Recognizing quality in Ryan White Part A medical case management services: a value-based payment pilot test

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Disclosures

- Jennifer Carmona & Faisal Abdelqader have no relevant financial or non-financial interests to disclose.
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Learning objectives

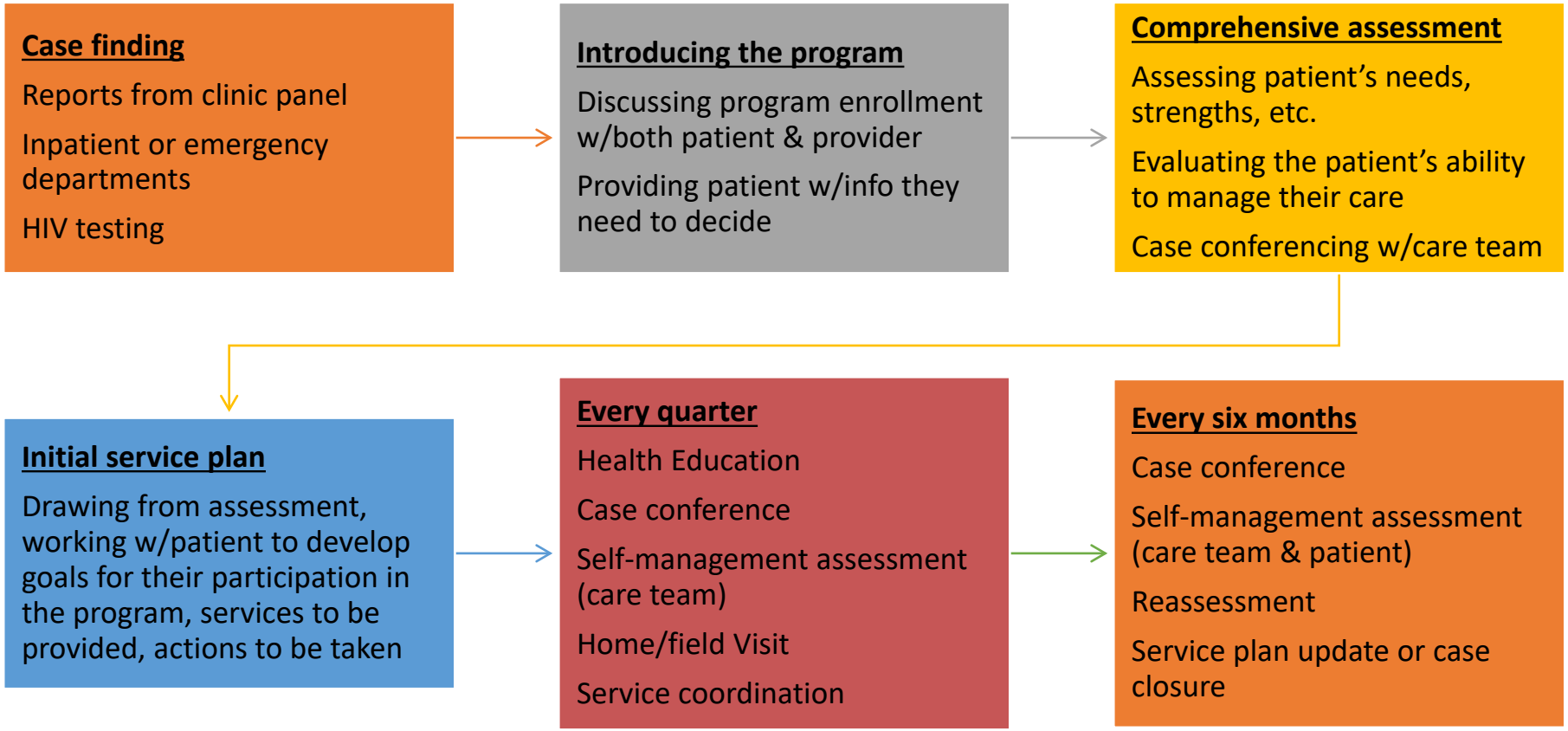
- Illustrate how value-based payment aligns incentives with service quality for subrecipients.
- Demonstrate participatory methods & tools for designing & implementing a system for value-based payment in collaboration with subrecipients and other key stakeholders in the Ryan White Part-A system.
- Explore options for annual implementation reflecting on the results from a pilot test of the system.

NYC Medical Case Management

Overview

Care coordination program design

- Team-based
- 24 programs in NYC
- Reimbursed fee-for-service



Solicitation for RWPA Care Coordination: November 2017

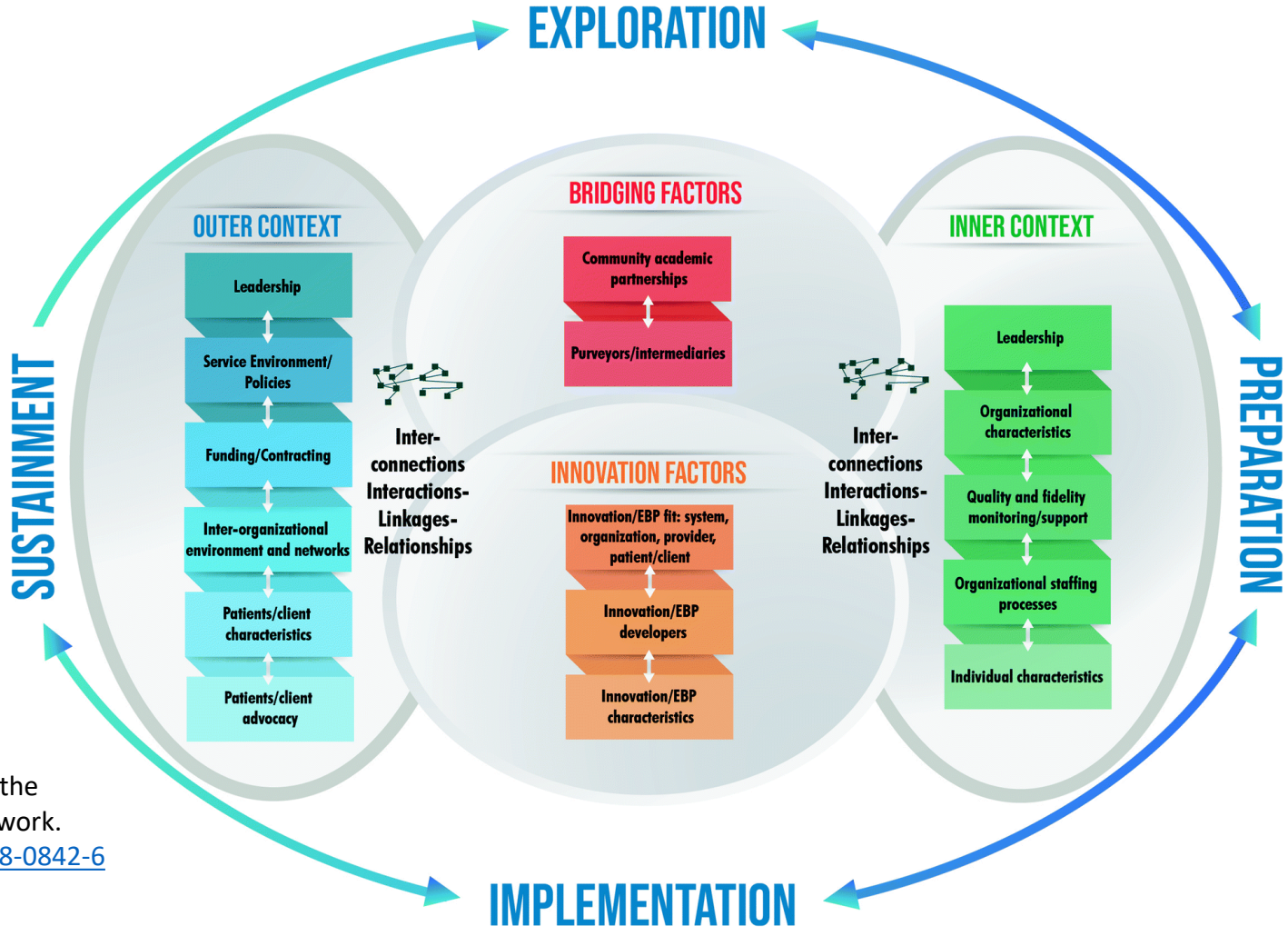
*"…Payment during subsequent contract years will be fee-for-service (reimbursement per month not to exceed 1/6 of total maximum reimbursable amount). NYC DOHMH and PHS also reserve the right to incorporate **value-based payments**."*

Why consider VBP for RWPA-funded services?

To align incentives with service quality

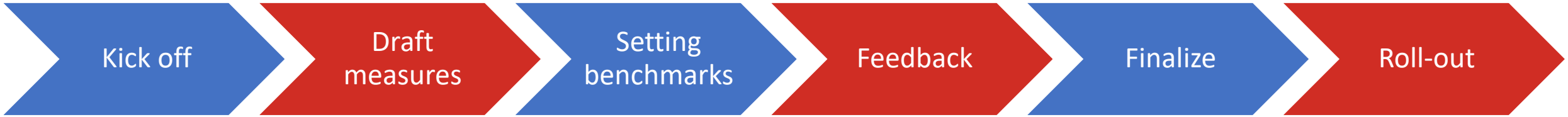
Implementation science framework: EPIS

- Exploration
- Preparation
- Implementation
- Sustainment



Moullin, J.C., Dickson, K.S., Stadnick, N.A. *et al.* Systematic review of the Exploration, Preparation, Implementation, Sustainment (EPIS) framework. *Implementation Sci* **14,** 1 (2019). https://doi.org/10.1186/s13012-018-0842-6

Project timeline



- June 2019
- Aug 2019
- Oct 2019
- Dec 2019
- Mar 2020

Types of measures considered

Processes

- How care coordination services are delivered
- What processes should we use to measure value for care coordination services?

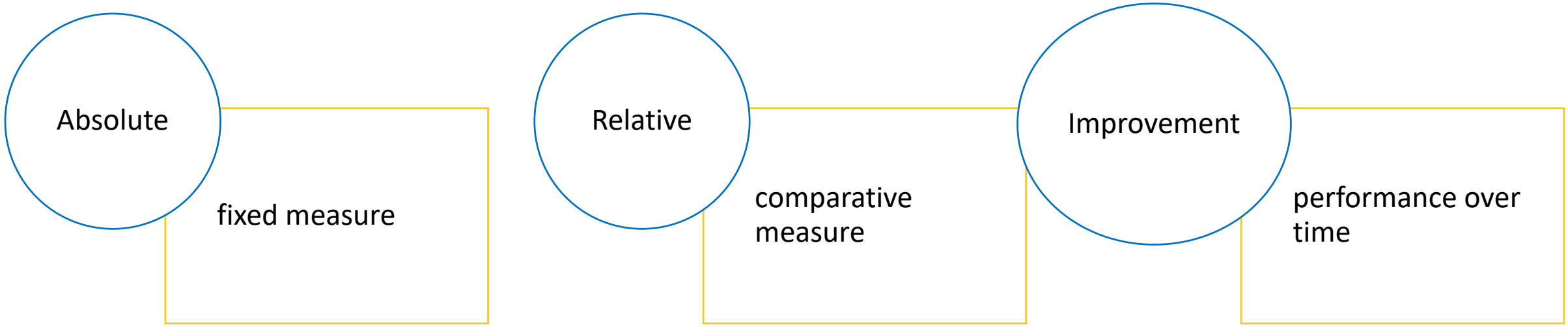
Outcomes

- What happens as a result of care coordination services
- What outcomes should we use to measure value for care coordination services?

Experiences

- How recipients of care coordination services perceive the experience
- What aspects of the client experience should we use to measure value for care coordination services?

Options for setting performance benchmarks



Options for making payments

Carve out part (%) of contract value

- Payment made only if benchmark is met

Enhance FFS rates

- Increase rates for services the following contract year

Use accruals

- Enhance contracts only for those programs meeting benchmarks

*Carve out part (%) of total portfolio allocation

- Payment made only if benchmark is met

Soliciting feedback from other programs

- Conference call to review progress so far with all programs (draft measures, benchmark options, payment options)
- Survey for feedback on draft measures
- Survey (inspired by DCE method) for feedback about:
  - Types of measures & benchmark options
  - Number of measures & award trigger

Final selections: conditions

Measures & benchmarks

- Measures
  - Process strongly preferred
- Benchmarks – toss-up
  - Absolute
  - Improvement over time

Number & triggers

- Number of measures
  - No clear preference
- Trigger
  - Programs must meet benchmark for over half of the measures in order to receive payment

VBP measures for care coordination services

- Five measures
- Must meet benchmark for over half of the measures

Measure	Measure type	Benchmark type	Benchmark value
% of clients with at least one community-based patient navigation service (coordination, accompaniment, linkage, engagement, assistance) per quarter	Process	Absolute	85%
% of clients enrolled who were not virally suppressed at intake	Process	Improvement	10%
% of clients with at least one case conference service per quarter	Process	Absolute	85%
% of clients with at least one health education session per quarter	Process	Absolute	85%
% of clients who have achieved viral load suppression within the first 6 months of program participation	Outcome	Improvement	10%

Pilot test of system for VBP

Summer-Fall 2021

How VBP pilot differed from proposed design

Proposed design

- 5 measures
- Benchmark types: absolute, improvement
- Threshold for VBP: 3 out of 5
- Source of VBP: TBD

Pilot

- 4 measures
- Benchmark type: absolute
- No threshold
- Source of VBP: carryover $

VBP pilot measures

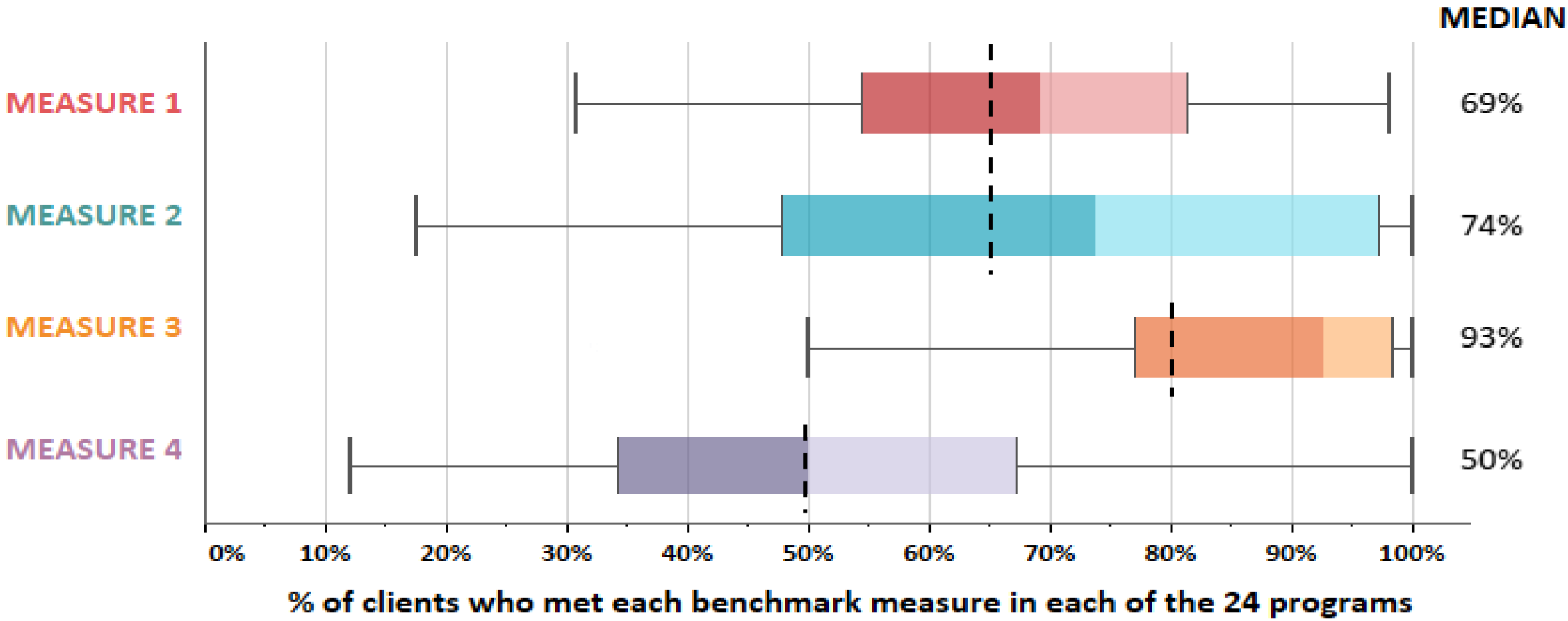
Measure	Measure type	Benchmark type	Benchmark value
~~% of clients with at least one community-based patient navigation service (coordination, accompaniment, linkage, engagement, assistance) per quarter~~	~~Process~~	~~Absolute~~	~~85%~~
% of clients enrolled who were not virally suppressed at intake	Process	~~Improvement~~ Absolute	~~10%~~ 65%
% of clients with at least one case conference service per quarter for 2 of 4 quarters	Process	Absolute	~~85%~~ 65%
% of clients with at least one health education session per quarter for 2 of 4 quarters	Process	Absolute	~~85%~~ 80%
% of clients who have achieved viral load suppression within the first 6 months of program participation	Outcome	~~Improvement~~ Absolute	~~10%~~ 50%

Operationalizing each measure

Measure	MEASURE 1 % of clients enrolled who were not virally suppressed at intake	MEASURE 2 % of clients with at least one case conference service per quarter for 2 of 4 quarters	MEASURE 3 % of clients with at least one health education session per quarter for 2 of 4 quarters	MEASURE 4 % of clients who have achieved viral load suppression within the first 6 mo. of program participation
Measurement period	Jul 1, 2020 – Jun 30, 2021	Jul 1, 2020 – Jun 30, 2021	Jul 1, 2020 – Jun 30, 2021	Jan 1, 2020 – Dec 31, 2020
Inclusion criteria	Clients who were enrolled and received at least one service during measurement period	Data include clients who were continuously enrolled* and received at least one service during the measurement period	Data include clients who were continuously enrolled* and received at least one service during the measurement period	Data include clients who were continuously enrolled* and received at least one service during the measurement period
Client minimum	10 clients	Not applicable	Not applicable	10 clients

**Continuously enrolled refers to clients who were continuously participating in the program (i.e., clients were not suspended or closed for more than 30 days in the 6-month period post program enrollment)*

Results by measure



– – – – *Dashed line represents benchmark value for each measure*

Results by program

- All 24 programs met the benchmark value for at least one of the four measures
  - **63%** met the benchmark value for **Measure 1** (virally unsuppressed at intake)
  - **58%** met the benchmark value for **Measure 2** (case conference service)
  - **71%** met the benchmark value for **Measure 3** (health education session)
  - **63%** met the benchmark value for **Measure 4** (achieving viral suppression)
- **24% of programs met the benchmark for payment on all four measures**

Computing VBP to distribute $360,000 allocated from carryover

- Summed all contract values across portfolio
- Computed each program's share of grand total
- Applied that proportion to compute each program's share of VBP $
- Programs received 25% of their share for achievement of each VBP benchmark

Program	Contract value	% of grand total	Share of VBP allocation	Value per benchmark
A	500,000	25%	90,000	22,500
B	500,000	25%	90,000	22,500
C	400,000	20%	72,000	18,000
D	600,000	30%	108,000	27,000
Grand total	2,000,000	-	-	-

Summary findings

- In total, over $205,000 was awarded for achievement of VBP benchmarks during the pilot.
- Active involvement of stakeholders critical to successful pilot test (especially service providers)
- Availability of carryover $ offered unique, no risk opportunity to test system
- Patients/clients were not invited to be part of the workgroup
- Use of carryover $ introduced limitations

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Value-based payment stakeholder group

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Thank you! Please keep in touch!

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