

The following is a summary of the Q&A from the all-PPS workshop held by DOH on January 16th 2015. The slides used in the session have been made available to PPSs through the Listserve and the operator-assisted call on 1/26 will include a brief recap of some of the key points discussed for those who were not able to attend.

Project scoring & ongoing evaluation and payment

Q: Do the Achievement Values associated with the organizational sections of the implementation plan apply across all of the projects?

A: Yes. The Achievement Values drive the DSRIP payments in each payment period, so the achievement (or not) of any of the achievement values will dictate the proportion of each project's total possible valuation that is awarded to a PPS in each payment period.

Q: Speed and Scale are worth 2/7 of the total achievement values available in each payment period, is that correct?

A: Yes. Speed & scale are important but they are not the only things that drive payments. Other Domain 1 process measures, as well as outcome measures also drive payment.

Q: What happens to the DSRIP payments if a particular application is not approved?

A: At this stage it seems very likely that all applications that were submitted will be approved. The only limit is if a PPS gets 60 points or less. In this case the State would consider what action would remedy the situation – perhaps engaging with other PPSs to discuss absorbing the PPS in question.

Q: Given that individual DSRIP payments will vary depending on the number of achievement values a PPS achieves in a given funding period, is there a risk that the total funding will not add up to \$6.4B?

A: PMPM will vary in order to ensure all money will be allocated. CMS has a firm commitment to spend all the money available.

Q: If a PPS only achieves a low score for a particular project – and therefore does not receive sufficient funding for that particular project to implement it successfully – can the PPS drop the project?

A: No, PPSs cannot drop projects they have selected and included in their application. However, DSRIP funds are not tied to specific projects once they have been allocated to a PPS. If a PPS found itself in this situation, it could spread its DSRIP funding across its various projects however it chose and thereby make up for the funding shortfall associated with that particular project.

Q: For Project 2.a.i, where every provider has to reach PCMH Level 3 certification by the end of DY 3, if there are 80 practices and some of them are very large, if they don't all achieve Level 3, will they get an achievement value of 0?

A: Yes. For speed & scale, what a PPS committed to in their project plan applications is the target they are expected to hit in order to get an achievement value.

Q: If DSRIP Year 1 is a shortened year, how will that impact on the idea that DSRIP payments are calculated based on a 60-month program?

A: DSRIP Year 1 is indeed a short year. DOH will be paying out on a 57 month payment schedule that will work in accordance with this shortened timeframe (DY1= 9 months; DY2-DY5=12 months). As per CMS's commitment, all the DSRIP money will be distributed across the life of the DSRIP program.

Q: Can we expect details of the metrics specification guide?

A: It is being finalized right now and should be available before the end of the month.

Q: Is the DOH going to give more detail about the Domain 1 process measures to the PPSs?

A: The presentation that was given today by PCG did not go into detail about the evaluation process for Domain 1 measures. PCG is going to put together a webinar that articulates the evaluation process to be released shortly.

Q: With regard to the attachment J metrics, have you engaged with CMS about modifying NCQA measures?

A: NCQA and HEDIS measures are deemed appropriate as of now. They were intensely negotiated with CMS.

Q: With regard to speed & scale, if you exceed your target for a particular project, could you use that to make up for a missed goal in another project (and thereby get the achievement value for the project where you have fallen short)?

A: No, the speed & scale numbers you enter as your targets are project specific; you either hit your goals and receive the achievement value or not.

Q: In the example given by PCG, payments are not even across the demonstration years. What drives the difference?

A: This is based on guidance in the STCs. Factors such as the PMPM figure and the relative split between P4R and P4P (which changes over the course of the DSRIP program) will drive variances in the payment amounts.

Q: There are key steps and milestones for the organizational components of the implementation plan. Are there Achievement Values associated with these key steps and milestones?

A: There are specific achievement values tied to four of the organizational sections of the implementation plan (governance, workforce, cultural competency and financial sustainability). There will be more detailed information about how these achievement values will be evaluated – as well as the timetable for reporting – forthcoming from the Independent Assessor very shortly.

The implementation plan

Q: The Cultural Competency section of the implementation plan refers to contracting with CBOs. Does that mean that CBOs should only be used for cultural competency /health literacy?

A: No, the reason for including this here was simply because CBOs will be important in terms of cultural competency, not because that is the only area where they can be involved.

Q: In the implementation plan structure document there is a matrix for the ‘Detailed speed of project implementation’. Is that table asking for information at a practice level or an individual clinician level?

A: This table is at the practice level.

Q: Should the ‘General project implementation’ section of the implementation plan be filled out once, covering all projects, or once per project?

A: This section should be filled out just once, covering a PPS’s plans for establishing all of its DSRIP projects.

Q: When will the finalized implementation plan template be issued and will there be a prototype?

A: The target date for issuing the template is Feb 1st and the first installment of the prototype is scheduled to be released in the first week of February.

Q: The timing of the Implementation Plans (IPs): if they are due to KPMG on March 1st and to the State on April 1st, what is the purpose of the additional 4 weeks?

A: The period between March 1st and April 1st is an opportunity for PPSs to use KPMG's DSRIP Support Team to review and discuss their work-in-progress implementation plans. The final, hard deadline for submitting the plans to DOH will then be 1st April.

Regulatory waivers

Q: With regard to the regulatory waivers, if you are granting a particular waiver to one PPS, why not do it for all PPSs, on the grounds that the rationale for waiving that particular waiver will apply to all PPSs? And if the reason for waiving the regulation is that there is no risk to patient safety, why not change the regulations permanently?

A: DOH is necessarily erring on the side of caution here. The regulatory authority that was given to the DOH requires it to perform case-by-case reviews of the 500+ requests received to date. DOH plans on getting back to the PPSs by Feb 6th. PPSs can still request waivers, the door is not yet closed.

Q: Will regulatory waivers apply only for the 5 demonstration years?

A: Yes, currently the regulatory waivers will apply only for the life of the DSRIP program but DOH understands that the processes and system put in place in the name of the DSRIP projects will not simply come to an abrupt end at the end of year 5, so will be looking closely at what makes more sense going forward.

Q: Will DOH be able to make any waivers relating to tele-psychiatry?

A: DOH is trying to be as helpful as possible to PPSs but unfortunately cannot waive NYS Education Department regulations.

Provider networks

Q: What will PPSs need to do with regard to providers that don't meet financial sustainability responsibilities?

A: PPS are responsible for ensuring that the delivery system provides patients with the access to the services they need. Whereas PPSs are not specifically 'on the hook' for the financial status for every partner in their system, they should have a strategy for getting providers to – and maintaining – financial sustainability. In particular, providers might be financially challenged because of excess capacity, or likely to be adversely impacted by a transition to value-based payments. PPSs need to ensure that the impacts of the DSRIP program (including cost savings and changes in revenue) are distributed in a way that maintains a financially sustainable system.

Q: Can PPSs still add some additional providers to their network in the MAPP tool?

A: DOH will allow PPSs to add performance partners to their network in late February or early March. The MAPP network tool itself will not open, but PPSs will have an opportunity to provide DOH with a list of providers it would like added to its network. DOH will then add these providers to the PPS network on behalf of the PPS. Please remember that while a PPS will be able to add providers for performance purposes, these newly added providers will not affect valuation. Additionally, please note that PPSs will not be able to delete providers from their network.

Q: What should PPSs do about network partners who are in counties that the PPS lost in the final round of attribution due to having low attribution in that county? Are these partners still going to be participants?

A: The providers will still stay in the PPS's network, yes. There will be a lot of patients that live in one county but get services in another, so the county boundaries should not be a barrier to a provider participating in a project. Having said that, throughout the life of the DSRIP program, PPSs have the opportunity to switch providers in and out of the list of providers dedicated to a specific project.

The DSRIP projects

Q: For project 2.d.i, are PPSs able to use the PAM tool **or** another, similar tool, or is it PAM only?

A: The PAM tool is the one that must be used for this project.

Q: If PAM is to be required across the entire DSRIP program, then could DOH consider providing training on this proprietary tool? Training of the CBOs will be necessary for all PPSs involved.

A: DOH is open to discussing with PPSs the most efficient way to get that project done, so we will look into this and can take this discussion up separately.

Q: For the co-location of primary care and the ED, is there a distance limitation on what counts as 'co-location'?

A: DOH considered this and concluded that identifying a specific distance that would apply to all PPSs wouldn't take account of local circumstances and would risk being arbitrary, so no specific distance will be required. However, in order for the project to be successful, clearly the primary care access will need to be close enough to the ED to make it a viable alternative for patients.

Q: When will additional planning funding be available to allow PPSs to continue with their implementation planning and establishing PMOs etc.?

A: This funding will be available shortly – the goal is for it to be available within the next couple of weeks. DOH will issue a clarification shortly.

Data

Q: Can DOH give an idea of when there will be Salient training to teach some more advanced functions?

A: DOH will try to come up with additional training. KPMG is tasked with performing a survey of training needs.

Q: Will PPSs be able to get member-specific demographic data about their patient population from DOH?

A: PHI authorization is still needed for that. DOH's hope is to have detailed data on members identified by the end of end of March 2015, but we need to finalize all privacy related components including PHI DEAs and the Opt out policy and process.

Q: Does this apply to the Medicaid members already attributed? Since the data is old, many of the members have moved on or deceased.

A: Attribution will be updated on a monthly basis so that members that have moved on would be removed, other members will be added. DOH does not envision PPSs would get PHI on members not attributed to a PPS.

Q: There are a number of services that are not billable to Medicaid but which are nonetheless crucial to the functioning of an effective provider network. Because they are not reflected in the claims data, they will not be reflected for the attribution. Will this be taken into account?

A: DOH will take that into consideration and try to find a solution.

Q: Will the PPSs have access to PHI for Medicaid members who are not attributed to that PPS but who are nonetheless users of services / providers in the PPS's network?

A: For sole PPSs in the area, this will not be a problem but for other PPSs, we will need to consider how this might be possible through the approval processes.

Q: Is DOH open to incorporating HEDIS measures – and the data feeds currently used for them – into the DSRIP program? Will DOH be leveraging any processes that are used for the MCOs if they are the same as for the PPSs?

A: Plans will be accountable to the same measures. There might be a natural synergy between the plans and the PPSs in this regard and this is something the State will look into.

Q: How does that relate to FFS?

A: This is also something the State will be looking into, although FFS is becoming a smaller pool and will continue to do so over the life of the DSRIP program.

Q: How will HIE sharing be impacted by integrated services?

A: DOH is looking closely at the ‘opt out’ model used by the ACOs. There may be some network consent as part of the information exchange, and hopefully a consent form built into Health Homes contracts for accessing data. This is still being finalized, and there will be a walk-through of patient consent forms within DSRIP in the future.

Capital funding

Q: Can someone clarify the capital funding process and what PPSs should do if they have questions?

A: The deadline is Feb 20th. If there are other basic questions around process, then we can field them.

Q: Capital funding. The success of some of the DSRIP projects will depend heavily on capital funding. If capital funding requests are not successful, how will the projects be implemented? When will capital be available?

A: DOH adjusted the timeline so that the announcements about capital funding will be made before implementation plans are finalized. Having said that, PPSs should not assume they will get the full amount of capital funding they requested. The total ask was approximately \$3bn, whereas the amount initially allocated for these funding requests was approximately \$1.2bn. PPSs should therefore have contingency plans to deal with a situation in which they do not receive the capital funding they have requested.

Other

Q: Is this DSRIP program – and particularly the performance model – a copy of what other states have done?

A: No, all 'DSRIPs' are all different. This is more complex than in CA, TX, and NJ, with more funds involved and a stronger accountability structure in place.

Q: Is there a source of this model?

A: This model is unique, although there are elements that were used in other places – for example MCOs have been accountable to many of these performance measures already. The speed and scale element is unique.