Overview of the Scoring Process of the PPS Proposal

This one pager was developed to provide a more detailed overview of the key components of the applications plans submitted including the scoring process for Delivery System Reform Incentive Payment Program (DSRIP) proposals. The scoring process is very complicated and so we decided to address only areas we felt were of importance to community and frontline workers. This 6-pager is meant as a companion piece to our DSRIP selected review of the city PPS proposals/plans, which can be found on our website at www.cphsnyc.org. We hope this helps with comments on what PPSs met or did not meet as required by DSRIP, including what the process missed. Regardless, we feel strongly for people to have this type of information to help them in any future engagement in the DSRIP process.

Background on the DSRIP Project Applications and Decision-Makers

In August 2014, The New York Department of Health awarded PCG Health a contract to serve as Independent Assessor for its Medicaid reform efforts. They will be reviewing the applications along with 6 anonymous reviewers, and a 27- member DSRIP Project Approval and Oversight Panel, which had their first meeting in January 2015 (see attachment for list of Panel Members –not included is the recent appointment of Judy Wessler, former Director of CPHS and still an active health advocate). The Panel will play an important role in approving DSRIP Project Plans from all areas of the state and will serve as advisors and reviewers of PPS status and project performance during the 5-year DSRIP duration.

In late September 2014, the Department of Health posted the Draft DSRIP Performing Provider System (PPS) Project Plan Application and Scoring Guide. The Project Plan Application consists of two components: the Project-Specific Application and an Organizational Application. The opportunity to comment ended in October 2014. The Project-Specific Application, the Organizational Application, and the Application Scoring Guide can all be accessed at the following website:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip_project_plan_application_draft.htm

The Performing Provider System (PPS) had to submit their DSRIP Project Application by December 22nd. Originally, the PPSs did not submit a full application because the state was delayed with the DSRIP Attribution calculations. This is the calculation done to connect Medicaid beneficiaries to providers that are partners in PPS networks. The applications were completed on January 12, 2015 and posted on the DSRIP website on January 13th, 2015. There is a public comment (30 days) that will end Sunday, February 15, 2015. The application will also include the Community Needs Health Assessments (CNHA's). The CNHA's were conducted by the PPS's to help them choose what DSRIP projects (will choose at least five and not more than 11 projects) they will work on.

Overall Troubling Issues

- The way the questions were developed in the DSRIP application allowed for obscure responses from the eligible PPSs, especially in areas related to how they would work with communities, their governance structure, and their plans to addressing disparities in health care.

- The language in the proposals and CHNA's for some of the PPS were very similar to each other and at times exactly the same. We know many of the PPSs contracted the same consultants. But the real issue to uncover would have been if the needs assessment were done right. CHNA's and proposals could have missed important health needs and gaps. Not all neighborhoods/communities are the same

and should not be treated as such. And what works in one community does not necessarily work in another community.

- We don't know the community experience and understanding of needs of low-income New Yorkers of the 6 reviewers

- The composition of the Panel is not fully representative of immigrants, people of color, Medicaid consumers, the uninsured, front-line workforce, LGBTQ, people with disabilities, and other key communities that should be at the table.

- It is clear by knowing who is on the DSRIP Project Oversight and Approval Panel (PAOP).that there must be some conflicts of interest. (i.e. Stephen Berger and others)

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- Our investigation has indicated that PCG has provided services in implementing health reforms and Medicaid expansion, but we can't identify the success and impact on the health care consumer. Their expertise is grounded on corporate marketing and connecting consumers to insurance products. We do not know if they have the experience in evaluating community engagement. We do know that they admitted to not having any workforce development experience.

- The objective scoring calculations in attributing a value to a project and then how much funding a PPS will be eligible for is not so impartial and fair. Information about this part of the scoring is further explained in this document.

- The scoring process for subjective sections of the project application is not discussed in the scoring guide. The scoring guide does describe the intricate process that will be used to score objective project components. As noted later, this issue is important because these components will often account for 80% of the project score.

- The "all or nothing" funds flow "formula" will destabilize the whole system from the beginning. Reimbursement should be proportional to effort achieved for each goal, not a complete loss for missing the goal even by a minor amount.

Scoring Guide & Process

The scoring guide illustrates how the DSRIP Independent Assessor (Public Consulting Group or "PCG") will calculate a project's and the PPS's total scores to determine a project's total value, or the amount of DSRIP funding a PPS is eligible to receive, per project, over the 5-year DSRIP waiver period.

The project application score is the sum of two calculations: a project-specific score and the PPS' organizational application score. The project-specific score is worth 70% of each project's total application score. It is determined based on the DSRIP Independent Assessor's (PCG) score of the subjective and objective components of the project. PPSs must select no fewer than five but no more than eleven projects, and must select at least two projects from both Domain 2 and 3, and at least one from Domain 4.1. If a PPS selects 10 projects across Domain 2, 3, and 4, they are eligible to participate in the 11th project, related to patient engagement of the uninsured and low Medicaid Utilizers (Project 2.d.i.)

The PPSs organizational application score is an assessment of the PPSs overall governance and systemic strength, and requires the PPS to describe its governance structure, workforce plans, community needs, and overall goal and vision. This score is applied to every project the PPS selects, and is worth 30% of the total application score.

1. Components of the Project Application: Scale and Speed

Every project-specific score includes a subjectively scored project description and justification section, and a set of objectively scored criteria that are intended to measure the total number of providers participating in the project and how many patients will be targeted or included in the project (scale) and how quickly will they achieve project requirements, and engage the targeted patients (speed)

Many projects also include a fifth criterion: the percentage of providers participating in the project that are safety net providers. For most projects, the project justification and description section will be the only subjectively scored element of the application, and account for 20% of the project-specific score. The remaining 80% of a project-specific score will be determined by the objective criteria listed above.

Based on this structure, PPSs that partner with a greater number of safety net providers and have indicated that they will achieve project milestones faster will receive a higher project-specific score.

An exception to the 20% -80% subjective/objective scoring split is Project 2.a.i. ("Create an Integrated Delivery System"). As one of the heaviest weighted projects, it was not surprising that this project was selected by many PPSs. For this project, 40% of the project-specific score will be determined based on subjectively scored sections that ask the PPS to discuss its system transformation vision and how the governance strategy will evolve PPS participants into its system.

In addition, all Domain 4 projects will be subjectively scored in their entirety. Domain 4 projects are population-wide projects that are based on the New York State Prevention Agenda, which CPHS has express concerns with it's a top-down medical-model approach to reducing health disparities. Unfortunately, these projects received a much lower project value than Domain 2 and 3 projects. We think there is some under-estimation of it being easier to implement.

2. Components of the Organizational Application

The organizational application consists of eleven sections, six of which are scored, while the remaining five are graded Pass/Fail only. These sections include: the executive summary; Governance (25%); Community Needs Assessment (25%); DSRIP Projects (P/F); PPS Workforce Strategy (20%); Data-Sharing, Confidentiality & Rapid Cycle Evaluation (5%); PPS Cultural Competency & Health Literacy (15%); DSRIP Budget & Flow of Funds (P/F); Financial Sustainability Plan (10%); Bonus Points (if applicable); and Attestation (P/F).

PPS's project scores depend on three organizational sections: the PPSs Governance plan and strategy, how it conducted, described, and applied projects to its Community Health Needs Assessment (CHNA), and its workforce strategy. It is worth noting that they will not need to actually implement these plans for several months/years to receive DSRIP incentive funds.

We will focus our attentions to six sections:

- *The Executive Summary & Regulatory Waiver Process:* Regardless of being graded P/F, the Executive Summary is an important section for advocates to review. In 500 words or less, the PPS had to describe its goals, objectives, and long term vision for what the PPS will look like after the DSRIP. The Executive Summary is where the PPS also requested regulatory relief to facilitate project implementation. Basically, the hospitals that are primarily leading the PPSs are given the opportunity to ask for the state and CMS to alleviate or remove temporarily any regulatory policies that maybe considered a "burden" to them executing a project. We must raise concerns and watch closely if regulatory relief is granted that it does not hurt patients and worker safety, access, and quality of care.

- *Governance:* Worth 25%, this section is comprised of six individual subsections. These subsections required information on governance members and processes. The types of information included were how members were selected, how the PPS ensured there was sufficient representation of PPS partners; a section that required a discussion on how the project advisory committee (PAC) was formed and the role it would serve; the governance model and a plan outlining commitments to achieve that model. The application also required the submission of a PPS organizational chart.

- *Community Health Needs Assessment*: Worth 25%, in this section the PPS described how it completed its community needs assessment. Important areas that had to be covered were information on its process, methodology, and the information and data that were leveraged from existing resources. The CHNA had to provide a comprehensive assessment of the health care resources and community based services available in the targeted area, along with the demographics and health needs of the population. In addition, they had to describe identified health challenges and gaps in available health care provider and community resources; and the stakeholder/community engagement process that was undertaken in developing the CHNA.

- *Cultural competence and health literacy:* worth 15%, the PPS must describe challenges to ensuring cultural competency, which need to be addressed and the strategic plan to implement a culturally competent organization. PPSs must also describe their plan to improve/reinforce health literacy of patients served. We do want to note that health literacy and cultural competency are not the same. Health literacy is only one approach to ensuring culturally competent care.

- *Workforce:* Worth 20%, the PPS had to identify all impacts on their workforce that could likely occur as a result of the implementation of their chosen projects. The PPS must summarize how existing workers would be impacted in terms of possible redeployment or reductions (and whether it will be voluntary); identify the specific workforce groupings of existing staff that would be impacted. PPSs were also required to describe their approach to mitigate the "negative impact" to the workforce, including any plans to re-train or re-deploy workers. The PPS had to discuss how these plans may also intersect with existing state programs.

- *Financial sustainability plan:* The PPS had to provide an assessment of its financial environment, including an assessment of its partner providers, and a course to achieve financial sustainability for the PPS and financially vulnerable providers. Based on prior experience, this raises suspicions on setting a path for more hospital closings, reduction of services, more mergers, and consolidations. This section also required the PPS to convey its strategy to implement "payment reform", including a plan to engage Medicaid Managed Care plans in this process. Reimbursement reform is necessary but done wrong bring some serious problems and negative impacts to communities (i.e. fee-for service to managed care).

We strongly recommend that community-based organizations, advocates, and unions continue to remain involved in the DSRIP process. In addition, we encourage groups to fight for specific health needs and issues that are not or insufficiently being addressed, capital or financial needs that the PPS could help address, as well as any areas where the waiver could facilitate your involvement in PPS projects.

Drafted 2.13.2015 by Anthony Feliciano, Director, Commission on the Public's Health System

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