HUMAN SERVICES
DEPARTMENT

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Letter of Direction #23

Date: **January 24, 2020**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **Delivery System Improvement Performance Targets**

Title: **DSIPTs**

This Letter of Direction (LOD) serves as notification to Centennial Care 2.0 Managed Care Organizations that Delivery System Improvement Performance Targets (DSIPTs) outlined in the Medicaid Managed Care Services Agreement, Attachment 3 are revised for Calendar Year (CY) 2020. This LOD replaces Attachment 3 and 3.A of the Medicaid Managed Care Services Agreement.

Attachment 3: Delivery System Improvement Performance Targets

Delivery System Improvement Performance Targets for Year Two (2) of Centennial Care 2.0

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Behavioral Health Visit with a Behavioral Health Provider	The CONTRACTOR shall increase the number of unduplicated Medicaid Managed Care members receiving Behavioral Health Services provided by a Behavioral Health provider. CY20 will be a baseline year for this Delivery System Improvement Performance Target. The CONTRACTOR shall submit CY20 data to HSD by April 1, 2021 to establish the baseline for the CY21 increase. The CONTRACTORs shall provide quarterly reports to HSD with the number of unique Members receiving Behavioral Health services by a Behavioral Health provider and an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the end of the quarter.	25

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Behavioral Health Visit with a Non-Behavioral Health Provider	The CONTRACTOR shall increase the number of unduplicated Medicaid Managed Care members receiving Behavioral Health services by a Non-Behavioral Health provider. CY20 will be a baseline year for this Delivery System Improvement Performance Target. The CONTRACTOR shall submit CY20 data to HSD by April 1, 2021 to establish the baseline for the CY21 increase. The CONTRACTORs shall provide quarterly reports to HSD with the number of unique Members receiving Behavioral Health services by a Non-Behavioral Health provider and an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the end of the quarter.	25
Telemedicine	The CONTRACTOR shall increase the number of unique Members with a Telemedicine visit by 20% in Rural, Frontier, and Urban areas for Physical Health Specialists and Behavioral Health Specialists. The MCOs shall use the end of calendar year 2019 as the baseline for calendar year 2020. The MCO baseline for each upcoming calendar year will be the total number of unique members with a Telemedicine visit at the end of the previous calendar year. • Members with Telemedicine visits conducted at I/T/Us are included. • Project ECHO is not considered "Telemedicine" for the purposes of this delivery system improvement performance target nor is routine Telemedicine, such as interpretations of radiologic exams by a radiologist at a remote site. • Telemedicine may include virtual visits or e-visits and asynchronous/store-and-forward Telemedicine. If the CONTRACTOR achieves a minimum of five percent (5%) of total membership, as of November 30th each year, with Telemedicine visits, then the CONTRACTOR must maintain that same the 5% percentage at the end of each calendar year in order to meet this target. • MCOs shall obtain the Medicaid enrollment data from HSD's website: https://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx The CONTRACTORs shall provide quarterly reports to HSD with the number of unique Members served through Telemedicine visits and an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the end	25

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100
	of the quarter.	
Value-Based Purchasing	The CONTRACTOR must implement a Value-Based Purchasing Strategy that addresses how the CONTRACTOR will meet VBP requirements in the following 3 component areas. See Attachment 3. A.	25

Centennial Care Contract Attachment [3.A]
Value-Based Purchasing (VBP) Delivery System Improvement Performance Targets:

CONTRACTOR'S VBP Program and Requirements
To support Centennial Care's VBP goals, the CONTRACTOR must implement a VBP Program that addresses 4.10.6 and how the CONTRACTOR will meet VBP requirements in the following three (3) component areas.

1. **VBP Required Components**

The VBP portion of the CONTRACTOR's DSIPT is worth 25 points but will be calculated on a 30-point achievement scale. The VBP portion of the CONTRACTOR's DSIPT consists of two (2) required components.

1. Total Points = 30 for meeting all components of VBP requirements.
2. Point Deductions:
    a. Ten (10) points for each level of provider payments target not achieved; and
    b. Two (2) point deduction for each additional requirement that the contractor fails to meet. Refer to Table 1 for additional requirements for each Level of VBP.

2. **VBP Strategy**

As noted above, the CONTRACTOR must develop a VBP Strategy. The VBP strategy must include a detailed work plan outlining all interventions the CONTRACTOR is implementing to reach VBP targets in each VBP component area during the contract period. The VBP Strategy for the contract period was submitted to HSD in January 2019. In subsequent years the CONTRACTOR shall develop a VBP Annual Plan that must include a detailed work plan outlining all the interventions the CONTRACTOR is implementing to reach VBP targets in each VBP component area during the contract year, prior period experience, and changes to the VBP Strategy. The CONTRACTOR's VBP Annual Plan shall be submitted to HSD annually by April 1.

3. **VBP Quarterly Report**

The CONTRACTOR must submit all required quarterly VBP Reports on the template provided by HSD and shall submit narrative updates of all VBP barriers, solutions, successes, status, supportive data and other pertinent information to the VBP. Quarterly reports are due sixty (60) Calendar Days from the end of the first quarter, the remaining quarterly reports are due forty-five (45) Calendar Days after the respective quarter close (or next business day if falls on a weekend or holiday) 1st Quarter: May 30th, 2nd Quarter: August 15th, 3rd Quarter: November 15th and 4th Quarter: February 15th. VBP reporting requirements will be developed by HSD and will be provided to the CONTRACTOR sixty (60) business days prior to the contract period. HSD reserves the right to modify the reporting requirements for each contract period.

Percentage of Provider Payments as a Component of a VBP Payment Arrangement
The CONTRACTOR must meet minimum targets for three levels of VBP arrangements. Failure to meet minimum targets will result in deductions to the points available. Percentage of provider payments are defined as Claims paid to a provider who is actively contracted under one of the three

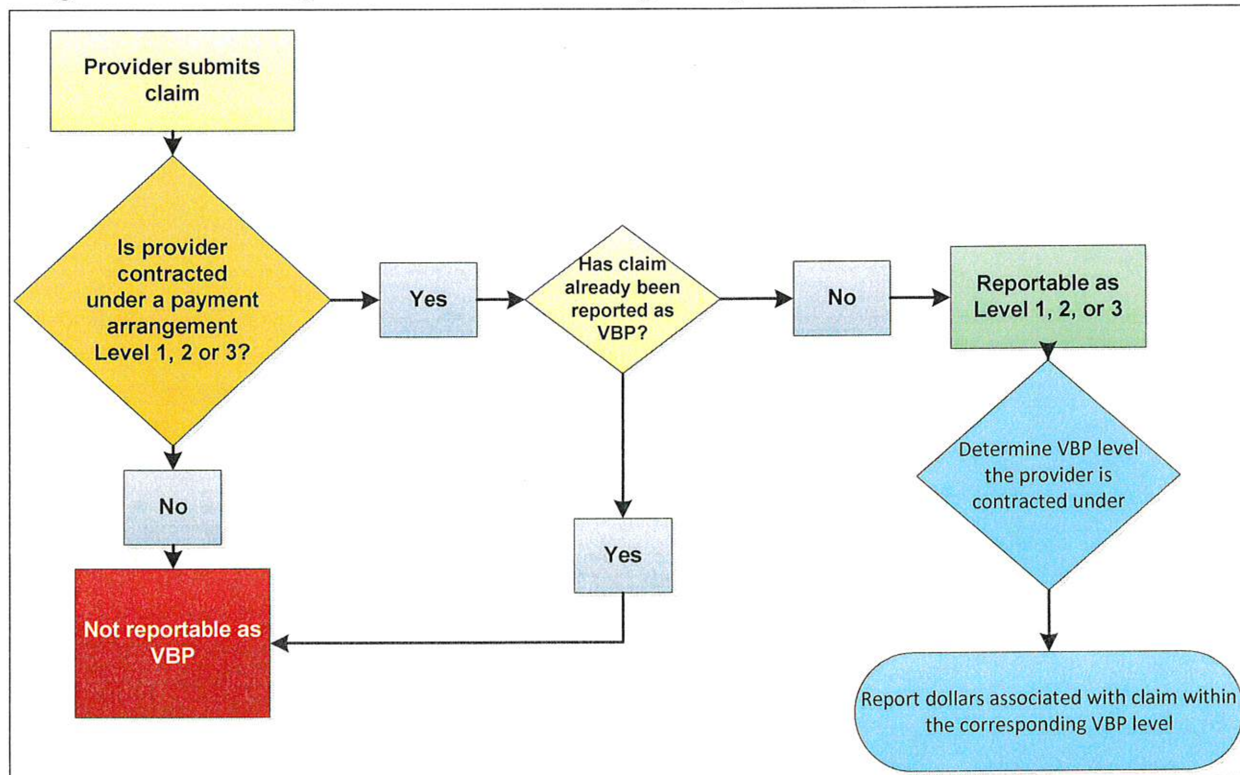
levels of VBP arrangements as defined in Table 1 below. For reporting purposes, the CONTRACTOR may exclude provider payment for dually-eligible Members, with the exception of those VBP arrangements that are with long- term care or Nursing Facility Providers, from the calculation. The CONTRACTOR must include payments to Behavioral Health Community Providers in calculating the percentage of overall spend in its VBP arrangements. For purposes of calculating VBP percentages for Community Benefit Providers and Nursing Facilities, the MCO may include dual-eligible Members within those calculations.
To meet the targets, the CONTRACTOR must have met the percentages established in Table 1 in all three levels, with the following exceptions:

- CONTRACTORS with more advanced VBP strategies may substitute higher percentages in Level three (3) for lower percentages in Level two (2) and higher percentages in Level one (1) as the overall minimum percentage targets (total for Level 1-3) are met for the contract year; and
- CONTRACTORS with disproportionate membership within the LTSS program may, at HSD's discretion, submit a plan to HSD for approval that substitutes a higher percentage in Level two (2) for a lower percentage in Level three (3).

4. VBP Percentage Calculation Methodology

For purposes of calculating the VBP percentage minimums in Tables 1-3, a Claim may be counted a maximum of once and is considered a VBP Claim only if the billing provider is contracted with the CONTRACTOR under one of the three types of payment arrangements defined in Table 1. Calculation methodology is outlined in the following diagram:

Diagram 1 – Counting Claims when calculating VBP percentages:



VBP Minimum Percentage of Provider Payments Requirements

The following outlines the minimum percentage of provider Claims that must be associated with a VBP payment arrangement for each Contract Year.

Table 1 – VBP Level Minimum Requirements:

Aggregate VBP Targets			
Contract Year 1 (Jan 1 – Dec 31, 2019)	**Contract Year 2** (Jan 1 – Dec 31, 2020)	**Contract Year 3** (Jan 1 – Dec 31, 2021)	**Contract Year 4** (Jan 1 – Dec 31, 2022)
• Level 1: 8% • Level 2: 11% • Level 3: 5% • **Total: 24%**	• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%** ***HSD reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.***	• Level 1: 12% • Level 2: 15% • Level 3: 9% • **Total: 36%** ***HSD reserves the right to modify the percentage in Year 4 increasing 5% from Contract Period 3.***
Modifications will be conveyed to the CONTRACTOR at least 60 days prior to the beginning of contract period three.			

VBP Level 1 – Minimum Requirements			
Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.			
Contract Year 1	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**
8%	**10%**	**11%**	**12%**
• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). • Long -Term Care Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***

Additional Requirements: (CONTRACTOR is subject to a 2-point deduction for each Additional Requirement that is not met during a contract year.)

1. Must include a mix of Physical Health, Behavioral Health, Long-Term Care and nursing facility Providers.
2. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis.

VBP Level 1 – Minimum Requirements

VBP Level 1 Definitions:

1. Traditional PH Providers are Providers whose primary services are not Behavioral Health, Long-Term Care or nursing facilities. Traditional PH Providers include FQHC, hospitals etc.
2. Small provider is defined as practices with 1,000 or less assigned/attributed Members or as determined by HSD prior to the start of the contract period.

VBP Level 2 – Minimum Requirements

Level 2: Fee schedule based, upside-only shared savings-- available when outcome/ quality scores meet agreed-upon targets (may include downside risk).

Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4
11%	**13%**	**14%**	**15%**
• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). Actively build readiness for Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH). Actively build readiness for Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers • BH Providers (whose primary services are BH) • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers (whose primary services are BH) • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

Additional Requirements: (CONTRACTOR is subject to a 2-point deduction for each Additional Requirement that is not met during a contract year.)

1. Must include two or more bundled payments for episodes of care.
2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets.**
3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis.

VBP Level 2 – Minimum Requirements

VBP Level 2 Definitions:

1. **Actively build** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for LTSS and Nursing Facility Providers in Level 2 by Contract Year 3.
2. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top 10 to 20 highest of contracted hospitals and serve at least 100 Members annually.
3. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR'S delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment for Care Coordination needs and Care Coordination assignment and linkage.

VBP Level 3 – Minimum Requirements

Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.

Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4
5%	**7%**	**8%**	**9%**
• Traditional PH Providers. • Implement a CONTRACTOR led BH provider level workgroup that works with BH Providers to design full risk model (see definitions).	• Traditional PH Providers. • Develop BH full-risk contracting model • Implement a CONTRACTOR led Long-Term Care Providers including nursing facilities provider level workgroup to design full-risk model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers. • BH Providers (whose primary services are BH). • Actively build Long-Term Care Providers including nursing facilities full-risk contracting model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• 8% with traditional PH Provider. • 1% with Providers who are primarily BH. • Long-Term Care Providers including nursing facilities over prior year. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

VBP Level 3 – Minimum Requirements

Additional Requirements: (CONTRACTOR is subject to a 2-point deduction for each Additional Requirement that is not met during a contract year.)

1. Global or capitated payments with full risk. Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in bullet 2 below. Full Delegation of Care Coordination within Level 3 VBP arrangements as outlined in definitions below.
2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets.**
3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis.

VBP Level 3 Definitions:

1. **Implement a Contractor led BH provider Level workgroup** is defined as is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for Behavioral Health Providers in Level 3 by Contract Year 3.
2. **Implement a Long-Term Care including nursing facilities provider level workgroup to design full-risk model** is defined as a

   CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for Long-Term Care including nursing facilities Providers in Level 3 by Contract Year 4.
3. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top 10 to 20 highest of contracted hospitals and serve at least 100 Members annually.
4. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, The CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR'S delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment for Care Coordination needs and Care Coordination assignment and linkage.

Full Delegation of Care Coordination within Level 3 VBP arrangements are tied to Level 3 full risk Providers and with Health Homes.