Balancing Relationships and Data in Evolving VBP Contracting in the New York State DSRIP Program


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The New York State DSRIP program aims to create accountability at a community level for improving health outcomes for the Medicaid population. It accomplishes this by using performance-based contracting to incentivize community providers to work together towards this common goal. These contracts are executed in multiple phases with distinct objectives, and rely on the core concepts of relationship management and data analytics to achieve the overarching system and state goals. Each DSRIP system of partnerships is referred to as a Performing Provider System (PPS), typically led by one large health care system whose role it is to facilitate building the infrastructure for long-term success within the DSRIP program and their local community[1]. These contracting methodologies and their associated phases were created by COPE Health Solutions and designed for the evolving needs of partners in the New York State DSRIP program.

The three phases (I, II, and III) discussed in this article are iterative and are distinguished from each other by their shifting reliance on relationship management and data analytics to guide their performance measures. Phase I contracting aims to establish partnerships and identify commonalities between providers with unique roles in their community. Phase II contracting focuses not only on continuing to build these relationships, but also on introducing partners to performance-based contracting metrics using preliminary data to measure progress for each provider. Lastly, Phase III contracting relies heavily on complex data analytics in order to quantify improvements in health outcomes and move towards further accountability for monitoring and improving Medicaid member health. Creating a sound infrastructure of relationship management of new partners, and then further building on this relationship using data analytics, is key to achieving success in value-based payment (VBP) for these community providers.

Overview of VBP Goals within the New York State DSRIP Program

New York State, through an approved Medicaid 1115 Waiver from the Centers for Medicare and

[1]NY DSRIP Program Funding and Mechanics Protocol

Medicaid Services (CMS), is in its second year of the innovative program to improve the Medicaid delivery system with a Delivery System Reform Incentive Payment (DSRIP) program[2]. The DSRIP program is meant to bridge the gap between current fee-for-service incentives and future value-based care models, to increase access to services that will position providers in New York State to take on financial risk in new payment models.

Along with many other goals of improving population health, the DSRIP program aims to reduce avoidable hospital utilization and move towards VBP-contracting that rewards improved coordination of care and health outcomes. This shift in incentive structure will not only result in financial savings for the state, but will also "allow providers to increase their margins by realizing value."[3] The concept of assigning value to desired services or outcomes is integral to achieving the "Triple Aim" of patient-centered care, quality and cost, but is operationally complex.[4]

Future risk agreements have the opportunity for an upside financial gain for successful providers if the defined population is well-managed in relation to total cost of care. To that end, contracts in the DSRIP program are designed to closely mirror future pay-for-performance-based contracts in VBP programs. This serves the purpose of familiarizing providers to a new form of contracting and giving the opportunity to develop some care management infrastructure, while achieving short-term goals of improved access and health outcomes specified by the DSRIP program.

The transition to value-based contracting within the DSRIP program can follow one of two principles: 1) Pay for specific steps in a defined processes that are designed to meet a final goal; and, 2) Pay for achieving desired health outcomes irrespective of the steps taken to achieve them. An example of this distinction would be paying a provider to develop policies and procedures for referrals to NYS Quitline (a state-sponsored tobacco cessation service) versus paying for an improvement in smoking cessation within the specified population. The first concept aims to standardize processes across providers while the second rewards the outcome regardless of process. The first strategy ensures the goals of the network are built into the care management and IT structure of the participating organizations. Once the relationships of the system partners have been clearly defined, the second strategy shifts to paying for outcomes.

DSRIP requires the PPS to set the performance goals for each measurement year (July 1st to June 30th) and to guide the network partners though increasingly complicated phases of contracting, to move the network toward true VBP readiness and the ability to take on risk in the Medicaid line of business. In the case of New York State, the PPS should interpret the overarching goals of the DSRIP program in the context of what makes sense in their health community. The PPS lead then distills these goals into smaller, more manageable steps for the network.

Creating accountability for system outcomes relies on established relationships and entities that have a history of working together with established channels of communication and defined expectations for the individual organizations. The role of the PPS lead matures over time from beginning as a relationship organizer and manager to providing the framework for organizations to be held accountable for their performance and to gauge improvements within their clinical care. Striking a balance between the core values of relationship-management and data analytics is central to achieving long-term success and scaling these accomplishments to serve a wider population.

[2]A Path Toward Value Based Payment. New York State Roadmap For Medicaid Payment Reform. June 2015.
[3]From Vision to Value in NYS Medicaid: the FQHC perspective. CHCANYS 2015 Annual Conference. October 19, 2015.
[4]The IHI Triple Aim. http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

Phase I Contracting: Identifying the Essential Partners in the Community Health Network
Phase I contracting is the initial phase of introducing the PPS network to goals of the DSRIP program, to understand the expertise and capabilities of individual entities and to define the essential players in the network. This first round of contracting informs the PPS of the types of partners in the local health system to inform a strategy for working together moving forward. This type of information is consolidated by the PPS lead to paint a full picture of the accessibility and capability of the community health network.

In order to achieve this level of understanding, partners must share information about their organization, such as services offered and associated provider types. This is a fundamental shift for many community organizations that may have served the health of a population in small silos until now and have never examined how they add to the overall 'value stream.'

Further, partners must also provide information to the PPS about their financial sustainability. As the goal of the DSRIP program is to align and integrate community health resources, the financial failure of a key partner could seriously impede access in a particular geography. Therefore, financial metrics, reported and tracked over time, are needed in order to trigger any intervention necessary to preserve the overall success of the network, such as advisory needs or financial assistance.

These initial aspects of the Phase I contract establish a relationship between the PPS and its partners to align the network. Once partners are initially aligned, the PPS can differentiate between partners' potential value and necessity within the network and measure their individual success and contribution within DSRIP goals. This differentiation begins in Phase II contracting and continuously progress as the network matures.

Phase II Contracting: Establishing Value for Best Practice Processes
The second phase of contracting designs the steps each partner must take on the road to VBP readiness by introducing defined performance metrics for each partner type (e.g. primary care provider, hospital, care management agency, etc.). These metrics are intended to move partner entities in the direction of standardized processes and best practice models. The goal of this phase is to familiarize entities to pay-for-performance-like contracting while utilizing data analytics as a tool to measure that performance. This new paradigm can be a shock to providers that, until now, have operated with independence to set their own practice standards and systems. To that end, it is imperative that metrics created for this phase of contracting are both clear and specific but conversely, broad enough to encourage participation and avoid intimidating partners weary of change and leery of prescriptive oversight.

Metrics should be created jointly by the PPS lead and governance workgroups made up of representatives of the partner network, and can range from the submission of an implementation plan to proof of actual implementation of a new workflow or protocol. This is a collaborative process that, depending on the capability and maturity of the individual PPS, can result in highly complex or intentionally simplified metrics. This process is ineffective without a foundational relationship between the PPS lead and the network partners. Ultimately, metrics must be developed by simultaneously understanding the current abilities of the network and aiming for future goals. Using simplified metrics in the early stages of the PPS can be effective in incentivizing the network to come to the table before longer-term changes and strategy are discussed.

During Phase II, the basis for allocating eligible dollars is based on attributed Medicaid lives. Attribution serves as a proxy to account for organization size and complexity of a partner, rather than their true ability to perform on these metrics. However, this oversimplification is also the major

drawback of using solely number of lives served (with some degree of modification) in order to design contracts. Attribution does not account for many characteristics of a partner, such as ability to meet prescribed goals that are integral to reaching VBP readiness.

While Phase II process goals are necessary stepping stones, they are intended merely to lay to lay the groundwork for outcome metrics. Unlike process metrics that are developed in-house, outcome metrics are taken from state-defined outcomes for the DSRIP program that are applicable to pre-determined provider types. These outcome measures are included in Phase II contracting (as pay-for-reporting metrics) initially to familiarize partners with the types of outcomes they will be held accountable for in the near future.

Ultimately, collecting data from Phase II contracts and observing partner ability to perform during this period will be invaluable information in creating the Phase III strategy moving forward.

Phase III Contracting: Quantifying Gap to Goal

Phase III contracting is the most data-dependent phase and least dependent on qualitative analysis (i.e. relationship-building measures) with the objective to clearly define the "gap to goal" steps necessary for each partner in a continuous improvement model. The goal of this contracting phase is on achieving desired health outcomes that incrementally differentiate between current and future state for each organization.

The first step in this process is for the PPS to perform a gap assessment for each partner in order to understand performance capability and to inform potential infrastructure investments in the greatest areas of need. This is a high-touch and complex process that requires rigorous effort to gain as much quantitative and qualitative information as possible from many different partners. From there, the PPS must tier partner readiness and ability to perform.

It is noteworthy that, while still imperative to success, relationship management begins to take a backseat to data analytics and quantitative measures in this iteration of the contracting process. A significant opportunity in Phase III is the availability of claims data from NYS Department of Health that has the potential to differentiate partner performance and allow for the identification of target populations for specific interventions. Appropriate use of claims data analytics will allow the PPS to more effectively incentivize change and ensure commitment to the long-term goals of DSRIP projects.

However, the limiting factor in any contracting phase, but especially this third phase, is the availability of reliable data, as it sets the stage for future contracting models to inform decision-making and performance measurement. The first claims data was released in June 2016. Before it can be used to quantify partner status, it must be sufficiently reliable, requiring vigorous data validation and scrubbing until it can be applied to standardized algorithms to further evaluate partner performance. As time progresses, useful data will become increasingly available and incorporated into performance-based contracts to align incentives with the right partners at the right time.

Going to Goal: Balancing Outcome Data with Critical Relationship-Building

Even the best data cannot ground successful outcomes without trusting relationships between the partners and policies that 'lift all boats' in the health community of the PPS. Therefore, there is a risk that utilizing complex data in the nascent stages of contracting may shift focus and dollars away from building necessary infrastructure among critical community health partners. It is important to develop a comprehensive strategy at the outset before diving into data because robust data analytics without solid relationships with partners will lead to early failure. The introduction of increasingly complex data will serve to enhance these relationships and solidify their success in the DSRIP program. Ultimately,

striking a balance between relationship management and data analytics is the key to achieving long-term success in value-based payment for population health strategies.

About COPE Health Solutions

COPE Health Solutions is a health care consulting firm that advises hospitals and health care systems on strategy, population health management, Medicaid waivers and workforce development solutions. COPE Health Solutions provides clients with the tools, services and advice they need to be leaders in the health care industry. COPE Health Solutions is currently working with multiple participants of the New York State DSRIP program to align their performance-based contracting methodologies with desired future goals of VBP readiness.