measurement stewards (e.g., 3M, AHRQ), and are commonly used in health care quality improvement activities.

That the evaluation of the NYS DSRIP evaluation will involve the testing of a large number of hypotheses poses the problem of inflated type I error rate. The method to be adopted to address this issue will be the control of the false discovery rate (FDR),⁶ defined as the expected proportion of errors (i.e., null hypotheses that are actually true) among a set of null hypotheses that have been rejected. In contrast to traditional Bonferroni methods, which adjust significance levels based on the number of tests, control of FDR makes adjustments in significance levels based on the number of null hypotheses expected to be true among a set of tests. Control of the FDR has been demonstrated to preserve more power to detect real effects than do traditional Bonferroni-type adjustments, as well as overcoming other interpretational problems associated with Bonferroni procedures.⁷

Though control of false discovery rate will be used as a means of statistically controlling the increased risk of type I error associated with conducting multiple test, the creation of composite measures will be considered as a means of reducing the number of individual outcome measures, and in turn, reducing the number of hypotheses to be tested. This would potentially be appropriate with a group of measures that relate to the same broad concept. Adopting the methodology used to create Prevention Quality Indicator composite measures, this would involve summing the numerators across a set of measures where the same population denominator can be applied.⁸

Commented [A3]: A timeline for the DSRIP regarding the three phases is needed. This will help with defining the periods for pre and post DSRIP implementation.

It's also helpful to provide the expected lag effect (the time period between the implementation of the policy/program and when the hypothesized impact will occur, particularly when the impact occurs gradually) for the DSRIP measures or groups of measures to be impacted by the PPSs' activity implementation (for objectives 1, 2, and 3).

Noticing the lag effect for avoidable hospital use (objective 4) and health care costs (objective 5) is estimated to be 6 months and additional three months for observation.

Commented [A4]: Noticing that there is a number of instances, when segmented regression analysis cannot be done because of the lack of a control group or not enough data points. If there are no alternative data sources available, traditional statistical methods for pre and post comparison can be used with certain assumptions.

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Objective 1: Evaluate the extent to which performing provider systems achieve health care system transformation.

All Performing Provider Systems will be required to select two projects under Domain 2, which focus on health care system transformation. Given the efforts under DSRIP to improve health care structure and delivery, it is hypothesized that, following the implementation of DSRIP:

- Integration of service delivery will increase.
- Increased care coordination will be demonstrated.
- Availability and use of primary care will increase.
- Access to health care will improve.
- Medicaid spending on ER and inpatient services will be reduced.
- Medicaid spending on primary care services will increase.

Pre- and post-DSRIP comparisons, on both the statewide and PPS levels, will be made on these outcome measures using the interrupted time series approach described above. The measures and associated data sources that will be used to test these hypotheses are shown in Table 1.

Table 1. System Transformation Outcome Variables and Measures		
Outcome	Measure	Data Source
Integration of Service Delivery	Percent of eligible providers with participating agreements with RHIO's; meeting MU criteria and able to participate in bidirectional exchange	PPS Reporting
Care Coordination	CAHPS Measures – Care coordination with provider up-to-date about care received from other providers	CAHPS Survey Data
Availability and Use of Primary Care	Percent of PCP meeting PCMH (NCQA)/ Advanced Primary Care (SHIP)	PPS Reporting
	CAHPS measures including usual source of care patient loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)	CAHPS Survey Data
Access to Care	HEDIS Access/Availability of Care; Use of Services	Medicaid/Medicare Claims
	CAHPS Measures: <ul style="list-style-type: none"> - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours Wait Time (days between call for appointment and getting appoint for urgent care)	CAHPS Survey Data

Commented [A5]: For tables 1, 2, and 3, it would be helpful to add the following columns for: 1) the level of analysis (i.e., statewide, PPS, or both); 2) number of data points for pre and post implementation; 3) whether a comparable control group is available; and 4) the types of statistical analysis will be used.

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- Potentially preventable hospitalizations for ambulatory care sensitive conditions-Pediatric (PDI composite measure).

Using Medicaid and Medicare (in the case of those dually eligible), measures will be calculated as the number of events on a per member per month basis (PMPM) in three month intervals over three years prior to the implementation of DSRIP. Given that reduced hospital use is in large part dependent on the shorter term DSRIP achievement of health care system transformation, clinical improvements, and improvements in population health, it is anticipated that DSRIP effects on avoidable hospital use would be delayed, i.e., some amount of time would pass following the implementation of DSRIP before reductions in avoidable hospital use would be observed. One way to account for lagged effects in segmented regression analysis is to exclude outcome measurement points during the expected delay period.⁹ Adopting this approach, and estimating six months of DSRIP implementation before reductions in avoidable hospital use would be observed, the three-month observation would be omitted and the first post-DSRIP PMPM measurement of avoidable hospital use on each of the four measures would be taken nine months following the implementation of DSRIP (capturing avoidable hospital usage over the previous three months). PMPM avoidable hospital visits will continue to be measured in three months intervals from that point forward.

Objective 5: Evaluate the impact of DSRIP on health care costs.

Consistent with the MRT triple aim of better care, better health, and at lower cost, a goal of the DSRIP initiative is to reduce Medicaid expenditures as a result of DSRIP implementation through payment reform based on positive health outcomes, as opposed to services delivered. It is therefore predicted that slowed growth or reduction of Medicaid expenditures will be observed on a state wide level in the three years following the implementation of DSRIP compared to three years prior to DSRIP.

Using Medicaid claims data, total Medicaid expenditures, including both capitation and fee for service, will be calculated on a PMPM basis in six month intervals over three years prior to the implementation of DSRIP. Like avoidable hospital use described above, reduction in Medicaid costs are a longer-term outcome, dependent upon shorter term DSRIP health care improvements, including the achievement of reduced avoidable hospital use. Given the expected lag in the effect of DSRIP on Medicaid expenditures, post-DSRIP measurement points will be handled in the same manner as for avoidable hospital use, with the first post-DSRIP PMPM calculation of Medicaid expenditures taken one year following the implementation of DSRIP, capturing the expenditures over the previous 6 months. Even though the expected reduction in avoidable hospital use would precede reduction in cost (Figure 1), the lag in DSRIP effect on cost is not expected to be longer than that expected for avoidable hospital use. This is because reductions in avoidable hospital use would likely have an immediate impact on Medicaid expenditures. As with the avoidable hospital use measures, PMPM Medicaid expenditures will continue to be measured in six months intervals for three years from that point forward.

Assessment of the effect of DSRIP on health care cost will also include an analysis of cost effectiveness^{10, 11} with respect to avoidable hospital use, as this outcome is central to the DSRIP initiative. The intention of these analyses is to assess value for the money by weighing additional expenditures incurred in the operation of DSRIP against reduction in avoidable hospital use, in a comparison of avoidable hospital use and cost before and after the implantation of DSRIP. Cost-effectiveness ratios, or CER's (change in cost divided by the change in outcome) will be used to express the dollar amount per unit reduction in avoidable hospital use. This information will then be compared to the average cost of an avoidable hospital use event (e.g., an avoidable hospital admission) to determine if additional expenditures

Commented [A6]: This will result in a total of 6 data points for pre DSRIP implementation.

Commented [A7]: This will result in a total of 6 data points for post DSRIP implementation. What statistical methods will be used if a minimum of 8 data points for each of the pre and post intervention period is needed to conduct the segmented regression analysis?

Commented [A8]: When comparing cost over time, it may be appropriate to apply the Consumer Price Index (CPI) for Medical Care category to adjust for inflation.

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incurred under DSRIP (e.g., incentive payments) are offset by savings through avoidable hospital use. This analysis will be conducted on all four measures of avoidable hospital use. Other analyses around cost effectiveness that may be useful would be to compare DSRIP cost effectiveness among subgroups, e.g., cost effectiveness comparisons across Medicaid recipients' health status.

Objective 6: Obtain detailed information on DSRIP implementation, successes, and challenges from stakeholders' perspectives.

Qualitative methods will be used to obtain stakeholders' perceptions of the DSRIP initiative at both the development and implementation stage of DSRIP, and at the operational stage of the initiative.

For qualitative analysis at both the implementation and operational phases of DSRIP, key informant interviews, focus groups, Web-based surveys, and analysis of planning documents and program materials will be methods used to obtain feedback from DSRIP stakeholders, along with appropriate background information. Survey and interview protocols will be approved by New York State Department of Health IRB, and all evaluation staff involved in data collection will receive training on the handling and storage of confidential information.

During the developmental stage of DSRIP initiative, stakeholder feedback will be gathered regarding the following questions:

- What positive outcomes are expected as the result of DSRIP?
- What difficulties were encountered in getting a PPS approved?
- What additional information would have been helpful in the application process?
- What were some obstacles in forming partnerships between providers participating in a PPS?
- What difficulties were encountered in developing and implementing a PPS?
- How was rapid-cycle evaluation used in developing PPS projects?
- How did the learning collaboratives support system change?
- What were some of the earliest improvements in health care delivery that were made as a result of DSRIP?
- What difficulties were encountered in gathering the necessary data about the PPS?
- How was DSRIP initially received by the community?

Key informant interviews will be conducted with members of PPS leadership, as well as NYSDOH staff involved in the development and implementation of DSRIP. Interviews will be semi-structured such that questions to be asked will be uniform across participants, while at the same time allowing for follow-up questions to probe for more in-depth responses. Responses will be reviewed and coded independently by at least two evaluation staff members to identify major themes. Modifications in the interview questions will be made as necessary based on responses obtained on early interviews. Survey data will be analyzed using statistical software in the case of closed-ended questions, or for open-ended questions that can be coded into categories. Open-ended questions that may elicit more complex responses will be analyzed in the same manner as the key informant data.

To obtain information from a broader group of PPS staff, a web-based survey will be constructed and administered to selected individuals involved in the administrative, clinical, and financial operations of the PPS's contracted under DSRIP. Informed in part by the key informant interviews, the Web-based

Commented [A9]: There may be a need for obtaining from PPS reporting data (if available) or collecting the information on the implementation of individual activities and associated time frame (initial and full implementation of each activity) from the PPSs. This would help to determine the full implementation phase for each activity and the whole domain for each PPS, and therefore, proper post-implementation data points can be defined.

Commented [A10]: It would be helpful if the definitions (what it is and the timeframe) for the few terms used in this plan such as "developmental phase", "implementation phase", and "operational phase" are provided so that this plan can be a stand-alone document.

Commented [A11]: How often these interviews will be conducted?

Maybe to have few focus groups and key informant interviews first to generate structured interview questions to survey all participants in the later steps.

Qualitative data, after collected, can be analyzed using qualitative software, such as NVivo or ATLAS.ti, to identify common themes, groups of themes; classify, sort and arrange information; and examine relationships in the data etc..

These themes, groups of themes and categories will then be quantified and used with statistical analysis software, such as SAS, to compare and contrast.

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surveys will obtain detailed information on collaboration with other providers within a PPS, patient enrollment, financial arrangements between providers participating in a PPS, patient receptivity to PPS care configuration, and recommendations for program modification.

Qualitative analysis for the operational stage of the DSRIP initiative will emphasize program functioning and outcomes as perceived by program stakeholders. The questions to be addressed include:

- What care improvements have been most notable?
- Which sub-populations saw the most improvement?
- What difficulties were encountered in operating a PPS?
- What were the notable partnerships that were formed in implementing a PPS?
- How was the PPS received by the community?
- What are the reactions of Medicaid enrollees to DSRIP?
- What intended PPS goals were not achieved, and why?

Key informant interviews will be conducted with members of PPS leadership, NYSDOH staff involved in the operation of DSRIP, as well as PPS clinical, administrative, and financial staff. A Web-based survey will also be developed to obtain additional information on DSRIP outcomes from stakeholder perspectives. Again, the content of this survey will be based on, in part, by the information obtained from the key informant interviews. Analysis of these data will be conducted in the same manner as described above.

Data Sources

Evaluation objectives 1-5 will involve the use of a number of existing data sources that are maintained by the New York State Department of Health. These data will be available for use by the Independent Evaluator as an agent of the Department, in accordance with public health law and/or under the appropriate data use agreements.

Medicaid Claims

This database contains billing records for health care services, including pharmacy, for approximately 5.7 million individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid claims database is updated on a monthly basis to include additional claims and modifications to existing claims.

Medicare Claims

For the approximately 15% of Medicaid enrollees who are dually eligible for Medicare, Medicare claims will be used to ensure data completeness, as many of the services received by this group will be paid by Medicare and thus not appear in the Medicaid database. Medicare claims contains billing records for health care services, including pharmacy services, along with data on diagnoses and provider information. Medicare data are received by the New York State Department of Health on an annual basis, under a care coordination data use agreement with CMS. Medicare Part D data are received on a monthly basis.

Statewide Planning and Research Cooperative System (SPARCS)

The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects, on a

Commented [A12]: Additional questions could be added to assess the sustainability of the QI activities such as:
- List of system changes implemented and the spread of implementation among providers in each PPS.
- List the QI process changes that are institutionalized into daily routine work (e.g., via electronic systems, protocols, clinical decision-support tools, routine data collection and used regularly for QIs, etc...)
- Which DSRIP activities are sustainable after DSRIP project is completed? Which ones are not? Why? What are the barriers for sustainability?

Comments related to Evaluation Design Webinar (Priti Irani, priti.irani@health.ny.gov)

(http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrrip_evaluation_design_webinar_6_16_14.pdf)

Disclaimer: These comments are from a personal perspective. Everyone is working on a grant deadline so this has not been discussed or vetted.

Everyone in the community, prevention and health care practitioners are excited about DSRIP and want to be engaged. I have organized my comments into strengths, and Potential questions that will be asked in the evaluation. My interest in DSRIP is from the "Promote Mental Health and Prevent Substance Abuse" (MHSA) Priority perspective. I do think all the Prevention Agenda priorities are interrelated to each other. I also understand that DOH does not have primary responsibility for activities related to MHSA as this rests with OMH and OASAS.

1. Strengths:

- Focus on three domains: System Transformation, Clinical Improvements, and Population-Wide Strategies
- For population-wide strategies, you are building on the Prevention Agenda
- Openness to get public input during the evaluation design phase
- Thinking about identifying an appropriate control group
- Working with an external evaluator

2. Potential questions that will be asked in the evaluation

a) What frameworks are being used for mhsa in the evaluation design?

Suggest using one of two frameworks - (1) IOM Intervention Spectrum, 2009 for a balanced Promotion/Prevention and Treatment/Recovery (2) Framework for Support. Both have a lot of overlapping areas. The IOM lens is more global/omniscient perspective, while the Framework for Support is pointing the lens from the treatment/recovery perspective.

b) What hypothesis are you working from?

My hypothesis is that at present almost all resources for mental health are allocated to medical care services. In order for all the sectors to play their parts effectively, resources must be more equitably balanced. Otherwise you will not see reductions.

c) How will the evaluation design question assumptions? How will evidence of balancing promotion/prevention with treatment/recovery approaches be evaluated? How will systems use of a life span/developmental approach be evaluated?

- There is stigma about mental illness and mental health.
- There is also an assumption that major mental health issues such as anxiety/depression cannot be prevented, and based on evidence; this is not accurate.
- All mental illness cannot be prevented, but neither can all physical illness be prevented. A significant proportion can be prevented.
- One way to address stigma is for healthy people to seek help for mental health issues before they become serious, just like we do for physical health.
- It is also important to adopt a life span/developmental approach

In summary, I am envisioning that the evaluation will provide guidance on how to continue to support the strengths and address the gaps.

