HANYS Healthcare Association of New York State

Proud to serve New York State's Not-For-Profit Hospitals, Health Systems, and Continuing Care Providers

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

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 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