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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

Re: MRT Waiver Amendment/DSRIP Attachment I and Attachment J

Dear Mr. Helgerson:

The Healthcare Association of New York State (HANYS) is responding to your request for comments on behalf of our statewide membership of more than 500 not-for-profit and public hospitals, health systems, nursing homes, and home care agencies. Thank you for the opportunity to comment and provide input on the Medicaid Redesign Team (MRT) Waiver Amendment/Delivery System Reform Incentive Payment (DSRIP) Special Terms and Conditions (STCs) Attachments I and J. We are also very appreciative of the time you and your team have spent with HANYS and our members and the numerous public events and forums to discuss this important program.

This multi-year waiver effort will require continuous and ongoing dialogue with DOH to address the myriad policy issues that exist today and will arise in the future. The operational issues associated with a new performance-based program of this magnitude and transformational goals will require tremendous time, energy, and focus. We will need to consistently work together to address issues and solve programs— HANYS looks forward to our continued partnership as DSRIP evolves.

We support the delivery system reform goals and will assist our members as they evaluate waiver opportunities. Clearly, the DSRIP process will require implementation of new models of care, infrastructure changes, partnerships between providers across multiple settings, and engagement with local communities.

It is vital that the detailed requirements of the DSRIP program not impose additional burdens that would add to the inherent complexity of this process. DSRIP should provide clear incentives for providers that choose to join in the transformation effort

and avoid inequitable performance measurement and payment provisions that could discourage providers from participating. Since this is a new and evolving program and health care needs and dynamics vary dramatically across New York State, it is important to maintain maximum flexibility.

Clarity is needed on several fundamental policy issues surrounding the make-up and governance of Performing Provider Systems (PPSs), how they will interact with Medicaid managed care plans, how savings realized by non-Medicaid payers from the DSRIP transformation will be recognized by the payment system, how Medicaid managed care premiums will be calculated and impact providers, how to best incentivize physician participation, and how to construct meaningful DSRIP sharing agreements to ensure they provide the promised “bridge” to hospitals for change and transformation.

There are also numerous operational details that need further discussion to ensure effective implementation. Additionally, it is imperative that detailed claims and encounter data be made available to HANYS and providers to support this program, enrollees, and the needs of communities.

Lastly, we strongly encourage the Department of Health (DOH) to fully utilize the regulatory flexibility afforded in recent statutory changes to support real change and demonstrate the need for wholesale changes in our regulatory environment.

HANYS’ comments on the State Terms and Conditions were submitted on April 29 and we continue to urge modifications and clarifications to this core document as outlined below:

- ensure fair and equitable treatment of public hospitals providing intergovernmental transfers (IGTs) to support DSRIP;
- reflect the diversity of provider readiness when phasing in managed care value-based contracting;
- require managed care value-based payments to be reasonable and adequate;
- ensure continued ongoing reinvestment of savings in the health care system;
- address potential gaps between PPS provider networks and managed care plans covering attributed Medicaid enrollees;
- utilize 2011 as the base year for performance measurement;
- modify restrictions on project selection for high performing hospitals;
- adopt a different methodology for distributing statewide penalties;
- eliminate unnecessary documentation;
- remove unnecessary budgeting requirements;
- develop comprehensive statewide workforce strategies;
- apply transparency and “no conflicts of interest” requirements to all contractors; and
- require managed care plans to share data with providers to support community health.

After reviewing STC Attachments I and J, HANYS has a number of comments, concerns, questions, and recommendations for improvement. In addition to our earlier comments, we request action in the following areas:

Attribution

- Ensure the attribution process is transparent with sufficient detailed data made available to PPSs.
- Clarify how Medicaid dual-eligibles will be included in attribution and performance metrics.
- Provide clarification on initial attribution and “true-up” process.
- Avoid problems and issues encountered with the health home attribution process.
- Address long-term care providers in the attribution methodology.
- Clarify attribution for providers in more than one PPS.
- Solicit active participation and input from PPSs in final attribution, consistent with feedback planned from managed care plans.

Projects and Metrics

- Allow flexibility (case-by-case basis) for exceptions to the project menu list and required selections.
- Utilize New York Medicaid data to set performance targets.
- Provide clarification on baseline data updates and impact on performance targets.
- Avoid use of a “moving target” for performance evaluation.

Organization of DSRIP Project Plan

- Streamline the reporting process to reduce undue and unnecessary burden on PPSs.
- Provide clarification on PPS “service areas”.
- Remove duplicative requirements related to documenting safety net status.
- Better characterize regional planning as community planning.
- Eliminate unnecessary and inconsistent budgeting requirements since DSRIP is performance based.
- Engage in active dialogue with HANYS and others on governance structure to ensure maximum flexibility and address regulatory issues, particularly centralized control, corporate practice of medicine, anti-trust, liability, and initial resource investment.
- Provide multiple template governance agreements as voluntary guidance to PPSs.

Project Valuation

- Ensure a transparent process with full details provided to each PPS.
- Improve calibration for discounting PPS project selections.
- Disclose scoring details to PPSs and allow the ability to appeal.
- Consider front-loading annual project value in early years to reflect the need for up-front investment.
- Allow partial-credit for performance improvement rather than just pass or fail on target achievement.

Project Plan Review

- Ensure ongoing dialogue and review prior to mid-point assessment.
- Permit PPS appeal of independent assessor reviews.
- Provide technical assistance to underperforming PPSs prior to termination.

Reporting Requirements and Ongoing Monitoring

- Streamline and simplify reporting requirements to avoid duplication and consider Centers for Medicare and Medicaid Services (CMS) Core Measure Vendors as a possible model.
- Expand the breadth of learning collaboratives.
- Develop a methodology to distribute DSRIP payments more than once a year for annual performance measures to assist with cash flow issues.
- Ensure collaboration and input from PPSs in development of the online learning collaborative reporting tool.
- Provide clarification on interim and summative evaluation standards.
- Reconcile the “real-time” reporting to the contemplated annual performance data.
- Accelerate the development of the data portal and provide additional detailed data with potential DSRIP applicants as soon as possible.

Strategies Menu and Metrics

- Provide a reporting waiver for PPSs impacted by natural disasters or other extraordinary circumstances.
- Use measures that are fully risk adjusted where possible.
- Appropriately weight the Potentially Avoidable Services measures.
- Provide separate behavioral health metrics for Potentially Avoidable Emergency Room Visits and Potentially Avoidable Readmissions.
- Revise the clinical improvement metrics for Diabetes Mellitus.

Jason Helgerson
May 14, 2014

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Thank you for the opportunity to comment on this critically important topic. If you have questions, please contact me at (518) 431-7760 or Val Grey, Executive Vice President, at (518) 431-7809.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Whalen", with a long horizontal line extending to the right.

Dennis P. Whalen
President

Enclosure

cc: Val Grey



Healthcare Association
of New York State

Comments on MRT Waiver Amendment

Attachment I: NY DSRIP Program Funding and Mechanics Protocol

Attachment J: NY DSRIP Strategies Menu and Metrics

May 14, 2014

HANYS submits the following comments on the Medicaid Redesign Team (MRT) waiver amendment's Delivery System Reform Incentive Payment (DSRIP) Attachments I and J (*the attachments' provisions are in italic*).

Attachment I: NY DSRIP Program Funding and Mechanics Protocol

Section II. DSRIP Performing Provider Systems

Section II. c. DSRIP Beneficiary Attribution Method (page 3)

Utilizing the proposed geography and proposed population as appropriate, for each DSRIP Project Plan submitted by a given Performing Provider System, the department will identify the Medicaid beneficiaries' population that will be attributed to that system prospectively at the start of each measurement year

HANYS' Comment: Population attribution should be a transparent process that will provide the Performing Provider System (PPS) with the data and calculation details necessary for the PPS to understand the basis for the population that was attributed to each of the providers in the PPS. This transparency should apply to the initial attribution and any subsequent "true up" or other material change to the attributed population.

It is our understanding that the Medicaid beneficiary population will include Medicaid dual eligible beneficiaries. We request clarification on how Medicaid dual eligible beneficiaries will be included in the attribution, in valuation, and in performance measurement.

. . . patient attribution for Performing Provider System quality measurement should be defined as of December 31 of the measurement year and that population will serve as the denominator base pool for domain 2 and 3 metrics. This will provide an initial, prospective attribution at the start of the measurement year to determine the populations to be included and a final attribution at the end of the year for evaluation and measurement. So, for measurement purposes, this prospective attribution, depending on the measure, may be adjusted at the end of

each performance year (“attribution true up”) to remove beneficiaries that were not enrolled in Medicaid per the specific measure specification for continuous enrollment criteria and add new Medicaid beneficiaries attributed to the Performing Provider System during the year and any other adjustments necessary to assure a proper measurement denominator (as further described in the Metric Specification Guide described in Attachment J). This denominator base may be further subdivided as needed to identify target populations (such as beneficiaries with diabetes or behavioral health) when that is appropriate for a metric associated with a particular project measure.

HANYS’ Comment: It is unclear to which metrics the attributed “denominator base pool” will apply. Many of the Domain 3 clinical metrics are process or outcome measures that are based on claims data or medical records. HANYS believes that both the numerator and the denominator for these clinical measures should come from PPS internal data for patients who received services from the PPS providers. Domain 2 includes a number of metrics based on survey data that would supply both the numerator and the denominator. How does the attributed “denominator base pool” apply to these metrics? The Metric Specification Guide referred to in this paragraph has not yet been released. We urge the state to release this Guide as quickly as possible and we reserve the right to comment further on attribution when it is available.

We request clarification of the attribution and “true up” process described in this paragraph. It indicates there will be an initial prospective attribution at the start of each measurement year. Does this mean an annual reassignment of populations each year during the DSRIP program based on updated utilization data using the hierarchical attribution methodology? The description of the end-of-year “true up” indicates an “adjustment” and only specifies factors related to enrollment changes. Does this indicate that the true up will **not** include a full population reassignment based on updated utilization data using the hierarchical methodology?

The DSRIP attribution methodology is derived from the New York State Health Home attribution protocol. Experience under that program found substantial problems with the initial attribution results, including enrollees who had died and individuals who were no longer Medicaid enrollees. We urge the Department of Health (DOH) to continue to refine the attribution methodology for Health Homes and to incorporate improvements into the DSRIP attribution methodology as appropriate.

Section II. c. DSRIP Beneficiary Attribution Method (page 4)

The results of the preliminary attribution process below will be shared with the Medicaid Managed Care organizations for their enrolled members In advance of this attribution process the state will share the DSRIP Performing Provider System network with the plan to identify any network alignment gaps that may exist so that the DSRIP Performing Provider System and the MCOs can work together to align service delivery and plan contracted networks as appropriate.

HANYS’ Comment: The state must address potential gaps in managed care networks. Each PPS will have responsibility for an attributed population. However, it is unclear if all participating providers in a PPS will have contracts with every Medicaid managed care plan that the attributed

Medicaid beneficiaries are enrolled in; particularly if there are multiple PPSs in a region. A PPS will be challenged in making health care improvements unless the managed care plan for each attributed enrollee contracts with the participating PPS providers.”

Preliminary Attribution (page 5)

4. Hierarchical matching - The method first tries to assign a recipient to a performing provider first based on case management connectivity, if no case management visits exist the method then moves on to try to assign based on outpatient connectivity (all visits physical and behavioral count), if no case management or outpatient visits exists the method then moves on to try to assign based on ER connectivity and then moves on accordingly for inpatient last. This tries to connect a beneficiary to the most critical service from a patient management perspective first and then uses volume from within those hierarchical categories.

HANYS’ Comment: The hierarchy included in the attachment does not address services provided by long-term care providers such as nursing homes, home care agencies, and some behavioral health providers. Further information is also required on the attribution methodology for providers in more than one PPS. It is important that potential PPS participants know how these providers will affect attribution results when planning projects. We request that the state provide this information as quickly as possible and we reserve the right to further comment on the attribution methodology when it is available.

The state has indicated that physician service will be included in the outpatient tier of the hierarchy. However, the Terms and Conditions document and attachments provide little detail on the treatment of physicians and physician groups in the DSRIP program. Clarification is needed on safety net criteria, the attribution methodology, and other policies as they relate to hospital-based physicians, physicians in group practices, and private practices. As it develops these policies, they state should seek further input and comment.

It is our understanding from DOH statements that “case management” is currently comprised of Health Homes and Targeted Case Management programs. Several of the projects relate to Patient Centered Medical Homes (PCMHs) and one of the required metrics for both individual PPS projects and for the statewide evaluation is the percent of primary care providers (PCP) meeting National Committee for Quality Assurance (NCQA) PCMH/Advance Primary Care criteria. Additional consideration should be given to visits to PCPs meeting PCMH or Advance Primary Care criteria.

Final Attribution with MCO Input (page 6)

The results of the preliminary attribution process (geographic and service utilization matching) will be shared with each Medicaid Managed Care plan for their enrolled membership. The plans will be asked to review the assignment list, make any necessary corrections, as practicable, based on more current beneficiary utilization information including more recent PCP assignment or specialty service access that may have occurred after the preliminary attribution

data was run. The plans will each submit to the state a recommended final DSRIP attribution list for each Performing Provider System for each enrolled member as appropriate to the target population for the given DSRIP project. The state will review the plan recommendation and make modifications if needed to assure better balance between DSRIP projects, especially where there are multiple MCOs in a given region. This MCO input into the attribution process will ensure that the most recent member access patterns are taken into account in developing the attribution and will begin to better connect MCOs to the DSRIP projects as performance improvement and payment reform components of the overall DSRIP are actuated.

HANYS' Comment: State sharing of PPS attribution results with MCOs should be only for purposes of updating the utilization or enrollment data used in the attribution methodology. It should **not** allow MCO to override the attribution methodology to reassign a member to a different PPS contrary to the assignment based on a member's service loyalty information.

In addition, the PPS must be an active participant in this final attribution process. All relevant data for initial assignment and proposed assignment changes should be shared and discussed with the PPS; the PPS should be allowed to provide input to the state on any proposed changes to the initial attribution; and the PPS should be allowed to modify the project plan if the changes are substantial.

Section II. d. Minimum Outpatient Service Level

Performing Provider Systems must have a minimum of 5,000 attributed Medicaid beneficiaries a year in outpatient settings.

Section III. Projects, Metrics, and Metric Targets

Section III. a. Projects (page 7)

Performing Provider Systems will design and implement at least five and no more than 10 DSRIP projects, selected from the Strategies Menu and Metrics (Attachment J)

. . . Performing Provider Systems will select at least two system transformation projects (including one project to create integrated delivery systems as well as another project from either the care coordination or connecting settings strategies list), two clinical improvement projects (including a behavioral health project), and one population-wide project. The selection of all projects must be based on the community needs assessment of the baseline data and as the target population selected by the performing provider system.

HANYS' Comment: Similar to the vital access provider exception to the safety net qualification criteria, the state should allow for exceptions to the list of required projects and the minimum outpatient service level on a case-by-case basis if it is deemed in the best interest of Medicaid

members. For example, an exception might be granted to allow modification of the required project list for a PPS that plans to incorporate several rural hospitals into a regional network to share resources with the intent of implementing individual related projects that address a single regional health need.

Section III. b. Metrics (page 8)

Additional measure specifications, including the process for addressing small n issues is described in the Metric Specification Guide supplement to Attachment J.

HANYS’ Comment: The referenced supplement has not yet been released and we reserve the right to comment further on the metrics when it is available.

Section III. c. Metric Targets (page 8)

All performing provider systems must have a target for all pay-for-performance metrics, which will be used to determine whether or not the performance target for the metric was achieved. Performance targets should be based on the higher of top decile of performance for state or national data, or an alternative method approved by CMS.

HANYS’ Comment: Targets should be based on New York Medicaid data to provide an appropriate standard for PPS performance in serving the Medicaid population.

The Performing Provider System baseline data will be established as soon as complete data is available for the baseline period (as specified in the Metric Specification Guide supplement to Attachment J) and will be used as the foundation to determine the gap to goal to set the improvement target Each subsequent year would continue to be set with a target using the most recent year’s data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

HANYS’ Comment: It is unclear if the annual update to the “target” refers to updating only the PPS’ own performance data for the gap to goal improvement target or if it refers to updating both the PPS performance data and the data used to set the top decile target. Updating the data for the top decile target would create an inequitable moving target, which would require the PPS to not only improve its own performance, but to improve at a higher rate than the moving target. The top decile performance targets should be established using data from the baseline period and should remain constant through the life of the DSRIP program allowing the PPS to establish a plan to move toward the target over a multi-year period.

Section IV. DSRIP Project Plan Requirements

Section IV. A. Project Plan Development Process (page 9)

According to a timeline developed by the state and CMS that aligns with the DSRIP deliverables schedule outlined in STC 40 in section IX, Performing Provider Systems must submit a final DSRIP Project Plan to the state for review with a complete budget and all other items described below, consistent with the requirements in STC 8 in section IX.

HANYS' Comment: As we stated in our comments on the Special Terms and Conditions (STC) document, providers that participate in DSRIP will face numerous, complex operational issues as they form networks to implement new models of care that link services across multiple settings. Therefore, it is vital that the detailed requirements of the DSRIP program not impose additional burdens that would add to the inherent complexity of this process. The project plan requirements in this section call for detailed information on numerous components of the proposed projects. We urge the state to balance the need for detailed, specific information about the planned projects against the time and resources that are required to develop and report such information. Care should be taken to avoid requiring submission of data or information that is redundant or irrelevant to the proposed projects.

Section IV. b. Organization of DSRIP Project Plan (page 9)

[The plan shall include:]

2) c) Definition of service area (according to the specifications in the DSRIP Strategies Menu and Metrics) and a discussion of how the providers in the coalition relate to (or inform) the service area definition. As further described in the DSRIP Strategies Menu and Metrics, Performing Provider Systems are accountable for improving the quality of care for all Medicaid and low-income uninsured beneficiaries in their service area as defined in the DSRIP Member Attribution Method above.

HANYS' Comment: We do not find any specifications for service areas in Attachment J - NY DSRIP Strategies Menu and Metrics document. It is unclear how the service area provided by the PPS in the project plan relates to the service area as defined by the attribution method.

[the plan shall include:]

2)d) Identification as a safety net provider with documentation supporting that identification as described in paragraph II.a above.

2)e) Current patient population including demographic information, payer mix to document qualification as described in paragraph II.c above.

HANYS' Comment: The state has identified safety net providers based on an analysis of historic data. Requiring the PPS to recreate this analysis and document qualification as a safety net provider is redundant and the requirement should be eliminated. In 2)e) there is a reference to paragraph II.c.

Paragraph II.c. covers the attribution methodology and does not include any qualification criteria. If the correct reference is to “II.a. Assessment of Safety Net Provider Status,” the state used historic data to determine safety net status and it is our understanding that there is no requirement to requalify based on more current data. Please confirm this and clarify the purpose for the current patient population data requested for the project plan.

[the plan shall include:]

5)b) Evidence of regional planning including names of partners involved in the proposed project (in addition to any coalition members in the Performing Provider System in accordance with the process described in paragraph II.b above) Detailed analysis of issues causing poor performance in the project area. These must include assessment of patient co-morbidities, patient characteristics, social system support, system capacity for primary care and disease management, and institutional issues such as finances, confounders to health care system improvement including fragmentation of services, competition, and assessment of regional planning issues.

HANYS’ Comment: The PPS applicant is required to select projects and define a service area based on a community needs assessment. Project plan requirements should be based on this community assessment. The term “regional planning” should be replaced by “community planning” in this paragraph.

[the plan shall include:]

9) Budget: Performing Provider Systems must provide a detailed budget for all 5 years of their DSRIP project. For Performing Provider Systems that were awarded HEAL grants, a detailed budget report along with a description of the similarities or differences must be included.

HANYS’ Comment: These budget requirements would impose an unnecessary burden on DSRIP participants. As we stated in our comments on the STC document, DSRIP is a performance-based system with incentive payments that are not intended to reflect project costs; submission of detailed budgets should not be required. The requirement for detailed Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) grant budgets and comparisons to DSRIP budgets provide one example of unnecessary reporting that would divert limited time and resources during the planning process. The state already has detailed information on the HEAL grants and a brief description of any HEAL grant projects would provide sufficient assurance that the DSRIP project does not duplicate a prior HEAL grant project. This requirement should be eliminated.

[the plan shall include:]

10) Governance: The plan must include a detailed description of how the system will be governed and how it will evolve into a highly effective Integrated Delivery System. A clear corporate structure will be necessary and all providers that participate in the project will need to commit to the project for the life of the waiver. Weak governance plans that do not demonstrate a strong commitment to the success of the project will be rejected. Strong centralized project control will

be encouraged especially for projects that require the greatest degree of transformation

HANYS' Comment: Governance structure is a critical component that potential coalition participants will need to consider as they discuss possible formation of a PPS. While not mandating a specific legal structure, this paragraph indicates a shared governance corporate structure will be required and that a strong centralized control is preferred.

HANYS recognizes the need for a PPS to have a defined business structure with some degree of shared governance. However, an overarching corporate structure with the powers and authority indicated in this section could face multiple challenges in complying with the New York State Public Health Law and attendant regulations. This raises a number of questions for providers considering formation of a PPS:

- Would centralized project control include such powers as are typically exercised by an “active parent”? Would the existing establishment and certificate of need statutes and regulations apply to the central corporate entity such that it may be required to obtain establishment approval? Does DOH have the authority to waive some or all of the provisions of 10 NYCRR §405.1 regarding establishment even though it cannot waive statutory provisions? These issues are significant since the current establishment application development and review process takes many months and would certainly impede rapid project implementation.
- How would the state’s corporate practice of medicine rules apply to a central governing entity that intends to carry out the role expected by the state?
- Would the PPS be required to establish a formal corporate structure with a parent organization? Alternatively, what is DOH’s view of PPS development using non-governance models such as joint ventures and contractual relationships with a single “dominant” entity?
- The Public Health Law prohibits a corporation the stock of which is owned by another corporation from owning or operating hospitals, nursing homes, and clinics. How would this Article 28 prohibition apply to a PPS entity that incorporates many types of providers?
- Will certificate of public advantage (COPA) regulations be available to PPS entities? If so, would a COPA apply only in the Medicaid context or would a COPA extend to activities of the PPS regardless of payer? HANYS urges that discussions with federal authorities be held in advance to ensure that a COPA will provide sufficient protection from federal antitrust enforcement for PPS organizations with the scope and authority envisioned under DSRIP.

The state has indicated they it will provide further guidance on PPS structure and governance. We urge the state to act quickly to provide this guidance as providers begin to discuss coalition formation and start to develop DSRIP project plans.

Section V. Project Valuation (page 13)

The DSRIP project and application valuations will be calculated by the state (with assistance from the independent assessor) according to the methodology described below.

HANYS' Comment: Full details of the calculations should be provided to each PPS and a process should be established for discussion and resolution of any PPS disagreements with the calculations.

Calculating Project PMPM (page 15)

Because additional projects will have synergistic properties, from leveraging shared infrastructure and resources, the valuation benchmark is discounted as follows for Performing Provider Systems selecting multiple projects.

HANYS' Comment: Some degree of discounting may be appropriate when a PPS proposes to implement optional projects beyond the minimum requirement of five projects. However, the level of discounting needs to be carefully calibrated to provide a reasonable increase in the total application valuation to reflect the incremental value of the additional optional projects.

The calculation below is based on the example provided in the attachment. The second calculation is identical except that it eliminates the sixth project. Because of the level of discounting, the total application valuation is actually lower with the sixth project included. We understand the Project per member per month (PMPM) figures in the attachment are for illustration only. However, it does demonstrate the need to set the final discounted PMPMs at a reasonable level to encourage the implementation of additional optional projects when there is a community need.

Example DSRIP Valuation Calculation from Attachment I							
	Project Index Score	Valuation Benchmark	Project PMPM	# of Medicaid Beneficiaries	Project Plan Application Score	# of DSRIP Months	Maximum Project Value
Project 1	0.93	\$7.20	\$6.70	100,000	0.85	60	\$34,149,600
Project 2	0.90	\$7.20	\$6.48	100,000	0.85	60	\$33,048,000
Project 3	0.78	\$7.20	\$5.62	100,000	0.85	60	\$28,662,000
Project 4	0.67	\$7.20	\$4.82	100,000	0.85	60	\$24,582,000
Project 5	0.67	\$7.20	\$4.82	100,000	0.85	60	\$24,582,000
Project 6	0.40	\$7.20	\$2.88	100,000	0.85	60	\$14,688,000
Maximum Application Valuation							\$159,711,600

Example DSRIP Valuation Calculation without Project 6							
	Project Index Score	Valuation Benchmark	Project PMPM	# of Medicaid Beneficiaries	Project Plan Application Score	# of DSRIP Months	Maximum Project Value
Project 1	0.93	\$8.00	\$7.44	100,000	0.85	60	\$37,944,000
Project 2	0.90	\$8.00	\$7.20	100,000	0.85	60	\$36,720,000
Project 3	0.78	\$8.00	\$6.24	100,000	0.85	60	\$31,824,000
Project 4	0.67	\$8.00	\$5.36	100,000	0.85	60	\$27,336,000
Project 5	0.67	\$8.00	\$5.36	100,000	0.85	60	\$27,336,000
Maximum Application Valuation							\$161,160,000

Plan Application Score (page 15)

Based on their submitted application, each project plan will receive a score based on the fidelity to the project description, and likelihood of achieving improvement by using that project. This plan application score will be used as a variable in calculating the maximum project value.

. . . The state will develop a rubric for the individual plan application score in collaboration with CMS. This rubric must include an assessment of whether each proposed project is sufficiently different from other DSRIP projects selected (and other existing projects being funded by other sources) so as to ensure that the performing provider system does not receive double-credit for performing similar activities.

HANYS' Comment: It is unclear how standardized this score will be as the methodology has not yet been defined. However, by its nature there will be some degree of subjectivity involved in determining this score. A PPS should be provided a detailed explanation of how its plan application score was determined and should be given an opportunity to appeal the score if the PPS disagrees.

Section V. b. Metric Valuation (page 19)

Once the overall project valuation is set, incentive payment values will be calculated for each metric/milestone domain in the DSRIP project plan by multiplying the total valuation of the project in a given year by the milestone percentages specified below.

HANYS' Comment: Based on the description and example provided in this section, the overall project valuation is the value of the project over the five-year period. It is unclear how the annual value of the project is determined. We recommend that the allocation of the overall project valuation to specific years provide higher valuations in the first years to recognize the higher level of resources that will be required during project initiation.

The points given for reaching a specified performance target/milestone will be called an Achievement value and will be calculated as a 0 or 1 value. If a performance target or reporting milestone is met, the Performing Provider System will receive an AV of 1 for that performance target/milestone in that reporting period. If the Performing Provider System does not meet its milestone or performance target, the Performing Provider System will receive an AV of 0 for that reporting period. This will be done across every project in every domain.

HANYS' Comment: The proposed “achievement value” calculation uses a pass/fail structure that provides either 100% credit for achieving the target or zero credit for failure. We believe it would be preferable to provide partial credit for pay-for-performance (P4P) metrics. This could be done by establishing an “improvement value” that would provide partial credit when a PPS fails to achieve the target, but improves its performance on the P4P metric compared to its performance in the prior year. This would provide a more equitable result, particularly when a PPS is just below the target.

Section V. c. Project Value Monitoring (page 20)

Performing Provider Systems will be required to develop budgets and report on DSRIP project spending throughout the demonstration. As described in paragraph VI.c below, CMS reserves the right to review project values to ensure that the project value index, the population denominator, and the overall project valuation are calculated correctly.

HANYS' Comment: As we stated in our comments on the STC document, DSRIP is a performance-based system with incentive payments that are not intended to reflect project costs. Therefore, there should not be any requirement for reporting of project budgets, project spending, or project costs. The effort and resources required to provide these for all providers in a coalition for each project would impose an unnecessary burden on DSRIP participants. The requirements for reporting project costs and detailed project budgets should be eliminated.

VI. DSRIP Project Plan Review Process

Section VI. a. Overview of Review Responsibilities (page 21)

All Performing Provider Systems will be subject to addition review during the mid-point assessment, at which point the state may require DSRIP plan modifications and may terminate some DSRIP projects, based on the feedback from the independent assessor, the public engagement process and the state's own assessment of project performance. CMS will also monitor this mid-point assessment review process and make determinations in accordance with V.d

HANYS' Comment: While HANYS supports the concept of a mid-point assessment of DSRIP, HANYS encourages DOH to include an appeals process, so that PPSs that disagree with the independent assessor's or DOH's analysis or interpretation of data have an avenue for presenting their perspective if a termination is being recommended.

In addition, HANYS recommends that there be ongoing dialogue between the independent assessor and the PPSs to discuss the data analysis and interpretation on a routine basis, so that all parties are clear on the performance of the PPS.

HANYS encourages DOH to ensure that the technical support provided through the Learning Collaboratives is robust, comprehensive, and responsive enough to concurrently address all of the challenges that the PPSs will face. Rather than terminate a DSRIP Project for poor performance, HANYS recommends DOH provide on-site technical assistance and/or access to national and state experts to assist with identification of evidence-based best practices, implementation strategies, and innovative approaches to help the PPSs achieve success.

Section VII. Reporting Requirements and Ongoing Monitoring

Section VII. Reporting Requirements and Ongoing Monitoring (pages 25)

1. Ongoing provider-level evaluations will occur on a regular basis, as described below, and seek to provide timely and actionable feedback on the initiative's progress, in terms of infrastructure changes, implementation activities, and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, performance objective attainment, and overall progress toward achieving a health care system based on improving the health, improving care, and reducing costs, and progress toward achieving the primary goals of DSRIP, to reduce avoidable hospitalization and seek improvements in other health and public health measures by transforming systems.

HANYS' Comment: HANYS strongly encourages DOH to streamline and simplify the reporting requirements and to reduce duplication of reporting efforts. DOH should directly collect and analyze all data available to the state and federal government—such as Healthcare Effectiveness Data and Information Set (HEDIS), Quality Assurance Reporting Requirements (QARR), Statewide

Planning and Research Cooperative System (SPARCS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Potentially Preventable Measures—and provide PPSs with timely and actionable reports on performance. HANYS recommends DOH consider the reports and processes developed by the Centers for Medicare and Medicaid Services (CMS) Core Measure Vendors as a model. Streamlining and reducing duplicative reporting requirements would help eliminate unnecessary work and diversion of resources and enable more focused quality improvement work.

2. Learning collaboratives will be implemented to seek peer-to-peer (provider-to-provider) input on project level development of action plans, implementation approaches and project assessment. New York will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g., best practices, case studies, challenges, results).

HANYS’ Comment: HANYS supports the use of Learning Collaboratives to encourage the sharing of evidence-based best practices; however, we encourage DOH to expand the scope of these collaboratives beyond the peer-to-peer model to include additional strategies that have proven to be successful, including on-site technical assistance and access to state and national content and process experts in the field of health care quality improvement. Such collaboratives should also focus on sharing and offering 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.

Section VII. a. Semi-annual Reporting on Project Achievement (page 26)

Two times per year, Performing Provider Systems seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by the milestones and metrics described in their approved DSRIP plan. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved in accordance with Section VII “Disbursement of DSRIP Funds”. . . .

Note: Because many domain 2, 3, and 4 metrics are annual measures, these annual measures will only be available to be reported once a year for purposes of authorizing and determining incentive payments.

HANYS’ Comment: As each PPS will be submitting reports and metric performance twice a year, incentive payments should also be distributed twice a year. A single year-end payment could result in cash flow problems for vulnerable safety net and public providers. The state should develop a methodology for a mid-year incentive payment that might include an interim payment based on year-to-date data with a year-end reconciliation if required.

Section VII. c. Learning Collaboratives (page 28)

. . . . the state will designate personnel to be responsible for guiding and facilitating the Learning Collaborative. An online, Web-based tool will be utilized in order to effectively manage the collection and dissemination of information related to the DSRIP and projects. A key component of the online tool will be a reporting feature that allows a tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP program. This tool will act as a repository with reporting capability for various audiences including that of the general public, the Department, CMS and the healthcare industry.

HANYS' Comment: HANYS recommends that DOH develop a streamlined, standardized reporting template that PPSs can use to report data through the online tool. The tool should be developed with PPS stakeholder input and used consistently across the state.

Section VII. d. Program Evaluation (page 29)

The interim and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

HANYS' Comment: HANYS requests clarification on intent of this sentence.

Section VII. e. Overall Data Standards (page 29)

The state will collect data from providers often as is practical in order to ensure that project impact is being viewed in as “real time” a fashion as possible. Collecting and analyzing data in this fashion will allow for rapid, life-cycle improvement which is an essential element of the DSRIP project plan.

HANYS' Comment: It is unclear how this “real time” data collection from providers relates to the requirement for PPS semi-annual reporting on project achievement in paragraph a. of this section.

Since managed care is an important component of the state’s quality improvement strategy, the state will implement a provider/plan data portal that will allow access to appropriately permissioned patient and provider specific data in the Medicaid Data Warehouse. Role based access to this portal will allow providers and their partnering health plans access to current Medicaid claims and encounters data and eventually real time EMR and care management data provided through connectivity with local regional health organizations (RHIOs).

HANYS' Comment: Access to the comprehensive data envisioned for the data portal is important not only for DSRIP participants but for providers in general as they seek the information needed for delivery system transformation. The ability to access individual patient data and share those data

for optimal care management of a patient is critical. DSRIP participants must have the ability to share data for all patients across all services in the project network. HANYS encourages the state to establish such a portal as quickly as possible.

However, the creation of the data portal will take time. In order for potential PPS providers to seek partners with the intention of forming networks, it is imperative that data be made available quickly. Therefore, HANYS encourages DOH to immediately share as much beneficiary and claims history data as possible so that a PPS lead can obtain information to make optimal decisions on network partners.

CMS policies related to Accountable Care Organizations (ACOs) and the Bundled Payments for Care Improvement Initiative (BPCI) can serve as a model for the type of data that should be provided. In both of these programs CMS released beneficiary enrollment and claims data that linked services across all settings including: inpatient, outpatient, nursing homes, home health agencies, physicians, supplier part B, Durable Medical Equipment, and Hospice, in order for providers to evaluate the needs and experience of their assigned population.

Section VII. e. Overall Data Standards (page 30)

The state will use the Quality Committee, established in 2013 to assist NYSDOH on quality measurement and improvement that will be responsible for supporting the clinical performance and improvement cycle of DSRIP activities . . . The Quality Committee will serve as an advisory group for DSRIP offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

HANYS' Comment: HANYS is a member of the DOH Quality Committee and appreciates the opportunity to continue serving in this role, particularly as it relates to DSRIP. However, because of the significant consequences associated with performance on the metrics, HANYS encourages DOH to engage additional state and national experts in the establishment of benchmarks and goals, as well as the attribution methodology.

XI. Disbursement of DSRIP Funds

Section XI. b. Public Hospital and Safety Net Provider Performance Provider System Transformation Funds (page 31)

All Performing Provider Systems with approved DSRIP Project Plans will be eligible to apply for funding from one of two DSRIP pools. The first, Public Hospital Transformation Fund, will be open to applicants led by a major public hospital system . . . The second fund Safety Net Performance Provider System Transformation Fund, would be available to all other DSRIP eligible providers.

Allocation of funds between the two pools will be determined after applications have been submitted, based on the valuation of applications submitted to each pool.

HANYS' Comment: The allocation must ensure public hospital DSRIP pool funding that recognizes the role they play and ensures public hospitals receive equitable incentive payments that reflect the proportion of total non-federal funds that are received from the public hospitals through IGT.

Attachment J: NY DSRIP Strategies Menu and Metrics

HANYS offers the following general comments that cross all Project Domains and projects.

Disaster Clause

CMS has established waivers for providers impacted by disasters and extraordinary circumstances under the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) Programs. In addition, in the federal fiscal year (FFY) 2015 Inpatient Prospective Payment System (IPPS) Proposed Rule, CMS is considering a disaster waiver for the Readmissions Reduction Program.

These waivers were most recently used by hospitals affected by Hurricane Sandy, which severely impacted hospitals' ability to comply with federal reporting requirements. HANYS strongly encourages DOH to include the ability to obtain a reporting waiver for PPSs impacted by natural disasters or other extraordinary circumstances.

Adjustment for Socioeconomic Status

An expert panel convened by the National Quality Forum (NQF) has recommended that NQF permit risk adjustment that includes socio-demographic factors when reviewing measures submitted for endorsement.

HANYS has long advocated for incorporation of socio-demographic risk adjustment for selected performance-based measures. Payment systems built from unadjusted measures will unfairly limit reimbursement to those serving disadvantaged communities, reducing their ability to provide needed services to their patients, while rewarding those providers serving advantaged communities.

Should NQF adopt the recommendations of the expert panel, HANYS strongly encourages DOH and the independent assessor to take this change into account, and use measures that are fully risk adjusted, including socio-demographic factors.

Domain 2 – System Transformation Metrics

General Comment on Domain 2: Domain 2 includes four performance measures for Potentially Avoidable Services and four groups of CAHPS performance measures (which list at least eight separate measures). The number of CAHPS measures in this Domain could have a disproportionate impact on project scores. Given that the primary goal of DSRIP is reduce avoidable hospitalizations, the Potentially Avoidable Services measures should have higher weight in the overall performance evaluation to reflect their importance.

Potentially Avoidable Emergency Room Visits

Potentially Avoidable Readmissions

HANYS' Comment: The behavioral health population is more likely to receive services that are determined to be potentially avoidable by the 3M software used for these metrics. As a result, performance on these metrics is lower for providers with larger behavioral health programs. In

addition, given the characteristics and complex needs of this population, performance improvement will be more difficult for these providers. We urge the state to provide separate behavioral health patient and non-behavioral health patient metrics for Potentially Avoidable Emergency Room Visits and Potentially Avoidable Readmissions.

Domain 3 – Clinical Improvement Metrics (pages 11 - 15)

C. Diabetes Mellitus Measure PQI #3 (Diabetes Management Long term complications)

HANYS' Comment: HANYS is not aware of any evidence that would indicate that PPSs that choose diabetes as a focus area could expect to see a significant impact on PQI #3 during the DSRIP project period. This measure focuses on long-term complications of poor diabetes management, which would not be expected to manifest for many years, including renal, eye, neurological, and circulatory complications.

A more appropriate measure for this focus area would be PQI #14: Uncontrolled Diabetes Admission Rate, which addresses admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population, ages 18 years and older.

May 14, 2014

New York State Department of Health
DSRIP Program

Re: MRT Waiver Amendment
DSRIP Special Terms and Conditions (STCs)
Program Funding and Mechanics Protocol (Attachment I)
Strategies and Metric Menu (Attachment J)

To Whom It May Concern,

The New York State Nurses Association is the union that represents 37,000 registered nurses in New York State and is a committed advocate for the health care needs of the people of New York State.

We have reviewed the terms of the MRT Waiver amendment agreed to between CMS and the state of New York and have the following comments.

1. DSRIP Special Terms and Conditions (STC) Document

We are generally supportive of the efforts of the state to obtain expanded funding to improve our healthcare delivery system. The agreement to provide \$8 billion in funding to support our hospitals and broader delivery network will provide needed funding for safety-net providers in their efforts to improve the delivery of health services to underserved communities.

We are particularly supportive of the recognition by the State and CMS, as set forth in the definition of safety-net providers, that our safety-net hospitals play an indispensable role in delivering vital healthcare to the populations in their service areas. It is particularly telling that 142 of the 185 hospitals in New York State (76.8%) are recognized as vital safety-net providers.

We trust that these designations will be recognized and taken into account in the event of future efforts to close hospitals or reduce the scope of services that they provide to their communities. We are further hopeful that the resources that are being made available through the waiver amendment and the recently enacted hospital capital fund program will provide a basis for maintaining and strengthening these vital institutions.

2. General Criteria for Selection of Proposals and Allocation of Funds

In reviewing past waiver programs, we and other advocates have questioned the formulas used to allocate funds. We have been concerned in the past that funds were not appropriately directed to hospitals and other providers on the basis of their actual need for support and that funding was unnecessarily or inappropriately channeled to institutions that did not have the same level of need for funding or did not provide the same degree of services to low income and uninsured populations as other facilities.

The current proposal seems to address this concern by creating a methodology that assigns patient populations to particular providers and which will allocate funding for proposals on the basis of the actual numbers of Medicaid patients. This is a positive development that we welcome.

We are concerned, however, that the current criteria for selection of proposals and allocating funding will possibly work to the detriment of those providers that are most in need of assistance to pursue restructuring and improved healthcare delivery to their service communities.

Within the broad category of safety-net provider hospitals, there are wide differences in the degree to which each hospital serves low-income Medicaid and uninsured populations. The range of Medicaid population percentages for safety net hospitals ranges from 35% at the low end to as much as 94% for some hospitals. In addition, some safety-net providers have better payer mixes and overall financials than others. There are, in short, important distinctions to be drawn between the levels of need for assistance within the range of facilities that have been designated as safety-net providers.

The differences between safety-net hospitals referred to above are illustrated by the following hypothetical comparison:

Hypothetical Safety-Net Hospital A

	Private Insurance	Medicare	Medicaid	Total
Payer Mix	38%	30%	32%	100%
Costs of service	\$38,000,000	\$30,000,000	\$32,000,000	\$100,000,000
Margin by Payer	+20%	-5%	-10%	
Revenue by Payer	\$45,600,000	\$28,500,000	\$28,800,000	\$102,900,000
Profit/Loss				+\$2,900,000 (+2.9%)

Hypothetical Safety-Net Hospital B

	Private Insurance	Medicare	Medicaid	Total
Payer Mix	10%	10%	80%	100%
Costs of service	\$10,000,000	\$10,000,000	\$80,000,000	\$100,000,000
Margin by Payer	+20%	-5%	-10%	
Revenue by Payer	\$12,000,000	\$9,500,000	\$72,000,000	\$93,500,000
Profit/Loss				-\$6,500,000 (-6.5%)

In this example, we assume that both hospitals have the same number of total patients, but hospital B has a higher number of Medicaid patients, based on the payer mix. The application of the proposed valuation methodology would award a higher level of funding to Hospital B, commensurate with its larger Medicaid/uninsured/dual eligible population.

In the scoring process for determining whether to accept applications, however, the only criterion that would consider the volume of Medicaid patients served is that based on the potential savings in state spending. Because this criterion is only one of five total criteria, the relative weight of Medicaid patients served will be reduced in determining whether to accept a proposal. This could allow hospitals with lower percentages of Medicaid patients to win out over hospitals with higher percentages. In the above example, this would penalize a hospital with negative cash flow and greater need in favor of a proposal from a hospital that is already in the black due to a more favorable payer mix.

We are also concerned that the proposed formula for allocating money will unfairly benefit large hospitals and penalize smaller facilities. This dynamic is illustrated by following example:

Hypothetical Large Safety-Net Hospital A

	Private Insurance	Medicare	Medicaid	Total
Payer Mix	38%	30%	32%	100%
100,000 patients	38,000	30,000	32,000	
Costs of service	\$38,000,000	\$30,000,000	\$32,000,000	\$100,000,000
Margin by Payer	+20%	-5%	-10%	
Revenue by Payer	\$45,600,000	\$28,500,000	\$28,800,000	\$102,900,000
Profit/Loss				+\$2,900,000 (+2.9%)

Hypothetical Small Safety-Net Hospital B

	Private Insurance	Medicare	Medicaid	Total
Payer Mix	10%	10%	80%	100%
40,000 Patients	4,000	4,000	32,000	
Costs of service	\$4,000,000	\$4,000,000	\$32,000,000	\$40,000,000
Margin by Payer	+20%	-5%	-10%	
Revenue by Payer	\$4,800,000	\$3,800,000	\$28,800,000	\$37,400,000
Profit/Loss				-\$2,600,000 (-6.5%)

In the above example, assuming that both hospitals have been selected to receive funding for similar proposals, the larger hospital would receive the same level of funding as the smaller hospital, because both have the same gross number of Medicaid patients served. Hospital A, however, has less relative need for the funding due to its payer mix and positive margin. Hospital B, on the other hand has a higher level of need for assistance because of its negative margin and because restructuring its programs will be more difficult to achieve due to the lack operating revenue and the higher percentage of its total patient population that is Medicaid eligible. This dynamic will also come into play in the process of meeting the metrics/measurements for applying the program. In this example, the inherent structural difference will produce a proportionately higher level of difficulty in attaining milestones for Hospital B and will result in a higher likelihood of default and the claw back of money or termination of the program.

3. Interim Access Assurance Fund

The inclusion in the DSRIP waiver program of the IAAF in the amount of \$500 million will help to alleviate the impact of disparities in financial condition and payer mix within the safety-net provider

definitions. This funding will also make it easier for hospitals that are in dire financial condition to find the resources to develop their applications and begin to implement them.

The IAAF funding, however, is not in and of itself sufficient to offset the underlying range of needs and disparities within the group of hospitals and providers that will qualify as safety-net providers. First, the funding is limited only to public hospitals and private hospitals that are in extremely dire condition (i.e., having less than 5 days cash on hand). This narrow definition of eligibility for IAAF funding will exclude most safety-net providers from seeking this special assistance. In our examples above the weaker hospital with the negative margin would not be likely to meet the IAAF eligibility criteria. It is also noted that the IAAF funding is only available in year zero. It ceases in year one of the program, so will not be of assistance to any hospitals after the program begins to be implemented.

We support the concept of IAAF funding for public hospitals and private hospital in extremely dire financial condition and do not propose to expand the fund to other hospitals to allow them to submit and implement waiver applications.

4. Weighting Applications and Funding Awards on the basis of financial need

We believe that the fairest approach to selecting proposals and awarding DRIP funding is to create a formula that gives an advantage or bonus to applicants that takes into consideration each facility's relative proportions of Medicaid/uninsured/dual eligible populations.

In the application process, preference should be given to hospitals that serve relatively higher proportions of Medicaid patients and less preference to those with lower proportions. It is our position that those safety-net institutions with relatively lower proportions of such patients will be more able to successfully restructure their operations without as much need for assistance. If choices have to be made, the applications with the highest proportions of Medicaid patients should receive preference.

In addition, we believe that the actual funding of selected applications should not be based solely on the PMPM (per member per month) formula being proposed. We believe that the PMPM value should be further weighted on the basis of payer mix and/or operating margins. PMPM payments should be adjusted upward or downward to account for financial status and relative payer mixes. This will allow finite funding resources to be deployed more intensively to those institutions that have the greatest relative need for funding.

Using this approach to modify the scoring and funding allocation processes will be fairer to the institutions involved, better for these safety-net patients and will also make the overall waiver program more likely to succeed.

5. Avoid Reliance on Rigid or Artificial Cost Cutting Targets

As a final point, we want to express concern that the DSRIP and other reform programs avoid overly relying upon cost cutting goals to the detriment of improving access to care and improved outcomes. The top priority of reform efforts is and must remain to improve the delivery of care and maintain equal and fair access to all segments of our population.

We are concerned, for example, that the target of a 25% reduction in "unnecessary" admissions and ER visits will be improperly conflated with a target of reducing actual capacity by 25%. We note that

“unnecessary” is not clearly defined in the program protocols and that there may easily be numerous situations in which the reduction in “unnecessary” usage of facilities goes hand in hand with increased volume (for example, with the confluence of an aging population and the expansion of the rolls of the newly ensured).

Accordingly, we would reject any efforts to use the DSRIP program to force facilities to downsize or close in a drive to meet political goals that are unrelated to actual health care needs, particularly in underserved communities.



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Center for Independence of the Disabled, NY

COMMENTS ON THE NEW YORK STATE DSRIP WAIVER ATTACHMENT J- Strategies Menu and Metrics

Addressing Health Disparities

Health disparities are an important driver of the outcomes that this waiver seeks to address including the overall outcome of reducing avoidable hospitalizations by 25% over five years. It will be important for Performing Provider Systems to address health disparities to achieve the desired outcomes.

Numerous studies have documented that people with disabilities are far less likely to access health care services than people without disabilities.¹ Similarly, LEP patients are more likely than non-LEP patients to report being in poor health, deferring medical care, experiencing adverse drug effects, and are less likely than non-LEP patients to have a regular source of care.² Health disparities research suggests that valid and reliable data are fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific population groups.³ Hospitals and other health care organizations armed with data from their own institutions will be better equipped to look at disparities in care, design targeted programs to improve quality of care, and provide patient-centered care.

Yet the metrics identified in this document do a poor job of tracking these disparities. In Domain 1, metric (1) (c) asks Performing Provider Systems to document the number of beneficiaries served through the projects, but does not break it down by disparities populations. Domain 4, Population Wide Metrics, relies on the deficient SPARCS data

¹ See, e.g., NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES (2009), http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf; see also, JUDY PANKO REIS ET AL., IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES 7 (2004), www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf; M. A. Nosek and C. A. Howland, *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 ARCHIVES OF PHYSICAL MED. & REHABILITATION S39 (1997).

² Leighton Ku and Glenn Flores, Health Affairs, Pay Now or Pay Later: Providing Interpreter Services in Health Care, March 2005, 435-444, vol. 24 available at <http://content.healthaffairs.org/content/24/2/435.full#ref-5> (citing B. Kirkman-Liff and D. Mondragón, "Language of Interview: Relevance for Research of Southwest Hispanics," *American Journal of Public Health* 81, no. 11 (1991): 1399-1404; G. Flores et al., "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics and Adolescent Medicine* 152, no. 11 (1998): 1119-1125; M. Alpert et al., "The Language Barrier in Evaluating Spanish-American Patients," *Archives of General Psychiatry* 29, no. 5 (1973): 655-659; R. Weinick and N. Krauss, "Racial/Ethnic Differences in Children's Access to Care," *American Journal of Public Health* 90, no. 11 (2000): 1771-1774; and T.K. Gandhi et al., "Drug Complications in Outpatients," *Journal of General Internal Medicine* 15, no. 3 (2000): 149-154.)

³ Romana Hasnain-Wynia and David W. Baker, *Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions*, 1501, 1502 (2006).

COMMENTS ON THE NEW YORK STATE DSRIP WAIVER

which tracks measures for Black non-Hispanics and Hispanics, but does not yet track any other health disparities populations.

Along with race and ethnicity, the Health Disparities Workgroup of the Medicaid Redesign Team recommended that DOH “implement and expand on data collection standards required by Section 4302 of the Affordable Care Act by including detailed reporting on...gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status.”⁴

While CMS did change many of the ideas that came out of the MRT participation process, it should be cognizant of the need to track disparities populations beyond race and ethnicity. The Affordable Care Act now requires any “federally supported health care or public health program, activity or survey” must collect and report, “to the extent practicable, data on race, ethnicity, primary language, and disability status, for applicants, recipients, or participants.”⁵

Recommendations:

1. Participating Provider Systems should identify the race, ethnicity, sex, primary language and disability status, gender identity, and housing status of the beneficiaries they serve. They should do this so that they can do a better job of serving them, so that they can comply with all applicable civil rights laws, and so that they can report the numbers and percentages for the purposes of overall project assessment.
2. Domain 4 projects should include population wide metrics which measure the differences in health indicators for all health disparities populations including race, ethnicity, sex, primary language, disability status, gender identity, and housing status. The U.S. Department of Health and Human Services Implementation Guidance on Data collection standards should be used for race, ethnicity, sex, primary language, and disability status. LGBTQ advocates and housing advocates should be consulted for standards to measure gender identity and housing status.

Including Community-Based Groups that Serve Health Disparities Populations

Community-based organizations have noted that they are often best able to provide evidence-based strategies for prevention and self-care, but that they are not now an integrated part of the delivery system and have not been able to access funding under the current “medical model” system. Independent Living Centers, for example, have a

⁴ See, NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID REDESIGN TEAM (MRT) HEALTH DISPARITIES WORK GROUP FINAL RECOMMENDATIONS (2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf, page 6. For the six ACS questions on disability status, see, U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES IMPLEMENTATION GUIDANCE ON DATA COLLECTION STANDARDS FOR RACE, ETHNICITY, SEX, PRIMARY LANGUAGE, AND DISABILITY STATUS, <http://aspe.hhs.gov/datacncl/standards/aca/4302/index.pdf>, page 7.

⁵ 42 U.S.C. 300kk(a)(1).

COMMENTS ON THE NEW YORK STATE DSRIP WAIVER

strong track record of improving the health of people with disabilities, but have been viewed as an add on in some of the other efforts at care coordination , such as Health Homes. We agree with the other commenters that technical assistance should be provided to community groups to help them identify projects they could participate in and to help them demonstrate that the value they bring to those projects should be compensated.

Complying with Civil Rights Laws

Participating Provider Systems should be assessed for their compliance with non-discrimination laws. People who experience health disparities will have better health outcomes when providers understand their legal obligations to accommodate people with different races, ethnicities, disabilities, gender identities, or languages that they speak. Under Section 1557 of the ACA, individuals shall not “be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part off which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance.”⁶

For further information, please contact Heidi Siegfried, Health Policy Director, 646.442.4147 or hsiegfried@cidny.org.

⁶ 42 U.S.C.A. § 18116(a).

***Letter Submitted on Behalf of
New York State United Teachers and United University Professions***

May 14, 2014

Mr. Jason A. Helgerson
Deputy Commissioner, Office of Health Insurance Programs
Medicaid Director
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY12237

Dear Mr. Helgerson,

This letter is sent in response to the Department of Health's request for comment on *Attachment I and Attachment J* associated with the Delivery System Reform Incentive Payments (DSRIP) under the recently-awarded Section 1115 waiver.

As we described in comments submitted April 29, 2014, we believe that it is imperative that all appropriate unions play a meaningful role within the DSRIP process. Our comments on *Attachments I and J* will once again focus on ensuring that the unions are an integral piece of the process. The comments will also emphasize the need for the DSRIP documents to reflect the public mission of the State University of New York hospitals and how to best protect that mission regardless of the collaborative relationships that are formed throughout the Performing Provider Systems.

New York State United Teachers (NYSUT) and United University Professions (UUP) submit the following comments on *Attachment I* for your consideration.

First, we propose that *Attachment I* be amended to reflect that all participating providers ***must*** include appropriate union representatives during the planning, development and implementation of DSRIP applications and projects. Appropriate unions include those officially recognized as representing employees of the hospitals, health centers, mental health facilities and other component participants in proposals for DSRIP funds. Specifically, we recommend that *Attachment I* (on page 11, Section IV DSRIP Project Plan Requirements, b.5. Organization of DSRIP Project Plan, Performance Assessment, part e – Evidence of Public Input into the Project) be amended as follows (additions are underlined):

e) Evidence of public input into the project. This should include documentation of collaboration with local departments of public health, public stakeholders and consumers. In addition, the provider will need to document how there will be ongoing engagement with the community stakeholders, including active participation in any regional health planning activities currently underway in their community. Applicants will need to include workers and all of the recognized employee representatives in the planning and implementation of their overall project with particular emphasis on the comprehensive workforce strategy. A document signed by all of the

indicating that they were included in the DSRIP application planning and development, project design, and project selection processes, as well as all other aspects of the DSRIP projects, must be included as evidence that worker representatives were included as part of the PPS coalition. The state may require Performing Provider Systems to maintain a website including contact information, overview of public comment opportunities, results of public processes, application materials, and required reporting.

Second, to ensure that representatives of employees (where collective bargaining agreements exist) have been involved in a meaningful manner we suggest that the following be included and explicitly stated in *Attachment I*:

- 1) Nothing in any application would be seen as contravening existing collective bargaining agreements;
- 2) All information shared between employers (who are part of PPS proposals for 1115 money) and the Department of Health must also be shared with a central contact designated by the bargaining units representing employees;
- 3) All DSRIP applications that fail to include labor/management collaborations, stipulated herein, will be given a lower award value;
- 4) Any application for funds be accompanied by a certificate signed by the CEO of the hospitals involved and the appropriate union representatives indicating that these steps have been taken;
- 5) Any funds set aside for training or re-training be treated through an appropriate labor-management mechanism.

Third, the "Governance Section" in *Attachment I* may actually impede the development of coalitions for the purpose of this waiver. As written, this section directs the providers to create a corporate structure, but fails to explicitly include worker representatives in this process or provide any protections for the mission and public employee status of the public health care providers. Without these protections the collaborations may be more intrusive than what is necessary. We recommend the following changes:

"The Performing Provider System will need to demonstrate that it has a governance strategy that ensures that participating providers, and all of the unions that represent employees within those facilities, work together as a 'system' and not as a series of loosely aligned providers nominally committed to the same goal. Plans to progressively move from a loosely organized network of affiliated entities to an actual Integrated Delivery System must be evident in the goals" (*page 10, Section IV DSRIP Project Plan Requirements, b.3. Organization of DSRIP Project Plan, Identification of Provider Overarching Goals*).

"The plan must include a detailed description of how the system will be governed and how it will evolve into a highly effective Integrated Delivery System. A clear corporate structure will be necessary and all providers that participate in the project, as well as the unions that represent employees within those facilities, will need to commit to the project for the life of the

waiver. However, any corporate structure established throughout the waiver shall maintain the State University of New York as the sole operator of its health care facilities, which shall remain state-operated public facilities staffed exclusively with public employees working in such State University of New York health care facilities. Such public employees shall maintain their collective bargaining rights within their current bargaining units pursuant to Article 14 of the Civil Service Law. Such state agency status shall continue in order to reflect the public nature and scope of the goods and services provided by such health care facilities" (page 12, Section IV DSRIP Project Plan Requirements, part b.10. Organization of DSRIP Project Plan, Governance).

Fourth, with regard to the "plan application score," we believe that it should reflect whether the PPS provided evidence of the inclusion and active participation of all of the unions that represent workers within the PPS during the application planning and development, project design, and project selection processes. The score should also reflect the PPS's ability to provide a plan for continued inclusion of the unions. We recommend the following change:

Step 3: Plan Application Score

"Based on their submitted application, each project plan will receive a score based on the fidelity to the project description, likelihood of achieving improvement by using that project, the applicants' ability to provide evidence of the inclusion and active participation of all union representatives during the application planning and development process, and the applicants' ability to provide a plan for continued inclusion of the unions. This plan application score will be used as a variable in calculating the maximum project value" (page 15, Section V Project Valuation, part a. Valuation for DSRIP Application, Step 3).

Fifth, the lead coalition provider will primarily be responsible for ensuring that the coalition meets all requirements of the Performing Provider System and distribution of DSRIP funds, while the public entities will be the primary source of the non-federal share of the intergovernmental transfer (IGT) funds. With the PPS having little control over the statewide benchmark, it should be able to monitor and have more control over the PPS's ability to reach its milestones. For this reason we believe that *Attachment 1* should clearly state that when a public provider is part of a PPS it should be designated the lead coalition provider. We recommend the following change:

"For coalitions that involve public hospitals that are providing Intergovernmental Transfer (IGT) funding for a project, the public entity providing IGT funding will ~~generally~~ be the lead coalition provider for the Performing Provider System that is directly using the IGT match. Private safety net providers can also service as coalition leads as provided in paragraph (d) below" (page 3, Section II DSRIP Performing Provider Systems, part b.v. Coalitions).

Finally, the statewide valuation benchmark is pre-set and only varies based upon the number of projects proposed – not by geographic cost differences. The cost of care delivered in New

York City may not be the same as the care delivered in Albany. Geographic difference should be considered in setting the valuation benchmark.

With regard to Attachment J, we submit the following comments for your consideration.

With the public teaching hospitals playing an important role in the DSRIP funding process we believe that it is critical that *Attachment J, NY DSRIP Strategies Menu and Metrics*, include projects that would improve their long term financial status with or without a private partnership. We ask that it be clarified that a public hospital can develop and own the ambulatory care centers, as described in Domain 2. This clarification would validate and encourage the public teaching hospitals to shift their business plan and create new ambulatory care centers. This shift will enable the teaching hospitals to establish a national model for training medical residents in ambulatory care settings, which will benefit all of the providers included in their PPS. This type of project should be scored in the same manner as a project that seeks out an already established community based health care centers as a partner. This plan would provide a new revenue source for the public teaching hospitals, which would contribute to their financial stability while they continue to work toward the New York State goal of reducing avoidable hospital use.

In general, *Attachment J* proposes that the State outline projects for local evaluation, that the State develop guides to review the “approvability” of those projects, and that the State subsequently give such approval. Specifically, Domain 2 projects suggest that top down, central planning, in the absence of the specific characteristics of the local care delivery system, should prevail. We suggest that the process be reversed and that great deference should be given to projects developed at the local (community, institutional) level, with “approvability” dependent on the conformity of such plans to demonstrated local need. We strongly believe that since the “savings” generated from the New York State Medicaid program are largely from the underpayment of hospitals and doctors under managed Medicaid, the funds necessary to “reform” the system should go back to those very same safety-net hospitals. These waiver “savings” should be used to repair the financial damage associated with managed Medicaid, as was done with public hospitals in California, and in the section 1115 waiver in Texas.

Thank you for your attention to these issues. We welcome further discussion on all of the comments that we have provided.

Sincerely,



Frederick E. Kowal, Ph.D.
President
United University Professions



Andrew Pallotta
Executive Vice President
New York State United Teachers

Comments on the Funding and Mechanics Protocol and the Strategies Menu and Metrics for the Delivery System Reform Incentive Payment Program

May 14, 2014

Through the Delivery System Reform Incentive Payment (DSRIP) program, the New York State Department of Health (the State or “DOH”) builds upon the Medicaid Redesign Team’s initiatives. CHCANYS applauds the State’s recognition of the need for a transformed health care system in New York—one that sustains and enhances the State’s primary care foundation and shifts away from the historic emphasis on inpatient care. CHCANYS is enthusiastic about the unique opportunity the DSRIP program provides and is pleased to offer comments on the program’s Funding and Mechanics Protocol (Attachment I).

Sections of Attachment I of the DSRIP program focus on: *attribution, governance, modification of project plans, and valuation criteria* -- key constructs that are critical for Federally Qualified Health Centers (FQHC). By design, FQHCs are fully-integrated, patient-centered medical homes providing primary care, specialty care, behavioral and oral health care, and disease prevention services. As major Medicaid safety net providers, it is essential that FQHCs are subject to parity within the attribution process, are genuine participants in the governance of Performing Provider System (PPS) networks, and are able to utilize their significant Medicaid populations as a benefit.

I. Recommendations for Attachment I

A. Comments on Attribution:

1. Joining More than One PPS—*Providing a Mechanism of Participation for Community-based Providers that Does Not Nullify the Value of Their Medicaid Population.*

CHCANYS proposes that DOH allow primary care patients to be attributed to more than one PPS in the same or overlapping geography. DOH has indicated that a primary care provider can participate in more than one PPS in a single or overlapping geography; however, it is CHCANYS’ understanding that the current attribution methodology would essentially nullify the attributions of primary care providers who choose to do so.

Given that a central goal of transforming New York's health care system is to shift from an emphasis on acute care to preventive and primary care, it is critical to ensure that attribution aligns with patients' primary care providers. In order to support patient care, many primary care providers have existing partnerships with more than one hospital, as well as with other providers. Ensuring that attribution enables primary care providers to form the foundation of care, including for more than one PPS, will support the true transformation called for in the Medicaid waiver.

2. Developing Performing Provider Systems Which Service Patients Based on Care Management – *Requiring that Patient-Centered Medical Homes Receive Preferential Service Priority When Attributing Patients*

Section II. C. of Attachment I delineates the hierarchical priorities of various service categories in the attribution of Medicaid beneficiaries to a Performing Provider System. The first priority service is for care management providers. It is our understanding that the care management category is currently intended to cover the care management services provided by health homes and is therefore restricted to specific populations targeted by the health home project. However, populations outside of health homes also require levels of care management. In recognition of this, NCQA has included care management in Patient-Centered Medical Home (PCMH) recognition requirements. Therefore, PCMH should also be included as a first priority for attribution in the outpatient service category. Doing so would also align with the State’s priority for advancing PCMH adoption and further leverage incentive dollars.

3. Ensuring Patients Are Attributed to Appropriate Performing Provider Systems – *Requiring the Attribution Algorithm to Clearly Prioritize Patients Based on Primary Care Services*

As noted in Attachment I, the first priority service category in the attribution of Medicaid beneficiaries is care management followed by outpatient (physical and behavioral health). The providers within the outpatient provider category are broad and can include outpatient departments of hospitals, FQHCs, clinics, behavioral health providers, and physician practices. Currently, there is no differentiation within this category regarding who is the patient’s primary care provider or medical home. For instance, if a patient visits a primary care provider once for an annual exam but then has two visits with another outpatient provider for extenuating circumstances, that Medicaid beneficiary will not be attributed to the primary care provider’s Performing Provider System.

To properly attribute patients in a manner consistent with the objectives of the DSRIP program and the shift toward a foundation of primary care, the algorithm within the outpatient service category should be modified to preferentially attribute a patient to his or her “true” primary care provider organization/medical home. Attribution should not be purely based on the number of visits to a given facility.

4. Incorporating the Input of Managed Care Plans on Attribution—*Ensuring Buy-in from Managed Care Plans to Further Sustainability and Feasibility.*

As discussed in Attachment I, an attribution algorithm based on a review of claims data will be utilized to assign Medicaid beneficiaries to Performing Provider Systems. Section II. C. further explains that the State will share its patient attributions with the managed care organizations (MCOs) of their specific members to seek input on assignments. MCOs may recommend modifications to the attributions and reassign their members to other Performing Provider Systems. Attachment I provides a broad explanation of the information that the MCOs may have available to inform their suggested reassignments.

The MCO reassignment exception process was utilized as part of the State’s Health

Home Demonstration Program; however, the process was not fully understood or transparent to Health Home participants. In the interest of transparency and appropriate member attribution, we suggest that Attachment I be expanded to further define the specific criteria that a MCO must use in determining appropriate reassignment of members. In addition, upon request, members of a Performing Provider System should be provided access to the data used by MCOs when determining reassignments.

B. Comments on Governance—Ensuring Community-Based Safety Net Providers Have Guaranteed Representation on Governance Boards of Performing Provider Systems.

The DSRIP program is designed to transform New York’s safety net into a high performing Integrated Delivery System. To accomplish this, Performing Provider Systems must establish a governance structure to monitor and manage DSRIP Project Plans. The State has indicated that it will not mandate a specific governing structure for Performing Provider Systems but prefers structures that support shared governance. However, Attachment I is silent with regard to parameters and composition of governing boards. Although CHCANYS understands the State’s desire to have the provider community work collaboratively in designing Performing Provider Systems, history has shown that the control of such joint ventures often rests with hospitals and large institutional health systems— which will not yield the level transformation called for in the Medicaid waiver. The transformation should be driven by a shift away from institutions that have historically focused primarily on acute care to providers that have focused primarily on preventive and primary care. Such a transformation will require governance structures that mirror this shift and do not replicate the status quo. CHCANYS recommends that the State issue specific requirements for structures to share governance across provider types and ensure that primary care providers have representation on governing bodies during the planning and implementation phase. These requirements should be developed to ensure that having a seat at the governance table is not based solely on a provider’s ability to invest upfront capital to support a DSRIP project. Rather, multiple factors should be required, including but not limited to number of attributed patients, geographic reach, and comprehensiveness of services.

C. Comments on Partnership and DSRIP Project Plan Modification—*Creating a Plausible Pathway for Foreseeable Modifications.*

Given the current timeline, safety net providers in New York State are scrambling to join Performing Provider Systems without ample time to assess potential partners, define value, create effective partnerships, and negotiate the myriad details required to form successful coalitions, all of which are essential to achieve DSRIP’s intended results. The current guidance is silent on the ability of coalitions to form during the planning and implementation periods, which would allow members to move to appropriate Performing Provider Systems as project plans evolve. This ongoing realignment of providers is common in other payment reform efforts (e.g. Massachusetts’ Primary Care Payment Reform Initiative) and should be permitted as part of DSRIP as well. CHCANYS suggests that Attachment I include a section permitting members of coalitions to realign during the planning and implementation stages of a project, as long as such realignments

are reasonable and in the best interest of Medicaid patients.

D. Comments on Payment Under the DSRIP Framework—Clarifying Parameters of Financial Models, Criteria for Application Quality, and the Engagement of Managed Care Plans.

1. Creating Strong, Sustainable Performing Provider Systems – Ensuring Access to Capital, IT and Infrastructure Dollars.

As aforementioned, the DSRIP program is designed to transform New York’s safety net into a high performing Integrated Delivery System. Noting that this transformation will require upgrades to existing technology and business processes as well as workforce transitions, Domain 1 was created to cover the cost of infrastructure development/transition. Aside from during Domain 1, Year One, all payments will be attached to after-the-fact reporting and the attainment of milestones/metrics. Payment demonstration models require early access to capital, IT and other necessary resources to allow for the investments in infrastructure, workforce, and system redesign necessary to effectuate the intended change.

We understand and appreciate the rationale for incentivizing payments for the attainment of milestones/metrics. However, there is concern that PPS network participants’ success may be slowed or derailed because of lack of access to necessary infrastructure and capital funding for infrastructure development. Particularly vulnerable are smaller health care providers who, without adequate access to upfront capital, may be reduced to more limited roles in the collaboration. We therefore urge the State to continue to make additional resources, including capital and IT dollars, available throughout the DSRIP program. We appreciate the State’s investment of \$1.2 billion in capital funding included in this fiscal year’s budget, but urge the State to continue to build on this investment and create other opportunities for PPS providers to access capital and IT dollars throughout the DSRIP project years. We believe this access is critical to creating sustainable infrastructures that will lead to successful health care integration and transformation.

2. Ensuring that Payments Within a Performing Provider System Are Clearly Distributed to Providers Impacting Transformation – Providing Clear Parameters on the Allocation of Incentive Payments to Primary Care Providers

Due to the uncertainty of the final governance structures of Performing Provider Systems, there is a general concern about how the allocation of incentive payments will flow within Performing Provider Systems. Given the belief that many Performing Provider Systems will be driven by hospitals and health systems, CHCANYS recommends that Attachment I contain protections to ensure that funds flow to the primary care providers who will be critical to the eventual success of the DSRIP initiatives and the ultimate transformation of the health care system. Specifically, CHCANYS suggests that Attachment I be revised to include a section on the distribution of incentive payments within Performing Provider Systems in order to establish clear parameters for all participants.

**3. Ensuring DSRIP Project Plan Valuations are Appropriately Understood –
*More Clearly Defining the Application Quality Score***

The maximum DSRIP project and application valuation is impacted by a Plan's application score, which is generally discussed in section V of Attachment I. Although the objective of this scoring approach is reasonable, the vagueness of the scoring and how it could impact a project's valuation is of concern. The Attachment discusses factors that could impact a score, but leaves the scoring and its impact on the project valuation unclear. Without a more thorough understanding of the application score range, it will be difficult to properly plan for the feasibility of selected projects. CHCANYS suggests that Attachment I be revised to include more detail on application scores in order to provide Performing Provider Systems with more clarity on scoring criteria and the potential range of a project's value.

4. Creating a Seamless Integration with Medicaid Managed Care – *More Clearly Describing the Alignment of DSRIP Transformation Projects with NYS' Medicaid Managed Care Contracting Plan*

Section IX.d.4. of Attachment I explains the statewide performance milestone regarding the implementation of New York State's managed care strategy plan, as described in the Special Terms and Conditions #39. Primary care providers, including FQHCs, are currently participating in surplus-sharing arrangements with MCOs in an effort to curb unnecessary use of specialists and reduce avoidable hospital use. These types of arrangements are gaining more traction as the managed care industry evolves. The strength of these arrangements is that incentives are shared with the providers who can directly impact the desired results.

As New York State works to develop the required managed care strategy plan, concerns have been raised as to whether the incentive payments from Medicaid MCOs will continue to reach the providers impacting change. This concern will become compounded should the managed care strategy shift towards global payment models to Performing Provider Systems, wherein primary care providers might not have the requisite voice to ensure that the incentives are appropriately shared among participants.

Given the size and capital contributions of FQHCs and other primary care providers as compared to those of hospitals and large health systems, it is questionable whether these essential providers will have the requisite say regarding the distribution of payment to the critical participants who are most impacting change. In order to ensure that providers are appropriately rewarded for their efforts in bringing about the transformation of the safety net delivery system, CHCANYS strongly recommends the establishment of clear requirements for primary care providers to participate on governance bodies and in the decision-making process regarding distribution of funds.

E. Comments on Data and Evaluation – *Developing a Sustainable Dialogue About Overall Data Standards and Primary Data Sources*

CHCANYS requests clarification regarding the proposed data portal and whether it will include tools to enable provider organizations to aggregate individual patient ambulatory

data within a single organization and across all provider organizations in a Performing Provider System to produce outcome measures. We are concerned that it may not, which will make it difficult to use this asset for required measures reporting.

The end of the second paragraph in section IV.e. seems to imply that DOH has a preference for outcome measures produced by the managed care plans:

Faster access to more real time clinical and managed care data...is...the rationale for using state-measured health plan metrics or Quality Assurance Reporting Requirements (QARR) as a major data source for this project.

The last two paragraphs of Section IV.e., however, state:

...the state must ensure... that each Performing Provider System receiving payments under DSRIP maintains (or participates in) a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this DSRIP. The state must require that each Performing Provider System ensure that data received from providers within the system is accurate and complete....To the degree that the data and metrics are generated and obtained via managed care systems already subject to 438.242, no additional validation of the data is required.

For data and metrics reported in systems not subject to 438.42, these agreements between the state and Performing Provider Systems should also be accompanied by validation process performed by the independent assessor to ensure that the processes are generally valid and accurate.

Since there will be an option to maintain a data system not subject to 438.42, we strongly encourage the State to work with health homes and membership associations to facilitate the interface and/or file uploads of existing information systems to the reporting mechanism developed for DSRIP metrics, thus minimizing the need for additional investment and/or manual data entry by participating providers.

Recognizing the need for exchange and sharing of electronic data to facilitate quality improvement and enhance care management/coordination, groups of providers across the state have collaborated in recent years to develop web-based and other systems that allow the aggregation of data for analytics and for shared care planning. This work was necessitated by the implementation of health homes, the imperative to improve quality of care and patient outcomes, and the impending shift toward value-based payment. As of this writing, such tools are not widely available through RHIOs and considerable investment of time and effort has been made by the provider community to develop and implement these systems.

II. Conclusion

CHCANYS again applauds the State for its vision to transform the health care safety net system in New York through the DSRIP program. A successfully transformed system will have at its core a comprehensive, high-performing primary care system that offers

each patient within its care a medical home. As major Medicaid safety net providers and comprehensive care providers, FQHCs are ready and well-equipped to play a central role in the development and governance of DSRIP PPS networks across the state, while leading or contributing to projects that drive transformation.

About CHCANYS

CHCANYS is New York State's Primary Care Association, designated by the Health Services Resources Administration, through which a set of services and resources are provided. CHCANYS represents, and provides technical assistance and training to, a large primary care provider network across the State. All of the FQHCs and Look-alikes are part of this network. We also have as members organizations interested in becoming FQHCs and many of our stakeholder partners across the State.

Founded 40 years ago, CHCANYS' mission is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high-quality, community-based health care services, including a primary care home. To do this, CHCANYS serves as the voice of community health centers by leading providers of primary health care in New York State. CHCANYS works closely with more than 60 FQHCs that operate approximately 600 sites across the state. These community health centers are not-for-profit, patient-centered medical homes located in medically underserved areas.

Health centers serve 1.6 million New Yorkers annually and are central to New York's health care safety net. FQHCs serve low-income patients, two-thirds are below the poverty level; one-fifth are best served in a language other than English; three-fourths are racial and ethnic minorities; one-quarter are uninsured; nearly 100,000 FQHC patients are homeless and a similar number are elderly. FQHCs provide a model of care, which is integrated with affiliated specialty and hospital partners in communities all over New York.

Please contact Elizabeth Swain for additional information at eswain@chcanys.org or 212-710-3802.

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**Comments from Nassau AHRC to NYSDOH on the DSRIP Program Funding and Mechanics
Protocol (Attachment I): Attribution Methodology**

Nassau AHRC is actively seeking to participate in one or more Performing Provider Systems' (PPS) on Long Island. At this time we are providing comments on the Attribution Methodology for DSRIP PPS'. It is our understanding from the information provided by the State Department of Health that the state and CMS desire that Medicaid beneficiaries with intellectual and developmental disabilities (IDD) be able to participate in the DSRIP initiative just like any other Medicaid eligible population sub-groups with or without other types of disabilities.

We further understand that the State's proposed attribution methodology prioritizes care management providers. Since the majority of persons with IDD receive Medicaid Service Coordination (MSC) we believe that these individuals should be attributed to a PPS that includes providers of MSC. MSC is provided by qualified service coordinators and uses a person-centered planning process in developing, implementing and maintaining an Individualized Service Plan. MSC is a type of care management service and is comparable to the care management services other Medicaid populations receive from other types of providers. MSC is an essential service for many persons with IDD who are receiving services through the state's 1915(c) waiver, although MSC is not a waiver service. MSC assists persons with IDD and their families in gaining access to services and supports appropriate to their needs. The Nassau AHRC's sister agency (Citizens) provides MSC to individuals it serves.

Similarly, we believe that individuals living in AHRC supervised and supportive residences and receiving habilitation services in residential and day habilitation programs should also be attributed to a PPS that includes these providers. Most, but not all, of these individuals will also be receiving MSC.

We thank you for your consideration of this comment on the proposed Attribution Methodology for the DSRIP PPS' for persons with IDD.

CompassionAndSupport.org, submits these comments in regards to **Attachment J - NY DSRIP Strategies Menu and Metrics**, which describes strategies and metrics available to Performing Provider Systems for including in their DSRIP Project Plan. Under the direction of Dr. Bomba, CompassionAndSupport.org leads development and implementation of NY's eMOLST Registry, a data source for SHIN-NY. CompassionAndSupport.org serves as a Technical Assistance Center, Professional & Public Resource Center, & Education Center for MOLST & Community Conversations on Compassionate Care (CCCC), NY's "Conversation Ready" model.

CompassionAndSupport.org is pleased that Palliative Care is included as a Clinical Improvement project area in which DSRIP funding will be used to transform health care delivery as well as to address the needs of New York residents. We believe, however, that the projects included in Attachment J, and further defined in the DSRIP Project Toolkit, should be expanded to provide Performing Provider Systems (PPSs) with greater flexibility in identifying and selecting projects.

We request that the expanded use of Medical Orders for Life Sustaining Treatment (MOLST) and eMOLST (the electronic form completion and process documentation system for NYDOH-5003 MOLST form) should be expressly included in the projects for Palliative Care. MOLST is a clinical process that emphasizes discussion of the patient's goals for care and shared medical decision-making between health care professionals and patients who are seriously ill or frail, for whom their physician would not be surprised if they died within the next year. The result is a set of medical orders that reflect the patient's preference for life-sustaining treatment they wish to receive or avoid. MOLST is approved for use and must be followed by all providers in all clinical multiple settings including the community. MOLST is the only medical order form approved under NYSPLH that EMS can follow both DNR and DNI orders in the community.

System transformation metrics that would result from the expanded use of MOLST include: (1) Avoidable ED visits (avoidable unwanted ED visits); and (2) Avoidable Re-hospitalizations (avoidable unwanted hospitalizations). We recommend that the project metric include a "advance care planning" objective that is met by the following earlier advance care planning discussion measures: percentage of members who have appointed a Health Care Agent for making Health Decisions and seriously ill persons have MOLST discussion & opportunity to complete MOLST/eMOLST.

In addition, we request that project 3.g.i (IHI "Conversation Ready" model) be expanded to expressly include other recognized "Conversation Ready" models. PPS systems should not be limited to the use of a single model when seeking to expand the use of advance care planning. While IHI is nationally recognized, it was developed as a model to apply to individuals nationwide. Organizations within New York have also developed "Conversation Ready" models and have tailored such models to directly address New York State specific requirements for the completion of end-of-life decisions, such as New York State Health Care Proxy requirements and Living Will forms. While some PPS systems may choose to expand advance care planning through the IHI model based on prior experience, all PPS systems should not be limited to using such model.

For example, CompassionAndSupport.org serves as the technical assistance center for the Conversations on Compassionate Care (CCCC), NY's "Conversation Ready" model. CCCC is an advance care planning program designed to motivate all adults 18 years of age and older to start advance care planning discussions and complete a health care proxy. The model has developed an extensive Advanced Care Planning toolkit that provides, in addition to other components, information regarding the types of advance directives available in New York and detailed instructions on completing a valid Health Care

Proxy and Living Will in New York. This model meets the rationale provided for Project ID 3.g.i, as stated in the DSRIP Project Toolkit, to “ensure care and end of life planning needs are understood, addressed and met prior to decisions to enter hospice or seek further aggressive care.” CCCC is nationally recognized by the National Quality Forum as an example of a preferred practice and has received awards based on positive outcomes as noted in the CCCC Pilot Study Results, 2002-2004 and the 2008 End of Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Action.

While we are not aware of other New York State “Conversation Ready” models, we recommend that PPSs are not limited to using the IHI “Conversation Ready” model when other models are readily available and tailored to the specific needs of New York residents.

Specifically, we recommend that Attachment J, Domain 3, Section G, be expanded in the following manner:

G. Palliative Care

- 3.g.i IHI “Conversation Ready” model, including Community Conversations on Compassionate Care (CCCC), New York’s “Conversation Ready” model
- 3.g.ii NYSDOH-5003 Medical Orders for Life-Sustaining Treatment (MOLST)/eMOLST
- 3.g.iii Integration of palliative care into medical homes, including CCCC, MOLST/eMOLST
- 3.g.iv Integration of palliative care into nursing homes, including CCCC, MOLST/eMOLST
- 3.g.v Integration of palliative care into assisted living facilities, including CCCC, MOLST/eMOLST

Comments on the New York State DSRIP Waiver

COORDINATING COMMITTEE

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We applaud Center for Medicaid Services (CMS) and the state for devising some of the strategic goals and metrics for the implementation and distribution of Waiver dollars. Many of which reflect better transparency and accountability of the dollars that will be spent. We see mechanisms for better monitoring. There are also opportunities for community input regarding how DSRIP funds are going to be distributed.

Our comments address several issues related to the following:

- Review of the Interim Access Assurance Fund (IAAF)
- Attachment I – Program Funding and Mechanics Protocol
- Attachment J – Strategies Menu and Metrics

These are:

- A major problem exists in the definition of the safety net. The definition is too broad, and the exceptions for awarding DSRIP dollars are troublesome. Certain providers that would become eligible for DSRIP dollars under these terms pose a problem because they have demonstrated a pattern of not meeting the needs of low-income, immigrant and communities of color, people who are likely on Medicaid or uninsured.
- There is no clarity on how health care facilities and the PPS's will be addressing health disparities in the development and implementation of DSRIP. Projects focused on health disparities are not seen to be a high priority because they are scored lower than the other metrics.
- There is a lack of clarity in what defines a hospital's relationship to the community in order to qualify as a DSRIP provider. Although there are mentions that community residents and organizations could/should be involved in PPS and planning. This system network will really not work unless there is ongoing involvement of consumers and workers. The same is true for community-based providers which should be made part of the PPS and delivery system.
- There is no designated funding to expand primary care services. There appears to be a lack of understanding of medically underserved communities lacking primary care resources. Yet there is no funding designated to expand community based ambulatory care services. Residents in these communities may have continued trouble accessing care.
- A provider's share of Medicaid and uninsured patients is included in determining whether it is a safety net provider but it is not used in the scoring and metrics for reviewing, approving, and evaluating DSRIP Projects. We know that Medicaid beneficiaries must be

attributed to a PPS, but raise concerns as to not counting the uninsured. There are sources of information available to assist in the scoring and metrics, such as the American Community Survey and Exhibit 50 of the Institutional Cost Report and FQHC state reporting mechanism. If uninsured residents are left out, access to care will become even more difficult for them.

- There are no explicit guidelines for the following
 - How providers should engage community stakeholders and the workforce in developing their plans, reports, and evaluation.
 - How hospitals will engage primary care providers. In the past, hospitals have not done well in reaching out to small clinics, especially FQHC's. Nor have hospital established strong and equal partnerships with primary care providers.
- There is no set of criteria for how the \$500 million dollars will be distributed to financially vulnerable hospitals through the Interim Access Assurance Fund (IAFF). In addition the IAFF funds are based on the safety-net definition, which we have stated concerns about.
- Collaboration is important, but coalitions of health providers have not always gone smoothly or equitably. This includes leadership and dynamics between small community hospitals and the large academic medical centers.
- The make-up of the DSRIP panel needs to be addressed. Too often in the past, working groups/panels were not representative of Medicaid consumers, the uninsured, and low-income, immigrant and communities of color. For example, most of the people appointed on the Brooklyn MRT Working Group were professionals who worked in the medical field and had clear conflicts; this resulted in making the process very political.
- The state has not yet made clear what they define as "Independent" when identifying and contracting Independent Accessors and Independent Evaluators

Recommendations

We recommend that CMS and the state address the following key areas:

1. Definition of safety-net provider

- The Safety-net definition needs to be change so as to limit the category to providers who serve higher numbers of people with Medicaid, uninsured, and Medicaid Dual Eligible.
- At a minimum, the allowable exceptions to the definition of safety-net providers should receive lower priority in the distribution of DSRIP dollars.

2. IAFF Funds (temporary funding for the financially vulnerable hospitals)

- It is important to ensure that the dollars are immediate available.
- The IAFF dollars should not be based on the current approved safety-net definition ((For more information about the definition. It should go to health facilities in high health need neighborhoods where large disparities in access and quality of health exist.
- Criteria for eligibility should include prioritizing community health needs and allocating dollars to real safety-net providers. The funding recipients should be providers that are currently in crisis and/or financially vulnerable because of the number of Medicaid and uninsured people they serve, and the impact of cuts and reductions in Medicaid reimbursement.

- All meeting and relevant background materials related to distribution of the temporary dollars public must be made public. This would include the list of eligible hospitals. In addition, there should be a comment period after these materials are posted.

3. DSRIP Funds

- Funds awarded should be weighted based not only on actual Medicaid percentages but also on the percentage of patients who are uninsured. This must be included in the needs assessment and plans of the DSRIP Projects. If not, we may see the uninsured less welcomed in the Performing Provider Systems (PPS). PPS are the coalition of Eligible safety-net providers that must be formed to be qualified for DSRIP dollars.
- Health disparities and social determinants should be a significant factor in assessing projects and measuring outcomes.
- It is necessary to better define and ensure community stakeholder involvement and collaboration in all aspects of the review, implementation, and evaluation process of DSRIP Projects
- Information shared in the PPS “learning collaborative” should be made public and involve community stakeholders.
- Federally qualified health centers should be part of planning, implementing, and evaluating the DSRIP Projects. They are critical Medicaid safety net providers. This should include designating funding and building in provisions to improve and expand primary care in the scoring of DSRIP Projects.
- Independent Assessors should not be from New York and they should not be chosen from a list of state contracted consultants.
- Community health advocates and stakeholders should participate in the development of criteria for identifying Independent Assessors and Independent Evaluators. The criteria should include:
 - Someone who has no conflict of interest or political ties to the hospital industry.
 - Someone who is culturally competent, sensitive, and knowledgeable about the issues faced by low-income, immigrant and communities of color.
 - Someone who understands that a plan submitted to transform the health care system must address racial and ethnic health disparities and promote (1) access, (2) high quality care, (3) patient empowerment, (4) strong health care infrastructure, and (5) responsive policy-making.
- Community-based organizations must be actively involved as the Independent Assessors and Independent Evaluators are completing their tasks.
- Although the stated distribution of the DSRIP funds is 50% of the total for the public hospitals, the ultimate safety net providers, there are several places in attachments I and J where this distribution conflicts. In one instance, public hospitals are encouraged to form PPS coalitions with voluntary providers, but the same provision appears to say the full funding should come from the public pool. This formula is a prescription for failure.
- Finally, we need to ensure that State Department of Health has the appropriate staff and capacity to do the planning, data development, technical assistance, monitoring, and evaluation of DSRIP/PPS. We know some of the planning dollars will be used for administrative costs, but that will not suffice. We want this program to succeed and be properly monitored.

DSRIP Comments on Attachment J

The DSRIP strategy menu (Attachment J) suggests a number of potential projects to provide “evidence-based strategies in the community”, especially for chronic disease control, self-care and prevention. This is a very important part of reforming the delivery system; chronic disease education and self-care strategies can routinely be delivered in the community both more cheaply---and with wider reach, especially reaching high need populations who avoid hospitals and clinics---than in clinical centers.

However, the community groups often best able to provide evidence-based strategies for disease prevention and self-care in the community are not now an integrated part of the delivery system. For many, in fact, being part of DSRIP would represent the first time they might receive regular payment through the medical system---rather than providing their services with grant funding.

For the state to truly achieve the aims of DSRIP and attachment J – especially to effectively move targeted services into the community---the state Department of Health will have to be sure to provide technical assistance to these community groups just as it is to the leads and big agencies in PPS’s. In the recent technical assistance Q and A, it was said the state would provide a range of technical assistance, including helping PPS’s prepare their plans, trying to bring together competing groups into one group, etc.

Within this, clear technical assistance must be available to and clearly designated for community groups---both to help them present themselves to the appropriate PPS and help them negotiate their position and role in the PPS.

Indeed having a designated “Office of Technical Assistance” for community groups would appear almost necessary for Service Delivery to be reformed as much as possible. (For this purpose, community groups might be defined as those who provide health-related activities---education, exercise, nutrition, etc.) but do not undertake any medically licensed activities. So far, there has been virtually no outreach to these groups and they appear to know very little about DSRIP.

Thank you,

Chris Norwood, executive Director, Health People May 14, 2014

The Finger Lakes Health Systems Agency is pleased to provide comments on the current NYS DSRIP proposal. We are a community based, not-for-profit health planning and improvement organization. We have been working collaboratively with stakeholders in our region for the past 5 years to decrease PQI admissions, avoidable ED use and hospital readmissions. We have also for the past 2 years worked on these metrics as part of our CMMI Award to implement PCMH in over 65 primary care offices in our nine county territory. Our experience in both measurement and interventions brings with it insights we feel it is important to share.

First we compliment the bold vision put forth to enable the fundamental delivery system changes that will improve quality while controlling costs. Given the structure of the proposal measurement that accurately captures improvement will be critical.

The accurate measurement of what is “avoidable” in ED is very difficult to capture. It either tends to limit the measurement to only those conditions that are black and white, or is dependent on probabilities to identify which visits could be avoided. In the former case many of the successfully avoided ED visits will not be detected. In the case of using probabilities (as in the NYU algorithm) measuring truly avoided visits will always be underestimated as the probability in the metric does not change even when an intervention has successfully decreased the avoidable use resulting in under measurement of impact. In our work with the IHI collaborative on ED avoidance it was suggested by their technical consultants that any algorithms only be used initially to size the opportunity and that success then be measured on use rate adjusted for identifiable impacts such as influenza outbreaks.

I particularly want to note that with the “avoidable ED algorithms” many circumstances where ED use can be avoided with primary care or other outpatient visits are excluded, such as trauma, alcohol and substance abuse, and psychiatric diagnosis. These exclusions account for 44% of our ED volume and as noted exclude behavioral health which will be a major focus for DSRIP.

As for measures on hospitalizations we have found that PQI is very limiting as many avoidable admissions are not measured. PQI and PDI were developed as indicators of opportunities to avoid admissions not as an exhaustive list of all potentially preventable hospitalizations. In DSRIP it would seem very important to be able to capture all the avoided hospitalizations to reach the goal of 25% reduction in admissions.

The issue of measuring disparities is appropriately included in the DSRIP plan but has some measurement issues also. Most notable is that the measures all use a ratio that compares rate or number to the white population. This in some instances will show “negative” disparities as the Latino outcomes are sometimes better than that in the white population especially where there is low socio economic status (SES) population in the comparison. It may be better to look at disparities taking the added variables of SES, location and age into account.

In conclusion, a general comment. There is significant disconnect between the projects set forth as acceptable and the target measurements. All the proposed projects would indeed have potential positive impacts on the health of the community BUT in many instances the impact on the PQI, PDI, PPV, and PPR measures in the short term is very problematic even as programs are showing significant impact on medical care transformation. This is well documented in PCMH implementations where the impact in ED and PQI lag well behind significant improvements in quality metrics, process improvement metrics, access metrics, etc.



Comments on DSRIP articles "I", "J", and the "IAAF"

From the NY Association of Psychiatric Rehabilitation Services

Harvey Rosenthal, Executive Director
Briana Gilmore, Director of Public Policy
14 May, 2014

Interim Access Assurance Fund

The current definition of safety net hospital is relatively broad, and encompasses a wide range of institutions across the state. This has potentially beneficial and/or negative consequences. The goals and conditions of the 1115 waiver are broad enough to achieve measurable transformation of the healthcare delivery system in NY, and by including as many hospitals as possible, DOH allows for inclusive systems of care that integrate rather than re-fragment communities. However, the nature of the IAAF may serve to bolster hospitals that have consistently failed to meet state standards for quality, and are facing imminent threat of closure due to well-documented negligence in business and care practices. While we applaud DOH's commitment to only provide financial security to hospitals committed to achieving DSRIP project goals, we believe that hospitals applying for IAAF funds should have to meet more rigorous standards, including:

1. Public disclosure of all assets including staff expenses, with a detailed plan of expenditures moving forward for at least two fiscal years;
2. Public review and comment period on IAAF applications with a statewide stakeholder panel to review final recommendations of awardees by DOH/ the Governor's office;
3. Commitment of IAAF applicants to engage in a full internal audit of care delivery activities, including an immediate geographic community needs

assessment that evaluates causes and effects of current treatment protocols;

4. An independent analysis of any and all psychiatric treatment facilities based on quality control and ethical treatment standards. All awardees of IAAF funds should undergo a planning process to identify areas where standards are inadequate and work to enhance scope of treatment from a rehabilitation-oriented lens, with respect to rights of recovery, informed consent, trauma-informed care, and cultural competence;
5. IAAF recipients should be held to a higher degree of scrutiny in designing their PPS, with full DOH participation at all area meetings as the PPS emerges, chooses DSRIP projects, and attains a community needs assessment. The PPS design process of each IAAF recipient should be fully public, with mandatory inclusion of community members before the final design grant is submitted in December, 2014.

Attachment “I”— Program Funding and Mechanics Protocol

We are consistently impressed by the thoroughness of attachments “I” and “J” in developing a progressive approach to system change and financing, with the following exceptions and considerations:

Attribution

1. The attribution model detailed by the state is person-centered in nature, which will hopefully provide a more accurate client representation than some other programs (ie. ACOs). However, the first protocol of excluding beneficiaries that have a plurality of services from non-PPS participating providers may be ultimately regressive. The state should note where such instances occur, examine the providers where those clients receive services, and collaborate with the area PPS and those providers to determine whether their inclusion in that PPS is advisable/ necessary to capture needed recipients. Creating a methodology in the attribution process that achieves this will be an extra “check” for DOH to monitor the inclusion of all appropriate providers in a given PPS. The state should create an attribution protocol for the individuals noted in these situations and, in the case that a provider will not join a PPS despite the final review process, there should be a mechanism to include the necessary recipients into a system of care and attribution that reflects the overall goals of the DSRIP projects.

2. The state should develop a progressive methodology that identifies uninsured individuals in each PPS region, including individuals eligible but not currently enrolled in Medicaid. Failure to exclude uninsured individuals in the DSRIP planning process will further fragment care for underserved community members that have, historically, the poorest health outcomes and the costliest use of treatment.

DSRIP Project Plan Requirements, part B-5; Performance Assessment

1. A review of current community health needs must reflect social determinants of health (housing, employment, environment, transportation, economic development opportunities, homelessness), as well as an analysis of persons with disabilities living in both institutions and in the community. An analysis of health disparities alone will ignore the specific relationships between socioeconomic factors and population health/ reduced avoidable admissions. Furthermore, an analysis of the scope of community members with disabilities and their supports and services will identify specific service needs. Doing so should be a requirement in fulfillment of state Olmstead activities, maintaining that any health system transformation or policy initiative must take into account the community inclusion of all persons with disabilities;
2. All PPS applicants should be required to identify providers in their geographic area that meet the safety net definition and provide a majority of their services to individuals with behavioral, intellectual, and physical disabilities; if any of these providers are not captured in a PPS system and project plan, the PPS applicant should be required to offer a written (and public) justification for each provider of that type that is excluded.

DSRIP Project Plan Review Process, part b-i; DSRIP plan review checklist

We recognize that this checklist for reviewing project applications is not finalized, and will be submitted to CMS on or before July 1, 2014. As such, we make the following recommendations to be included in the project review process:

1. The DSRIP project plans reflect networks relative to other state health transitions, particularly managed care products, health homes, IPAs, community inclusion, regional centers of excellence for behavioral health.
2. The project reflects CMS' goals of not only the triple aim, but subsequent initiatives to improve population health including an assessment of social

health determinants, and inclusion of providers that are not currently Medicaid providers but offer medically and socially necessary services.

3. The application addresses a detailed process for meeting the structural and financial needs of participating providers that have not previously billed Medicaid, including funding distribution that appropriately meets their needs for growth and sustainability.
4. The application includes a 5-year projection of necessary changes to the PPS and its' component providers to ensure that value-based projects are also rehabilitation- and recovery-oriented, specifically where it concerns the needs of persons with disabilities, and within programs that have not been historically integrated across disability services.

Attachment "J" – DSRIP Strategies Menu and Metrics

The DSRIP projects included in attachment J demonstrate DOH's sincere commitment to systems transformation that accounts for the whole-person needs of Medicaid beneficiaries. The following recommendations to the projects menu offer slight modifications or additions that could further facilitate the goals of DSRIP, while being as inclusive as possible of rehabilitation-oriented providers:

Domain 2:

2.a.v: Create a medical village/ alternative housing using existing nursing home, *psychiatric facility, congregate housing unit, or other institution that may be modified to offer community based services and housing supports.*

2.b.iii: ED care triage for at-risk populations, *before or both before and after admission, for example a triage/ discharge service that bridges admitted individuals to appropriate community supports, housing, social services, etc.*

2.c.iii (recommendation for additional project): *Expand transportation access for health and non-health related (social service) appointments for at-risk populations.*

Domain 3:

3.a.vi (recommendation for additional project): *Outreach and engagement to behaviorally at-risk populations in underserved communities.*

3.e.ii (recommendation for additional project): *Behavioral health interventions for persons with HIV/AIDS.*

Case Management

Beyond specific projects, NYAPRS has concerns regarding the clarity of case management activities within the PPS structure. DOH should fully clarify a robust definition of case management, and delineate what case management activities will be the responsibility of community-based organizations, PPS networks, health homes, and managed care organizations. Not only is this of vital importance to systems transformation—to ensure that case management is effectively and efficiently provided without overlap—but it is essential that each consumer attributed to a PPS understands what is available to them, what choices they have, and what expectations to assume in regards to case management. We recommend that DOH take the opportunity to collaborate with independent stakeholders to formulate appropriate definitions and service expectations for case management that respects the access and quality rights of consumers.

Conclusion

NYAPRS appreciates DOH's commitment to an open and transparent process that encourages robust stakeholder engagement into the planning and implementation of the 1115 waiver. We encourage you to consider these recommendations thoughtfully, along with those from other community advocates and representatives; the success of DSRIP and related 1115 activities relies on DOH's commitment to the rights, dignity, and quality of care provided each recipient. We welcome further opportunities to collaborate and inform the DSRIP process.

Thank you for the opportunity to submit comments on Attachment I and J of Delivery System Reform Incentive Payment (DSRIP) Program.

I was on the DSRIP Q&A call on 5/7/14 led by Jason H. and Greg A. and would like to thank DOH again for that session. I would like to reiterate what Jason and Greg said on the call in regards to "DD population needing to be included in the reforms according to CMS. DD providers need a webinar due to the confusion, and DOH will actively work with OPWDD." During that session Jason and Greg mentioned that Developmental Disability Individual Support and Care Coordination Organizations (DISCOs) will contract with Performing Provider Systems (PPSs) 4-5 years from now, but why not sooner and be a part of DSRIP?

After reviewing Attachments I and J I'm wondering why people with disabilities are not mentioned and feel they should be. From what I found on the MRT website DSRIP Program mentions PPS must serve Medicaid beneficiaries, low income uninsured individuals in their local communities, and Dual Eligibles. Does this mean that DSRIP Program excludes Independent Living Centers that might be interested in collaborating with PPSs or becoming a PPS? As you know, ILCs offer services to people with disabilities many of which are Medicaid beneficiaries or Dual Eligibles.

In regards to metrics, I feel that all health disparities should be measured.

Respectfully Submitted,

Elizabeth Berka

In Domain 2, Project 2.a.v “Create a medical village/ alternative housing using existing nursing home” is too limiting if the intent is to repurpose a facility. An existing facility may not be optimally configured or located to be redeveloped into alternative housing. The scope of the project should be given greater flexibility to allow a nursing home to reduce its bed capacity while developing new alternative housing at another site.

The number of projects to be selected from Domain 2 should not be capped at 4. Out of a list of 16 projects, a limit of 4 does not reflect the breadth of changes that a Performing Provider System (PPS) can effectuate. **A PPS should be able to select at least 8 projects for valuation scoring purposes.**

In addition, the Index Scores assigned to the projects (as shown below) do not reflect an equitable weighting. For example, why is “Create a medical village using existing hospital infrastructure” given a score of 54 while “Create a medical village/ alternative housing using existing nursing home” is rated 42? This reflects a hospital-centric scoring system. It is also unclear why these 2 projects cannot be combined into 1 project.

The methodology for developing the Index scores is not transparent for any of the projects in the various domains. A more equitable scoring system must be established, and the methodology should be presented for public comment.

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May 14, 2014

VIA E-MAIL to:
DSRIP@health.state.ny.us

Jason A. Helgerson
New York State Medicaid Director
Deputy Commissioner, Office of Health Insurance Programs
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Subject: New York's Delivery System Reform Incentive Payment (DSRIP) Program
Attachment I - Funding and Mechanics Protocol and Attachment J - Strategies
Menu and Metrics

Dear Mr. Helgerson:

The Continuing Care Leadership Coalition (CCLC) represents not-for-profit and public long term care (LTC) providers in the New York metropolitan area and beyond. The members of CCLC provide services across the continuum of LTC to older and disabled individuals. CCLC's members are leaders in the delivery of skilled nursing care, home care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. CCLC's members also have had a significant impact on the development of innovative solutions to post-acute and LTC financing and service delivery. Several of its members played pioneering roles in the development of managed LTC programs in New York.

On behalf of the LTC providers in the CCLC membership, I appreciate this opportunity to submit comments on New York State's Medicaid Redesign Team (MRT) Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Program Attachment I - Funding and Mechanics Protocol and Attachment J - Strategies Menu and Metrics. CCLC is grateful for the collaborative spirit that the State has adopted throughout its MRT process, and its active cultivation of stakeholder participation and guidance. We support a DSRIP process that echoes MRT principles by broadly incorporating stakeholder input, and we offer our expertise in developing aspects related to the long term care sector.

General Comments

Long term care providers are essential to helping the State reduce potentially avoidable hospitalizations, the DSRIP guidepost for Statewide reform. As discussed in CCLC's comments to the Special Terms and Conditions (attached), the participation of not-for-profit and public long term care providers in DSRIP is essential to the achievement of the State's goals, in light of their experience in collaborative activities across the continuum of health care service delivery, their specific commitment to reducing avoidable hospitalizations, and their record of driving quality improvement and innovation. CCLC recommends that the State ensure that not-for-profit and public long term care providers serve as priority partners in the design, development, and implementation of the DSRIP program.

ATTACHMENT I - FUNDING AND MECHANICS PROTOCOL

General Observations

CCLC recommends that the State require system transformation projects to include a long term care component, and provide higher index scores for PPSs applying to work not only with long term care providers, but also with those long term care providers specifically serving specialty populations, such as those living with HIV/AIDS, individuals with traumatic brain injury (TBI), those who are ventilator-dependent or diagnosed with Huntington's Disease, and children. Some of the greatest opportunities to reduce avoidable hospitalizations arise from partnership with long term care providers.¹ Under the current description of DSRIP project requirements, we are concerned that a PPS may be considered sufficiently integrated even if it excludes long term care provider participation. Consequently, CCLC recommends that the State add clear language expressing the State's expectation that PPSs partner with long term care providers to serve the high-need, high-opportunity populations with which they interact.

Specific Section Observations

Below, CCLC offers guidance concerning particular provisions of Attachment I:

Section II. a. - Assessment of Safety Net Provider Status

CCLC is pleased that the State has undertaken a review to ensure that the dual eligible population is factored fully into the determination of the certified home health agencies that are qualified as safety net providers. To the extent the State intends to incorporate hospice services within the scope of DSRIP (which CCLC fully supports), we note that a similar analysis should be undertaken of hospice services to ensure that the Medicaid and the dual populations are taken into account when determining safety net status for such providers.

Section II. b. - Coalitions

CCLC recommends that the State explicitly encourage coalitions to include long term care providers during development of PPS applications, or, in the alternative, to include a plan for engaging the long term care provider community before any final application is approved. Further, we strongly encourage the State to direct PPSs to identify how they will support specialty populations receiving long term care services.

¹ CMS Innovation Center, Funding Opportunity Announcement for Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, page 9 at <http://innovation.cms.gov/initiatives/rahnfr/>. See also Tena-Nelson R, Santos K, Weingast E, Amrhein S, Ouslander J, and Boockvar K. Reducing potentially preventable hospital transfers: results from a thirty nursing home collaborative, J Am Med Dir Assoc. (2012 Sep)13(7):651-6.

Section II. c. - DSRIP Beneficiary Attribution Model

CCLC recommends that the State revise the beneficiary attribution model to reflect the following core principles:

1. Guidance to PPSs should stress that they are to be responsible for most or all beneficiaries, including those that are receiving long term services and supports, in the proposed geographic region or medical market area which they propose to serve;
2. The model should clearly provide for and accommodate situations in which long term care providers may be working in multiple PPSs; and
3. Although the State has indicated that the attribution model carefully will weigh an individual's contacts with the health care system, the State should ensure a) that for any long term care inpatient, the geography of the inpatient's service site (e.g., a nursing home) is considered a prominent factor in determining attribution, and b) for individuals receiving services through a certified home health agency, that any such CHHA be treated as a priority provider within the hierarchical model used in the assignment of attribution.

To facilitate partnership and network formation, CCLC recommends that the State provide data to developing PPSs on long term care recipients and managed care enrollment. Crucially, the timing of the preliminary attribution and "tune up" will need to factor in the immense change that will be happening while residents in nursing facilities are being transitioned to care management for all.

Under the Final Attribution step, CCLC also recommends that the State provide a pathway for the PPS to work with populations that are not included in a specific PPS, and to allow PPSs to receive credit for such work. Currently, the State indicates that "[t]he department will strongly encourage these providers to join an appropriate Performing Provider System in their geographic/geopolitical region." CCLC suggests that the State proactively explain to the PPSs that the State plans to analyze the applications that are received in the planning phase and direct PPSs to work with providers that will include additional beneficiaries in their geographic region or medical marketplace, such as long term care providers that may not be considered in the original planning stage.

Section II. d. - Minimum Outpatient Service Level

The State will require PPSs to incorporate a minimum number of patients receiving outpatient services. CCLC recommends that the State similarly create a minimum long term care service level, including specific numbers of patients receiving long term care services in nursing homes and through home care.

Section III. Projects, Metrics, and Metric Targets

As elsewhere noted, CCLC recommends that the State do more to prioritize the partnership with long term care providers, as it relates to the number of projects that can be indexed for the application. To that end, CCLC recommends that the State provide PPSs with potentially avoidable hospitalization measures for most nursing homes in New York State, as analyzed for the NYS Nursing Home Quality Pool. We encourage the State also to explain to PPSs the importance of partnering with nursing homes serving special populations, even though they are not part of the NYS Nursing Home Quality Pool, due strictly to the fact that they serve a specialty population, as distinct from facilities that are excluded from the quality pool as a result of quality problems.

Section V. Project Valuation

In the calculation for the benchmark per member per month payment, CCLC calls for more explicit inclusion of community-based and nursing home residents. There should be opportunities to gain additional points for working with long term care providers, or specialty populations receiving care through long term care providers. Further, CCLC encourages the development of a more equitable and transparent scoring system. In the tabulation of the scoring for various DSRIP projects below, it is notable that those projects (highlighted) that most significantly depend upon the involvement of facility-based long term care providers to be successful are given lower relative scores than several others that do not explicitly engage such providers (seen clearly, for example, in the differential scoring between projects 2.a.iv and 2.a.v). We urge reconsideration of these differentials to give increased weight to the value of projects that impact cost and quality in the delivery of services to long term care recipients.

Project	Description	Index Score* (out of 60 pts)
2.a.i	Create Integrated Delivery Systems that are focused on Evidence Based Medicine Population Health Management	56
2.a.iv	Create a medical village using existing hospital infrastructure.	54
2.b.vi	Transitional supportive housing services	47
2.a.iii	Health Home At Risk Intervention Program-Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.	46
2.b.viii	Hospital-Home Care Collaboration Solutions	45
2.b.iii	ED care triage for at-risk populations	43
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	43
2.a.v	Create a medical village/ alternative housing using existing nursing home.	42
2.b.v	Care transitions intervention for skilled nursing facility residents	41
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	41
2.b.ii	Development of co-located of primary care services in the emergency department (ED)	40
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan [SHIP])	37
2.c.i	Development of community-based health navigation services	37
2.b.i	Ambulatory ICUs	36
2.b.ix	Implementation of observational programs in hospitals	36
2.c.ii	Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services	31

ATTACHMENT J - STRATEGIES MENU AND METRICS

Below, CCLC offers its comments on Attachment J, intended as a complement to those, above, concerning Attachment I:

Domain 2: System Transformation Projects, Generally

CCLC recommends a more flexible approach to the number of projects to be selected from Domain 2. A PPS should be afforded the ability to take on a broader portfolio of projects to encompass a wider array of work, including the important collaborations possible with the long term care community.

Domain 2: A More Expansive Medical Village Model

In project 2.a.v., the State describes a track for the creation of medical village styled alternative housing, using an *existing* nursing home (emphasis added). CCLC is concerned that the program is too narrowly defined and should be broadened to beyond strict repurposing of a facility. Instead, the scope of the project should be given greater flexibility to allow a nursing home to reduce its bed capacity while developing new alternative housing at another site.

CCLC also recommends a more equitable approach to scoring of similar projects under the medical village umbrella, to ensure that the same incentives exist to work with the long term care community as those in place for hospital-based providers. It is not evident why “Create a medical village using existing hospital infrastructure” is given a score of 54 (see above), while “Create a medical village / alternative housing using existing nursing home” is rated as 42. It is also unclear why these two projects cannot be combined into one project. Therefore, CCLC recommends that the medical village concept maintain a high index score of 54 regardless of where the medical village originates.

Domain 3: Clinical Improvement Projects

CCLC urges the State to integrate a mandate for PPSs to focus on the challenges of the long term care community in the same way it has mandated a focus on behavioral health (requiring PPSs to work on at least one Domain 3 project involving behavioral health). CCLC recommends the same kind of prioritization with the long term care community. With older adults particularly placing increasing pressure on the Medicaid system, any transformation that DSRIP affords must squarely attend to this cohort’s health needs.

CCLC supports the inclusion of palliative care in the Domain 3 band, but recommends awarding of points for palliative care’s integration into community based settings beyond those articulated in 3.g. Later in Attachment J, in the discussion of related metrics (p. 14 of Attachment J), CCLC notes an absence of measurement around patient satisfaction or quality of life: instead, palliative care seems to be synonymous in the State’s eyes with pain reduction, at least for the purposes of measurement. This unduly will narrow focus of palliative care interventions, which can be far broader and focused on a wider array of symptom relief activities.

Dementia Intervention

Research shows that the largest component of current Federal and State spending related to dementia is for long term services and supports. Indeed, high medical costs (including avoidable hospitalizations) are tied to individuals with dementia as compared with those without dementia.²

² See special issue of Health Affairs, April 2014; Volume 33, Issue 4, “The Long Reach Of Alzheimer’s Disease,” available here: <http://content.healthaffairs.org/content/33/4.toc>.

CCLC proposes the inclusion of "Dementia Care" as a category, along with evidence-based non-pharmacologic interventions for management as a strategy, and diminished long-stay use of antipsychotic medications as a potential metric.

Other Global Observations

Notwithstanding comments on Attachments I and J, above, we respectfully request your consideration of a requirement that Medicaid Managed Care Organizations that contract with DSRIP Performing Provider Systems (PPSs) reimburse for home health services provided through Certified Home Health Agencies (CHHAs) participating in the DSRIP PPS on an episodic basis, as has been the State's policy for CHHA services for the past several years. This would provide consistency and standardization of in-home post-acute and sub-acute care for patients needing these home health services when they are most vulnerable.

CCLC appreciates the State's consideration of the comments submitted herein. Please do not hesitate to contact me if you have any questions about the above.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Amrhein". The signature is written in a cursive style with a long horizontal line extending to the right.

Scott C. Amrhein
President



Family Planning Advocates of New York State

Comments on Attachment I for the Delivery System Reform Incentive Payment Program May 14, 2014

Family Planning Advocates of New York State applauds the efforts undertaken by the state to realign our expansive Medicaid program to place a greater emphasis on primary and preventive care. For women of childbearing age, reproductive health care services are an integral component of their primary care, and thus the inclusion of reproductive health focused providers in transformative efforts is critical. FPA's membership is eager to engage in the state's new Delivery System Reform Incentive Payment (DSRIP) program, and look forward to being a true partner in this historic initiative. On behalf of our membership, we value the opportunity to engage in a dialogue with the state as you formalize the vast components necessary for implementation of DSRIP. To that end we would like to take this opportunity to comment on the reference to data sharing and confidentiality in Attachment I.

Confidentiality is a cornerstone of reproductive health care services. An absence of confidentiality, perceived or real, can be a deterring obstacle that stands in the way of patient access to needed reproductive care services. Reproductive health focused providers are acutely aware of this, and go to great lengths to preserve the confidentiality of the patients they serve. This is particularly the case for minors, whose sensitivity to the issue of confidentiality is well documented.¹

We understand the inherent value in the sharing health information between providers to advance enhanced care delivery and improved health outcomes. However, we urge the state to ensure such efforts do not erode critical protections that preserve access to confidential services for the women, men and adolescents in New York. Attachment I does specifically mention addressing "all HIPAA privacy provisions." See number 11 on page 12. This provision should be expanded to say "all privacy protections contained in HIPAA and New York law". One of the most significant concerns we have surround patient portals and the potential for breach of confidentiality. It will be important to ensure that information about minor-consented services is not inadvertently revealed to parents without the consent of the minor.

New York has a long-standing record of recognizing minors' ability to control some aspects of their health care and the associated medical information related to the minor-consented care. Minors have the ability to consent to a range of health services, including treatment for sexually transmitted infections,² prenatal and related care,³ alcohol and substance abuse care,⁴ mental health services,⁵ HIV testing,⁶ rape crisis treatment⁷ as well as

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¹ Guttmacher Institute. Moving Forward: Family Planning in the Era of Health Reform, 2014, <http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf>, accessed May 14, 2014.

² Public Health Law section 2305.

³ Public Health Law section 2504.

⁴ Mental Hygiene Law section 22.11.

⁵ Mental Hygiene Law section 33.21.

contraception and abortion which minors have a constitutional right to consent for pursuant to state and federal case law. Minors who are parents and minors who are emancipated can consent to all of their own health care.⁸

When minors consent to a minor-consented health service, state and federal law contain varying provisions which prevent the disclosure of information related to such care without the minor's permission. For example, pursuant to 42 CFR section 2.14 the release of records relating to substance abuse treatment is prohibited for situations in which state law permits a minor to consent to such care. Additionally, New York law contains protections for a minor's confidentiality by limiting access to medical records concerning care related to abortion and treatment of sexually transmitted infections, specifically providing that "records concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant."⁹

FPA thanks you for your consideration. We would be happy to work with you to address the concerns we raise in this comment.



⁶ Public Health Law section 2782.

⁷ Public Health Law section 2805-i.

⁸ Public Health Law section 2504.

⁹ Public Health Law section 17.



Greater New York Hospital Association

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

May
Fourteen
2014

Jason Helgeson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgeson:

The Delivery System Reform Incentive Payment (DSRIP) program will provide critically needed funding for safety net providers across the State as they engage in delivery system transformation. Attachments I (DSRIP Program Funding and Mechanics Protocol) and J (DSRIP Strategies Menu and Metrics) of the Partnership Plan Special Terms and Conditions (STCs) provide the framework for DSRIP implementation, and we appreciate the opportunity to comment on these important documents.

Attachments I and J provide substantial details on the general DSRIP program components set forth in the STCs. As there is overlap between these documents, some of the comments provided herein repeat or reinforce the comments previously submitted by GNYHA on the overall STCs. We appreciate your consideration of these comments.

Attachment I - DSRIP Program Funding and Mechanics Protocol

Throughout Attachment I, reference is made to Section IX of the STCs. We believe the correct reference is to Section VIII.

Section II. DSRIP Performing Provider Systems (PPSs)

b. Coalitions –PPSs are required to designate a lead coalition provider who is responsible for ensuring that the coalition meets all DSRIP requirements. This language is overly broad and we request that the responsibilities of the lead be more clearly specified. We also request that this section clarify that DSRIP funds may be used to reimburse the administrative costs incurred by the PPS lead.

In addition, with respect to “partners,” we request confirmation that individual physicians from a larger independent practice association (IPA) would be eligible to participate in a PPS, without requiring inclusion of the entire IPA.

c. DSRIP Beneficiary Attribution – It is the New York State Department of Health’s (DOH) goal to attribute most or all Medicaid beneficiaries to a PPS. We are concerned that the utilization thresholds for defining a safety net provider could be at cross purposes with this goal. We strongly recommend that hospital outpatient clinics that meet the 35% threshold be permitted to join PPSs without being subject to the 5% cap (see GNYHA’s April 29, 2014 comment letter). We are concerned that patients of these providers could end up unattributed or could be attributed to a PPS that does not include their primary care provider (PCP). We also suggest that any PCP serving Medicaid patients be permitted to join a PPS without being counted towards the aggregate 5% cap on payments to non-safety net providers.

The attribution methodology is somewhat unclear. Reference is made to both a hierarchical assignment and consideration of all service utilization. Since the interaction of these criteria is unclear, we request specific clarification that if a beneficiary obtains a majority or clear plurality of services from a particular provider, then attribution will be made to that provider, regardless of the provider’s position on the hierarchy. For example, if a patient has received a care management service from a provider in only one PPS, but obtains most services from a clinic in a different PPS, then the patient will be assigned to the clinic’s PPS. It may be easier for a PPS to change a patient’s care manager than to change a well-established caregiver, especially if the care management service is new or very lightly used. In addition, we request clarification on how the patient attribution will be affected if a provider participates in multiple PPSs.

Finally, the attribution methodology includes a process by which Medicaid managed care plans will review and potentially make changes to the DOH attribution. We believe that managed care plans should be given specific permissible criteria on which they can make recommendations for attribution changes. We also recommend that DOH have a process for validating any plan recommendations.

Section III. DSRIP Projects, Metrics, and Metric Targets

b. Metrics – This section specifies that each project must include metrics in all four domains. We believe the reference to “project” here is not to a single PPS project but to the PPS’ overall project plan. In fact, the term “project” is used with these two different meanings throughout the STCs and attachments, leading to confusion. We therefore recommend using distinct terms for an individual project and for the overall project plan.

c. Metric Targets - Clarification is needed on the establishment of performance targets. In the absence of an alternative method approved by the Centers for Medicare & Medicaid Services (CMS), must the State always choose between national and State-level top-decile performance based on the more favorable result, or can DOH use discretion in setting performance targets?

We recommend that DOH use discretion in establishing targets in order to choose ones that best fit the attributed DSRIP population. So, for example, if a target based on national data for *non-Medicaid* patients is more favorable than a target based on State data for the Medicaid/Medicare dual population, we believe DOH should choose the target based on the Medicaid/Medicare dual population. This is an important way to adjust performance goals for socio-demographic risk factors, as recently recommended by the National Quality Forum's Expert Panel on risk adjustment. We also recommend that the committee advising DOH on the performance measurement and target selection include not only clinical experts, but also experts in quantitative methods for performance-based payment policies, including GNYHA's health economists.

With respect to measuring the DSRIP participant performance, we request that Attachment I explicitly state that references to Medicaid beneficiaries include Medicaid and Medicare dual-eligible beneficiaries, and that data for dual eligibles be included in all performance metrics whenever possible.

Annual improvement targets are to be set based on reducing the gap to goal by 10%. Is this method to be used across the board? As for the overarching goal of achieving a 25% reduction in avoidable hospital utilization over five years, are the annual improvement targets set the same way for this metric (i.e., 10% of the gap to goal with the goal being the 25% overall reduction)?

Section IV. DSRIP Project Plan Requirements

b. Organization of DSRIP Project Plan – The project plan requirements include two provisions that we believe are unnecessary. Under provider demographics, the PPS must provide documentation supporting eligibility as a safety net provider. Since DOH has already posted lists of providers that meet the safety net definition, it is not clear what additional documentation is needed from the PPS unless it is including providers absent from the DOH posting. Our understanding is that DOH will implement an appeals process for providers not on the DOH lists who believe they meet the safety net criteria. We encourage DOH to issue this quickly so that these providers do not miss any critical deadlines.

In addition, project plans are required to provide a detailed budget for all five years of DSRIP. In our STC comment letter, we recommended deleting the STC requirement for budgets to justify project funding because DSRIP payments are incentive payments tied to project performance and are specifically unrelated to project costs. If the STCs are not modified, we strongly recommend that Attachment I be revised to clarify that the budget is for planning purposes only and is not intended to be the basis for DSRIP funding. We also request that DOH clarify that the budget represents a plan for project implementation and not a proposal for use of DSRIP payments.

Section V. Project Valuation

a. Valuation for DSRIP Application – The second step in the DSRIP project valuation converts the project index score to a project per member per month (PMPM) amount using the State valuation benchmark. The valuation benchmark is predetermined by the State and varies only on the number of projects chosen by the PPS. We recommend that an additional adjustment be made to reflect the risk of the population served by the PPS. While all PPSs will target a primarily Medicaid population, there will still be differences between PPSs in terms of patient acuity, percentage of dual eligibles, age, ethnicity, and other factors which can impact the difficulty of achieving performance metrics. If DOH does not believe that a traditional form of risk adjustment is appropriate, we recommend that DOH at a minimum adjust the PMPM to recognize the portion of attributed lives that are dual-eligibles or have multiple chronic conditions.

b. Metric Valuation - The DSRIP application valuation establishes individual project values by applying the project PMPM to the number of Medicaid beneficiaries served, the plan application score, and the length of the project. The individual project values are then rolled up into a maximum project value. At this point, based on our interpretation of Attachment I, the individual project values become irrelevant. For purposes of making DSRIP payments, the maximum project value is reallocated in accordance with the milestone percentage chart on page 19 of Attachment I and based on the achievement of milestones. We therefore think it is confusing to tie earned DSRIP payments to individual projects, as in the example on page 20, and recommend clarifying the methodology as follows:

- The maximum DSRIP payment should be derived as the product of the following variables: number of selected projects, applicable PMPM, *average selected project score*, application score, number of attributed beneficiaries, and beneficiary member months.
- The earned DSRIP payment should be derived by first allocating the maximum payment to the reporting and performance categories in each domain and in each year, and then illustrating the effect on payments of achieving or not achieving the target for each category, domain, and year.

Section VI. DSRIP Project Plan Review Process

b. State-Level Review Process – Section ii describes the independent assessment and public engagement process and provides for the convening of a panel of relevant experts and public stakeholders to assist with scoring projects. Please clarify who would qualify as a “public stakeholder.” Also, the independent assessor is required to ensure that standards are followed in order to prevent conflict of interest in the panel scoring process. Does this apply to the selection of the panel or to the scoring process?

Section VII. Reporting Requirements and Ongoing Monitoring

c. Learning Collaboratives – Learning Collaboratives are to be established by the State and/or the independent assessor. We respectfully request that GNYHA be included in the development

of these collaboratives. We have successfully developed numerous hospital quality improvement collaboratives over the years, including most recently, in partnership with the Healthcare Association of New York State, the NYS Partnership for Patients.

e. Overall Data Standards – We appreciate DOH’s efforts to develop the provider data portal to ensure that PPSs have access to real time data to assist in care coordination, and look forward to viewing the capabilities of the portal integrated with the 3M and Salient tools. We also are pleased to continue our discussions with DOH on access to Medicaid data from the data warehouse and the capabilities of the Verisk Population Focus tool in managing patient populations under DSRIP.

Section VIII. DSRIP Funding Limits

c. High Performance Fund – Up to 10% of overall DSRIP funds will be set aside for a high performance fund. Forfeited funds from PPSs that do not achieve milestones will also be used for this purpose. Please clarify how DOH will determine the amount to be withheld each year. In addition, clarification on how the high performance fund is to be awarded is needed. Attachment J specifies the metrics to be used for awarding high performance. Must providers achieve high performance on all metrics to receive funding? If high performance is achieved on certain metrics but the PPS fails to meet one or more of the other metrics, will they still qualify for high performance funding? Our recommendation is that the funding be awarded for any of the metrics for which the high performance is achieved.

d. Accountability for State Performance – The calculation of the milestone for growth in inpatient and emergency room spending PMPM does not specify how managed care spending for these services will be measured. Since State spending for these services for managed care beneficiaries is imbedded in plan premiums, clarification is needed on the mechanism and data source for incorporating managed care expenditures.

Attachment J – NY DSRIP Strategies Menu and Metrics

Section II. Metrics – Metrics are characterized as pay for reporting or pay for performance. For the pay for reporting measures, in cases where the data is population-wide or the data source is claims, survey, or other State sources, our understanding is that the reporting will actually be done by the State. Reporting that will be required of PPSs will be for Domain 1 metrics, certain Domain 2 metrics, and Domain 3 measures requiring medical record review. We would appreciate confirmation of this.

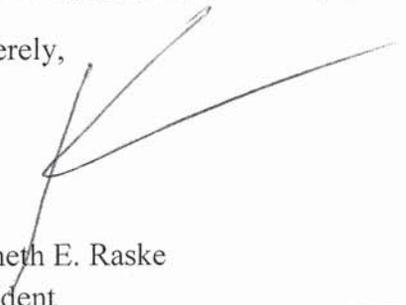
Domain 2 includes a reporting measure on the percent of PPS providers participating in regional health information organizations (RHIOs) and meeting meaningful use criteria. Federal fiscal year 2014 meaningful use requirements for hospitals and other eligible professionals focus heavily on meeting health information exchange criteria, referred to as the “transition of care objective,” which requires providers to electronically send a summary of care record for more

than 10% of their referrals to other providers. To meet this requirement, providers must have an electronic health record (EHR) with the capability to exchange health information as well as connectivity with sufficient other providers to meet the 10% threshold. Additionally, for eligible providers to meet the 10% threshold, other providers *without an EHR* (e.g., nursing homes, home health care) must have the electronic capability to receive a summary of care record. We strongly recommend that as a condition of participation in a PPS, providers without an EHR be required to receive and send a summary of care record using CMS-accepted standards for these transmissions, as defined by the Medicare and Medicaid Electronic Health Record Incentive Program.

Domain 4 includes metrics that apparently will be measured for the entire population (not just Medicaid) and with geographical area denominators that vary but appear to be largely statewide, regional, or county. It was our understanding that DOH would develop prevention agenda measures specific to the Medicaid population and that measurement would be possible at the zip code level. Is this no longer feasible? Since there will likely be multiple PPSs serving a region, particularly downstate, it would seem important to match the denominator with the geographic area served by the PPS wherever possible, particularly since different PPSs will choose different projects from this domain. While we recognize these measures will be pay for reporting, it is not clear how impactful DSRIP initiatives will be in terms of county-wide performance. Domain 4 metrics also appear to be all State reported. Please clarify whether any additional reporting will be required of PPSs for Domain 4.

We appreciate the opportunity to comment on the waiver terms and conditions and look forward to working together on DSRIP implementation. Please contact Kathleen Shure at 212-506-5407 or kshure@gnyha.org with any questions.

Sincerely,



Kenneth E. Raske
President

all the best!

To DSRIP team:

Our Hospice and Palliative Care program is currently providing care transitions services for Medicare patients with progressive chronic illnesses. We are doing this under the section of the New York law covering hospices that allow us to provide services for persons who have a progressive life-threatening disease but who have longer than the 6 months prognosis required to be a hospice patient.

We would like to do the same services for the Medicaid population through our local PPS, as specified in project 2.b.iv. The project description is virtually identical to our services, except that it adds a target group with behavioral health disorders. We have social work staff who could address this group's needs. Our problem is that those patients are not included among those we are authorized to serve under Article 40.

My question is, are there any provisions in DSRIP to grant waivers to state regulatory requirements that would bar an otherwise qualified provider from serving the target group for a DRIP project? Granting such waivers would be consistent with DSRIP's intent to spur innovation and break down barriers to integrated care.

Thanks you.

Brian Gardam

Executive Director

[Hospice and Palliative Care of St. Lawrence Valley](#)

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May 15, 2014

Mr. Jason A. Helgerson
Director of NYS Medicaid
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, N.Y. 12237

And by email: dsrip@health.state.ny.us

Dear Mr. Helgerson,

DC 37 represents 18,000 public hospital employees in the NYC Health and Hospitals Corporation. On behalf of our members and the patients we serve, we are commenting on the Delivery System Reform Incentive Payment Plan *Interim Access Assurance Fund (IAAF)*.

The requirement that the public hospitals develop special projects in order to access funding for this special pool is an unfair burden that is not placed on the non-public hospitals. Rather, the funding should be available to support existing services that are necessary but may be at risk due to lack of funding. The existence of a large budget gap next year, which only grows larger is evidence enough of the need for Interim Access funding.

HHC has already reduced headcounts by over 3,000 employees in the last several years, and reduced costs through LEAN projects and contracting out of services. The requirement to create special projects will divert resources even further.

The IAAF funding should be available to out-patient settings as well as acute care facilities, since the goal of health care reform is to provide more primary care in the communities where people live and to avoid hospitalizations. If anything there should be provisions to expand these services in the Interim funding in order to strengthen primary care and related services.

Finally, we cannot say enough times that the safety net definition should be clearly defined to only include those systems that serve more than 50% of Medicaid, uninsured and dual eligible patients.

Despite these many challenges, HHC and our members continue to provide excellent care to all patients who come through its doors whether undocumented, uninsured or unable to pay. It is critical that they be fairly compensated for such care.

Sincerely,


Lillian Roberts

C: HHC Local Presidents
File: HHC/MRT

**COMMENTS ON THE NEW YORK STATE DSRIP WAIVER—
Review of the Interim Access Assurance Fund (IAAF), and
Attachment I – Program Funding and Mechanics Protocol, and
Attachment J – Strategies Menu and Metrics**

These comments will be brief, raising only key points without details or description. Further time for review and discussion could greatly enhance the waiver.

THE IAAF

Inclusion of this interim funding program is important and welcome. There are true safety net providers that have been hurt by official policy, in particular, the MRT-backed policy for across-the-board reductions in Medicaid reimbursement which have had an inordinate impact on high Medicaid public and voluntary community hospitals. The IAAF funds, if well directed, could address and begin to fix the financial fragility of these needed hospitals and health services.

The waiver definition for the safety net is too broad and could result in supporting hospitals that do not need the funds. This is particularly a problem since decisions about this funding is solely in the hands of the State Health Department (Governor) during an election year. In other states with a DSRIP programs limit funding to a true public and voluntary providers.

We know that hospitals maintain different sets of financial information, so that even the financial status of a hospital can be reported in different ways. This is undoubtedly true within large hospital systems, where money can be moved around.

RECOMMENDED CHANGES

Redefine the safety net for more appropriate designations.

Make the decision-making process for distribution of funds open to the public

ATTACHMENTS I and J

Overall, the New York Special Terms and Conditions (STC) is an impressive document with creative and intricate ideas. The level of accountability and transparency is much appreciated. Posting of information is important, as is the continued involvement of CMS.

There is also a delicate balance in the efforts to transform the health care system. Some of the balance should focus on the beneficiary/consumer/resident and the diversity of people within cities/counties. Individual preferences and differences are not recognized and addressed in the way that individuals are “attributed” to a Performing Provider System (PPS). It is unclear how race and ethnicity, primary language, and disability are considered, if at all, in PPS designation. As a matter of fact, health care disparities are a major cause and outcome in problematic use of the health system that this funding is meant to address. Racial differences are only tracked in Domain 4. Disabilities are not tracked.

Although there are mentions that community residents and organizations could/should be involved in PPS and planning. This system network will really not work unless there is ongoing involvement of consumers and workers. The same is true for community-based providers which should be made part of the PPS and delivery system.

Uninsured residents are counted in use of health system for safety net designation, signifying a population of need. Yet, only Medicaid beneficiaries are attributed to a PPS. Concern was raised as to count of the uninsured, yet there are sources of information available, such as the American Community Survey and Exhibit 50 of the Institutional

Cost Report and FQHC state reporting mechanism. If uninsured residents are left out, access to care will become even more difficult for them.

Although the stated distribution of the DSRIP funds is 50% of the total for the public hospitals, the ultimate safety net providers, there are several places in I and J where this distribution is challenged. In one instance, public hospitals are encouraged to form PPS coalitions with voluntary providers, but the same provision appears to say the full funding should come from the public pool. This is unacceptable..

There appears to be a lack of understanding of medically underserved communities lacking primary care resources. Yet there is no funding designated to expand community based ambulatory care services. Residents in these communities may have continued trouble accessing care.

Finally, a major concern needs to be monitored. The State Health Department has been losing staff, yet it has a major role in planning, data development, technical assistance, monitoring, and evaluation of DSRIP/PPS. It would be tragic for this whole demonstration to fall apart because the department cannot hold up their end.

Judy Wessler

Medicaid **Medicaid Matters New York** *Matters*

Comments on the Delivery System Reform Incentive Payment Program Attachments I and J

As New York State begins to transform the entire delivery system through Medicaid Redesign, Medicaid Matters New York (MMNY) looks at the Delivery System Reform Incentive Payment (DSRIP) program in terms of how real people will interface with a newly-transformed system, how the providers and community-based organizations that serve them will continue to do their work, and how the Medicaid program will continue to meet the needs of everyone it is intended to serve.

MMNY submits the following comments regarding key areas of interest and concern to Attachments I and J, as they are intended to govern the implementation of Performing Provider Systems (PPS) and the DSRIP projects, along with the Special Terms and Conditions agreed upon by the Department of Health and the Centers for Medicare and Medicaid Services (CMS):

Transparency and Accountability

MMNY applauds the level of transparency and accountability required throughout the implementation of DSRIP. Public disclosure of PPS applications, including participating providers and chosen projects (through the posting of the Letters of Intent and Design Grant applications, for instance) will afford advocates and community members the opportunity to examine the intricacies of DSRIP as it is taking shape. MMNY encourages DOH to utilize us and other advocates as resources and knowledge-brokers throughout the design process, as our intimate knowledge of community needs and capacities would enhance accountability as projects develop both at the state and local levels.

MMNY has long advocated for transparency and accountability in the allocation of public Medicaid funding and is encouraged that the DSRIP design reflects this transformative effort.

Attribution

A significant focus of health care system transformation must be on the experience of the consumer and the diversity of people within and between communities across the state. The DSRIP attribution methodology does not incorporate individual preferences, cultural differences and subjectivities, or health and socioeconomic disparities. It is unclear how race and ethnicity, primary language, disability, and other dimensions of diversity are considered, if at all, in PPS designation. Health care disparities are a major factor in problematic use of the health system that DSRIP funding is meant to address. Racial differences are only tracked in Domain 4, and disabilities are not tracked at all [see section on addressing health disparities below].

Uninsured residents are counted in use of the health system for safety net designation, signifying a population of need. Yet, only Medicaid beneficiaries are attributed to a PPS. DOH has raised

May 14, 2014

concerns as to how to count the uninsured; MMNY submits that there are sources of information available, such as the American Community Survey, and Exhibit 50 of the Institutional Cost Report and Federally Qualified Health Center state reporting mechanism. If uninsured residents are left out, access to care will become even more difficult for them. Uninsured individuals must not be left out of PPS considerations; doing so will jeopardize health access and care for New York's most vulnerable residents, increase health disparities, further fragment care delivery, and potentially raise the burden of unnecessary utilization.

MMNY requests that the DSRIP attribution model incorporate a methodology that acknowledges disparate disability, ethnic, linguistic, and geographic groups, as well as individuals who are uninsured and ineligible for, or eligible and currently unenrolled in, Medicaid.

Community Engagement

Although the DSRIP documents make mention of the involvement of community residents and organizations in PPS development and planning, this effort will not work unless there is ongoing, meaningful involvement of consumers and consumer advocates. The same is true for community-based providers and organizations that should be made part of each PPS. MMNY requests that DOH create a specific structure and timeline for involvement of community residents and organizations in PPS development and planning, which should include meaningful efforts to include consumers and consumer representatives in that process. An inclusive community engagement process could include, but should not be limited to:

- Mandatory community involvement in planning meetings between members of a PPS when addressing the community needs assessment and selection of DSRIP projects;
- Participation of community members, organizations, consumers and consumer representatives in the independent review process of DSRIP final applications; and,
- Recognition of individuals or community organizations in each geographic area that could provide expertise to each PPS in development of a community needs assessment and project selection.

A series of Medicaid member focus group meetings were convened upon the development of the original MRT waiver amendment in 2012. The Medicaid Director and staff toured the state and sat down with Medicaid consumers to engage them in conversation about what the state should achieve under a new waiver application. Those meetings should be replicated as part of stakeholder engagement in the DSRIP, particularly because the content of the waiver amendment is drastically different than it was when those meetings took place.

Community-Based Services

The DSRIP strategy menu (Attachment J) suggests a number of potential projects to provide "evidence-based strategies in the community," especially for chronic disease control, self-care and prevention. This is a very important part of reforming the delivery system; chronic disease education and self-care strategies can routinely be delivered in the community both more affordably and with wider reach, especially reaching high-need populations that tend to avoid the medical system.

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The community groups often best equipped to provide evidence-based strategies for disease prevention and self-care in the community do not necessarily hold a current integrated role in the delivery system. For many “non-traditional” providers, DSRIP participation would represent their first opportunity for Medicaid funding beyond grants and state aid. Independent living centers, for example, have a strong track record of improving the health of people with disabilities, but have been viewed as an add-on in some of the other efforts at care coordination, such as Health Homes. For the state to truly achieve the aims of DSRIP, DOH will have to provide technical assistance to community groups to the same extent it provides assistance to lead agencies. Technical assistance must be clearly designated and available to community groups for the following purposes:

- Recognition of geographically appropriate PPSs with which to form partnerships;
- Coordination with potential PPS partners for inclusion into DSRIP networks;
- Assistance in providing information and expertise to the community assessment process;
- Organizational data collection on participants and outcomes; and,
- Infrastructure and capacity development, regardless of planning funds distributed to the other members of the PPS.

To this end, the state should create a designated “Office of Technical Assistance” within DOH with special representatives for community groups to enhance the opportunities for “non-traditional” providers.

Care Coordination and Case Management

MMNY supports the Department of Health’s efforts to enhance and expand care coordination and case management services to Medicaid consumers through DSRIP; it is clear that care coordination is an essential component and a high priority of this new delivery system. This focus on case management is essential in addressing many of the barriers that low-income New Yorkers face in accessing care and reaching the health improvement goals of the DSRIP. However, there is a lack of clarity in the Special Terms and Conditions and Attachments I and J about what case management services are, how consumers will access them, and whether the services will be provided in a meaningful way.

For example, case management connectivity is the first priority listed in the DSRIP’s attribution methodology. As there is no definition of case management in the glossary, it is not clear which definition of case management services DOH is referring to; it may refer to case management services as defined in the Federal regulations and/or the Medicaid managed care model contracts. It is also not clear if a PPS that provides these services will also assist consumers who need less intensive case management but do require navigation assistance.

Although the project goals described in Domain 2 of Attachment J indicate the importance of care coordination in the DSRIP, it is not clear how this new delivery model will expand case management services to consumers. In fact, Domain 2 does not refer to case management services, and presumably not all PPSs will provide case management. This lack of clarity will potentially lead to confusion for consumers. For example, it is not clear how a consumer would know that he or she is attributed to a PPS that provides case management services.

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Further, it is not clear how case management services provided by a PPS will be coordinated with the case management services already provided by Health Homes and managed care plans. The Special Terms and Conditions identify a specific role in participation and funding for Health Homes, but do not clarify their position to a PPS and correlated insurance plans. Clarification on roles and responsibilities, particularly for assessment and service planning, must be identified before provider systems identify community needs. Further clarification on the role of financial accountability and oversight must be provided so that providers of case management in CBOs, Health Homes, and managed care plans understand their rights and responsibilities prior to final provider system and project development.

Finally, the role of managed care plans in providing case management services must be clarified within this new delivery model. Case management provided by a PPS must be coordinated with the same services required by plans, but without overlap and with clear roles and expectations delineated for consumers. Medicaid consumers must have access to information about seeking assistance when they experience barriers to accessing services or navigating the PPS in relationship to their insurance product. To the extent that case management services are provided by a CBO working with a PPS, the CBOs should be able to maintain the independence needed to advocate for consumers in their community. It is important that consumers be able to continue to seek assistance with appeals and Fair Hearings from CBOs.

In seeking clarity, the following questions / issues should be addressed:

- 1) Define the components of case management, and any services or activities that are excluded.
- 2) Clarify whether case management is voluntary, and for which members case management is mandatory if applicable.
- 3) Delineate safeguards to ensure consumer confidentiality.
- 4) Clarify whether participants can choose their case manager, and whether participants will have meaningful choice in case management provision, including information about how a participant would identify and select a new case manager.
- 5) Assurances that case managers are not able to limit services otherwise provided by the Medicaid state plan, with a clearly identified appeals process for consumers in the case that state plan or otherwise eligible services are denied.
- 6) Identify which participants are eligible for case management services and how a participant becomes eligible or loses eligibility.
- 7) Provide a description of staff qualifications and structure for each model/definition of case management.
- 8) Set case load limit in policy and procedures to maximize effectiveness and prevent staff burnout, with a methodology that respects the risk stratification no more conservative than that approved for managed care plans.

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- 9) Define the process for soliciting client feedback on current and planned programs and services.
- 10) Define the methods for ensuring that consumers are aware of steps for filing a grievance and/or appeal of case management decisions and explain the interrelatedness with appeals of service determinations.
- 11) Explain interrelationship between disease management and case management, including related responsibilities for oversight, accountability, and coordination between relevant providers.

Health Disparities

Health disparities are an important driver of the outcomes that this waiver seeks to address including the overall outcome of reducing avoidable hospitalizations by 25% over five years. It will be important for Performing Provider Systems to address health disparities to achieve the desired outcomes.

Numerous studies have documented that people with disabilities are far less likely to access health care services than people without disabilities.¹ Similarly, people with Limited English Proficiency (LEP) are more likely than non-LEP individuals to report being in poor health, deferring medical care, experiencing adverse drug effects, and are less likely than non-LEP individuals to have a regular source of care.² Health disparities research suggests that valid and reliable data are fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific population groups.³ Hospitals and other health care organizations armed with data from their own institutions will be better equipped to look at disparities in care, design targeted programs to improve quality of care, and provide patient-centered care.

Yet the metrics identified in Attachment J do not provide an adequate method of tracking health-related disparities. In Domain 1, metric (1)(c) asks Performing Provider Systems to document the number of beneficiaries served through the projects, but does not further delineate disparate ethnic, linguistic, cultural, or disability populations. Domain 4, Population Wide Metrics, relies on the deficient SPARCS data which tracks measures for Black non-Hispanics and Hispanics, but does not yet track any other health disparities populations.

¹ See, e.g., NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES (2009), http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf; see also, JUDY PANKO REIS ET AL., IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES 7 (2004), www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf; M. A. Nosek and C. A. Howland, *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 ARCHIVES OF PHYSICAL MED. & REHABILITATION S39 (1997).

² Leighton Ku and Glenn Flores, Health Affairs, Pay Now or Pay Later: Providing Interpreter Services in Health Care, March 2005, 435-444, vol. 24 available at <http://content.healthaffairs.org/content/24/2/435.full#ref-5> (citing B. Kirkman-Liff and D. Mondragón, "Language of Interview: Relevance for Research of Southwest Hispanics," *American Journal of Public Health* 81, no. 11 (1991): 1399-1404; G. Flores et al., "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics and Adolescent Medicine* 152, no. 11 (1998): 1119-1125; M. Alpert et al., "The Language Barrier in Evaluating Spanish-American Patients," *Archives of General Psychiatry* 29, no. 5 (1973): 655-659; R. Weinick and N. Krauss, "Racial/Ethnic Differences in Children's Access to Care," *American Journal of Public Health* 90, no. 11 (2000): 1771-1774; and T.K. Gandhi et al., "Drug Complications in Outpatients," *Journal of General Internal Medicine* 15, no. 3 (2000): 149-154.)

³ Romana Hasnain-Wynia and David W. Baker, *Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions*, 1501, 1502 (2006).

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Along with race and ethnicity, the Health Disparities Workgroup of the Medicaid Redesign Team recommended that DOH “implement and expand on data collection standards required by Section 4302 of the Affordable Care Act by including detailed reporting on...gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status.”⁴

While CMS did change many of the ideas that came out of the MRT participation process, it should be aware of the need to track disparities populations beyond race and ethnicity. The *Affordable Care Act* now requires any “federally supported health care or public health program, activity or survey” must collect and report “to the extent practicable, data on race, ethnicity, primary language, and disability status, for applicants, recipients, or participants.”⁵

Recommendations:

- 1) Performing Provider Systems should identify the race, ethnicity, sex, primary language, disability status, gender identity, and housing status of the beneficiaries they serve. They should do this so they can do a better job of serving them, comply with all applicable civil rights laws, and report the numbers and percentages for the purposes of overall project assessment.
- 2) Domain 4 projects should include population-wide metrics that measure the differences in health indicators for all health disparities populations including race, ethnicity, sex, primary language, disability status, gender identity, and housing status. The U.S. Department of Health and Human Services Implementation Guidance on Data collection standards should be used for race, ethnicity, sex, primary language, and disability status. LGBTQ advocates and housing advocates should be consulted for standards to measure gender identity and housing status.
- 3) The community needs assessment for each PPS must include the above relevant information on diverse populations correlated to health and health-related community needs such as housing, employment, culturally responsive social services, and community navigation services.
- 4) Reflect medically underserved communities in the expansion of potential DSRIP projects to include an opportunity for primary care, ambulatory care, or specialty services (such as behavioral health, cross-disability, prevention, maternal health, tribal health) to meet the needs of underserved populations.
- 5) Compliance with non-discrimination laws should be assessed as a requirement of the DSRIP project application review to ensure accommodation of people of different races, ethnicities, disabilities, gender identities, languages they speak, and other dimensions of diversity.

⁴ See, NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID REDESIGN TEAM (MRT) HEALTH DISPARITIES WORK GROUP FINAL RECOMMENDATIONS (2011), http://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf, page 6. For the six ACS questions on disability status, see, U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES IMPLEMENTATION GUIDANCE ON DATA COLLECTION STANDARDS FOR RACE, ETHNICITY, SEX, PRIMARY LANGUAGE, AND DISABILITY STATUS, <http://aspe.hhs.gov/datacncl/standards/aca/4302/index.pdf>, page 7.

⁵42 U.S.C. 300kk(a)(1).

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Social Determinants of Health

A review of current community health needs must reflect social determinants of health (housing status, employment, environmental factors, access to transportation, economic development opportunities), as well as an analysis of persons with disabilities living in both institutions and in the community. An analysis of health disparities alone will ignore the specific relationships between socioeconomic factors and population health. Furthermore, an analysis of the scope of community members with disabilities and their supports and services will identify specific service needs. Doing so should be a requirement in fulfillment of state *Olmstead* activities, maintaining that any health system transformation or policy initiative must take into account the community inclusion of all people with disabilities.

Department of Health Staff Structure

The Department of Health has undergone significant redesign of its own over the past few years, and it has been losing staff. Despite a significant portion of DSRIP work being done by outside entities, DOH has a major role in planning, data development, technical assistance, monitoring, and evaluation of DSRIP. It would be tragic for Medicaid Redesign to stagnate or not meet its full potential because of a lack of state resources or failure to transform and integrate departments. There should be clear recognition of the need for an investment in state staff, and DOH should publicly offer a strategic plan to transform and integrate state systems in direct relationship to Medicaid Redesign and 1115 waiver amendment activities. In addition, information should be posted as to the DOH organizational structure that will be dedicated to the work associated with DSRIP, and inter-organizational relationships to other agencies and policy planning processes.

Conclusion

We urge DOH to reflect considerably on the recommendations herein. Failure to address the needs of Medicaid consumers and uninsured, underserved community members will contribute to the ultimate failure of this historic systems transformation. We look forward to further communication with DOH on these issues and further implementation details of the DSRIP plan, and appreciate the Department's continued commitment to the health needs, rights, and dignity of all New Yorkers.

Medicaid Matters New York is a statewide coalition of over 140 organizations united around the interests of Medicaid beneficiaries. Components of these comments were drafted by Belkys Garcia and Carol Santangelo of the Legal Aid Society, Chris Norwood of Health People, Heidi Siegfried of New Yorkers for Accessible Health Coverage, Briana Gilmore of the New York Association of Psychiatric Rehabilitation Services, and Judy Wessler.

*For more information, please contact:
MMNY Coordinator, Lara Kassel, at lkassel@cdrnys.org or 518-320-7100.*

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To whom it may concern:

Montefiore is pleased to submit the following comments on the Delivery System Reform Incentive Payment Program Attachments J and I:

1. Attachment J: Employ a more flexible approach in metric selection

We appreciate that the Department of Health has carefully curated a list of evidence-based metrics to hold Performing Provider Systems (PPSs) accountable, and has sought to align these metrics wherever possible with standards in existing Medicaid programs. Based on our experience participating in a number of value-based payment arrangements, we would request greater flexibility in the precise array of performance metrics for which PPSs will be held responsible, to be finalized via negotiation with the state. We specifically request this flexibility with regard to Domain 3, Clinical Improvement Metrics.

As the language in the attachment currently suggests, PPSs will be held accountable for behavioral health metrics outlined and then strategy specific milestones detailed in the Project Toolkit for Domain 3 activities. We believe that the state would have a more precise picture of performance if PPSs could choose a subset of measures from the state's menu, informed by detailed project planning, rather than being expected to achieve *all* measures outlined in attachment J and the toolkit. This approach mirrors the way the Meaningful Use and Patient-Centered Medical Home programs work, where there are set metrics for which providers are held accountable and then providers can choose additional ones tailored to programmatic efforts.

Additionally, we would appreciate the flexibility to propose additional metrics outside of the state's menu, when there is an evidence base as rationale. For example, as the attachment is currently worded, all PPSs will report on "Antidepressant Medication Management" for project 3.a.i, integrating primary care and behavioral health services. In our experience managing populations with behavioral health disorders, we have found that results from standardized depression screens like the Patient Health Questionnaire 9 (PHQ-9) better reflect patient behavioral health status overall than more focused metrics like antidepressant usage. We would appreciate the opportunity to engage in a dialogue with the Department of Health on alternative accountability metrics once projects are more fully developed.

2. Attachment J: Importance of medical village concept

We are supportive of the general concept outlined in project 2.a.iv to support a medical village using hospital infrastructure. We would like to underscore the importance of having channels for repurposing inpatient capacity for other, non-inpatient uses such as

urgent care and want to clarify that this type of activity will be fully supported under the auspices of this project.

3. Attachment I: Consider addition to the attribution methodology

We recommend that the state consider school-based health utilization in the attribution algorithm and that these types of providers be considered on par with primary care providers in situations where utilization suggests that the school-based health center is the main provider of care.

Thank you for your consideration. If you have any questions, feel free to contact Hope Glassberg, Director of Public Policy, at hglassbe@montefiore.org or 347-637-0674.



NEXT WAVE

We Understand Health Care

Comments on DSRIP Attachments I and J

1) **Base Period for Performance Measurement**

- a) A 12 month base period for performance testing is necessary to avoid seasonal variations.
- b) Due to Hurricane Sandy, the initially identified base period (calendar 2013) is not appropriate for affected closed providers (or other providers which took up their slack volume) AND displaced Medicaid member volume and demand. *We recommend either:*
 - i) *Move the Base Period to avoid the months affected for all for consistency.*
 - OR**
 - ii) *Only move base period or interpolate performance for affected providers and members (perhaps affected zip codes) for volume/demand and for each measure.*

2) **NYSDOH Evaluation of Submitted LOIs for Sufficient Breadth for each proposed Performing Provider System (PPS)**

- a) A NYSDOH review comparing Provider-filed Community Health Improvement Plans (CHIPs) versus County-filed CHIPs filed in November 2013 demonstrated significant differences for inclusion of local social service organizations. These organizations are critical to shifting focus upstream and downstream (Population Health and Well Being) from the current focus on health care delivery, particularly for impact on avoidable admissions, readmissions, and ED visits.
- b) *NYSDOH should also look for missing local Community/Social Service organizations in proposed PPSs, not just missing Providers.*
 - i) *Review of specific Community participants in County-submitted CHIPs can inform this.*
- c) *When listing LOIs, consider placing location of the lead organization on interactive maps, with a link-through to the full PPS list. This will assist all to look for gaps.*

3) **Regional Assignments – DSRIP Regions vs. RHIC Regions**

- a) The county assignments to DSRIP Regions are overly broad to facilitate local engagement, particularly for local social service organizations in upstate rural areas.
 - i) *We recommend assessing PPS Breadth relative to more local regions, e.g. the Regional Health Improvement Collaboratives (RHICs).*
- b) PPS that arise from the LOIs may appropriately cross pre-defined geographic regional boundaries to reflect actual Medicaid member health service use.
 - i) *This should be allowed, combined with analysis to insure all Medicaid members have access to a proposed PPS.*

4) **Learning Collaborative Effectiveness/Link to High Performance Fund Criteria**

- a) The Learning Collaboratives are designed to identify and share best practices for improvement.
- b) Exchange of ideas at the front lines is most effective for process improvement – as referenced on page 61 as the primary focus for the Learning Collaboratives.
- c) However, front line staff is inherently reluctant to take time away from caring for THEIR patients to be involved in process/quality improvement activities.
- d) A NYSDOH funded Workforce grant we worked on demonstrated a solution. For the intervention, grant funding was used to “back-fill” staffing so that the front line workers could place their full attention on identifying, testing, and sharing improvements. This was highly successful, resulting in Magnet nursing recognition and front-line staff presentations of their improvements at regional and national Nursing meetings.
 - i) This is also consistent with the concept of the “Pay to Test” and “Pay to Share” components of the overall Value Based Purchasing Framework (along with Pay for Reporting, Pay for Performance Attainment, and Pay for Performance Improvement).
- e) ***We recommend that the High Performance Fund criteria be enhanced to incorporate a condition for use of these residual bonus funds:***
 - i) ***Top performers will be expected to utilize at least ___% of the High Performance Funds distributed to facilitate their active front line staff involvement in the Learning Collaboratives to test, document, and share their best practices (through “backfilling” direct care staffing to enable improvement activities, investment in data collection, evaluation, and sharing, etc.).***

5) **Adjusting Performance Measures for Socio-Demographic Status**

- a) As indicated in our oral comments at the April 16 Listening session in Albany, performance measures that are at least partially reliant on actions of the patient, their family, or informal caregivers are affected by the capabilities of these informal caregivers.
- b) A preponderance of evidence over many years demonstrates that frequently half of the variability of outcome measures like avoidable hospitalizations, rehospitalizations, and ED visits are dependent on the effectiveness of these informal caregivers.
- c) There is a significant movement nationally to apply risk adjustment for socio-demographic factors (education, language, poverty, etc.) to the outcome measures critical to demonstrating success of DSRIP (and retaining the CMS funding).
- d) ***The NYSDOH should accelerate efforts to incorporate such adjustments as soon as feasible to both effectively focus PPS improvement efforts and measure their results.***
 - i) ***These adjustments should be targeted for the mid-stream update contemplated. This allows time to collect sufficient socio-demographic data to perform such measures, and evaluate (or participate in) the formal measure refinement efforts.***
 - ii) We note that some added detail has already been provided to NYSDOH staff (Lynda Hohmann , Carol M. DeLaMarter) in response to their inquiries triggered by our verbal comments at the listening session.



NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Mary Bassett, MD, MPH
Commissioner

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May 14, 2014

dsrip@health.state.ny.us

Re: Medicaid 1115 Waiver Amendment Request Delivery System Reform Incentive Payment (DSRIP) Plan Related Documents

To whom it may concern:

The New York City Department of Health and Mental Hygiene (the “Department” or “DOHMH”) submits the following comments providing collective feedback and recommendations for the Delivery System Reform Incentive Payment (“DSRIP”) Plan Related Documents: Special Terms and Conditions, Attachments I and J, and the Project Toolkit. The Department strongly supports the effort to transform New York’s healthcare delivery system and looks forward to working with the NY State Department of Health, lead grantees and collaborative partners in implementing these new initiatives over the next five years to ensure the highest success rate.

Special Terms and Conditions

As part of its efforts to ensure that potential funding was to be most effectively and appropriately spent, the Medicaid Redesign Team (“MRT”) extensively solicited feedback from interested parties during the initial phases of the waiver request formulation. According to the stakeholder feedback that the MRT collected in 2012, reinvestment into primary care programs was a top priority. In addition, members of the public (largely self-identified as healthcare providers or workers) using the MRT’s online survey tool, indicated that using New York State’s reinvestment funds for primary care had the highest rating among the thirteen waiver initiatives listed.¹

To address this identified need, the original waiver amendment request included \$1.25 billion to expand access to high-quality primary care which included technical assistance, and capital investment. We greatly applauded this focus on expanding access to primary care in these earlier iterations of the waiver, recognizing that many of the individuals newly insured through the Affordable Care Act seek out services. We also recognized the correlation between high-quality primary care capacity and reducing avoidable emergency room utilization. However, although the New York State Department of Health has explicitly stated many times that the original aims and goals of the waiver request have stayed the same, we are concerned that the strong emphasis

¹ Pages 7-11. NY State Medicaid Redesign Team Waiver Amendment.
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

attributed to increasing access to primary care, including the integration of services and expansion of primary care capacity that was included in the original proposal, has been diminished in this latest version. Therefore we would like to make the following recommendations in order to ensure the prioritization of primary care in the overall effort:

- Restore specific funding opportunities for primary care technical assistance. We are concerned that the technical assistance program for primary care, originally budgeted at \$305 million, has been completely eliminated. This component is critical in order to enable the transformative change this program seeks to achieve in all levels of primary care provider settings. Particularly with smaller practices, assistance regarding process expertise and developing more efficient and effective delivery of care is greatly needed in order to undertake the difficult and complicated transformations required by the DSRIP. We urge the reintroduction of this component to the overall program.
 - We are particularly concerned with the requirements, incorporated within the Toolkit document, for all eligible providers in each Performing Provider System (PPS) to achieve: 1. 2014 Level 3 patient centered medical home (“PCMH”) standards or the NYS Advanced Primary Care (“APC”) Model requirements by the end of Year 2; 2. Meaningful Use (“MU”) by the end of Year 2; 3. Connection to a regional health information organization (“RHIO”) or the Statewide Health Information Network for New York (“SHIN-NY”) by the end of year 3. These requirements, which are not reflected in Attachments I and J, represent a heavy burden in an accelerated timeline to all providers, with particular implications for smaller practices. Through the Regional Extension Center for New York City, NYC REACH, located within DOHMH, the Department has provided support to over 12,000 providers across NYC in adopting and implementing Health Information Technology as well as in pursuing achievement of Meaningful Use, PCMH Certification, and RHIO connectivity. Practices, particularly those serving high-need populations, need technical support to achieve these goals. The initial financial commitments needed to achieve these goals, including equipment, staff re-training, certification costs, and lost productivity, may be prohibitive for smaller practices. Additionally, technical assistance for training, workflow redesign, and implementation of new processes would likely be required to fully and quickly transition to the new systems envisioned by DSRIP while maintaining new processes and procedures.
 - From our conversations with prospective DSRIP applicants, the following issues are becoming clear: Lead coalition providers, including hospitals, are considering the targeted primary care network among their employed provider base or partner community health centers. However, a large component of their attributed patient population seeks care among the thousands of independent, small-practice providers in New York City. Therefore, by not including these primary care providers, these lead coalition provider applicants will face unexpected barriers to executing on their commitments, and we are concerned that DSRIP applicant coalitions in NYC may not be budgeting and planning today for what will become a clear need once their programming begins and Medicaid claims data has been analyzed. Even ‘conveners’

of primary care providers like Independent Physician Organizations and Medicare Shared Savings Program Accountable Care Organizations (“ACOs”) lack the staffing, relationships, and resources needed to outreach to these independent primary care providers and provide the quality improvement and practice transformation support that would be needed in order to achieve DSRIP goals. The existing Regional Extension Centers, New York eHealth Collaborative (“NYeC”) and NYC REACH, do have the relationships, resources, and track record in place to help the disparate, independent provider community achieve the quality goals of the program, and the process measures around PCMH, MU, and RHIO connectivity. We strongly suggest consideration of formal incorporation of these technical assistance resources into the DSRIP application proposal.

- Require a comprehensive primary care plan for all DSRIP proposals. We applaud the strong emphasis through high index scores on the Domain 2 projects, which focus on primary care improvement and integration as well as the Attribution model strategy which prioritizes primary care utilization. However, there still exist scenarios where a grantee could choose projects from this domain that do not include new primary care efforts. For example, in domain 2 – selection of projects iv or v from sublist A and another project from sublist B or C would result in this outcome. Therefore we believe primary care expansion, improvement and integration efforts should be explicitly required in each proposal. In order to achieve this, we urge the inclusion of a required comprehensive primary care plan that describes the grantees strategy to deliver high quality primary care to their population, similar to the existing requirement that all proposals include a workforce strategy.

Attachment I and Attachment J

Most broadly, DOHMH supports the request of the New York State Association of County Health Official that SDOH urge, if not require, all Performing Provider Systems (PPS) to link to their local health departments. This linkage could easily be documented by a letter of support that is either mandatory or voluntary with an incentive attached. As DOHMH collaborates frequently with local health care facilities, safety-net providers, unions, and community groups, the requirement would not be overly burdensome to PPS networks. And, a requirement would allow DOHMH to ensure that proposed projects are meeting the health needs of the communities they will serve.

Attachment J and Project Toolkit - Domain 2:

Domain 2.a.i “Create Integrated Delivery Systems . . .” (Toolkit p 8)

- “Expand access to high quality primary care. This will require both an increase in primary care capacity as well as a commitment to meeting 2014 Level 3 PCMH . . . “ Other core components incorporate more specific requirements. For example, this core component could require that the health care delivery system provide projections of primary care capacity shortage, and develop plans for workforce, infrastructure, services

(preventive, chronic care, etc.) and community education to support appropriate levels of primary care for the relevant population.

- “Support EHR linkage . . . ” We are concerned about the requirements around EHR linkages:
 - We are concerned that the requirements under Domain 2 regarding electronic health record (“EHR”) linkages to RHIOs will not be achievable, due to factors outside of PPS control. Simply, EHR vendors, RHIO vendors, and private health information exchange (“HIE”) vendors remain, predominantly, in the development phase, and are actively developing guidelines and infrastructure. Currently, approximately 2% of providers in New York City and 10% across New York State are connected to a RHIO, and fewer are actively exchanging information. The schedules for roll-out that have been quoted to us by these entities indicate that thousands of independent physicians will not be in the implementation schedule for months, and in many cases years, to come. Furthermore, some of the existing impediments to EHR linkage are related to a lack of clarity for providers surrounding the legal and policy-related issues of patient consent and physician liability. Therefore, we recommend that a mechanism for relief be provided to account for situations in which third party technical development progress has created persistent barriers to adoption and/or state or federal policies changes need to be made to remove existing barriers. We suggest that the State use MRT funding to incentivize and underwrite the regulatory and state public HIE infrastructure with deadlines that precede that of the DSRIP program adoption requirements, in order to ensure PPS participants can achieve their goals and thereby support the State’s achievements.
 - Given the aggressive goals for Meaningful Use achievement and PCMH Level 3/APC achievement stated in the Toolkit, sufficient technical assistance and support must be available to providers. In our experience, achievement of PCMH Level 3 takes between 12-18 months; smaller practices and Community Health Centers serving high-need populations may not be able to meet the stated goal of achieving 100% Meaningful Use, PCMH Level 3 or APC, and RHIO connectivity within the available timeframe in the absence of significant support or practice facilitation from external sources.
 - Regarding the requirement to meet the NCQA 2014 PPC-2014 PCMH Level 3 standards by the end of year 2, practices that completed the lengthy and expensive practice transformation process needed to achieve the 2011 standards for PCMH, which expire in June 2013, will be hesitant to meet the 2014 standards due to real and perceived duplication with the significant investment made in meeting the 2011 standards. Furthermore, NYS Medicaid (along with commercial payers like Empire BCBS) is continuing to pay enhanced reimbursement rates to practices meeting the 2011 standards. Therefore, independent providers may be financially incentivized to stay on the 2011 standards instead of upgrading to 2014 standards. Most importantly, the functionality required to meet the 2014 standards is not yet in place in most EHR and HIE vendors. As a result, many practices will not be

able to meet these requirements, regardless of their interest in doing so. Therefore, we recommend that New York State consider re-focusing the DSRIP goal to focus on 2011 standards and institute a framework to ensure compliance, rather than prioritize the 2014 standards. We believe that by focusing on the 2011 standards, particularly for the first two years, the financial incentives in place for key stakeholders, including the health plans and the independent providers, are aligned. Alternatively, the State could delay the 2014 PCMH Level 3 requirement until PY 4 or 5 to enable providers to plan and upgrade their programs within a realistic time frame.

- The goal of 100% RHIO/SHIN-NY connectivity by the end of Year 3 stated in the Toolkit should be revised to reflect the reliance of this measure on factors outside of the control of the PPS. RHIOs must be sufficiently capable of providing useful services at appropriate costs in order for the PPSs to drive connectivity. In the absence of a clear business case and appropriate pricing structure, particularly for smaller practices, this goal may not be achievable in the timeframe allotted. We also suggest the State consider the current status of the RHIOs: without clear incentives to grow and related guidance from the State, RHIOs may not be able to meet the demand created by the DSRIP requirements.
- The stated goals of achieving 100% participation in a RHIO by the end of Year 3 and achieving 100% Meaningful Use and PCMH Level 3/APC are incorporated into the metrics for Domain 2 as pay-for-reporting metrics. In order to more clearly indicate the expectations for PPSs for these achievements, we suggest using a pay-for-performance structure and setting performance targets using the protocol outlined in Attachment I. This would similarly offer an avenue towards achievement of the long-term goal while ensuring that PPS for whom baseline participation rates are low can be appropriately rewarded for making progress towards the goal.

Domain 2.a.iii “Proactive management of higher risk patients not currently eligible for Health Homes . . . “(Toolkit p 12)

- As the NYS Health Home eligibility definition is *two* chronic conditions or *one* qualifying condition (HIV/AIDS or serious mental illness), many people already ‘eligible’ but not the object of much outreach (e.g., any Medicaid recipient who is obese, likely also has arthritis). Therefore, we recommend this to be revised to “patients eligible for but not enrolled in”

Domain 2.b.ix “Implementation of observational programs in hospitals” [*note that this refers to observation beds/units, not personnel shadowing*] (Toolkit p 32)

- Although we agree that observation units can be very useful, we are concerned that “observation stays” may not be covered by non-Medicaid payers. If observational programs become more standard as a result of DSRIP projects, this could result in non-Medicaid patients incurring charges not covered by their insurance. Similarly, we believe

it would be undesirable to have observation units that only serve Medicaid patients (a 2-tier system).

Domain 2 System Transformation Metrics

- The Domain 2 metrics include measures which are vital for PPS planning and monitoring. Drawing on lessons from the ACO Medicare Shared Savings Program, lack of access to data in a timely manner was a fundamental challenge and cause of programs failing to achieve their goals. We request insight into the timeframes and turnaround times to be incorporated into the measure specifications in order to ensure that the PPS have access to the data they need in a timeframe that enables performance assessment and modification as needed to ensure achievement of the overall DSRIP goals.
- Regarding the 3M measures of Potentially Avoidable Emergency Room Visits (“PPV”) and Potentially Avoidable Readmissions (“PPR”), we are concerned that PPS may not have access to the 3M software for PPV and PPR calculations, and that some PPS may not have sufficient familiarity with these measures.
- Given recent research regarding factors other than quality of care affecting hospital readmission rates, how will PPSs be protected from being inappropriately penalized for high hospital readmission rates?
- The use of antipsychotic medications is associated with reports of dramatic weight gain, diabetes and increased LDL cholesterol levels. All adults should be screened for obesity (BMI of 30 or higher according to the United States Preventive Services Task Force recommendation (2012). We propose that the National Quality Forum (NQF) measure for BMI (defined below) be included in this list of metrics.
 - Measure name: Adult Weight Screening and Follow-Up
 - Description: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.
 - Reference: Meaningful Use Core Measure: PQRI 128 NQF 0421
- In addition to emergency department visit and re-hospitalizations, we recommend that rates of incarceration and/or arrest be considered an avoidable event or negative outcome that should be used to measure system transformation and project assessment.

Domain 3 Clinical Improvement Metrics

- We propose implementing NQF #0028 in place of #0027. Measure #0028 has actually been collapsed into one single measure titled “Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention,” by the National Quality Forum. This metric measures the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.²

² <https://www.qualityforum.org/QPS/0028>

- We recommend #0028 because it is a core metric for Meaningful Use Stage 1 and is included for Stage 2, whereas #0027 is an optional measure and is not included for Stage 2.³
- Additionally, although the measures themselves are quite similar, #0028 asks about intervention, which includes medication, while #0027 is limited to asking only about advice and counseling.

Domain 4 Population-Wide Metrics

- In this section for population metrics listed under: “Promote Healthy Women, Infants and Children” we propose including the following three additional metrics:
 - Percentage of mothers exposed to intimate partner violence.
 - Rates of tobacco use at the end of pregnancy and rates of tobacco use three months postpartum based on results from the NYC Pregnancy Risk Assessment Monitoring System (PRAMS) 2009-2011 survey.
- In this section for population metrics listed under “Promote Mental Health and Prevention Substance Abuse,” we propose including a metric to measure the percent of people reporting ‘poor mental health’ that received outpatient treatment or medication for mental health in the past 12 months.

Attachment I – NY DSRIP Program Funding and Mechanics Protocol

Assessment of Safety Net Provider Status (Attachment I p 2)

- We suggest [adjustments to the scoring or methodology] for providers who see particularly high volumes of Medicaid, dually eligible or uninsured patients, i.e., far beyond the criteria for parts A(2) or A(3) of the hospital safety net analysis.

Coalitions (Attachment I p 2)

- As NYS has health system entities of every size and type, how will NYS ensure that very large health systems do not have a competitive advantage over smaller entities?
- We are concerned that Brooklyn’s previously identified crisis hospitals⁴ may be at an unfair disadvantage in negotiating with potential PPS groups. Such facilities may be less attractive DSRIP coalition partners yet exclusion from the relevant PPS would likely further threaten market share and raise additional financial challenges for these facilities.
 - In particular, Long Island College Hospital (“LICH”) or its successor organization may be at a distinct disadvantage in coalition discussions given the uncertainty of the LICH negotiation outcome during the crucial start of the DRSRIP planning period.

³ http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

⁴ The Brooklyn MRT Work Group Report identified six Brooklyn “focus hospitals” described as lacking “business model[s] and sufficient margins to remain viable and provide high quality care to their communities as currently structured”: Interfaith, Wyckoff, Brookdale, Long Island College Hospital, Brooklyn Hospital Center, Kingsbrook Jewish Hospital.

DSRIP Beneficiary Attribution Method (Attachment I p 3)

- We are concerned that the attribution methodology may have some negative impacts on patient care:
 - Might a PPS encourage certain patients (e.g., those with greater likelihood of improvement) to obtain all care from PPS providers while referring particularly difficult and/or high risk patients out of the PPS in the hopes that these patients would be attributed to another PPS? How can we ensure that referral patterns will not vary depending on whether a patient is perceived as a one person improvement opportunity or as a lost cause?
 - Will attribution encourage PPS members to excessively inquire into a patient's other sources of care?
 - Will the methodology encourage PPSs to "chase" Medicaid patients to the detriment of uninsured patients? Although the uninsured population is expected to decrease, it will not be zero.
 - We are concerned that the attribution process as described has the potential to create unintended consequences. Specifically it is unclear how these consequences would impact the State's primary care providers working in smaller practices with the least amount of direct support and resources available to meet the DSRIP goals, as these providers will be critical to bridging care coordination gaps and integral to the achievement of the State's goals.
- Grant administration and reporting: Within the DSRIP administration and reporting plan, PPS will be required to collect, analyze, manage, and share complex and large amounts of data from multiple sources. In the absence of interoperable electronic data systems, this process may create undue burdens on the participating providers, particularly among those who are not currently staffed or resourced to conduct these activities (e.g. small independent practices). We suggest drawing on the experiences of Accountable Care Organizations and Health Homes in New York State, and develop a plan to incorporate a third party, e.g. the State's Quality Improvement Organization or Regional Extension Centers, to facilitate these processes.
- Overall Data Standards: While we support the State's emphasis on utilizing already-collected data, e.g. Healthcare Effectiveness Data and Information Set ("HEDIS")/Quality Assurance Reporting Requirements ("QARR") measures, we strongly support the implementation of additional guidance from the state surrounding measure specifications. Health plans vary in the measures required, potentially creating scenarios in which participating providers are required to report one set to the health plan and another to NYS. The need for such alignment is further supported by the significant burden placed on the State to gather data and develop reports; standardization of data collection and reporting will be a key factor in the State's ability to achieve these requirements. In order to support the achievement of the State's stated goals of HIE connectivity and facilitate the efficient collection of standard data in appropriate time frames, we suggest the State consider requiring or strongly incentivizing reporting through the RHIOs/SHIN-NY. This will provide a strong driver of use across

participants, and create a use case for participation in the state HIE for entities currently using or developing private HIEs.

- Medicaid Claims Data: We look forward with great interest to the development of the integrated RHIO connection within the Medicaid Data Warehouse; we request further clarification as to the implementation strategy for role-based access and the strategies the state will implement in order to ensure secure data access. Additionally, we seek to clarify whether DSRIP funding may be used to pay for connections to RHIOs. We also note that, in our experience with Salient, the large amounts of data available within the system will not be easily translated into actionable information for PPS in the absence of significant bandwidth from highly trained individuals. We suggest the State consider developing or expanding tools that can facilitate the use of such data for quality improvement and monitoring activities; Psychiatric Services and Clinical Knowledge Enhancement System (“PSYCKES”), a proven tool in use by NYS Office of Mental Health across the state, may represent a useful model on which to expand.
- Health Information Systems: We request additional detail on the health information systems that each PPS will be required to maintain or participate in. We are aware of information system challenges experienced by Accountable Care Organizations in which multiple, non-interoperable EHRs are in use, and believe that the paper-based, time-intensive systems currently in use by numerous major organizations should be phased out as rapidly as possible. In coordination with the HIE and other health information technology-related goals of the DSRIP, we suggest the state incorporate HIT requirements into this portion of the plan. Ensuring that all PPS participating providers go live on an EHR within a specified timeframe should be included; further, incorporation of some funding or resource availability to support this requirement would greatly facilitate the achievement of an electronic, interoperable health information system. However, we acknowledge that this will be a long-term goal.
- Quality Committee: We suggest that LGU representatives should be included as members of the Quality Committee responsible for supporting the clinical performance improvement cycle of DSRIP activities. The LGU role is particularly important in offering an informed perspective on consumers and providers as well as expertise in health care quality measurement.

Evidence of Public Input into the Project (Attachment I, p 10)

- This section states that providers must include “documentation of collaboration with local departments of public health, public stakeholders and consumers.” However, we suggest additional detail be included on the role of the consumer in evaluating or providing feedback on projects. Additionally, we believe the sentence should be revised to include behavioral health: “documentation of collaboration with local departments of public health, behavioral health, public stakeholders and consumers.”

Overview of Review Responsibilities (Attachment I, p 21)

- In addition to the independent assessment of DSRIP plans and public engagement period which are meant to inform the state's decision of whether to approve a DSRIP plan, we believe that it is important to ensure that local government be provided opportunities for consultation with the State during its review of all DSRIP plans.

State-level Review Process, DSRIP Plan Review Checklist (Attachment I, p 22)

- We propose that the following additional items be added to the DSRIP plan review checklist:
 - The plan includes a marketing component for outreach and motivating beneficiaries to take advantage of new integrated health care system.
 - The plan demonstrates that the current assets and systems in place of collaborating providers are beneficial to achieving successful outcomes.
 - The plan describes current database systems providers are using to collect and analyze data, to maximize results.
 - The plan supports opportunities to partner with educational institutions to research results and performance improvement options.

Data Workbook

- We noted that the time frame for the data workbook includes the period of Superstorm Sandy. Due to evacuations (and sometimes lengthy displacements), there may have been some distortion in utilization as a result.

Thank you for the opportunity to comment on these critically important documents.

Sincerely,



Thomas Merrill
General Counsel

COMMENTS ON THE NEW YORK STATE DSRIP WAIVER— Review of the Interim Access Assurance Fund (IAAF) and Attachment I – Program Funding and Mechanics Protocol and Attachment J – Strategies Menu and Metrics

Thank you for the opportunity to provide comment on the **Interim Access Assurance Fund (IAAF)** and **Attachments I and J**. The Medicaid waiver offers an important opportunity to strengthen immigrant health access and improve health outcomes. We are pleased to provide the following comments.

THE IAAF

Inclusion of this interim funding program is important and welcomed. There are true safety net providers that have been hurt by official policy, in particular, the Medicaid Redesign Team-backed policy for across-the-board reductions in Medicaid reimbursement which have had an inordinate impact on high Medicaid public and voluntary community hospitals. The IAAF funds, if well directed, could address and begin to fix the financial fragility of these needed hospitals and health services.

The waiver definition for the safety net is too broad and could result in supporting hospitals that provide only limited services to underserved populations. This is particularly a problem since decisions about this funding are solely in the hands of the State Health Department. Other states with a DSRIP programs limit funding to true public and voluntary providers.

RECOMMENDED CHANGES

- Redefine the safety net for more appropriate designations.
- Make the decision-making process for distribution of funds open to the public

ATTACHMENTS I and J

Overall, the New York Special Terms and Conditions (STC) is an impressive document with creative and intricate ideas. The level of accountability and transparency is much appreciated. Posting of information is important, as is the continued involvement of CMS.

There is also a delicate balance in the efforts to transform the health care system. Some of the balance should focus on the beneficiary/consumer/resident and the diversity of people within cities/counties. Individual preferences and differences are not recognized and addressed in the attribution methods of individuals to a Performing Provider System (PPS). It is unclear how race and ethnicity, primary language, and disability are considered, if at all, in PPS designation. Health care disparities are a major cause and outcome in problematic use of the health system that this funding is

meant to address. Racial differences are only tracked in Domain 4. Disabilities are not tracked.

Although the role of community residents and organizations in PPS and planning is acknowledged, clearer delineation of processes for involvement would ensure meaningful and ongoing involvement of consumers. The same is true for community-based providers which should be made part of the PPS and delivery system.

Uninsured residents are counted in use of health system for safety net designation, signifying a population of need. Yet, only Medicaid beneficiaries are attributed to a PPS. Although concerns have been articulated about the availability of reliable data on the uninsured, sources of information exist, such as the American Community Survey and Exhibit 50 of the Institutional Cost Report and FQHC state reporting mechanism. If uninsured residents are left out, access to care will become even more difficult for them.

Although the stated distribution of the DSRIP funds is 50% of the total for the public hospitals, the ultimate safety net providers, there are several places in I and J where this distribution is challenged. In one instance, public hospitals are encouraged to form PPS coalitions with voluntary providers, but the same provision appears to say the full funding should come from the public pool. This language appears to favor voluntary hospitals at the expense of resources for public facilities.

Documents describing the Medicaid Waiver articulate and promise “New Models of Care for the Uninsured.” However there is no funding designated to expand community-based ambulatory care services as part of the IAAF. Access to primary care services is an integral part of preventing reduction in avoidable hospital use and we encourage the State to dedicate resources to explicitly address gaps in primary care.



May 14, 2014

Jason Helgerson
 Medicaid Director, NYS Department of Health
 Corning Tower, Empire State Plaza
 Albany, NY 12237

Comments - Delivery System Reform Incentive Payment (DSRIP) Program Attachments I & J

Thank you for the opportunity to submit comments on Attachments I & J of New York's DSRIP Program.

The New York State Area Health Education Center (AHEC) System is a statewide health workforce development initiative focused on recruiting and training the next generation of health professionals and retaining current providers working in underserved communities. Our statewide system of nine centers, three regional offices and the Statewide Office builds community partnerships between institutions that educate and train health professionals and communities that need them most. **AHECs are neutral brokers with all health disciplines and organizations and help develop a diverse workforce for underserved urban and rural areas ensuring that each community has the right number of health care providers and staff with the right skills.**

While Attachments I & J offer several specific details, we are concerned that there is no mention of health and health-related professions students who are critical to DSRIP success and sustainability (doctors, nurse practitioners, physician assistants, nurses and social workers). While it is true that each Performing Provider System (PPS) must submit a “comprehensive workforce strategy” it is not mandated that this plan engage the trainee workforce.

From our experience with health workforce recruitment, training and retention, it is not enough to train the current workforce for DSRIP projects. Each year health professions students will continue to train in DSRIP environments (hospitals, practices, health centers, community organizations, etc.). The health care system cannot undergo true transformation without coordination between the state’s efforts to achieve the Triple Aim and students who are currently training and will be employed with DSRIP-engaged entities or agencies influenced by DSRIP outcomes.

Given the statewide performance measures and the need for all PPSs to achieve milestones, we believe resources must be invested to integrate DSRIP into health professions student training. With additional resources, the New York State AHEC System could lead a demonstration project with selected health professions schools and other workforce stakeholders to craft a solution to meet this need. This effort would dovetail with interprofessional care models being prioritized in health professions curricula and ensure students have knowledge of DSRIP activity.

We appreciate the Department’s intent to adhere to the tenets of the original 2012 Waiver proposal where the New York State AHEC System was included as a collaborator for Regional Health Workforce Information Centers (RHWIC). While CMS did not fund the RHWIC concept, what has not changed is the rationale of utilizing existing infrastructure like the New York State AHEC System to communicate and implement Waiver goals and objectives. Our statewide network is prepared to leverage past successes and build capacity to help the New York State Department of Health transform the skills of current and future health professionals so more patients can benefit from coordinated and integrated care.

The aforementioned suggestions are based on the New York State AHEC System’s 15 years of successful workforce development programming and evaluation for the Health Resources and Services Administration and the New York State Department of Health. AHECS are currently conducting outreach to possible PPS partners to share our expertise in training the current workforce, including HWRI and New York State Department of Labor projects. I will follow-up with further details on ways DSRIP projects can prioritize the involvement of health professions students.

Sincerely,

Mary J. Sienkiewicz, MBA – Director

Leadership for the New York State AHEC System is provided by community-based centers, the Statewide Office at the University at Buffalo and regional offices at Upstate Medical University, Albany Medical College and The Institute for Family Health.

Comments on the New York State Delivery System Reform Incentive Program Special Terms and Conditions from the Primary Care Development Corporation

April 29, 2014

The Primary Care Development Corporation (PCDC) provides these comments as strong supporters of New York State's efforts to transform its health care delivery and payment system to make it more affordable, accountable and effective for all New Yorkers.

Mounting evidence makes it clear that access to quality primary care is central to achieving the Triple Aim. Given New York's profound lack of primary care (about 2.3 million lack sufficient access), as well as historic underinvestment in this sector, strengthening primary care should be a top priority use for the Medicaid Waiver. We also note that **primary care received the greatest number of responses by far and was ranked as a priority by the greatest percentage of respondents (93%)** when NYS DOH surveyed stakeholders to gauge their priorities early in 2012. [*New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim. Pages 10-11. August 6, 2012- see Attachment A*]

In many ways, the current Delivery System Reform Incentive Plan (DSRIP) terms and conditions are more cohesive than previous iterations of the Waiver. The concept of four interrelated "Domains" is a rational structure for achieving DSRIP goals for individual Performing Provider Systems (PPS) and for New York State and CMS. Likewise, the accountability requirements to receive incentive payments will help ensure DSRIP goals are met in each of the domains.

Over the last several years, New York has emphasized the need to build a strong primary care infrastructure, and has embraced bold initiatives to strengthen and improve primary care. We believe the MRT Waiver in its present form needs to reflect these values and priorities more sufficiently.

We make the following recommendations to modify the Special Terms and Conditions and related Attachments that we believe will re-emphasize primary care in the Medicaid Waiver.

1. Restore Primary Care Technical and Operational Assistance in the Waiver

The Waiver documents released last year indicated \$1.25 billion for primary care expansion. Soon thereafter, funding for capital, health information technology and regional planning initiatives were disallowed, leaving the Technical and Operational Assistance program as the only targeted investment in primary care. While it appears that other programs in the waiver were modified, incorporated into DSRIP, or reduced to accommodate the reduction from \$10 billion to \$8 billion, the technical assistance (TA) program, originally budgeted at \$305 million, was completely eliminated.

Technical and operational assistance to develop more efficient and effective primary care is critical to the delivery system transformation New York seeks. Based on our experience as national primary care safety-net technical assistance providers, there is a significant undersupply of content and process expertise to help primary care providers undertake the difficult road of transformation. This support

would have helped New York State build that TA infrastructure in each the State's regions, and would have provided the support for much of the training and TA required to enable the health system transformation New York is pursuing. We urge restoration of a primary care technical and operational assistance program in the Waiver.

2. Require a Comprehensive Primary Care Plan of each DSRIP PPS

We are encouraged that the DSRIP attribution model prioritizes primary care, and we recognize that primary care improvement and integration are key elements of DSRIP projects (in all four domains). Likewise, designations of Health Professional Shortage Areas and assessments of "system capacity for primary care" are included in baseline PPS Performance Assessments [Attachment I, IV. DSRIP Project Plan Requirements/b. Organization of DSRIP Project Plan/ 5) Performance Assessment/ a) and b)].

We are also encouraged that the DSRIP plan requires PPSs to choose at least one project from Domain 2, sublist A. In sublist A, projects i, ii, and iii appear to have high-performing primary care (PCMH Level 3, 2014 NCQA standards) as a requirement. For projects iv and v (the "Medical Village" projects), it is not as clear. Both projects require that primary care practices developed as part of a bed closure plan must be PCMH Level 3, but that could create a scenario where the PPS relies on existing primary care capacity, even if it is inadequate in capacity or quality.

The situation is similar with Domain 2, sublists B and C, from which PPSs are expected to select at least 1 project. Most of these projects require a strong foundation of primary care, but in most cases, it is not clear that PPSs are expected to have primary care in sufficient quality and quantity to engage in these projects.

We can also envision scenarios in which PPSs could include no primary care expansion, even when it is warranted. The PPSs would select projects iv or v from sublist A and another project from sublists B or C that does not require primary care.

To emphasize its foundational importance, the DSRIP program should specifically require that each PPS demonstrate a comprehensive strategy to deliver quality primary care to the PPS attributed population. The terms and conditions now require that each PPS plan have a comprehensive workforce strategy. Similarly, each PPS plan should have a specific strategy to ensure that the patients served have timely access to quality primary care. (Attachment I, IV. DSRIP Project Plan Requirements/b. Organization of DSRIP Project Plan/ 5) Performance Assessment.)

This strategy should include a baseline assessment of primary care access, capacity and quality. While HPSA designation is an important baseline measurement of need, it is often inadequate in measuring true access to primary care. Other factors, such as provider hours of operation and after hours availability, whether the practice is accepting new patients, and number of practices that are Level 2-3 PCMH (2011 or 2014), should be considered in the assessment.

PPS plans should specify how the PPS will ensure primary care access to the target population. Those plans should include how the PPS would build, acquire, redesign or collaborate to expand primary care capacity; how primary care would be integrated into the delivery system, including the PPS governance structure; how primary care would be reimbursed or otherwise compensated through incentive

payments; and how clinical and support staff in the primary care setting would be trained in patient-centered models of care.

There have been too many initiatives in the past that assumed a significant role for primary care, only to have it subsumed and fade into a minor role. Primary care is a foundational element to transformation. As with workforce, the requirement for a primary care strategy should be explicit in the terms and conditions.

3. Clarify that Appropriate Primary Care Practices or Networks Can Serve as “Lead Coalition Providers”

In some cases, a primary care network may be beneficial as a Lead Coalition Provider for a PPS. Indeed, some high-performing federally qualified health centers have already had considerable success in achieving DSRIP domains 2, 3 and 4, and have strong relationships with other providers in their service areas. A strong primary care provider organization serving as a lead would make sense in terms of their expertise and value to the system. It is often understood that the health system of the future will be driven by primary care. A PPS that reflects this configuration would send a strong message about where New York’s health system should be heading. Finally, having several PPSs led by primary care organizations would allow New York to compare the performance of individual PPS DSRIP projects across the state based on governance structure.

4. Ensure Integration of DSRIP and the State Health Innovation Plan

The goals of DSRIP/Waiver and New York’s State Health Innovation Plan (SHIP) are similar (transformation of the payment and delivery system to achieve the Triple Aim), even as DSRIP focuses on the safety net while SHIP proposes broader systems change. A stated goal of the SHIP is that 80% of residents receive “Advanced Primary Care.” We are pleased that Domain 2.a.ii requires the PPS to “Increase certification of primary care practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP).” The majority of Medicaid enrollees attributed to DSRIP PPS plans will be those most in need of Advanced Primary Care. There are many other elements between DSRIP and SHIP (i.e. payment reform) that should be aligned. We would recommend that a clear chain of authority for managing these two interrelated initiatives should be explicitly stated and articulated to stakeholders.

5. Payment Reform Should Begin in Year 1, Should be Accelerated, and Should Prioritize Primary cCare

While the DSRIP incentive payments provide greater incentive for change than upfront grants, they are no substitute for Medicaid payments that align with and support DSRIP goals. We are encouraged that New York State must have a payment reform “roadmap,” for amending Medicaid managed care contract terms. We believe that the road should be relatively short, and by the end of Year One, New York should have managed care contracts in place that align with and support a transformed delivery system. By “frontloading” payment reform, New York can accelerate the pace of change in the delivery system.

Payment reform must address two issues: the form of payment and its adequacy. Payment reform should explicitly include alternatives to fee-for-service reimbursement; payments that value care

coordination, telehealth, group visits, health information exchange and other enabling services; and increased payment for primary care. Primary care accounts for only about *five percent* of health care spending in New York State. We will never achieve true transformation if we continue to undervalue parts of the system that are essential to improving health and reducing costs. Given the very low base of current primary care spending, increasing primary care spending to 10% would entail a minor spending shift while doubling the resources for primary care and, sustaining the key elements of true Patient Centered Medical Home/Advanced Primary Care.

Conclusion

We believe the Medicaid Waiver represents a historic opportunity to redesign our health care system. All evidence suggests that strong and sustainable primary care is essential to that effort. We urge New York State and CMS to consider our recommendations and place the appropriate emphasis on increasing the quality and capacity of primary care in the final Special Terms and Conditions and related Attachments.

Thank you for the opportunity to comment.

Contact: Dan Lowenstein, PCDC Senior Director of Public Affairs – 212-437-3942;

dlowenstein@pcdc.org

May 14, 2014

RE: Public Health Solutions Comments – Attachments I: NY DSRIP Program Funding and Mechanics Protocols and Attachment J: NY DSRIP Strategies Menu and Metrics

Thank you for the opportunity to provide comments on New York State’s Medicaid Redesign Team (MRT) Waiver Amendment and Delivery System Reform Incentive Payment (DSRIP) Program implementation documents. Public Health Solutions (PHS) applauds New York State’s (NYS) ambitious effort to transform the health care safety net, reduce avoidable hospital use and improve health and public health measures. Through Attachments I and J, the State has provided a strong menu of projects and strategies to achieve these goals, and PHS looks forward to participating in Performing Provider Systems (PPS) to support implementation of these projects.

PHS, one of the largest not-for-profit organizations in New York City and a nationally recognized Public Health Institute, addresses critical public health needs such as food security and nutrition; women’s reproductive health; early childhood development and family support; HIV prevention and care; healthcare access and quality; tobacco control; and health information technology. Our community health programs serve close to 80,000 low-income individuals and families annually and we operate a range of programs that have records of success in supporting healthy women and infants and preventing HIV and STDs.

Our comments below relate to both Attachments I and J:

Comment 1: Attachment I – Hierarchical Matching

The described hierarchical geographic and service loyalty methodology, specifically in regards to priority one – care management providers, needs clarification. For example, PHS operates two programs, Nurse-Family Partnership™ (NFP) and Early Intervention Service Coordination (EISC), that currently bill NYS Medicaid for case management services. It is unclear from the description of the attribution methodology as written whether these NFP and EISC providers would be integrated into the attribution methodology.

We recommend that the State provide clearer guidance on the definition of care management for the purposes of the attribution methodology to ensure that the implications of the methodology are transparent to providers and clients.

Comment 2: Attachment J – Domain 3

PHS applauds the State’s efforts to integrate a strong focus on maternal and child health into the DSRIP Program, including high risk pregnancies, and on projects that have the potential to reduce preterm births, improve prenatal care, and reduce unintended pregnancies, including Projects 3.f.i and 4.d.i. PHS currently operates two evidence-based home visiting programs: our Nurse-Family Partnership™ (NFP) program serves Northern Queens County and our Healthy Families New York (HFNY) program serves Bushwick, Brooklyn. Both programs have resulted in notable outcomes including reductions in preterm births, improved birth spacing, reduction in emergency room visits, as well as improved childhood immunization and breastfeeding initiation rates, among others. PHS is the only organization in NYC that operates both of these evidence-based home visiting models. NYSDOH has recognized the value of both of these models: in implementing NYS’ Maternal, Infant and Early Childhood Home Visiting (MIECHV)

federal grant funding and approved MIECHV State Plan, NYSDOH has distributed funding to both NFP and HFNY.

We recommend that NYSDOH expand upon the definition of evidence-based home visiting to include other successful models in addition to NFP, such as HFNY. This inclusion should be explicitly noted in Attachment J as well as in the DSRIP Project Toolkit.

Comment 3: Attachment J – Domains 3 and 4

As noted in our comments regarding the DSRIP Special Terms and Conditions, PHS supports the DSRIP Plan’s focus on transforming patient care systems to create strong links between different settings in which care is provided. Many essential preventive care services are provided within the context of sexual and reproductive health visits for both women and men. In fact, six in 10 women visiting Title X–funded clinics for contraceptive and related services describe the clinic as their usual source for medical care.¹ Access to high-quality family planning services, with an emphasis on Long Acting Reversible Contraceptives, is linked to a reduction in unintended pregnancy, a DSRIP priority and Metric #60. The ROI is clear: by providing women the contraception they need to avoid unintended pregnancies, publicly funded contraceptive services yielded savings of \$10.5 billion, or \$5.68 for every \$1 spent to Medicaid.²

As an example, PHS is currently leading an 18-month quality improvement (QI) collaborative with four FQHCS to improve the quality of family planning services, leading to a reduction in unintended pregnancies. The collaborative is introducing key evidence-based practices through a site-specific tailored QI process, resulting in clinical, operational and administrative improvements, and creating sustainable infrastructure and reimbursement streams. The project is designed to leverage and improve the use of electronic health records to identify patients in need of these services, appropriately document and report, provide data for QI activities, and improve billing practices.

We recommend that the State include a specific project in Attachment J (Domains 3 and 4) and the Project Toolkit that explicitly focuses on increasing access to and use of contraceptive methods, with a focus on long-acting reversible contraceptives.

Thank you for your consideration of our comments. Please feel free to contact me at 646-619-6401 (erautenberg@healthsolutions.org) or Louise Cohen, Vice President for Programs, at 646-619-6404 (lcohen@healthsolutions.org) if you would like more information or to discuss any of our comments in further detail.

Sincerely,



Ellen Rautenberg
President and CEO

¹ Frost, J (2013). U.S. Women’s Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010. Guttmacher Institute. Accessed at: <http://www.guttmacher.org/pubs/sources-of-care-2013.pdf>

² Guttmacher Institute (2013). Publicly Funded Family Planning Services Help Women Avoid Unintended Pregnancies While Generating Substantial Financial Savings. [http://www.guttmacher.org/media/nr/2013/07/30/index.html?utm_campaign=Feed:+Guttmacher+\(New+from+the+Guttmacher+Institute\)&utm_medium=feed&utm_source=feedburner](http://www.guttmacher.org/media/nr/2013/07/30/index.html?utm_campaign=Feed:+Guttmacher+(New+from+the+Guttmacher+Institute)&utm_medium=feed&utm_source=feedburner)



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Kate Breslin
President and CEO

To: Jason Helgeson, Deputy Commissioner, Office of Health Insurance Programs, NYS
Medicaid Director
From: Kate Breslin, President and CEO, Schuyler Center for Analysis and Advocacy
Re: Comments on New York State DSRIP Attachment I and J
Date May 14, 2014

The Schuyler Center for Analysis and Advocacy (Schuyler Center) is a 142-year-old statewide, nonprofit organization dedicated to providing policy analysis and advocacy in support of public systems that meet the needs of people in poverty and disenfranchised populations. Schuyler Center often works in areas that fall between multiple systems of care including physical, oral and behavioral health; child welfare; human services; and early care and learning.

Schuyler Center serves as a steering committee member of both Medicaid Matters New York, a coalition dedicated to advocating on behalf of Medicaid members and Health Care for All New York, a coalition of 160 organizations dedicated to assuring all New Yorkers have affordable high-quality insurance. On behalf of Schuyler Center, I participate in several of the State's Medicaid and health-oriented advisory bodies, including Medicaid Redesign Team workgroups, the Medicaid Evidence-Based Benefit Review Workgroup, the Basic Health Plan Advisory Committee and the Governor-appointed Behavioral Health Services Advisory Council. For more information about Schuyler Center and our work please visit our website www.scaany.org

We appreciate the opportunity to comment on New York's Medicaid Delivery System Reform Incentive Payment (DSRIP) Program, intended to achieve a 25% reduction in avoidable hospitalizations and restructure the health care delivery system. Schuyler center applauds the transparency and accountability built into this waiver, particularly the laudable goals of efforts to incorporate the Triple Aim: improve patient experience of care (particularly satisfaction and timely care), improve health outcomes and achieve system efficiencies. We look forward to working with the State to assure that Medicaid members are at the center of this transformative plan which also has the potential to shift how all New Yorkers interface with the health care system.

Most of the DSRIP plan is focused on the integration of providers and moving New York toward value-based purchasing. Although we commend the transparency and accountability of the DSRIP, our recommendations center on strengthening accountability and transparency; ensuring genuine, accountable and ongoing consumer engagement and feedback; and ensuring that projects are a genuine reflection of community needs.

Schuyler Center supports the following aspects of the MRT-DSRIP:

- The goals of the DSRIP plan to direct investments to safety net providers that serve the Medicaid, uninsured and dual eligible populations
- The quality measures as identified in Attachment J, particularly the consumer experience of care measures (CAHPS) and health disparities

- Requirement for Performing Provider Systems to develop plans in collaboration with community stakeholders and be responsive to community needs (page 8 of Attachment I)
- Performance Assessment which includes:
 - A community health needs assessment to include health disparities, Health Professional Shortage Areas, public health concerns. (Page 10 of Attachment I)
 - Evidence of regional planning and the inclusion of both health and social system supports, health system improvements and regional planning issues. (Page 10 of Attachment I)
 - Comprehensive Workforce Strategy (Page 10 of Attachment I)
 - Public input (Page 10 of Attachment I).
- Quality Committee as an advisory group for DSRIP, inclusive of consumer representation (page 30 of Attachment I).

Overall: The DSRIP plan provides for consumer and public input but the plan would be improved with stronger and more specific requirements.

Consumer Engagement and Communication

Medicaid managed care already presents challenges for many members. It is not clear how Medicaid consumers will influence the development of, learn about, and understand Performing Provider Systems. It is likely that there will be confusion regarding what is expected or what consumers need to do to engage with the health care system differently. We recommend a series of consumer information meetings to educate Medicaid members about this new program; allowing them time to understand the new program so they are prepared to participate in community needs assessments, regional planning or other public input opportunities. The state should not wait until there are designated PPS before engaging Medicaid members in this process but rather start immediately so they may have the opportunity to contribute to the process.

The health care system is difficult to navigate and even a ‘seamless’ transition is often not as seamless as hoped. Although the intention of DSRIP seamlessness for Medicaid members, this type of transformative delivery practice, together with co-occurring changes in New York’s health care delivery, payment and coverage systems, may have the unintended consequence of causing confusion, anxiety and distrust among Medicaid members. Medicaid members may need support to navigate the health care delivery system, and they need information to start.

Recommendation: The State should implement a strategic plan to share information with Medicaid members about the DSRIP plan, how it will impact them, ways they can share their feedback about what is working and what is not and have several statewide consumer meetings to answer questions. Materials should be developed in multiple languages. This should be in addition to the already incorporated requirements for the developing Performing Provider Systems to engage their community stakeholders. It is unrealistic for DSRIP to truly work without engaging Medicaid members in the process of both shaping and using the delivery care system more efficiently.

Governance

Attachment I expects a PPS to identify a governance structure that primarily engages the lead provider and partners of the PPS and workforce representation but not consumers.

Recommendation: Schuyler Center recommends that the governance structure of PPS include representation from community-based providers that may or may not be a partner in the PPS and from consumers, much the way Boards of Federally Qualified Health Centers have consumer representation (Page 12 of Attachment I).

Quality Measures

As stated above, one of the strengths of the DSRIP plan is the collection and monitoring of important metric based on consumer experience of care and disparities. Important pieces of information are missing from what is collected:

- 1) Attachment J does not appear to have a measurement to track health care delivery, outcomes and access to people with limited English proficiency;
- 2) Physical access: people with physical disabilities often cannot access health services they need. DSRIP is an opportunity to assure all health facilities are accessible for all people. New York needs a physically accessible health care infrastructure that includes the physical plant of the building as well as necessary physically accessible diagnostic and treatment equipment. This is an essential piece of improving health disparities and it will not happen until the state requires it and starts to measure and track it. The state should measure the physical access challenges of all providers in a PPS and measure how the providers improve access.
- 3) People with developmental disabilities: people with developmental disabilities are largely invisible in the DSRIP plan. While the number of people who have developmental disabilities as a share of those covered by Medicaid is small, it is a population that often has limited access to care. The health care system as a whole needs to better address the needs and be accessible to this population. In addition to the physical access barriers noted above all providers should be trained in delivering services to people with disabilities.

Recommendation: Add quality measures that track how DSRIP projects reduce disparities to people with limited English proficiency, physical access, and people with disabilities

Workforce

The DSRIP project plan must include a comprehensive workforce strategy including the employment levels, wages and benefits, and distribution of skills (page 10 of Attachment I). This section should explicitly include the use of non-licensed providers such as community health workers and peers and how they may fit into the workforce strategy.

As the health care delivery system becomes more efficient the use of non-licensed community health workers and peers will become increasing important. PPS should count them in their

workforce evaluations and determine how best to educate and employ them. Expanding the use of community health workers will be pivotal to helping Medicaid members use the health care delivery system differently and for those members who do not qualify for care management, community health workers could be a pivotal role in helping them engage in their own care and answer important questions.

Community health workers are particularly important for Medicaid members with limited English-proficiency and racial and ethnic minorities reaching them in linguistically and culturally appropriate ways. Community health workers are an important piece of the PPS workforce and should be resourced under the DSRIP plan.

Recommendation: Include Community Health Workers and the use of peers in the PPS workforce strategy and in workforce milestones (page 8 Attachment J).

Evidence of public input

Section e of the Performance Assessment of Attachment I requires documentation regarding how PPS collaborates with local departments of public health, public stakeholders and consumers. To strengthen this process, we supports the State's proposal to require PPS to maintain a website that would include public comment opportunities (page 11 of Attachment I).

The DSRIP plan builds in opportunity for consumer and public engagement and it will be essential to ensure that this is implemented in a meaningful manner, with PPS actively engaged in publicizing when and how such feedback can happen. Some PPS may need to be creative regarding how to solicit this engagement, for example, in rural areas of the state and communities where language and transportation barriers may present special challenges. Ensuring that public stakeholder and consumer feedback is genuine is essential to making sure the DSRIP plan is truly accountable and transparent.

Recommendation: Schuyler Center strongly recommends the state require PPS to maintain a website with contact information in multiple languages, available public comment opportunities with multiple ways to collect such feedback and an overview of what was received, how it informed their final projects.

Mid-point Assessment

The DSRIP Project Plan Review Process calls for a mid-point assessment (page 23, Attachment I). In addition to assessing the quantitative benefit of the project to Medicaid and uninsured health outcomes (page 24, v., Attachment I), Schuyler Center recommends that consumer feedback be solicited along with a public stakeholder comment period. This mid-point assessment time is a good time to assure that consumer and public input is ongoing and that there are expected touch points in the DSRIP project when this will occur. The State and independent assessor can use this feedback as part of the assessment process.

The assessment will also evaluate the governance structure and how it is working (page 24, vi., Attachment I). This is another opportunity to see how the PPS incorporates the input of consumer and consumer advocates in the decision making of the PPS.

Recommendations: Require each PPS to engage in a community stakeholder and consumer feedback as part of the mid-point assessment. Information from consumers should include how they perceive the benefits of the DSRIP projects, satisfaction with communication, engagement, timeliness of care, access to the specialists, case managers, and specialists, social support services, how they can get questions addressed and when appropriate decision making.

Reporting Requirements and ongoing Monitoring

The state will be publishing quarterly project updates which shows available data that reflects the progress on metrics. Schuyler Center expects that metrics capturing health disparities and consumer experience regarding timely care and satisfaction will be part of what will be made available. We also recommend that the metrics are broken up by age, race, and gender.

Recommendation: Published measures and progress indicators should include measurements that track disparities, and are broken out by age, race/ethnicity and gender.

Quality Committee

As stated above, Schuyler Center supports the use of the Quality Committee as an advisory group to DSRIP. We recommend that in addition to providing feedback on the attribution model, selection metrics, and target goals that this group also look at timeliness of care, patient satisfaction, and disparities data to help shape measures that may get at these issues.

Recommendation: Use the Quality Committee as another vehicle to include consumer representation and tracking of measures that reflect the impact DSRIP projects have on Medicaid consumers particularly on their care experience and satisfaction and tracking disparities.

Thank you for the opportunity to provide comments on New York State MRT-DSRIP Program, Attachments I and J.

May 14, 2014

Mr. Jason A. Helgerson
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Medicaid Director
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY12237

Transmitted electronically to: dsrip@health.state.ny.us

Dear Mr. Helgerson,

These comments are submitted in response to the Department's request for comments concerning Attachment I and Attachment J of the New York State Section 1115 Medicaid waiver. Our previous comments, submitted in response to the proposed Special Terms and Conditions, appear not to have had any effect. Hopefully, the same fate will not befall these requests.

We represent the employees who work at public hospitals, mental health facilities and in services for the developmentally disabled. We ask that you consider our concerns and recommendations for them and for their patients as you work to implement your waiver agreement with CMS. Labor/management collaboration should be recognized in all domains of Attachments I and J, tied to the scoring (project value index) and award amounts allocated to proposed projects. In your waiver extension application submitted to the CMS, workforce planning and labor/management collaborations were listed as key components of DSRIP applications; to date, no such recognition has been given in the Special Terms and Conditions, these Attachments, or any other documents intended to guide applicants. We have written—and here reiterate—that labor unions which represent health and mental health service employees should be active participants in the planning and implementation process of the DSRIP projects.

In addition, New York State's implementation of its section 1115 waiver extension must ensure that public hospitals receive their fair share of the waiver funds, and especially that preference is given to those hospitals that currently serve a large number of Medicaid patients. We ask that you consider a scoring system that encourages public hospitals to maintain their public service mission. Attempts to change the business model of safety net hospitals—the parties actually serving your beneficiaries—should not, in the end, undermine those institutions.

Thank you for your immediate attention to our concerns and recommendations. We look forward to meeting with you in the near future to further discuss the Medicaid Waiver and the role our members will play in any proposed transformation of our safety net health care system.

Very truly yours,



President, NYS Public Employees Federation

With regard at Attachment I, we would like to make these points:

(NY DSRIP Program Funding and Mechanics Protocol)

pg. 2, Definition of DSRIP Performing Provider Systems, assessment of safety net provider status: The definition of safety net provider status here is less precise than others in waiver material, more susceptible to subjective information (“other available information...”). Your definition should be limited to organizations that have substantial responsibility for uninsured, Medicaid and Medicaid managed care patients.

C, DRSIP Beneficiary Attribution Method: attribution of the beneficiary to only one performing provider system creates an artificially narrow network, an outcome more limiting and arbitrary than those networks involved in managed Medicaid services and in the developing health exchanges.

The DSRIP Beneficiary Attribution Method should mimic that associated with Medicare’s attribution of patients in Accountable Care Organizations, namely, they should be accounted for in a manner which is “invisible” to the patient, and which does not limit the patient’s access to services.

III. Projects, Telemetric and Metric Targets: Omitted entirely in this section is any mention of the welfare of individual patients. The proposal indicates that the projects will be “responsive to community needs and the goal of system transformation.”

We suggest that these projects must be, first and foremost, responsive to the needs of patients in the communities served, and to individual patients whose care may otherwise be disrupted through the arbitrary directives of this program. Even a statement of the *importance* of individual patient and clinical outcomes would help.

IV. DSRIP Project Plan Requirements, number ten, governance. The credible execution of the projects described is difficult to envision, success hard to define. Therefore, the proposed evolution of these Performance Provider Systems into “a highly effective integrated delivery system” should be resisted; this is a level of complexity which is unnecessary for your purposes, suggesting a mandate which goes beyond both federal and state statute.

V. Project Valuation Step One, Calculating Project PMPM. The limitation on the value of the projects on the basis of per member per month funding of \$15 is entirely arbitrary, without reference to any basis or evidence.

In the absence of evidence, this goal should be restated as a hypothetical, tentative, interim goal, pending the development of evidence that would link per member per month valuation and particular projects. At such time as additional evidence is offered, it should be based on patient and clinical experience, not an arbitrary “top down” limit. These comments apply to the remainder of the calculations (through page 18) concerning “project value,” as all of them are dependent on arbitrary judgment, free of evidence grounded in clinical or organization experience.

VI. DSRIP Project Plan Review Process, ii Independent Assessment: The characteristics of the independent assessor are not noted, only that the “State must identify” such an independent assessor. In fact, the definition of independent assessor should be straightforward, namely, an individual or organization *with no existing commercial ties to any of the applicants*, nor any existing commercial ties for similar work with the State.

With regard to Attachment J, we would like to make these points:

Attachment J – NY DSRIP Strategies, Menus and Metrics. In general, this section proposes that the State outline projects for local evaluation, that the State develop guides to review the “approvability” of those projects, and that the State subsequently give such approval. This is entirely backward or, more accurately, upside down. Great deference should be given to projects developed at the local (community, institutional) level, with “approvability” dependent on the conformity of such plans to demonstrated local need, not on public health or policy theory, or State predisposition. Notwithstanding this general objection, the following notes are offered in response to the specific “strategies, menu and metrics.”

Domain 2 System Transformation Projects, Page three: The general objection to Attachment J applies emphatically to this section. There is nothing inherently valuable about any of the Tasks (“create integrated delivery systems...”) outlined here. Indeed, the meanings of many of these words and theories have changed. “Integrated delivery systems” five years ago meant doctors and hospitals acting in concert; its meaning is unclear now. Moreover, most if not all of these proposals have yet to demonstrate evidence in terms of improvement of patient care services, including their quality or cost. For example, “increase certification of primary care practitioners at PCMH” has been demonstrated to increase reimbursement to family physicians, but has yet to demonstrate merit for patients, cost reduction, or other desirable end-results.

In summary of **Domain 2**, these projects suggest that top down, central planning, in the absence of the specific characteristics of the local care delivery system, should prevail. This is indefensible, in the face of this MRT reality: these waiver “savings” should be used to repair the financial damage associated with managed Medicaid (underpayment to doctors and hospitals in managed Medicaid programs). This was done with public hospitals in California, and in the section 1115 waiver in Texas. If this cannot be the goal of New York, CMS should intervene.

Domain 3 “Clinical Improvement Projects”: We support the inclusion of consideration for behavioral health in all projects. At the same time, our earlier observations are repeated here, that the top down planning for such inclusion will be inherently *inefficient*, that planning based on sloganeering will be *ineffective*, and that, in the end, dissipation of funds through central decision-making will lead to *inequity*.

Here is an example, concerning cardiovascular health. The only entry in this section which cites any evidence or literature is a link to yet another governmental planning exercise. Nowhere is any peer reviewed material concerning cardiovascular health referenced, only, to the contrary, a federal government “campaign.”

Even more serious, the “system transformation metrics” in Domain 2 posit a “Measures Steward” which refers to commercial products (3M) not otherwise disclosed or discussed in any of these materials. When materials are referenced that are public—for example to AHRQ—no notation or citation is given which would allow the reader or applicant to access the proposal, or evidence for its support. A more accurate job is done in identifying NCQA standards and sources, for behavioral health, but for example the Measures Steward for palliative care (“NYS”) has no traceable source.

Finally, in **Domain 4**, page 16ff, the measures required have no apparent basis in any analysis, and only the most general basic (SPARCS, Vital Statistics) references to source. The entirety of Domain 4 suffers from imprecision in definition, inattention to demonstration of the relevance of the measurement to improvement in public health, lack of linkage to any peer reviewed or well-accepted evidence. It appears to be a listing of hypotheses concerning “health reform.”

In summary, the four domains have as their apparent premises:

- (1) That the State’s development of projects is a strategy superior to community-based planning;**
- (2) That espousing “evidence-based medicine” does not require reference to any actual evidence or literature which would provide same; and**
- (3) That funds generated through underpayment of doctors and hospitals should be devoted to any projects other than repair of the resulting financial compromises to providers; and**
- (4) That the State’s role as offerer, evaluator and overseer of these projects does not contain obvious conflict.**

We reject all of these premises.

Comment regarding DSRIP Project Toolkit, Clinical Improvement Project 3.e.i HIV/AIDS

New York City has the largest population of injection drug users (IDUs) in the US, estimated to number 40,000-120,000, based on the 2009 National HIV Behavioral Health study's sample of NYC residents.¹ According to the New York City Department of Health (NYCDOH), 9% of new HIV diagnoses in 2008 were attributable to injection drug use² – markedly lower than the 15% rate for the US as a whole.³ The estimated HIV incidence among IDUs in NYC decreased from 3.6/100 person-years at risk (PYAR) in 1991 to 0.3 PYAR in 2008, a decline “largely based on the success of sterile syringe access programs,” according to NYCDOH.⁴ The CDC summarizes that, “[g]iven the number of Syringe Exchange Programs (SEPs) providing preventive health services, as well as provision of sterile syringes, these programs contribute to a comprehensive approach to the prevention of HIV and other bloodborne infections among IDUs.”⁵ Evidence of the effectiveness of SEPs in reducing new transmission of HIV is voluminous.^{6,7,8,9} Not only do SEPs reduce incidence of new HIV infection among IDUs, but also among the sexual partners of IDUs.

Considering this evidence base, it is surprising that the DSRIP Project Toolkit released on April 28, 2014 makes no mention of syringe exchange programs being integrated into Preferred Provider Systems' (PPS) network of service providers, nor mentioned as integral to Centers of Excellence Management for HIV/AIDS (including HCV), as described in the toolkit under Clinical Improvement Project 3.e.i HIV/AIDS.

In consideration of the evidence, candidate Performing Provider Systems that choose to undertake Clinical Improvement Project 3.e.i HIV AIDS should be encouraged by NYS DOH to include SEPs in their provider systems. Without such guidance, lead PPS organizations unaware of the evidence of the effectiveness of SEPs in preventing HIV transmission are more likely to neglect these providers who have established trust and rapport with a traditionally hard-to-reach high-cost population at elevated risk for HIV and HCV infection. (A mention of syringe exchange programs could be accompanied by a parenthetical note that such services are funded by NYS DOH AIDS Institute grants with State-only funds and not Medicaid.)

Submitted by:
The New York Academy of Medicine
May 14, 2014

^[1] http://www.nyc.gov/html/doh/downloads/pdf/dires/nhbs_idu_mar2010.pdf

² *Ibid.*

³ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5945a4.htm>

⁴ http://www.nyc.gov/html/doh/downloads/pdf/dires/nhbs_idu_mar2010.pdf

⁵ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5945a4.htm>

⁶ Jarlais, D. C. Des, Marmor, M., Paone, D., Titus, S., Shi, Q., Perlis, T., ... Friedman, S. R. (1996). HIV incidence among injecting drug users in New York City syringe-exchange programmes. *The Lancet*, 348(9033), 987–991. doi:10.1016/S0140-6736(96)02536-6

⁷ Hurley, S. F., Jolley, D. J., & Kaldor, J. M. (1997). Effectiveness of needle-exchange programmes for prevention of HIV infection. *Lancet*, 349(9068), 1797–800. doi:10.1016/S0140-6736(96)11380-5

⁸ Gibson, D.R., Flynn, N.M., Perales, D. (2001). Effectiveness of syringe exchange programs in reducing HIV risk behavior and HIV seroconversion among injecting drug users. *AIDS*, 15 (11), 1329-1341.

⁹ Strathdee, S. A., & Stockman, J. K. (2010). Epidemiology of HIV among injecting and non-injecting drug users: current trends and implications for interventions. *Current HIV/AIDS Reports*, 7(2), 99–106.
doi:10.1007/s11904-010-0043-7

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Good afternoon.

We are writing on behalf of Visiting Nurse Service of New York (VNSNY) and MJHS, the two largest providers of home and community based care in metropolitan New York. We respectfully request your consideration of requiring that Medicaid Managed Care Organizations that contract with DSRIP Performing Provider Systems (PPSs) reimburse for home health services provided through Certified Home Health Agencies (CHHAs) participating in the DSRIP PPS on an episodic basis, as has been the state's policy for CHHA services for the past several years. This requirement would provide consistency and standardization of in-home post-acute and sub-acute care for patients needing these home health services when they are most vulnerable.

Please do not hesitate to contact either of us with any follow-up questions or comments.

Thank you.

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May 14, 2014

Jason Helgerson
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Re: Attachments I and J from MRT Waiver Amendment/DSRIP Special Terms and Conditions

Dear Mr. Helgerson:

Thank you for the opportunity to comment and provide input on Attachments I and J of the Medicaid Redesign Team (MRT) Waiver Amendment/Delivery System Reform Incentive Payment (DSRIP) Special Terms and Conditions (STCs). Westchester Medical Center's (WMC) comments are intended to strengthen the guidance and support provided to coalitions of providers interested in pursuing qualification as a Performing Provider System (PPS) under the DSRIP program in pursuit of a health system that achieves the triple aim of lower cost, better care, and higher quality.

WMC is a public hospital located in New York's Westchester County. Our mission is to serve as the regional healthcare referral center providing high-quality advanced health services to the residents of the Hudson Valley and the surrounding area, regardless of their ability to pay. In support of this primary mission, WMC also serves as an academic medical center committed to education and research that enables advanced care and prepares future generations of care-givers. WMC has formed close partnerships with local community providers with the intent to create a Performing Provider System and participate in the DSRIP program.

The DSRIP program has the potential to be a driver of change in how care is delivered, paid for, and experienced in New York State. Full and comprehensive support for potential PPSs is a vital component in ensuring DSRIP achieves success. Overall, the New York STC is a very detailed, carefully considered and helpful guide to the DSRIP program and process. It is critical that the information presented in these attachments adequately support the creation and execution of successful DSRIP programs.

Our detailed comments are attached. If you have questions, please contact me at (914) 493-5086 or via email at MahlerA@WCMC.com.

Sincerely,

Anthony Mahler

Senior Vice President, Strategic Planning

Westchester Medical Center (WMC) submits the following comments on Attachment I and Attachment J from the Medicaid Redesign Team (MRT) waiver amendment's Delivery System Reform Incentive Payment (DSRIP) Special Terms and Conditions (STC) (*provisions from the attachments are in italic*).

Attachment I Section 2. b. DSRIP Performing Provider Systems (page 2)

Coalitions must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers. The funding distribution plan must comply with all applicable laws and regulations, including, without limitation, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). CMS approval of a DSRIP plan does not alter the responsibility of Performing Provider Systems to comply with all federal fraud and abuse requirements of the Medicaid program.

WMC's Comment: WMC appreciates the State's desire to seek input on waivers that would improve PPS's proposed projects. At a minimum, the State and CMS should confer the same set of waivers approved for other value-based purchasing arrangements (e.g., ACO Pioneers, Medicare Shared Savings Program, Bundled Payment for Care Improvement).

Attachment I Section 2. c. DSRIP Performing Provider Systems (page 3)

WMC's Comment: The State should describe and develop plans to communicate with beneficiaries regarding their participation in DSRIP and their assignments to a PPS.

Attachment I Section 2. c. DSRIP Performing Provider Systems (page 3)

So, for measurement purposes, this prospective attribution, depending on the measure, may be adjusted at the end of each performance year ("attribution true up") to remove beneficiaries that that were not enrolled in Medicaid per the specific measure specification for continuous enrollment criteria and add new Medicaid beneficiaries attributed to the Performing Provider System during the year and any other adjustments necessary to assure a proper measurement denominator...

WMC's Comment: For the purpose of evaluation, attribution will need to be adjusted for each measure. For example, a number of measures are based on PCP attribution: PCMH status, screening for depression, CAHPS surveys asking patients to evaluate their experience with their PCP. If the patient's PCP and providers are affiliated with another PPS, these metrics will not be applicable. This misalignment of attribution could occur because the first order of attribution for PPS valuation is Health Home Affiliation, not PCP affiliation. Other measures (PQIs) are

based on hospital discharges, again the denominator for each PPS should be based on PPS participation by the discharging hospital.

Attachment I Section 2. c. DSRIP Performing Provider Systems (page 6)

WMC's Comment: The DSRIP Beneficiary Attribution Method Final Attribution with MCO Input section describes the process by which MCO's will provide input into beneficiary attribution. The State should provide a process and sufficient time for PPS to review the Medicaid Managed Care Organizations' proposed recommendations for changes to the PPS beneficiary assignment list.

Attachment I Section 4. a. Project Plan Development Process (page 8)

WMC's Comment: At the public DSRIP hearing conducted in Brooklyn, State officials indicated that planning grant awards will be approximately \$500,000. The amount of funds awarded for planning should be commensurate to the relative size and complexity of the PPS's Project Plan. Factors should include the number of the beneficiaries and population to be served, the geographic area to be covered, the number of proposed partners, the scope of the community needs assessment and research required, and the number of committees and hearings proposed to engage the community. Larger, more complicated projects should receive relatively more funding than smaller, less complex projects. Allotting funding this way recognizes the effort and cost of forming effective and cohesive Performing Provider Systems (PPS) which are the hallmark of the DSRIP program.

Attachment I Section 5. a. Valuation of DSRIP Application (page 15)

Valuation benchmark table (PMPMs may be revised according to the schedule described above, subject to the standards described in STC 9 in section IX).

WMC's Comment: The STC indicate the maximum valuation is \$15 PMPM, and Table 1 on page 15 of the Attachment I indicates a maximum assigned valuation benchmark of \$8 PMPM and an increasing discount factor as the number of projects increases. The STCs attribute the discounting to the marginal costs associated with each project added above the minimum threshold of five projects. The State should consider increasing the valuation benchmarks to be in line with the maximum \$15 PMPM valuation.

Attachment I Section 5. a. Valuation of DSRIP Application (page 15)

Each plan application score will be expressed as a score out of 100, which will drive the percent of the maximum project valuation for each project that will be allocated to that individual project plan.

WMC's Comment: The Project Plans application score is proposed to be based on a score scale from 1-100. The State should implement a "pass/fail" application score with 100% awarded for passing applications. Project Plans that are not workable and have limited opportunity to succeed should not be approved. This is particularly important given the State-wide accountability metrics: poor implementation will result in losses for all.

Attachment I Section 5. a. Valuation of DSRIP Application (page 17)

Performing Provider System submits a six project Performing Provider System application and receives a plan application score of 85/100. As part of the 15 point reduction from a perfect score, the Performing Provider System received a reduction because the Performing Provider System selected two projects that share the same metric set.

WMC's Comment: The example DSRIP valuation calculation includes an illustration in which an Project Plan score is reduced because of duplication of project metric sets. Since Project Valuation already addresses potential project duplication through a sliding scale valuation benchmark based on the number of projects (Table 1 on page 15), the scoring mechanism does not need to reduce the total valuation further for projects that may have similar metric sets.

Attachment I Section 5. b. Metric valuation (page 19)

Within each project, the value for achieving each performance target/milestone is the same (evenly weighted) and will be calculated as "meeting" or "not meeting" the performance target/milestone. The points given for reaching a specified performance target/milestone will be called an Achievement value and will be calculated as a 0 or 1 value.

WMC's Comment: Providers will receive DSRIP payments based on achievement of reporting milestones (PAR) and/or performance targets for metrics (PAP) for a given project during a performance period. The State proposes a binary scaling system. However, a binary "pass/fail" scale does not reward PPS's incremental performance gains and could significantly impact a PPS's ability to continue its project. Payments should be tied to a percentage achievement scale based on the PPS performance against the State's proposed targets.

Attachment I Section 6. b. State-level Review Process (page 22)

The independent assessor will notify the Performing Provider System in writing of any initial questions or concerns identified with the provider's submitted DSRIP Plan and provide an opportunity for Performing Provider Systems to address these concerns.

WMC's Comment: The proposed Project Plan review process includes an initial review to assist PPS's improve their Project Plan. To ensure the development of the highest quality Project Plans with the greatest probability of achieving the State's goals, review process should include

an additional step whereby the PPS has the opportunity to: (1) review final scores and reviewers' comments, and (2) propose corrective changes that improve the Project Plan and its score.

Attachment I Section 6. b. State-level Review Process (page 22)

All Performing Provider Systems will be subject to addition review during the mid-point assessment, at which point the state may require DSRIP plan modifications and may terminate some DSRIP projects, based on the feedback from the independent assessor, the public engagement process and the state's own assessment of project performance.

WMC's Comment: The State should include details on the termination criteria and process, the appeals mechanisms, and the process for final determinations.

Attachment I Section 7. a. Semi-annual Reporting on Project Achievement (page 26)

The state shall schedule the payment transaction for each Performing Provider System within 30 days following state approval of the Performing Provider System's semi-annual report.

WMC's Comment: The State proposes a semi-annual reporting and payment methodology. The State should consider which metrics could be measured and reported quarterly to allow for more frequent incentive payments and afford a more stable cash flow.

Attachment I Section 8. a. Overall Data Standards (page 30)

WMC's Comment: Given the importance of its advisory role, the State's Quality Committee should include designated representatives from PPS and/or provisions for a DSRIP workgroup that would inform the full committee.

Attachment J Section 2. Domain 2. System Transformation Metrics (page 9)

Percent of Eligible Providers with participating agreements with RHIO's; meeting MU Criteria and able to participate in bidirectional exchange.

WMC's Comment: The definition of eligible providers in this measure should align with the definition for Eligible Professionals and Hospitals in CMS's Medicaid EHR Incentive Program and exclude providers of non-clinical services. Information exchange between providers of clinical and non-clinical services is essential; however, it can be accomplished in ways that don't require the use of tools that are certified as part of CMS's EHR Incentive Program. PPS should receive credit and/or not be penalized for non-clinical providers who: (1) utilizing a community wide system that enables information exchange among providers engaged in patient care, and (2) are connected to statewide Health Information Exchange.

Attachment J Section 2. Domain 2. System Transformation Metrics (page 10)

C. Connecting Settings: Performing Provider Systems will be required to meet all of the above metrics for A and B.

WMC's Comment: Domain 2. Connecting Settings includes two projects: "2.c.i. Development of community-based health navigation services." and "2.c.ii. Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services."

The measures for A. and B. described on pages 9 and 10 represent a range of activities that may be broader than the scopes for projects 2.c.i. and 2.c.ii. The State should identify an applicable subset of measures or propose new measures that are more specifically tailored to Connecting Setting projects.

Attachment J Section 2. Domain 3. Clinical Improvement Metrics (pages 13-14)

*Well Care Visits in the first 15 months
Childhood Immunization Status
Lead Screening in Children*

WMC's Comment: Domain 3. Clinical Improvement Metrics projects include seven measures to gauge perinatal care performance. Three pediatric measures which would require that perinatal projects follow children through their second year which is beyond the scope of a pregnancy related intervention "Well Care Visits in the first 15 months," "Childhood Immunization Status," and "Lead Screening in Children." Some PPS's perinatal projects may only include activities that focus on shorter intervention timeframe and may not be able to affect the longer-term measures. The State should allow a PPS to propose specific measures from this subset for which it will focus on and be held accountable.

In addition, a significant omission is the QARR measure: "Risk Adjusted Primary Caesarean Rate." It would be appropriate to add this measure because it is largely in the control of hospitals and has significant impact on outcomes.

Attachment J Section 2. Domain 3. Clinical Improvement Metrics (page 14)

G. Palliative Care (UAS measures)

WMC's Comment: When fully implemented, New York's UAS will be a rich source of information for monitoring care and outcomes. The UAS assessment is, however, time consuming and costly to administer, which may render it an impractical instrument for frequently repeated assessments. Appendix J proposes five UAS-based measures to evaluate palliative care. The first: risk adjusted percentage of members who remained stable or demonstrated improvement in pain would be an example of an appropriate measure that would require two or more assessments.

In contrast to this first measure, three of the proposed UAS based measures, as stated in appendix J, do not require repeated assessments, and therefore are not appropriate for evaluating the success of a palliative care program. These measures assess the presence of symptoms that may be very the reason that the member was referred to palliative care: members who had severe or more intense daily pain; members whose pain was not controlled; and members who experienced depressive symptoms.

The palliative care measure set is also too narrowly focused (three of five measures) on pain management. A palliative care program can be very effective in helping patients and families to cope with other symptoms that often lead to inappropriate hospitalization or ED utilization: dyspnea, anxiety, etc.

Further testing of UAS based measures and additional input from palliative care providers and programs should be incorporated before determining a final set of metrics for palliative care evaluation.

Attachment J Section 2. Domain 3. Clinical Improvement Metrics (pages 14-15)

G. Renal Care

WMC's Comment: The measures proposed are inappropriate to evaluate the effectiveness of a program for managing chronic renal disease. The proposed measures are convenient, because they are collected through QARR but they are mostly measures of the effectiveness of care to prevent renal disease in those at risk due to diabetes or hypertension. The measure, monitoring for patients on ACE and ARB, requires one BUN and one potassium level annually. That would be a "low bar" for monitoring a renal care program. NQF and AHRQ sites list a number of measures that have been developed and endorsed for the management of renal disease which would be more appropriate for a PPS project that addresses kidney disease.