NEW YORK STATE HEALTH INNOVATION PLAN: Comments Received / Areas for Improvement

1. OVERALL SHIP

A. The Plan's scope needs greater clarity; it appears to shift between a primary care focus and a much broader focus. If the Plan is intended to be a blueprint for broadly addressing the many significant issues across the entire delivery system, it requires significant expansion. But if it instead represents a proposal for a statewide commitment to the APC model as the primary vehicle for achieving Triple Aim progress over the next five years, that should be made clear throughout the document.

B. This SHIP does not address Medical liability reform and is crucial in reducing the cost of healthcare in New York.

C. Access to care: The SHIP should include specific provisions to ensure access to care for racial and ethnic minorities, people with limited English-proficiency, immigrants, LGBT individuals, and people with disabilities; also vulnerable populations.

D. Imposition of a health care expenditure cap should be considered to ensure accountability and discipline of the project. It is important to measure the projected savings of $5 billion to $10 billion against the anticipated $1 billion cost of the SHIP. In redesigning New York's Medicaid program, the Medicaid Redesign Team (MRT) instituted a Medicaid global spending cap that has forced the state to closely track Medicaid expenditures and track performance relative to a spending target. Analogous to the MRT's global cap, imposition of spending benchmarks such as the one adopted in Massachusetts should be considered.

E. Long Term Care and Post-Acute Care is missing throughout the SHIP; The SHIP relies almost entirely on the advanced primary care (APC) model to achieve its goals. It overlooks the role that LTPAC providers can play in advancing the Triple Aim.

F. Include greater breadth of mental health, behavioral health, and psychiatric providers and stakeholders in process; include appropriate agencies.

2. USE OF POLICY/REGULATORY LEVERS

A. What policy levers will the state use to achieve price and quality transparency? Given standard contract restrictions on the release of price information, it will be important to understand how the state will drive this in commercial markets in particular. You note the CMS Cycle III grant, but it's unclear how you will get broad participation by commercial plans.

B. Put upfront the payer mix and phases of roll-out. Emphasize the policy levers that will ensure multi-payer participation in the delivery/payment model.

C. Medicaid: It is generally unclear what Medicaid is committed to doing in terms of adopting the APC model and payments for populations other than those served by health homes and FIDA.

D. The mechanism and amount of funding required by commercial insurers remains a significant concern, including the potential of the Draft Plan to create an unfunded mandate on payers. Recent experience with the investments necessary to implement the Medicaid Managed Care-mandated

performance improvement program confirms this concern. Funding solutions will require substantial additional discussion among stakeholders. In this regard, the assumption of/commitment to a "time-bound levy on payers to fund practice transformation and care coordination" (Page 158) is premature and should be deleted from the Draft Plan.

3. STAKEHOLDER ENGAGEMENT/GOVERNANCE

A. Provide further details to describe the types of stakeholders engaged in the planning process, how they were engaged, and how they will be engaged moving forward.

B. Might the state further align outreach for consumer transparency portal (p.80) and patient portal (p.126) in terms of plans to engage users since, as I understand, these are geared towards same audience?

C. The proposed governance model seems heavily tilted towards state agencies. You may want to explore ways to infuse more public-private partnership into the overall governance structure, which may significantly increase private payer and provider buy-in and support and help the state reach its ambitious goals.

D. Include in multi-stakeholder efforts those organizations that serve persons with disabilities.

E. Allow adequate <u>time</u> for discussion and response. We are interested and engaged now and hope to be included as the plan moves into the more detailed planning and implementation stages.

4. CARE DELIVERY TRANSFORMATION/POPULATION HEALTH

A. <u>Patient Engagement</u>
   a. Patients as active participants in their health care needs to be more fully addressed in the final document.
   b. Health literacy, health consumerism and community health promotion should all be clearly called out in the SHIP.
   c. Develop a fourth “enabler” to address the need for robust consumer education, engagement, and assistance, or infuse these strategies throughout the document, to facilitate achievement of the five pillars and three aims.

B. <u>Role of Family Caregivers</u>
   a. Recognize critical role family plays in preventing hospital readmissions and their needs for training and support.
   b. Plan should explicitly address needs of family caregivers of patients with chronic illness and at risk for hospitalization, poor outcomes and high costs.

C. <u>Role of Hospitals</u>
   a. Close collaboration between hospitals, community-based providers, primary care and specialists and community service agencies is critical to reducing avoidable admissions and readmissions.
   b. Closing or merging safety net providers in medically underserved communities will only worsen health disparities – care must be taken to assure access regardless of financial health/stability of hospitals.

D. Persons with Disabilities
   a. As care moves from hospitals to community sites care must be taken to assure that those sites are accessible in terms of architectural barrier removal, accessible diagnostic medical equipment and provider training on provision of disability literate care is critical.

E. FQHCs and existing investments: In addition to the Medicaid and Public Health Service financing opportunities for the community, an FQHC designation brings with it a set of assets for the community from economic development, to participation in the National Health Services Corps tuition payment and loan repayment programs, professional liability coverage for providers through the Federal Tort Claims Act, participation on the 340B drug pricing program, and other valuable programs. Additionally, in the years since the ACA was signed into law, New York State FQHCs have been awarded $17,282,037 in New Access Point grants – to build the infrastructure of new FQHC capacity across the State. These grants represent ongoing operational funding which will be renewed every year as part of the base grant funding of the community health center funding program (HRSA) nationally. Some mention of this significant federal-state partnership in reaching stated goals of the SHIP would strengthen the document in ways that would resonate with CMS.

F. Explicitly include Community Health Workers in the proposed Health Innovation Plan so as to integrate CHWs as inter-professional healthcare team members as we move to transform the healthcare system to become more effective, efficient and patient-centered. Excluding CHWs is regrettable and we believe such exclusion of CHWs would be a missed opportunity for New York to become a national leader in transforming our healthcare system.

G. Should include the role family planning providers play in primary care. Further, the State should consider the critical role that Title X and New York State-funded family planning clinics and reproductive health care play in an integrated health care system and in reaching the population health goal of reduced unintended pregnancy.

5. THE APC MODEL

A. The plan should be more specific with regard to the attributes of an APC-model practice both in terms of the level of integration required and the specific technological and clinical support envisioned.

B. The SHIP must specify the health care providers who are necessary to a successful APC practice and to describe the manner by which revenue would flow among practice participants.

C. Physician Attraction and Retention. The state should not support the use of nurse practitioners and physician assistants in lieu of physicians. We believe the state must do more to attract and retain physicians in New York State. Additional resources must be directed to the Doctors Across New York program to allow for more cohorts of awardees and modify eligibility to assure a more equitable balance of awards between institutionally based and private-practice physicians.

D. Civil Justice Reform. The state must also reduce the overhead burden shouldered by physician practices through meaningful civil justice reform and the elimination of burdensome regulation.

E. Practice Support. Primary Care practice demands will require significant support for transformation as well as strong partners in the community. The proposed SHIP makes no commitment to working to advance an extension of the Medicare payment rate for primary care services. Moreover, the proposed SHIP does not specify how the advanced primary care practice will be supported financially, although ostensibly, enhanced payer payment could be utilized. Nor does it specify whether and to what extent seed funding will be provided.

F. Specialty Care. Many small physician practices provide needed specialty services. Therefore, while New York must take steps to attract and retain primary care physicians, particularly to our rural and underserved communities, the success of the APC model is dependent upon the provision of specialty care to the chronically ill. Therefore, we also must assure continued access to specialty care. The SHIP fails to articulate the practice/patient connectivity and payment flow for specialty care associated with patients served by APC-model practices. We believe that this creates a huge gap in the SHIP, making it unworkable and impractical for the future.

G. Utilize the ob-gyn within the primary healthcare team by specifically including such women's health providers in the definition of primary care provider.

H. Measurement. Consolidated measurement across practices is essential; quality measures should be applied to the whole practice – not segmented.
    a. Measures should be validated to assure minimal variation across different EHR vendor products.

I. APC patient attribution challenging – suggest requiring that individuals select a primary care provider.

J. Comments for the three APC stages:
    a. Pre-APC practices to conduct family caregiver identification and needs assessment for all patients, integrated into the patient's electronic health record.
    b. Standard APC in addition to engagement of family caregivers into patient care planning process including end-of life decision making.
    c. Enhanced APC to include family caregivers, end of life and linkages with community resource and referral supports.

K. To strengthen the pre-APC level, it may be helpful to be explicit about how this model is an improvement from existing or baseline PCP capabilities, particularly small practices.

L. In section 2, some discussion of how the state intends to bring APC to scale would be helpful, given the size of the state and its SIM goals.

M. It may be helpful to define on p. 71-72 what process might be used for practices to demonstrate adherence to new APC criteria. The SHIP discusses the use of onsite verification and more frequent check-ins/data collection from providers (alluded to in the Evaluation section on p.137-8) to make certification process more meaningful, so might be worth mentioning this approach earlier.

N. Plan also notes consolidated market share among health systems in larger cities; how will this be leveraged to spread integrated delivery models?

O. How will providers pay for the investments (non-EHR) needed to transform a practice along the APC spectrum? Will there be a PMPM similar to CPCi, since shared saving would not kick in until the second level (and would be retrospective)? If not rolled into the payment model, how would the state/regional health improvement collaboratives support practice transformation (beyond the TA under MRT)?

P. In the future, think about how to enumerate a targeted # of practices at Pre-, APC, and Enhanced-APC at what point in time.

Q. How will patient panel pooling be operationalized when shared savings kick in, for smaller practices?

R. Suggests referencing continued support for school-based health centers (SBHCs) as important access points for primary care. SBHCs can be important participants in APC team-based care, and we believe the Plan is remiss in overlooking their important role.

S. We recommend that the State explicitly identify "80% of primary care providers in the State participating in an enhanced APC model" as the Plan's number one goal. We believe that all other components and deliverables should be subordinate to that effort, as most if not all of them will flow naturally if this main goal is achieved.

T. With regard to the specific model being proposed, we support the idea of the State making APC a universal model for multi-payer adoption and working with all payers to coordinate efforts where reasonable. Provider input will be key to the success of this initiative.

U. Payment: Expected enhanced payments to primary care must be quantified. Enhanced primary care payments must be linked to identified primary care goals.

V. "Advanced Primary Care" Nomenclature: There is ample reason to move away from the "Patient Centered Medical Home" nomenclature toward one that is more broadly understandable to consumers, providers, payers, purchasers and policymakers. "Advanced Primary Care" should be seen as a placeholder for the framework, standards and measures in the Plan, but serious consideration should be given to a more accessible nomenclature that can be the public face of the APC model and that can be flexible to accommodate future changes without invoking yet another new nomenclature. For instance, the Plan could establish a Primary Care Star System in which practices are given anywhere from one to three or one to five stars based on meeting certain standards and measures. This way, consumers searching for primary care providers or evaluating health plans will be able to conduct easy searches based on how many stars a practice received. As standards evolve, the criteria for achieving each "star" can evolve as well (like PCMH levels).

6. BEHAVIORAL HEALTH:

A. Plan places disproportionate emphasis on patient care management with APC.

B. Not enough horizontal integration with behavioral health providers.

C. Will primary care providers be expected to provide behavioral health prevention, treatment and recovery services?

D. OASAS is absent from the plan; Final plan should elevate OMH and OASAS to equal status with DOH, DFS and DCS and DOB.

E. HEAL funds have not been available to behavioral health agencies – this is not addressed in the SHIP.

F. Behavioral health providers should be explicitly designated as "safety net providers" in the Plan. For many individuals, the behavioral health provider serves as the "medical home".

G. Behavioral health barriers that impact disparities, or disabilities more generally, be included in the first pillar of the SHIP's strategy to achieve the triple aim.

H. Identify community based health settings that could utilize strategic innovation to grow their capacity in serving persons with complex health and behavioral health needs but are also vulnerable to health disparities due to cultural, regional, geographic, financial, operational, and disability barriers.

I. Coordinate with MRT Disparities Workgroup.

7. PUBLIC HEALTH:

A. The conceptual model for public health and population management is strong. However, greater clarity on specific components would make this section stronger. Explaining how primary care be held responsible for connecting patients to community resources would be helpful. For example, embedding related criteria in the APC tiers or tying payment to population health metrics would help make this stronger.

B. Plan should detail mechanisms for strengthening linkages between primary care, hospitals, LHDs and community-based organizations (including disability organizations and independent living centers).

C. The Plan should address disability-based health disparities and promote public private partnerships to improve health by removing barriers to effective care and treatment for persons with disabilities.

D. Undocumented Immigrants. Initiatives to provide low-cost health insurance to undocumented immigrants is crucial to overall population health.

E. How will the Commissioner be holding local health departments/hospitals accountable for any measures related to the plans (as mentioned on p. 53) they are submitting?

8. PAYMENT REFORM/MULTI-PAYER ALIGNMENT

A. Multi-payer alignment on payment methods: Given that payers will have great flexibility in implementing a range of value-based payment models, what levers, governance structures, or processes will be used to foster payment alignment across these payers to make it easier for providers to participate with multiple payers? The SHCIP mentions alignment across APC care standards, quality metrics, and practice transformation supports, but not across payment models/methodologies. Will the multi-payer Steering Group be charged with fostering alignment where necessary?

B. Steering group to develop multi-payer alignment around a payment model should include all stakeholders.

C. Revenue to physician practices must be enhanced by leveling the playing field for physicians in their negotiations with health insurers, and by assuring the offering of out-of-network coverage which significantly reimburses for the reasonable cost of services.

D. V-BID- The plan does not call for the state to also engage with physicians on front-end discussions on the intrinsic worth and negative implications of VBID payment.

VBID necessarily will incorporate a transfer of risk from payers to physicians and other healthcare stakeholders. Appropriate rules must be established to protect physician practices from inappropriate and fiscally unsustainable risk-sharing strategies foisted on them by health insurers.

i. Include consumers, union delegates, and other insureds as members of the working group on VBID and specify these stakeholder groups in the SHIP (p. 85).

E. The Draft Plan should be clearer regarding the ability of payers to continue the value based payment arrangements that are already in place. In essence, these existing arrangements should be "grandfathered" without a requirement that they be amended to comply with the final Plan. Criteria for "grandfathered" status could be included.

F. Any requirements or mandates must apply uniformly to all insurers, HMOs and Prepaid Health Services Plans (PHSPs) doing business in NYS.

9. QUALITY MEASUREMENT/DATA

A. Public cost and Performance reporting – caution offered not to report prematurely and to include those being measured in the development of measurement design to be allowed to view data prior to public release.

B. Health Information Exchange – barriers to accessing information that can be addressed by the State should be promoted. Need to re-consent patients and movement to dual factor authentication hinder or reduce provider participation in HIEs.

C. SHIN-NY – Costs. Without funding for the interfaces, physicians cannot participate on the SHIN-NY, and care coordination—the linchpin of the SHIP—is severely hampered. Moreover since only 4 software vendors to date are SHIN-NY compliant, most physicians will have to switch to a different vendor, at enormous cost. Data transfer, in particular, from one vendor to another, is wildly expensive and, in some cases, impossible.

D. HIT to Track disability Status: HIT data collection should model ACA HHS data collection standards to track disability status; portals and sites through with EHR is offered must be “accessible”.

E. Data to support the APC:

i. The SHIP calls for the measures to be grounded in nationally accepted approaches from NQF, HEDIS, CAHPS etc. However, many of the measures promulgated by these national entities are not developed by physician specialty societies or the AMA. They are developed

and used primarily by the health insurance industry and can be influenced by cost factors. We believe that PQRS measures should be used. Most of the PQRS measures were developed by the AMA's Physicians Consortium for Performance Improvement (PCPI), which included recommendations from national and state specialty societies in the development of the recognized measures. These measures are already in place and are well known to all of medicine.

ii. A strong APC will require provider access to utilization (claims) data and/or analytic reports to support effective patient management. The development and provision of these tools could be presented more clearly and holistically. For the APC Performance Tool, what is the source of data and what investments need to be made? This is outlined on page 141, but couched in qualifying terms. If the APD is not up and running with commercial data by implementation (as you note on page 125), what other paths might the state pursue to provide such data, given the data availability in the HIE? This component is not as strongly delineated as the others in the SHIP. It is fine that the state may still be working through this piece, but presenting work plans and identifying more specific processes that the state will use to get this key component figured out would strengthen this component. As a side note, it's unclear on page 143 in the Exhibit what is meant by the APC Performance Tool being linked to payment.

F. April 2015 date for the launch of final metrics conflicts with the HEDIS/QARR calendar year data collection cycle.

10. OTHER

A. Workforce:
   i. The report should be refined to assure that it is not construed to support scope-of-practice changes that could enable non-physician practitioners to practice beyond their education and training, and/or without physician supervision, collaborative agreement, or required physician referral.
   ii. Generally speaking your workforce component is quite strong. What might be helpful is to clarify the role of the state on workforce, under SIM. Or will your model simply leverage and align with existing investments in workforce outlined throughout and funded primarily under the MRT waiver? May be worth being more explicit about this distinction between MRT-funded workforce activities and those that are unique to or will be funded under SIM. A quick summary table at the end of the section, similar to how you've outlined the next steps, might accomplish this.
      a. On page 103, the Draft Plan should highlight workforce training needs related to quality/performance improvement tools/techniques to continually drive higher levels of performance at a grass-roots/front-line level, the provision of physician leadership training to lead/sustain that change, expertise in quality measurement, and population health management training for providers.

B. Participation by hospitals: Given the ambitious goal of reducing avoidable admissions and readmissions and the intended scope of SIM, it is important to define the role of hospitals in the SHIP. Environmental scan identified NYS as having 22% higher cost than the US average and ranking 50th on avoidable hospitalizations, but hospital engagement is not specifically called out in the plan. How will hospitals be engaged via governance and the new care delivery models to undertake care

transformation? The state may want to consider how to best leverage the DSRIP under SIM, particularly since this new payment model will create value-based incentives for hospitals.

C. Limited English Proficient Individuals. The plan must explicitly include translation and interpretation services for LEP individuals particularly in the medical setting. An explicit language access policy regarding patient medical records and other communications to patients is recommended (NYS of Health Website needs to be translated into languages other than English).

D. RHICs:
   i. On p. 14, graphic depicts role of RHICs – more description around how they might interface with APCs would be helpful to make this part more concrete, understanding this hasn't been fully fleshed out yet…(as noted on p.20)
   ii. Bottom of p. 32 and p. 151 refer to part of RHIC role but could be further fleshed out OR just make reference to additional information on p. 99+(although description of linkage between APCs and local health departments could be strengthened)

E. HIE: (pg. 10) What is the current gap in EHR/HIE adoption? What change is needed to get to specified adoption aim?

F. Access:
   i. Under-insured not addressed and should be. Bad debt and charity/public support of hospitals is a huge cost factor. Parity of the Medicaid FFS primary care rates at Medicare levels must be continued UNTIL this plan is operational….a priority or the private sector will continue to withdraw and use of higher cost providers for Medicaid will occur.

11. GENERAL/OTHER

A. Formatting/Flow:
   i. Exhibit 19 on p. 129 is blurry – suggest revising format/font size
   ii. P.134 blank, can be deleted and header moved to p. 135
   iii. P.140 add sub-header "structure, process, outcome" to Exhibit 23
   iv. I would suggest moving up high-level timeline on p.153 and milestones (p.157) or making reference to them earlier on in plan since these pages help readers map out phased approach of plan well
   v. On page 8, the bullets under pillar 1 don't seem to align well with the narrative directly beneath, which makes it confusing for the reader

B. On page 5, include footnote with source: "*Within 10 years, we anticipate our investments in health improvement and clinical innovation will translate to improved health through measurably lower prevalence of illness and injury, reduced health insurance premium rates, and a more sustainable growth rate in healthcare spending, approximately 2 percentage points below historical trends.*[1]"

[1] Health care spending per capita in New York State grew at a compound annual rate of 5.5% from 1999–2009, while gross state product per capita grew at a compound annual rate of 3.6%. Source for state health expenditures data: the Centers for Medicare & Medicaid Services (CMS), www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence. Source for gross state product data: the U.S. Bureau of Economic Analysis (BEA).

C. New York health care coverage policy initiatives must not conflict with the stated SHIP goals. The state cannot adopt policies such as mandatory out-of-network benefits with defined levels of reimbursement or out-of-network facility fees which undercut the goals of the SHIP by expending limited funds to promote non-coordinated medical care paid on a fee-for-service basis.

D. The role of DFS and the scope of its authority must be clearly defined. DFS needs to clarify its intent and its perceived scope of authority to affect plan rate applications which do not meet state expectations about progress, speed and magnitude of "investments" in the endeavor. Conversely, it does not appear that any similar encouragement tool exists to modify provider behavior. Physician participation, cooperation and accountability will be as important to the project. A better balance is needed to avoid the SHIP from listing.

E. Page 42: The Plan notes higher hospital cost per discharge than national averages for New York and attributes this to hospital efficiency. This section should be revised to also reflect the significant impact of higher labor costs, due to New York's higher cost of living, on health care costs in New York. In addition, New York hospitals incur higher graduate medical education costs because New York hospitals train significantly more physicians than any other state (as noted later in the Plan).

F. On page 11, the Draft Plan states "Ensure that 80 percent of health care spending is contracted under value-based payment models". However, elsewhere on that page, an "...80 percent of covered lives in value-based arrangements" test is used. These references should be revised to be consistent.

G. Pg. 6 – Pitfalls of the current system: We have an "undersupply of some critical health care services" - What are these?