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April 18, 2016

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Re: *Comments on VBP Roadmap – Stark Law and Anti-Kickback recommendations*

To Whom It May Concern:

On behalf of the New York Physical Therapy Association (“NYPTA”), which represents the interests of physical therapists and physical therapist assistants in New York, we respectfully submit the following comments regarding the VBP Roadmap’s recommendation to “fully align” the State’s Stark Law and Anti-kickback Statute with equivalent federal laws.¹

While we share the apparent intent of the proposal to provide health care providers the necessary flexibility to structure their practice arrangements in support of value based payment, the proposal goes much further than that intent and would weaken, without justification or analysis, New York’s strong laws which protect against the influence of an improper profit motive. Assuming change needs to occur and the report is wholly void of any justification other than broad statements for the suggested change, the Department can achieve that goal through much more limited and targeted exceptions for value based payments.

Moreover, any change at this point is premature. The majority of health care in New York is delivered outside of value based payments. As a result, weakening the prohibition on self-referral would expose the majority of the State’s health care system to additional wasteful and unnecessary care. The cost of self-referral is significant. As recent as 2014, President Obama proposed to further restrict self-referral by eliminating the in-office ancillary service exception, unfortunately that proposal failed due to physician opposition. The federal Office of Management and Budget scored the proposal with saving \$6 billion over 10 years. Any marginal costs saved by providing greater flexibility from the self-referral prohibition would likely be outweighed by the increased costs to the State’s health care system considering the limited presence of value based payments in health care today.

¹ See VBP Roadmap at 48 and 49.

We are also concerned with the proposal to permit the formation of multi-specialty professional corporations with physicians. Frequently, fraudulent situations involve the use of multi-specialty practice arrangements under which members are incentivized directly or indirectly to order unnecessary care or services. We would anticipate permitting non-physician health care providers to jointly form professional entities with physicians would worsen the situation. Additionally, we do not see the current limitations on ownership of professional entities as interfering with value based payment arrangements. The ability to structure arrangements through contract and professional collaboration are sufficient to accommodate value based payments.

Governor Cuomo Vetoed a Similar Proposal in 2012:

A narrower bill was vetoed in 2012 which would adopt only the federal exceptions to the Stark law. Governor Cuomo stated that due to “real and apparent conflicts of interest that this change would engender, I see no reason to upset New York’s rules for determining the propriety of practitioner referrals.”² We believe the Governor had it right and New York’s relatively strong prohibitions on self-referral and kickbacks have served the state well and should not be summarily and wholly discarded under the guise of making changes to enable value based payments. A broad adoption of the federal statutes is not necessary and would undermine the protection that the state statutes provide against wasteful practices in health care.

The Physical Therapy Benefit is Routinely Subject to Self-Referral Abuse:

Physical therapy services have been widely shown to be the target of physician self-referral abuse. Studies have demonstrated that physician-owned physical therapy arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists.³ Specifically, a 2006 report by the Department of Health and Human Services’ Office of the Inspector General (OIG) showed that physical therapy billed directly by physicians represents a large and growing percentage of Medicare’s total expenditures for these services.⁴ The OIG found that 91% of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines which resulted in a significant amount of improper payments. In addition, Medicare claims from 2002 to 2004 were analyzed and aberrant patterns of billing and unusually high volumes of claims were identified. In a report issued in August 2009, the OIG examined physician “incident to” services billed in 2007 under the Medicare program, and found that 49 percent of rehabilitation therapy services (including primarily therapeutic exercise, massage therapy, ultrasound therapy, therapeutic activities, and electrical stimulation) performed by non-physicians were furnished by staff not trained as therapists that the OIG found to be unqualified.

More recent studies confirm the waste caused by self-referral for physical therapy services continues largely unabated *even with the Stark laws*. A study released this February

² Veto Message 153 of 2012.

³ Mitchell JM, Scott E. *Physician ownership of physical therapy services: Effects on charges, utilization, profits, and service characteristics*. JAMA. 1992; 268:19-23; Swedlow A, Johnson G, Smithline N, Milstein A. *Increased costs and rates of use in the California Workers’ Compensation System as a result of self-referral by physicians*. N Engl J Med. 1992;327:1502-1506; Office of the Inspector General, Department of Health and Human Services. 1994.

⁴ *Physical Therapy in Physician’s Offices*, no. OEI-02-90-00590. Washington, DC: OIG and OIG, *Physical Therapy Billed By Physicians* (May 1, 2006).

concludes that patients who undergo total knee replacement (TKR) surgery and are referred to a physical therapist not affiliated with their surgeon's practice have fewer visits and more individualized, one-on-one care. Conversely, the research showed that those who received physical therapy services from a clinic owned by their physician had twice as many visits and were provided a less-intensive approach.⁵ Other findings include duration of care was a week longer with 8.3 more visits and less one on one care in physician ownership situations.

The ongoing problem of self-referral is not limited to physical therapy services. These findings are consistent with a growing body of literature that demonstrates physician self-referral increases costs across a broad array of health care services. Among others, the following recent studies demonstrate the increased costs of self-referral:

- Review of Florida data for five common ambulatory surgery center procedures revealed a significant association between physician ownership and higher surgical volume⁶;
- Physicians with an ownership interest in on-site laboratories were more likely to order five common laboratory tests⁷;
- Musculoskeletal ultrasounds shown to increase dramatically from 2000 – 2009 with volume increases significantly greater among non-radiologists, especially podiatrists, when compared to radiologist volume⁸, and
- The cost of increased imaging in self-referral settings was estimated nationally to be \$3.6 billion⁹.

Notably, these outcomes all occurred with the existing statutory prohibitions in place. Weakening New York's prohibition would only increase unnecessary costs generated by self-referral practices.

Fully Aligning Federal and New York Stark Laws Unjustifiably Weakens Both Laws:

Fully aligning the State and the federal prohibitions on self-referral and anti-kickback statutes would result in significant change to New York's prohibitions. Meaningful differences exist between the two laws and the State's health care system benefits from those differences. For instance, New York's prohibition on self-referral applies to all payors and for all prescribers. The federal version is limited to Medicaid and Medicare. The reach of New York law to payors

⁵ Mitchell, Jean M. et. al. *Use of Physical Therapy Following Total Knee Replacement Surgery: Implications of Orthopedic Surgeons Ownership of Physical Therapy Services* Health Services Research February 23, 2016.

⁶ JM Hollingsworth et. al., "Physician-Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries Health Aff.," Apr. 29, 2010 (4) 683-9.

⁷ TF Bishop, AD Federman and JS Ross, *Laboratory Test Ordering at Physician Offices With and Without On-Site Laboratories*, J Gen. Intern. Med., Oct. 25, 2010, 1057-63.

⁸ RE Sharpe et. al. *Dramatically increased musculoskeletal ultrasound utilization from 2000 – 2009, especially by podiatrists in private offices*, J Am. Coll. Radiology, Feb., 2012 141-6.

⁹ RK Kilani, *Self-Referral in Medical Imaging: a meta analysis of the literature*, J. Am. Coll. Radiology, July, 8 2011 469 – 76.

outside of Medicaid and Medicare has deterred and prevented wasteful and fraudulent care. Insurers routinely deny commercial claims on the basis that they constitute illegal self-referral arrangements.

Additionally, no-fault insurers have successfully invoked the prohibition to avoid payment of dubious claims by gaining additional information on questionable claims or using as an affirmative defense to such claims.¹⁰ The broader reach of New York's prohibition has benefitted the State. Additionally, the State statute's application to non-physician prescribers simply makes sense. The harmful profit motive created by self-referral is not somehow limited to physicians, rather it applies equally to any prescribing practitioner – nurse practitioner, nurse midwife or podiatrist particularly when non-physician providers are playing an increasingly important role in delivering primary care. New York has also prevented abusive practices by failing to adopt federal exceptions, notably prohibiting the gifting of laboratory computer equipment and limiting the in-office ancillary service exception to employer/employee relationships excluding independent contractors offering services in a physician's office from the exception. These differences are far from harmful to the State's health care system. They have served the State well.

Conclusion:

We welcome the opportunity to provide comment on the value based payment roadmap. For the reasons stated above, we have significant reservations with weakening the State's protection against inappropriate referral arrangements. We would respectfully request that the State proceed with caution if it chooses to enact changes, tailor any changes narrowly to address specific and identified needs and weigh the benefit of those changes against the possibility that they will increase abusive practices.

We thank you for your time and attention.

Very truly yours,



Brian J. Lucey

¹⁰ See Stand-Up MRI of the Bronx v. General Assurance Insurance, 10 Misc.3d 551 (D.Ct. Suffolk County 2005), no fault insurer properly denied a claim on the basis it violated the prohibition on self-referral) and Fair Price Medical Supply Corp. v. Elrac Inc., 820 N.Y.S.2d 679 (2d Dep't 2006) (Defendant entitled to conduct discovery to determine if plaintiff had violated the prohibition on self-referral in what Defendant alleged was a "fraudulent scheme in the happening of the accident").

Comments from the United Hospital Fund on the 1st Annual Update to the VBP Roadmap

Submitted by Andrea Cohen, Senior Vice President for Program

April 8, 2016

1. Clarifying the important next set of activities focusing on VBP for children's health care.

The draft 1st Annual Update to the VBP Roadmap contains two references to value-based payment for health care for children. On p. 34, the document states, "A small number of CAGs will continue in Year 2, and new CAGs may be formed around additional priorities, such as Special Needs Children." On p. 59, the Update states, "The Advocacy and Engagement and social Determinants of Health Subcommittees also recommended the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: a taskforce focused on children and adolescents in the context of VBP...."

We recommend:

The CAG on Special Needs Children and the Children and Adolescent Taskforce should be clarified as separate but complementary streams of work with unique mandates. The recommendation of the Social Determinants of Health Subcommittee was to establish a Taskforce focused on the broad, population-oriented preventive and primary care needs of **all** children. The logic behind a special workgroup on this topic is that the patterns of child health utilization, and the opportunities of strong preventive/primary pediatric care to promote better health, differ from the patterns of adult health care utilization and the opportunities of strong preventive/primary care for adults. A CAG focused on Special Needs Children would be a positive development, but would address different issues for a narrower subset of children.

The Children and Adolescent Taskforce should have a clear and robust mandate. This mandate could include:

- Developing a plain language "value" statement for the health and well-being of New York's child and adolescent Medicaid beneficiaries
- Collecting and selecting measures for value-based payment that would reflect that value statement

- Determining which measures could be applied to Medicaid providers in the near-term and which could be applied in the future with measure refinement, data collection developments, etc.
- Identifying potential challenges within the VBP Roadmap where certain mechanisms may not be applicable/appropriate for the pediatric population
- Identifying child and adolescent specific preventive services where fee-for-service should be utilized as a value-based payment mechanism
- Considering and aligning- where possible- recommendations from the CAGs on Special Needs Children and Labor and Delivery

2. Recognizing the large number of small and medium-sized practices serving Medicaid beneficiaries and addressing their capacity to handle complex integrated primary care (IPC) contracts

The Roadmap Update reduces complexity by combining previously individual chronic condition bundles into a single chronic condition bundle (CCB). However, the apparent required connection of the integrated primary care (IPC) contracts with the CCB raises concerns regarding the complexity of administration of this combined contracting vehicle, and about the ability of small and medium sized providers to effectively participate in such contracts. While intermediary organizations like ACOs, IPAs, and integrated delivery systems will play important roles in bringing groups of smaller providers into contracting mechanisms that are too complex for individual practices to handle, the complexity and administrative difficulty of managing calculations and analytics for multiple plans and populations will still be challenging for larger organizations trying to group smaller practices, certainly for the near future. It is important to have strategies for this transition that recognize the very significant role that small providers play in providing access for Medicaid beneficiaries, especially for those in immigrant communities. Some analyses of primary care practices in NYC, for example, have demonstrated the very large number of small practices serving low-income and immigrant communities, and it will be important not to leave these providers out of the important improvements and advances that VBP arrangements can incentivize.

April 18, 2016

VIA ELECTRONIC SUBMISSION

Howard Zucker, M.D., J.D.
Commissioner of Health
New York State Department of Health
Corning Tower
Empire State Plaza,
Albany, NY 12237

RE: A Path toward Value Base Payment: Annual Update (March 2016) to the New York State Roadmap for Medicaid Payment Reform

Dear Commissioner Zucker:

The Biotechnology Innovation Organization (BIO) is pleased to submit the following comments regarding New York State's Annual Update to Value-Based Payment (VBP) Roadmap (the "Roadmap") released by the Department of Health for New York State (the "Department") in March 2016.¹ We understand that the Roadmap is a requirement of the state's broader participation in the Delivery System Reform Incentive Payment (DSRIP) Plan under a Medicaid waiver granted by the Centers for Medicare and Medicaid Services (CMS) in April 2014. The comments herein respond directly to the Annual Update Roadmap document released in March 2016, and not to the broader efforts around implementing the waiver or to other programs under the DSRIP.

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or to prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions.

BIO represents an industry that is devoted to discovering, and ensuring patient access to, innovative treatments. Accordingly, we closely monitor payment policies for their potential impact on innovation and patient access to drugs and biologicals, including at the state level. We once again appreciate the opportunity to provide feedback on the Department's Roadmap, given that New York is one of the first states to explore an integrated VBP-based payment approach to improving care in Medicaid managed care organizations (MCOs) and thus, is a potential thought leader among its peers.

We share the Department's goals of improving population health, improving individual health outcomes, and rewarding high value care delivery. BIO strongly believes that, while innovation in the payment and delivery of care has great potential to achieve these aims, it requires robust patient protections and a focus on appropriate quality-of-care

¹ New York State Department of Health (March 2016). *A Path toward Value Based Payment: Annual Update*, Available at: http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/1st_annual_update_nystate_roadmap.pdf

measures to guard against incentives to underutilize appropriate care. We applaud the Department's recognition that "one size does not fit all," as evidenced by its proposal to allow MCOs and PPS and/or groups of their constituent providers to choose from several VBP arrangements or request to develop alternatives. However, we note the need for the Department to ensure that Medicaid patients are afforded the same access to appropriate care, and especially to appropriate therapies, regardless of the arrangement under which their provider participates.

Bearing in mind the scope of the Roadmap, BIO has organized our comments on the Roadmap by topic. However, several themes are consistent throughout, including:

- The need to ensure patient access to needed prescription therapies and providers with necessary expertise;
- The need to provide more detail around the calculation of certain metrics—like attribution and benchmarking—across MCO/PPS contracts to avoid establishing perverse incentives that negatively impact the sickest, most vulnerable Medicaid beneficiaries; and,
- The importance of establishing robust, meaningful, and specific quality measures.

More detailed comments encompassing and expanding on these themes are included below.

I. Ensuring Patient Access to Innovative Prescription Medicines within the Roadmap-Identified VBP Arrangements.

The Roadmap provides a list of prioritized VBP arrangements from which an MCO and the PPS with whom it contracts can choose. However, there is still uncertainty with regard to: the broad language that prefaces the description of the VBP arrangements in the Roadmap; the scope of the health outcomes, services, and technologies that each arrangement can target; and the resulting potential impact of these models on patient access to needed care.^{2,3} Given the importance of innovative drugs and biologicals as part of a comprehensive treatment regimen for many patients—including those with some of the most complex, chronic diseases, and those with rare diseases—we ask that the Department consider how these models will take into account innovative therapies. Additionally, we ask that the Department establish a standard for the inclusion of innovative therapies that applies to all MCO/PPS participants. This is important so that patients have reliable access to the therapies most appropriate for them irrespective of the providers they see, the MCO that manages their health care, or the chosen VBP arrangement.

BIO also urges the Department to ensure that any VBP arrangement included in the Roadmap is structured in a manner that allows patients and their providers to choose the most appropriate therapy at each stage of care, as well as to allow, but not require, for the successive trial of multiple drugs before a final regimen is selected for those patients whose illness requires this approach. For example, BIO raises concerns with any model that inherently relies on establishing payment reflecting the "average" of care provided, rather than addressing the disease presentation and prognosis of an individual patient or the underlying disease severity of a provider's, or a provider group's, patient population. We are concerned that the models described in the Roadmap may not account for the fact that entire sub-specialties may be devoted to treating patients whose care necessarily diverges—

² 2016 VBP Roadmap at 35.

³ With the exception of vaccines and other types of preventive medicine, which the Roadmap notes will continue to be paid for at fee-for-service rates to improve the volume of furnished services. See Roadmap at 32.

in terms of amount, type, and/or cost—from such an average. Additionally, in some patient populations, the heterogeneity of the disease, its presentation, the impact of patient comorbidities, and/or other clinical factors renders the concept of the “average patient” moot. This is especially true for conditions where the most appropriate therapy is a biological: patients may have highly-individualized responses to complex biologicals, and thus biologicals are not easily substitutable.

Specifically, as outlined in the 2016 Roadmap, the use of an all-inclusive chronic care bundle^{4,5} gives BIO significant concerns. The Department intends to create a single payment episode for 14 very different chronic conditions, which we do not believe can sufficiently account for unique patient and subpopulation needs. Of particular concern is access to drug and biologic treatments—especially when new, innovative treatments for one or more of the 14 conditions included in the bundle are introduced. Additionally, because patients with chronic diseases often rely on ongoing access and utilization of providers and medications, BIO urges the Department to make public—and allow stakeholders to comment on—additional details with regard to how medications are factored into the bundle for subpopulations.

Equally important to ensuring patients’ timely access to appropriate care is the need for the Department to ensure that any VBP arrangement under the Roadmap provides a pathway for the utilization of new technologies. The Roadmap appears to rely on historical data to determine the benchmark that will drive MCO/PPS decisions around a budget target, an approach that is inherently incapable of capturing the benefits and costs of new drugs and technologies (discussed in more detail in a subsequent section of these comments). Failing to allow for new technologies may limit patients’ access to the evolving standard of care. One possibility to provide for the use of new, innovative technologies that become available between updates to the budget targets is to require that these technologies be paid for separately for a period of time after they become available on the market, akin to the transitional pass-through payments under Medicare’s Hospital Outpatient Prospective Payment System. Ultimately, it is important that the Department’s approach maintains a dual focus on improving the quality of care patients receive and decreasing overall healthcare expenditures. Additionally, the Department should bear in mind that innovative drugs and biologicals are a small percentage of overall spending and have the potential to actually decrease spending on other, costly services like hospitalizations and surgical interventions. Thus, we urge the Department to take a patient-centered, quality-focused approach in defining such models and developing cost and quality parameters, particularly with regard to innovative therapies and new technologies.

II. Establishing Robust Patient Protections.

BIO supports and appreciates the importance of affording MCOs and PPS flexibility to develop arrangements that are most appropriate based on the healthcare needs of a specific Medicaid patient (sub)population. However, we urge the Department to establish standard beneficiary protections that apply across the Medicaid MCO population. First, the Department should ensure that patients are afforded robust and timely access to the most appropriate drugs and biologicals, including with regard to new-to-market therapies and therapies that are the subject of a pending grievance or appeal.

⁴ Total Care for General Population, Total Care for HIV/AIDs Subpopulation, Total Care for HARP Subpopulation, Total Care for MLTC Subpopulation, Total Care for DD Subpopulation, Maternity Bundle, Integrate Primary Care, and Chronic Bundle

⁵ 2016 VBP Roadmap at 34.

Second, BIO urges the Department to develop requirements to ensure beneficiaries are well-informed about the various types of payment and delivery-of-care models that may guide their individual care. In 2015 BIO included support for the Department's discussion of the potential to explore beneficiary attestation as part of the attribution determination, but is disappointed this was not explicitly included in the 2016 Roadmap. The 2016 Roadmap indicates that enrollee selection of PCP will drive prospective attribution but does not include beneficiary attestation, enrollee selection of a PPS, or disclosure of participation in a VBP arrangement with the enrollee. Beneficiary attestation is a prime opportunity to provide that information in a way that is specific to the provider/provider practice from which a beneficiary receives care. Additionally, the opportunity for a beneficiary to designate a PPS or specific provider is especially important for prospective attribution models, as it can be used as a proxy measure for the provider/PPS that will bear the plurality of responsibility for that patient's care. In such circumstances, beneficiary attestation would not only ensure that the beneficiary is aware of his or her provider's participation in the model, but it would help a provider/PPS proactively plan for the needs of a known patient population from the beginning of a performance year. In evaluating the benefits of beneficiary attestation, we encourage the Department to work with a diverse group of stakeholders to consider and implement a process for beneficiaries to designate a specific provider/PPS at the start of each benefit year as part of the Roadmap as appropriate. Moreover, regardless of the attestation model employed, beneficiaries should retain the freedom to change providers and mechanisms should be built into models developed under the Roadmap that adjust assessments of a provider's performance on quality and cost measures accordingly.

Third, in addition to seeking stakeholder feedback, we also urge the Department to conduct its own monitoring activities. Specifically, the Department should actively monitor patient feedback and work with stakeholders representing the patient community to ensure the VBP arrangements established under the Roadmap are fulfilling their goals without compromising patient access to care. One source of meaningful data as the state conducts such monitoring activities will be information collected on patient experience.

III. Providing Additional Details with regard to the Attribution Methodology to Ensure Patient Access to a Range of Providers.

Medicaid member attribution determines which members a VBP contractor will be responsible for, in terms of quality outcomes and costs. Attribution allows for the calculation of the total costs of care, patient-centered outcomes, and potential shared savings per member or episode of care – measures that allow for the continual monitoring of VBP arrangements. BIO had previously commented that 1) a standard methodology for attribution should be used, 2) the methodology should clearly identify that a particular provider is responsible, and 3) the Department should be sensitive to perverse financial incentives that exist and could put quality of care at risk.

While BIO generally supports the attribution methods outlined in the 2016 Roadmap⁶, it is not clear that the Department has considered the technical aspects and potential unintended consequences of attributing patients. Therefore we reiterate our 2015 comments that:

- BIO supports a standard attribution methodology across all MCO/PPS contracts to prevent the establishment of perverse provider incentives, such

⁶ 2016 VBP Roadmap at 22.

as incentivizing the treatment of patients with less severe health conditions (e.g., since these patients are likely to have lower overall costs than those with more severe health conditions).

- The attribution methodology should be: able to clearly identify that a particular provider is responsible for the care provided during the measurement period; and sensitive to the significant differences in how specialists and primary care providers are likely to share responsibility for the care of patients with different conditions.
- The Department should ensure that the attribution does not distort incentives for provider to furnish the most efficient, effective care; in doing so, the Department to evaluate the experiences of public and private insurers with other value-based programs to better inform the development of an attribution process that does not favor providers in institutional settings over providers in other settings.

Given the complexities of, and potentially perverse incentives that may arise from, establishing an attribution methodology, BIO urges the Department to consider focusing on only those diseases for which the ability of providers to impact patients' overall health outcomes, and provider incentives, are well documented. This is crucial to ensuring providers are not unduly penalized for the underlying disease severity of their patient population and to tracking the extent to which the effectiveness of the care they provide is impacted by patient behavior and the care offered by other providers.

IV. Implementing Differentiated Risk-Sharing Options for VBP Program Participants Governed by the Roadmap.

The 2016 Roadmap identifies several levels of risk sharing, described as "Level 0" through "Level 3," and envisions VBP program participants moving from arrangements with low risk sharing to arrangements with higher risk sharing over time. BIO appreciates that this approach provides participants with flexibility to accommodate those MCO/PPS that may not have as much experience with VBP arrangements as their peers. Because of the perverse incentives that can be established by a sole focus on cost-containment, we believe it is crucial that providers be allowed time to build the infrastructure and expertise to transition to higher levels of risk sharing to ensure that patient care is not negatively impacted by hasty attempts to do so. As MCO/PPS participants transition to higher-level risk-sharing arrangements, it becomes increasingly crucial to ensure that they are adequately reimbursed for utilizing technologies, including new technologies, that may be more expensive in the short-term, but offer long-term benefits, to avoid disincentivizing appropriate patient care.

In the 2016 Roadmap, the Department specifically notes that the VBP contractor should have a minimum number of Medicaid members for each type of arrangement.^{7,8} We agree with this assessment because smaller patient populations pose challenges to accurately assessing risk—current, commonly used risk-adjustment methodologies less accurately account for the underlying risk of a smaller sized patient population—and to allowing a provider to absorb natural variation in the cost of care and patient outcomes evaluated via cost and quality measures.

⁷ 2016 VBP Roadmap at 84.

⁸ 25,000 Medicaid members (excluding dual eligible members) attributed for a TCTP contract, or 5,000 Medicaid members (excluding dual eligible members) attributed for a total care for a subpopulation contract. For the MLTC subpopulation contract, the minimum number of dually eligible members is recommended to be 10,000.

V. Establishing Robust, Meaningful, Specific Quality Measures.

Throughout the 2015 and 2016 Roadmaps, the Department notes that the VBP options require practices to meet both cost and quality targets. The 2016 Roadmap also mentions that it is tasking the clinical advisory groups with identification of relevant measures focusing first on Domain 2 and 3 DSRIP measures and also considering applicable measures for third-party organizations (e.g., the National Quality Forum).⁹ Additionally, the Department notes that “Patient Reported Outcome Measures (including quality-of-life metrics)” will be employed.¹⁰ As the Department continues to refine its approach to the utilization of quality measures, BIO urges the Department to consider whether, for a given patient population:

1. Quality measures exist that are sufficiently specific to measure the type of care received and provide actionable assessments;
2. That any available quality measures selected for inclusion meet certain criteria, such as endorsement by the National Quality Forum (NQF), to ensure their validity and appropriateness to the condition in question;
3. That such measures adequately take into account how specialty care may be affected by factors outside of the specialty providers’ control (e.g., care rendered by other providers); and
4. That the quality measures themselves do not inappropriately incentivize providers to focus on costs.

In particular, the Department should adopt certain protections to ensure that quality measures are not used solely to drive down costs. For instance, quality measures that focus on drug adherence, medication management, and care coordination should be prioritized to address the weakness of almost all of the current measures in guiding the use of medications and the lack of robust measures across diseases states. However, the Department must be aware of the limitations of existing adherence measures in order to appropriately employ and interpret them in an episodic payment model. Careful evaluation of these measures and their appropriateness for inclusion is crucial to ensure that the quality measures serve as an effective check against the incentive to shift costs (e.g., from medical benefit drugs to pharmacy benefit drugs, or between care provided in different settings) even when it is clinically inappropriate for the patient or to encourage providers to focus on short-term cost goals at the expense of longer-term health outcomes.

⁹ 2016 VBP Roadmap at 34.

¹⁰ 2016 VBP Roadmap at 35.

Commissioner Zucker

April 18, 2016

Page **7** of **7**

VI. Conclusion

BIO appreciates the opportunity to comment on the Roadmap. We look forward to continuing to work with the Department to address these critical issues in the future. [REDACTED]

[REDACTED]

[REDACTED] Thank you for your attention to this very important matter.

Sincerely,

/s/

Patrick J. Plues
Vice President, State Government Affairs

Kristin Viswanathan
Director, Health Policy & Research

April 18, 2016

To: Jason Helgerson, New York State Medicaid Director
From: Larry Marx, Executive Director, The Children's Agenda
Re: Comments on Value Based Payment Roadmap Annual Update

Thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment Roadmap (the Roadmap). Our comments focus on the implementation of value based payment as it relates to children. By definition VBP for children must address the needs of their families and services in their communities, as children's health and well-being are shaped by those around them.

We strongly support a separate process and workgroup to consider how to assess / measure value for children, in the context of value based payment. The Roadmap includes a recommendation regarding the development of workgroups to dig deeper into a number of critical issues, including a **taskforce focused on children and adolescents in the context of VBP...**" (p. 59). This should be focused on the broad, population-oriented preventive and primary care needs of all children.

Though there has been little discussion of the unique needs of and approaches for children in New York's health system transformation, the approaches being considered would be applicable to payment for services for children. To the extent that system transformation efforts currently underway aim to fundamentally change New York's health care delivery system, it is critical that we look closely at value from a pediatric perspective or risk creating a system that, by design, ignores the developmental trajectory of children.

The Roadmap suggests that a small number of Clinical Advisory Groups (CAGs) will continue in Year 2 and that new CAGs may be formed around additional priorities, such as **Special Needs Children** (p. 34). One or more CAGs focused on Special Needs Children is a good idea. This, more narrow focus should not substitute for a workgroup or task force described on page 59 of the Roadmap (and supported above) that will make recommendations regarding value-based payment and the broad, population-oriented preventive and primary care needs of **all** children.

The Roadmap articulates a guiding principal of financially rewarding, rather than penalizing, providers and plans who deliver high value care through emphasizing **prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health** (p. 8). We strongly support this principal and note that, for children, addressing underlying social determinants of health will include focusing on the family.

We support the Roadmap's plan that Level 2 and 3 VBP contractors be required to implement at least one intervention designed to address a **social determinant of health** and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)

We support the Roadmap's statement that providers and plans that focus on health education, increased uptake of prenatal care, pre- and inter-conception counseling, adequate C-Section rates and resource utilization, screening for post-partum depression and so forth have the opportunity to further improve maternity care outcomes and generate savings (p. 13). We welcome this focus on prevention and maternal mental health and note that contractors/ subcontractors in this field may be community-based

organizations (CBO) and that evidence-informed maternal/infant home visiting is among the strategies for successfully improving prenatal and post-partum outcomes as well as child health and well-being.



Comments on the First Annual Update of the Value Based Payment (VBP) Roadmap April 15, 2016

The NYS Coalition for Children's Behavioral Health welcomes the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment Roadmap. The Coalition urges that the Update create a "glide path" for specialty children's providers to actively engage in the DSRIP-driven Value Based Payment effort. We are encouraged that the Update recommends the creation of a "taskforce focused on children and adolescent services in the context of VBP" (p.59). However, do not wait for the creation and process of a new workgroup before acting! We urge that consideration be given to the inclusion in this Update of an additional Priority VBP, because there is not an appropriate child and adolescent category for children's behavioral health. This is because the children's system of care does not recognize childhood behavioral health challenges as a "chronic disease" state.

Child & Adolescent Priority/Focus:

We urge consideration be given, at a minimum, to an appropriate priority such as "Total Care for Early Childhood Development" or a specialty project that allows for a Child & Adolescent Resiliency Bundle. The model would focus on getting to the total child costs of youth involved in multiple system specialty services and developing stabilizing, predictable alternative payment models to a high-performing children's programs for "special needs children" (p. 34)

The existing fiscal vulnerability across the child-serving system makes the need to address this area of service delivery an immediate need. Without linking the services to the future alternative payment models, the lack of attention on the outdated service models and payment methodologies across the sector will soon make the nonprofit agencies unable to respond to changing market designs or able to meet the needs of many children, not just Medicaid-eligible children. The most unfortunate consequence of that would be underutilization of the children's provider and systems of care which have spearheaded and are heavily involved with Evidence Based Practices (EBPs) and transforming out-date care models into community-based models.

Child & Adolescent Involvement:

Few child and adolescent advocates have not been involved in the Roadmap development through representation on the VBP Workgroups and the Subcommittees. This fact is incongruous with the development of Social Determinants of Health & Community-Based Organizations, when research shows the economic link between early childhood investment that promotes child development as one of the best predictors of young adult and adult health, wellness and economic success.

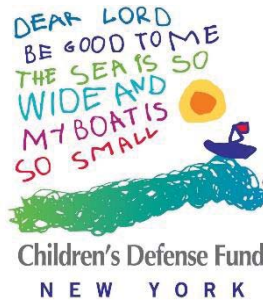
So, while the level of stakeholder engagement in this process may be unprecedented in many ways, when viewed through the "Early Development" lens, the involvement needs to be expanded. We recommend the

Roadmap reflect a continued commitment to maintaining robust stakeholder engagement that includes the voices of childhood advocates and family members.

Specific References to the Roadmap:

- Addressing social determinants of health, particularly through the following Payment Reform Guiding Principles: “Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health.” (pg. 8)
- Act on the suggestion that a new Clinical Advisory Group (CAG) be developed around additional priorities, like Total Care for Early Childhood Development or Child & Adolescent Resiliency Bundle
- Regarding patient incentives, we support the State’s interest in measuring and encouraging creativity in incentive programs, which must be specifically designed to respond to families with children in complex care. The State is willing to convene a group of experts and consumers, but must include family members, to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design.” (pg. 40)
- We support the recommendation that Level 2 and 3 VBP contractors be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. We urge that consideration be given to school attendance being highly valued as an outcome for the child and adolescent population (pg. 41).
- The requirement that “starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO” must be clarified for the child and adolescent population. Are schools community based organizations, afterschool programs, recreational programs, nonprofits engaged in supporting families? They should be especially as the expansion of Community Schools models that link health, mental health, nutrition and preventive services to families and children through school hubs (pg. 42).
- We applaud the inclusion of the Advocacy & Engagement, and Social Determinants of Health & CBOs Subcommittees’ recommendation to develop several workgroups to dig deeper into a number of critical issues (pg. 59), such as including a taskforce on children and adolescents in the context of VBP;
- In the Quality Measures section (pg. 34), the Roadmap should include references to the fact that the presence of EBPs can reduce the need to identify “new” quality measures for child and adolescent measures. EBPs have been vetted to prove improved outcomes. The new state plan amendment services for children will include EBPs – the adherence to EBP required standards negates the need to “categorize” measures that are not data-driven. The data on outcomes for child & adolescent services is not robust (and building up data analytics on child & adolescent services should be a result of including a new Priority VBP)
- Related to the Managed Care Patient Bill of Rights (p.43), a more thorough effort may be needed by the Advocacy and Engagement Subcommittee with a focus on child & adolescent needs to empower families members and other legally responsible for the children to understand how the VBP system will be different, offer “higher value” and support specific individualized needs of each child.





April 18, 2016

Jason Helgerson, Director
New York State Medicaid

Dear Director Helgerson:

The Children's Defense Fund-New York (CDF-NY) thanks the New York State Department of Health for the opportunity to provide comments on the updated Value-Based Payment (VBP) Roadmap (the Roadmap). As an agency committed to ensuring all children receive a healthy start in life, CDF-NY works to guarantee that all children have access to affordable, high-quality health care. CDF-NY believes that the shift towards value-based payment structures holds significant potential to increase the health and wellbeing of children and families across the state. Our comments focus on the elements of the Roadmap that have the potential to create a more effective and efficient children's health care delivery system.

Adapting Value-Based Payments to Serve Children

To date, New York State's health transformation efforts have largely focused on adults. Conversations regarding health transformation, particularly those around the development of VBP arrangements, should sufficiently address the unique needs of children. By focusing exclusively on the adult population, the state runs the risk of creating a VBP landscape that will fail to appropriately incentivize quality care for children.

Given that concern, CDF-NY was very pleased to see the addition of a recommendation for "...the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: *a taskforce focused on children and adolescents in the context of VBP...*" (p. 59). CDF-NY strongly supports this recommendation. In order to best ensure that VBP mechanisms adequately capture the level of services pediatric providers must deliver and that payers appropriately evaluate these arrangement using child-specific metrics, the state must create a forum specifically focused on adapting the VBP model for children.

Relatedly, CDF-NY appreciates the recognition that the Clinical Advisory Groups may need to expand to cover a wider breadth of topics, specifically "Special Needs Children" (p. 34). Since children with special health care needs require a greater volume of services and more complex treatments, it is appropriate to designate a unique space for these discussions. While this CAG will be necessary, this forum should not displace any new taskforce explicitly established to address the general population of children in the context of VBP.

Addressing Social Determinants of Health

The Roadmap states, “The overall well-being of individuals, families, and communities should be the driving purpose of a health care system. Viewed from that lens, addressing social determinants of health (SDH) should come naturally to health care providers” (p. 44). CDF-NY greatly appreciates the emphasis on addressing social determinants of health as a cost-effective means for preventing more costly chronic and acute disease management services later in a person’s life. CDF-NY believes that initiatives aimed at addressing the social determinants of health have their greatest impact when they are delivered to families with children. By safeguarding access to high-quality housing, minimizing the prevalence of trauma, and guaranteeing access to safe neighborhoods and nutritious foods, providers can create an environment in which children have the greatest opportunity for wellness.

The recommendation to “financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health,” will help further incentivize the delivery of services that address the social determinants of health (p.8). Accordingly, CDF-NY strongly supports the requirement for Level 2 and 3 VBP contract arrangements “to implement at least one social determinant of health intervention” (p. 41).

Lastly, CDF-NY lauds the decision to inform VBP social determinant arrangements with “information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources” (p. 42). Such consumer focused information gathering will ensure that initiatives address those social needs that a community has identified as posing the greatest barriers to health and wellness. Also, the emphasis placed on tactics, like SDH screenings of individual members, will lead to innovative ways to better integrate needed social services into primary care, such as evaluating housing status during a routine well-child exam.

New York’s proud history of connecting many children to health insurance coverage, and consequently health care services, has created a foundation upon which payment and delivery system reforms, and specifically value-based payment models, can work to ensure that every child receives high-quality care that addresses the full spectrum of physical and social determinants of health. In order to do so, the state must establish the appropriate forums for translating reforms proposed for the general population into child-friendly delivery and payment mechanisms. The recommendations highlighted in our comments demarcate a path upon which that ideal can be achieved.

Thank you for your attention to our comments. [REDACTED]

Sincerely,



Andrew Leonard
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www.CIDNY.org

Center for Independence of the Disabled, NY

COMMENTS on the 1st annual update on the Value Based Payment Roadmap

Thank you for the opportunity to comment on the first annual update to the Value Based Payment Roadmap. Center for Independence of the Disabled, New York (CIDNY) is a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. It has now more than 25 years since the signing of the Americans with Disabilities Act. We are redoubling our efforts towards achieving these goals.

CIDNY helps consumers understand, enroll in and navigate private commercial and public health insurance and free or low-cost coverage alternatives. We advocate informally; file and represent consumers in grievance processes, appeals, and fair hearings; and advocate for optimal coverage, (e.g., sufficient home care hours; medically necessary durable medical equipment; personal care; and prescription drugs).

We also facilitate a Consumer Action Network that discusses proposed health policy changes monthly and weighs on them at the Capitol and with policy makers.

CONSUMER PROTECTIONS AGAINST DENIAL OF CARE

People with disabilities and serious illnesses often have chronic conditions that require a complex combinations of treatments and medications. Because they are "high cost" patients, they are at most high risk for under service and providers who are subject to value based systems of payment are less likely to want them as patients. One way to counter adverse selection and under treatment is to have strong risk adjustment mechanisms and quality measures that counter the incentives to deny needed care. One particularly galling denial of care our consumers have encountered in the Medicaid program is the arbitrary 20 limit on PT and OT and Speech Therapy. These limits discriminate against people with disabilities and may lead to the need for more expensive and invasive treatment. The adoption of this MRT proposal undermines the confidence of people with disabilities in policy makers who clearly do not understand their needs.

Consumers also need to understand the Value Based Payment incentives their providers are operating under, should understand their rights and should have access to ombuds programs and consumer assistance to help them exercise their rights.

QUALITY MEASURES

Consumers should be involved in selecting the quality measures that will be used to measure the success of the program. It should not be left entirely to Clinical Advisory Groups. CIDNY appreciates the goal of inclusion of Patient Reported Outcome Measures (including quality of life metrics), a key missing link in assessing the outcomes of care for many health problems and conditions. People with disabilities often report that they are not treated with dignity and that alone can have a great impact on their health outcomes. These kinds of measures can be an important



Re:

feedback loop to improve the delivery of care. Quality information and data such as the number of complaints made should be provided to consumers and to the public.

MEMBER INCENTIVES

CIDNY was disappointed to hear that the Consumer engagement workgroup was focusing on this area. A previous MRT workgroup that decided not to make these kinds of recommendations as there is very little evidence to support them. There is also abundant opportunity for discrimination on the basis of disability status and health status. CIDNY has provided extensive comments to CMS and to the EEOC regarding wellness programs. We appreciate the decision not to introduce co-pays or co-insurance as disincentives, but the providing cash incentives for “lifestyle choices” can be equally detrimental if they offered without providing reasonable accommodations so that all can participate in the programs that are being offered and if they do not recognize that Medicaid recipients are, by definition, low income people who may be juggling multiple jobs and family responsibilities. A Bloomberg initiative using private dollars to “incentivize” low income people to engage in behaviors, judged to be desirable by policy makers, was discontinued because the evaluation conducted of it determined that it did not work. It also appeared to many to be demeaning and to assume that low income people were not good parents.

SOCIAL DETERMINANTS OF HEALTH

CIDNY applauds the inclusion in the road map of the need to address social determinant of health. With all the bar graphs that show that only 20% of health status is determined the health care delivery system and 80% is determined by other factors, it is important to begin to address the social determinants. It is critical that the health care delivery system be involved in realigning societal priorities.

Comments on Value Based Payment Roadmap Annual Update

April 8, 2016

The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to comment on the 2016 Annual Update of the Value Based Payment Roadmap. CHCANYS is a member of the Value Based Payment Workgroup and CHCANYS representatives participated in all of the VBP Subcommittees. As such, we have previously commented on many of the issues below when they were discussed at the Subcommittee or Workgroup level. The comments below build on our previous comments.

1. Shared Savings Requirement for Professional-Led VBP Contractors

CHCANYS participated in the Tech Design I Work Group, which discussed and developed recommendations for the Integrated Primary Care (IPC) bundle, the Chronic Care bundles and the Total Cost of Care Model. Throughout this process, CHCANYS expressed concerns about the State's proposal to require community based providers to share savings equally with hospital providers. The most recent edition of the Roadmap elevates this concern.

Scope of Shared Savings Requirement

The original Roadmap would have required the contracting entity in an IPC arrangement to share equally in the savings with local hospitals. The current Roadmap has extended that requirement to include both Chronic Bundle payments and total cost of patient care arrangements. This expansion means that professional-led VBP contractors must share a portion of their savings with hospitals in any type of arrangement they participate in. However, there is no reciprocal requirement that hospitals share their savings with professional-led VBP contractors in any type of hospital-led VBP contract. For example, unlike hospitals, primary care providers are given no guarantee of savings when they are not part of the hospital VBP arrangement, even though their efforts increase the hospitals outcomes and

savings. However, professional-led VBP contractors are mandated to share half of their savings with associated hospitals.

New York State's health system has historically undervalued and underpaid for primary care services. Now as part of New York's transformation efforts, professional-led primary care providers are being asked to increase access to their services while transforming into team based medical home models with care coordination at their core. This expansion and care transformation requires primary care providers to invest significant resources. VBP contracts should reward these investments by providing providers access to the savings generated by their transformational investments. However, the Roadmap dictates that professional-led primary care providers share half of their savings- savings generated by their investments and efforts- thus limiting the return on their investment and creating a disincentive to participating in VBP arrangements. Additionally, if professional-led practices cooperate in VBP arrangements led by a hospital contractor, there is no mandate guaranteeing the practices receive an equitable share of savings from the hospital even though they were generated through the associated primary care provider's efforts. This arrangement again limits the primary care providers' return on investment and creates yet another disincentive to their participation in VBP contracts.

CHCANYS is concerned that this paradigm not only disincentivizes primary care providers from participating in VBP arrangements but creates an unequal playing field that continues to perpetuate a hospital centric delivery model.

Notification of VBP Intent

Appendix III of the Roadmap Update outlines the criteria for shared savings in IPC and TCGP between professional-led VBP contractors and "downstream" hospitals. The first paragraph notes, "It is the responsibility of the contractor to notify downstream hospitals of its intent to negotiate value based agreements with an MCO." Notifying the hospital that a contractor

“intends” to begin negotiations seems not only extremely premature in the context of determining shared savings arrangements, but may serve as a flag to the downstream hospital to initiate negotiations of their own with the MCO that could disadvantage the professional-led practice. The Roadmap does not contain any similar requirement that hospitals notify providers of their intention to begin negotiating a value based arrangement. It may make sense for a provider to notify the downstream hospital of a VBP contract with an MCO once it has been negotiated and finalized, but notification prior to this point in contract negotiations seems to serve little purpose and has the potential of greatly harming the provider’s ability to negotiation freely with the MCO. CHCANYS strongly advocates removing this language.

Calculating Savings for Purposes of Sharing

A major emphasis of the State’s healthcare transformation efforts is the focus on addressing social determinants of health at the community level. The Roadmap Update reflects this priority by mandating that providers in level 2 or 3 arrangements implement at least one intervention addressing social determinants of health and all level 2 and 3 arrangements must include at least one non-Medicaid billing community-based provider. CHCANYS supports the focus on social determinants of health and the inclusion of community-based providers in VBP arrangements. The intention of a value based payment system is to generate savings for providers that can then be re-invested into those initiatives that provide the greatest value. However, requiring that professional-led VBP contractors share up to 75% of the savings they earn in VBP arrangements reduces the amount that can then be re-invested into these valuable initiatives. On one hand the State is lauding the importance of addressing social determinants of health and working with community-based organizations, yet on the other hand, it is restricting the amount of funding available to community-based healthcare providers who seek to engage these organizations. Therefore, CHCANYS recommends that the cost of contracting with non-Medicaid billing CBOs and leading initiatives focused on addressing social determinants of health be subtracted from the VBP contractor’s shared savings prior to calculating the percentage that must be shared with the associated hospital. This will further

incentivize the inclusion of CBOs in VBP arrangements and ensure that VBP contractors have funding to adequately invest in effective initiatives that address social determinants of health and ultimately reduce costs to the system.

Additionally, footnote 80 on page 68 states that “For downstream hospitals to share in the savings, no causal relation between the VBP contract and the revenue loss has to be established.” CHCANYS strongly disagrees with this premise. For example, if the loss of hospital revenue was a result of construction, renovations or poor fiscal management, the professional-led VBP contractor should not be required to share savings with the hospital, as the loss is in no way related to any actions taken by the contractor. A causal relationship between the revenue loss and the VBP contract *must* be established to trigger shared savings with the associated hospital. Furthermore, since the State will be sharing and assigning cost savings to VBP arrangements, such as IPC, there is a clear way to demonstrate how the actions of VBP contractor resulted in savings and caused revenue losses at the associated hospital.

Definition and Criteria for Cooperating Hospitals

The Roadmap Update would require downstream hospitals to cooperate with professional-led VBP contractors in order to be eligible to share in their savings. However, the Roadmap does not include a definition of “associated” hospital. It may be clear in some areas which hospital or hospitals are downstream from a provider, but in larger urban areas, where there are numerous hospitals it will be much more difficult to determine the associated hospital for purposes of shared savings. The State must articulate a clear methodology for determining “associated” hospitals in this context. Furthermore, the Roadmap switches between the terms “downstream” and “associated” hospital throughout the document, adding to the confusion.

While CHCANYS appreciates the inclusion of criteria to which hospitals must comply prior to qualifying for a portion of the shared savings, the criterial is unilateral and does not necessarily

require cooperation by the associated hospital that is relevant to the work of the professional-led VBP contractor.

Appendix III provides that a hospital must meet three criteria in order to be able to share in savings: (1) providing real time data feeds; (2) collaborating on DSRIP metrics affecting population health; and (3) choosing one of several options relating to palliative care or hospice, care transitions, or standardized care plans.

The Roadmap Update mandates that the hospital meet these criteria, but does not include any directive about the professional-led VBP contractor's role in determining what type of cooperation would be most relevant or helpful to the VBP arrangement. Instead, it appears as though the hospital can choose within these criteria how it cooperates, without any relationship to the IPC or bundled care arrangement and without consulting with the contracting entity. For example, a professional-led VBP contractor and an MCO could enter into an IPC arrangement where the attributed lives are primarily young families or children, but the hospital is entitled to equal savings because it has implemented a palliative care program in collaboration with hospice or has a program related to transitioning patients from nursing homes. While the hospital may have excellent programs, they bear little to no relationship to the IPC arrangement and should not be used as a basis to qualify the hospital for a share of savings for that arrangement.

Furthermore, questions about the criteria as outlined in the Roadmap remain, including what qualifies as providing real time data feeds and what is meant by collaboration on Domain 2 and 3 metrics quality indicators affecting population health. Would a hospital qualify for equal savings if the data feed does not interface with the IPC contractor's system? How many population health metrics must be selected in order for there to be "collaboration" and must they relate to the IPC model? These questions and others must be addressed prior to adopting

this method of determining cooperation by a hospital for purposes of calculating shared savings.

CHCANYS recommends that the specifics of the IPC arrangement at issue inform the determination of whether an associated hospital is cooperating for purposes of sharing in savings and whether and how the hospital programs and systems support that arrangement.

Duration of Shared Savings Program

In discussions with the State, it has been explained that professional-led primary care providers must share their VBP savings with associated hospitals to assist the hospitals “transition” to new payment systems. The shared savings program Roadmap lays out, however, does not appear to contemplate a time limited process. Indeed, community based health care providers appear to be required to share equally with “cooperating” hospitals in perpetuity with no indication that this arrangement will cease even after new payment systems have been fully implemented throughout the system. Transformation is a difficult process for all sectors of the healthcare system and efforts should be borne equitably by all participants.

CHCANYS recommends that if any requirement is included to share savings “equally,” that requirement sunset after three years, after which such arrangements would be determined exclusively between the parties.

Equitable Distribution of Resources

Every provider in this system is struggling with the real-time issues of continuing to provide quality services while also implementing and participating in health care transformation initiatives, including payment reform. Hospitals, particularly -- but not exclusively -- PPS leads, have benefitted from significant infusion of working capital dollars under DSRIP and capital and other dollars under other State programs (e.g., CRFP, the Essential Plan, VAPAP). These are funding streams that simply have not been accessible to community based health care

providers. The aspect of realizing savings from the work that is occurring in the community has generated excitement among community based health care providers because it rightfully recognizes the value they add to the system. Denying community based health care organizations 50% of their savings to benefit stakeholders that have already received billions of state and federal dollars further disadvantages the community based health care providers.

2. General Guiding Principles for Distribution of Shared Savings

Principal V on page 21 of the Roadmap states that certain providers with “a regulatory limitation on accepting certain losses may be treated differently by the VBP contractor to protect these individual providers from financial harm. It is legitimate that this ‘special’ treatment would weigh in as an additional factor in determining the amount of shared savings that these providers would receive.” As detailed in the previous sections, the historical underinvestment in primary care means that primary care providers will need additional investment to develop the infrastructure and internal systems necessary to generate shared savings. Limiting the amount of savings a provider may receive in a VBP arrangement based, not on their performance or value to the contract, may further reduce primary care providers ability to access resources necessary to succeed in VBP arrangements and effectively ghettoize certain providers by creating a two tiered system in which certain providers are never able to catch up to others as the savings remain primarily within larger providers and systems who are able to shoulder more risk. The fact that a provider is unable to take risk shouldn’t access their ability to share in savings, as their investment and participation in the VBP arrangement generated savings and as such, should be returned to them for future investment.

3. Future Budget Adjustments in VBP Arrangements

Page 29 of the Roadmap states that when adjusted costs for a specific VBP arrangement, “start to converge around the State average, that State average can become the starting point for target setting, and these efficiency adjustments would no longer be used.” However, New York is a large state with large urban centers and small rural areas, and a statewide average would

not account for these vast differences in costs. CHCANYS recommends the State incorporate regional adjustments that take into cost of living and wages when calculating target budgets in the future.

4. Ongoing Role of PPS

The Roadmap indicates that the PPSs/hubs that are not contracting entities should maintain infrastructure for population health, patient-centered integration and workforce strategy. (p. 16). Non-contracting PPSs will be well-positioned to contribute reports on the impact of VBP arrangements. However, reports on the impact of Medicaid VBP arrangements will be most valuable viewed in the context of other payer initiatives, including Medicare VBP and commercial arrangements. It will be important for the State to ensure that PPS reports and population health planning activities are integrated into broader community assessment and planning efforts, such as those generated by successful Population Health Improvement Programs (PHIPs). We recommend that the State explicitly recognize PPSs population health assessments as taking place in collaboration with other state-funded entities conducting broader health planning activities that include Medicare and commercial VBP arrangements.

The State should also develop a process for the PPSs/hubs to utilize in developing the community needs and resource assessments required for selection of the social determinant intervention. Two points are important to keep in mind regarding the process for developing the community needs assessment. First, community needs assessments are best undertaken by neutral, independent entities that are not providing the services in question. Without neutrality, trust and community buy-in are difficult to develop and maintain. Without trust, reports on capacity and gaps in services may be less than complete and alignment between new initiatives and existing services will be difficult to achieve. Without community buy-in regarding priorities, social determinant programs will fail to capitalize on potential synergies and lack critical momentum.

Additionally, VBP arrangements for Medicaid services will of necessity operate in close juxtaposition with VBP arrangements for Medicare and commercial payers. Unless clinical programs share goals and milestones across payers, progress will remain erratic and uncertain. Thus, it will be critical for the PPSs/hubs undertaking community needs assessments and social interventions to coordinate with initiatives launched across payers.

The Roadmap states on page 42, “After a period of two to three years, the State will create a process, which would include an independent review of the role of the CBO, to determine whether the VBP providers are leveraging community based resources, identify best practices and determine if future guidance or technical assistance *or other resources are* (added) ~~is~~ needed.” We propose adding “or other resources.” In addition, we recommend that the State urge PPSs/hubs to partner with independent community planning entities, such as the PHIPs, to perform the review of the role of the CBO.

5. Quality Measures and Model Contract

In the section on Quality Measures, the Roadmap references Category 1 and Category 2 measures, which have not yet been shared with the VBP workgroup. It is difficult to support this section of the Roadmap without having a sense of the measures that are being discussed by the Clinical Advisory Groups (CAGs) in each category (p. 34). It is important that quality measures capture the impacts of both under-treatment and over-treatment on health outcomes, and solidly integrate clinical outcomes with measures related to social determinants of health. However, without further detail on the measures providers will be required to report on, we cannot provide specific comments on these issues.

The Roadmap should clarify that the work of the CAGs and the proposed measures will be shared with the VBP workgroup and that the public will have a chance to comment on the measures actually adopted for reporting in drafts of the new model contracts. For example, the Roadmap states that “measures focusing on rehabilitation and individual recovery including

housing stability and vocational opportunities...are as yet underrepresented.” The CAG on Behavioral Health has been working to identify metrics, both clinical and HCBS-related, but their work has not been integrated into the Update, and it is not clear if these essential metrics will be included in the revised model contract, the most definitive way to ensure MCOs are accountable for these metrics.

The Roadmap indicates that the State foresees including these metrics in the model contract, but fails to provide an opportunity to comment on the model contract before it is finalized, stating that that the model contract "will not be posted until it is approved by CMS." In an earlier version of the recommendations from the Regulatory Subcommittee (SC), it stated that “after consideration of the comments from the SC, DOH will share the updated Model Contract with the public and solicit additional comments before finalization. DOH will post all of the received comments on the DOH website prior to the adoption the Model Contract.”

CHCANYS strongly recommends that the State establish a public comment period on the model contract before it is finalized, so that stakeholders have an opportunity to ensure the inclusion of metrics is representative of the successful work many are already engaged in.

6. VBP and Consumers

The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant in the VBP context. That is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it affects them. The Roadmap should reference some of the other important actions recommended by the Subcommittee that the State has committed to undertake, such as ensuring that plans and providers communicate information to consumers that explains the difference in incentives that payment mechanisms generate; the workgroup that will be created to develop a larger communication strategy. Consumer education and patient activation are needed around what is meant by a “high value provider,” as well as their right to question their providers, seek a second opinion, and obtain

consumer assistance/ombuds services. The State’s Independent Consumer Advocacy Network and any and all consumer assistance/ombuds programs should be equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment. More specifically, the State should expand the Ombuds Program for people with Medicaid long-term care services to include Medicaid members enrolled in VBP.

7. VBP Bootcamps

The Roadmap is a rather high-level overview of the State’s plan to transition to VBP, but many providers and other potential VBP participants will need more in-depth technical assistance to understand how to prepare for and participate fully in successful VBP arrangements. CHCANY supports the State’s plan to provide an educational series for providers and plans, although these sessions should emphasize the overarching system transformation goals of VBP beyond just changing how providers are paid. Sessions should focus on the care component of VBP and its use as a tool to move to a more coordinated, patient-centered model of care. Creating care teams, increased use of care coordinators, working across provider types to enhance care delivery and bringing in new partners like pharmacy and CBOs are all critical components to success in VBP arrangements. It is this system of care transformation that will ultimately lead to increased savings in the system that can then be reinvested into these new care delivery approaches.

Additionally, it would be very helpful to include in the sessions a moderated discussion for safety net providers and CBOs on the new skills and infrastructure requirements necessary for success in a VBP environment, so they can begin to assess how their entity may fit into a VBP relationship. Since different provider types may have different roles and questions about how they can be successful in VBP, there should be either breakout sections in each session by provider types. Provider participants will have a wide variety of perspectives may greatly benefit from targeted discussions specific to their needs and questions.

8. Additional Comments

CHCANYS supports the following new concepts included in the Roadmap Update:

- The State’s recognition that housing plays a critical role in a person’s health, demonstrated by the Roadmap’s commitment to:
 - Collect standardized housing data for purposes of rate setting and appropriate intervention research and analysis
 - Ensure coordination with Continuum of Care (COC) entities when considering investments to expand housing resources
 - Leveraging the Medicaid Reform Team (MRT) housing workgroup money to advance a VBP-focused action plan and submit a New York State waiver application to CMS that tracks the *CMCS Information Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. (p. 39)

However, while CHCANYS support the content of the content of the box on Housing and Vocational Opportunities, (p. 39), we ask that this box be moved *from* Incentivizing the Member *to* Public Health and Social Determinants of Health (beginning p. 41). We would not want anyone to interpret placement to suggest that these should be used as patient incentives; rather, these are essential to achieving good health outcomes.

- The State’s plan to eliminate the \$125 incentive cap for incentive programs (the roadmap describes the current cap as applying to *preventive services*. We believe the reference should be to an existing cap on *incentive payments*. (p. 40)
- The State’s interest in measuring and encouraging creativity in incentive programs, specifically its plan to “analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publically available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of

incentive programs, with a particular focus on achieving cultural competency in program design.” (p. 40)

- The requirement that Level 2 and 3 VBP contractors implement at least one intervention designed to address a social determinant of health. We strongly support the proposal that that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)
- The proposal that a social determinant intervention “should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources.” (p. 42). It is critical that any intervention addressing social determinants of health be guided by individual members’ own health goals and desires and community needs and resources.
- The mandate that all level 2 and 3 VBP arrangement include a minimum of one Tier 1 CBO, with the understanding that this may be difficult in some more rural regions of the state, as noted on page 42. It is critical that community-based organizations are included in VBP arrangements, and CHCANY appreciates the State’s recognition that contractors may engage with CBOs in a variety of ways to address social determinates of health and further their VBP goals.
- The creation of a taskforce focused on children and adolescents in the context of VBP. (page 59) CHCANY strongly supports a separate process to consider how to measure value for children, in the context of value-based payment. Though there has not been discussion of the unique needs of children in VBP, the approaches being considered would be applicable to payment for services for children. To the extent that system transformation efforts currently underway aim to fundamentally change New York’s health care delivery

system, it is critical that we look closely at value from a pediatric perspective or risk creating a system that, by design, ignores the developmental trajectory of children.

CHCANYS is grateful for the opportunity to comment on the Roadmap Update and looks forward to continue to work with the State on this issue.



Comments on the First Annual Update of the Value Based Payment Roadmap

April 18, 2016

Thank you for the opportunity to comment on the First Annual Update on the Value Based Payment (VBP) Roadmap. The Coalition of Behavioral Health Agencies (The Coalition) supports the concept of payment methodologies that incentivize payment mechanisms to community-based providers (CBO) that enable individuals living with severe mental illness and substance use disorders to recover and thrive in the community. Comprehensive behavioral health services provided in the community effectuate better outcomes, which reduce medical expenses overall, particularly from averted hospitalizations and inpatient care admissions.

The behavioral health CBOs have been a willing partner with the State in the ongoing transition of Medicaid-funded services. We support a more efficient service delivery system that results in better outcomes, however, CBOs need the tools to make this happen and they need to be included in the process.

The New York State rollout of VBP includes a number of initiatives that The Coalition supports and is looking forward to seeing greater detail on their proposed implementation. These include the Roadmap's explicit recognition of the importance of the Social Determinants of Health (SDH) and positive incentives for consumer lifestyle changes.

Social Determinants of Health

We appreciate that the Plan recognizes that addressing the social determinants of health is necessary to achieve high value care. As exciting is the ability to reward members by positively incentivizing desired behavior and the clear statement made in the Roadmap that "burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option." (pg. 38). However, because agencies have functioned under existing federal and state regulations, in which such incentives have not been allowed, **The Coalition is concerned that all State agencies, including the Office of the Medicaid Inspector General, recognize this change in policy and hopefully, New York State law.**

The State's decision to require VBP contractors to provide "a measureable reason why the SDH was selected, and identify metrics that will be used to track its success" is certainly appropriate.

However, we are concerned that many behavioral health agencies, particularly agencies that provide child and adolescent services, do not have the current infrastructure necessary to provide such metrics. The emphasis on metrics is critically important in making efforts to address social determinants of health meaningful and effective, but the funding, especially for children's agencies, has not been sufficient to date. We do note that some funds were allocated in the 2016-17 Enacted budget for this purpose, but to date we remain unsure if that is sufficient, or that the funding will be timely provided such that the necessary IT structures are up and running on a timely basis as to provide the metrics. (pg. 42)

We appreciate the requirement that "starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO" (pg. 42), but we believe that it may not be sufficient. We join many other voices throughout this process to highlight the importance of supporting community-based organizations and emphasizing their role as critical to reaching intended outcomes. The document mentions CBOs but the emphasis is not on CBOs as a necessary part of the overall network.

- **The Coalition urges that VBP payments to community-based providers include MCO rate guarantees that ensure that community based providers are reimbursed actuarially sound VBP rates. These rates must fully support the cost of efficient care that meets quality standards.**

We support the SDH & CBOs Subcommittees' recommendation to develop several workgroups to dig deeper into a number of critical issues (pg. 59), including:

- Children and adolescents behavioral health services in the context of VBP;
- How to reliably track metrics related to social determinants;
- Development of a communications system for providers and CBOs to better address SDH needs;
- Updating the current Managed Care Bill of Rights to include information relevant to VBP and to provide information on VBP to Medicaid beneficiaries; and
- Examining and tracking the use of patient incentives, including particular focus on ensuring cultural competency in patient incentives.

Challenges to Overcome

As we stated above, The Coalition and the providers we represent strongly support the goals of value based payments. We most underscore that the partnerships between large stakeholders (hospitals and MCOs) and CBOs must create a payment system that compensates the participants fairly for the true value of the services provided as well as the resources expended in achieving positive outcomes. What follows are some of our concerns about the Roadmap in its current form

as well as ideas on how to make the VBP system viable for all of the stakeholders.

Capacity and Organizational Infrastructure to Achieve Outcomes

In New York City, most Performing Provider Systems (PPS) will have attributed members that belong to multiple managed care organizations (MCOs). In such a complex environment, community based organizations may be faced with multiple VBP methodologies that could stretch their administrative capacities. In addition, since individuals living with behavioral health conditions could qualify for the Chronic Care Bundle payment mechanism as well as behavioral Health and Recovery Plans (HARPs) and Home and Community Based Services (HCBS) services, etc., providers will need to keep track of a number of VBP reimbursement mechanisms and care coordination structures for each individual they serve.

Outside of New York City, network adequacy may make VBP a significant challenge as well. Areas where specialty services such as medication assistant treatment, supportive employment and crisis intervention services, for example, are non-existent or require long travel distances, will make meeting VBP benchmarks and outcomes nearly impossible.

The Coalition is concerned that many providers are not fully included in the payment structures that are being developed.

The State should invest in CBOs that show promise with helping to address the social determinants of health, such as safe housing, access to jobs and job training and social support. The State should also make additional funding available to CBOs to help prepare for participation in VBP arrangements.

- We recommend that the State work with CBOs to explore the development of payment methodologies that incentivize/reward providers for taking on patients with challenging social determinant of health barriers.
- CBOs will need funding for, among other things: infrastructure development, including IT systems; ability to measure and collect data to demonstrate their value; and contracted services, such as fiscal and legal expertise.
- The State should create a “design and consultation team” of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support in a way that is affordable to CBOs who are either involved in or considering involvement in VBP.
- Special consideration should be given to HCBS. The exciting new expansion of services for individuals with behavioral health needs are in developmental stages, and additional support is necessary from VBP while experience is gained with the program.

It is important that the Roadmap reflect a continued commitment to maintaining robust stakeholder engagement, which includes input from consumers, providers, and advocates. In this

vein, it is particularly important that the process to revise the Medicaid managed care Model Contract be as transparent as possible, as so many components of the State's move to a value-based system will be implemented through that contract. It is also important that OMH and OASAS are kept closely involved in the development and oversight of the Model Contract, since they are the state oversight agencies most knowledgeable of behavioral health care.

- **The Coalition advocates strongly that the State provide an opportunity for stakeholders to comment on the Model Contract before it is finalized, as was previously the recommendation of the Regulations Committee. This public comment period will ensure the inclusion of metrics is representative of the successful work many are already engaged in.**

Ensuring Outcomes

The State will “convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design.” (pg. 40) The State's interest in measuring and encouraging creativity in incentive programs, specifically its plan to “analyze any collected data and identify best practices” and making that information publicly available will be a boon to all agencies to help them develop more effective programs.

- **We encourage that providers and advocates be involved in this group to ensure the development of sound and achievable guidance and metrics that reflects the work of comprehensively serving communities in need.**

Another serious concern is that the Roadmap contains little information regarding the measures that are being advanced by the Clinical Advisory Groups (CAGs). Without that information, it is difficult to determine whether those measures will be effective; are reasonable; and can be implemented on a timely basis. As stated above, the Coalition strongly believes that public comment on the Model Contract could help shape the recommended measures.

The Coalition has concerns regarding the references to Housing and Vocational Opportunities (pg. 39). Although we absolutely agree that “Offering a stable, safe, and accessible housing environment can be highly efficient and improve outcomes for vulnerable, homeless Medicaid members,” it must be understood that supportive housing is considered permanent housing with voluntary services throughout the duration of tenancy, which in many cases is a lifetime.

- **If Medicaid were to pay for those services, in order to maintain the successful model, the services would have to be permanent and flexible.**

In addition, the Roadmap states that “DSRIP offers the chance to introduce credentialed

positions such as Community Health Care Workers and Peers, which offer a continuum of vocational opportunities to people living with chronic conditions.” In order to bill for these services, many housing providers will have to implement more sophisticated billing systems, since to date, supportive housing has been funded pursuant to state contracts. In addition, the Roadmap provides that “To further acknowledge that housing plays a critical role in overall health and patient behavior, the State is determined to collect standardized housing data for purposes of rate setting and appropriate intervention research and analysis.” **Again, in order to provide this type of information, supportive housing providers will need a funding source to build the necessary reporting systems.**

The Coalition supports the State’s plan to eliminate the \$125 incentive cap for incentive programs. The language in the Roadmap, however, describes the current cap as applying to preventive services. **The reference should be to an existing cap on incentive payments. (pg. 40)**

The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant to VBP (pg. 43). That is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it may affect them.

The Roadmap should reference some of the other important actions recommended by the Advocacy and Engagement Subcommittee that the State has committed to undertake, such as:

- Ensuring that plans and providers communicate information to consumers that explains the incentives that different payment mechanisms generate;
- Providing consumer education and promoting patient activation around what is meant by a “high value provider,” as well as the right to question their providers, seek second opinions, and obtain consumer assistance services;
- Assuring that the State’s Independent Consumer Advocacy Network (ICAN) and any and all consumer assistance programs are equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment; and
- Expanding the ICAN program to include Medicaid members receiving services from providers reimbursed under VBP.

Additional Considerations:

- **Children:** It is also unclear how providers that primarily serve children will be incorporated. The timeframe for children’s managed care transitions is on a different trajectory than adults, and VBP requirements must reflect this alternative schedule so that these providers can meaningfully participate.
- **Mental Health Parity:** Mental health parity is at a critical juncture in its implementation. VBP should encourage access to behavioral health services.

The Coalition appreciates the opportunity to comment on the revised VBP roadmap and trusts that our comments will be thoughtfully considered as VBPs implemented.



April 18, 2015

New York State Department of Health
Medicaid Redesign Team

Submitted to dsrip@health.ny.gov

Subject: A Path toward Value Based Payment (VBP): Annual Update

Community Healthcare Network (CHN) welcomes this opportunity to comment on the 2016 Annual Update of the New York State Department of Health's (DOH) Value Based Payment Roadmap. We are a not-for profit network of 14 community health centers, including a school based health center and mobile medical vans. We offer free and low-cost, high quality primary care and complementary health related services to 85,000 New Yorkers annually in underserved communities in the Bronx, Brooklyn, Manhattan, and Queens.

We support the comments submitted by the Community Health Care Association of New York State (CHCANYS), and in particular those around the requirement that professional-led VBP contractors share 50% of their savings with hospitals. While we are not adverse to hospitals sharing in the savings associated with VBP, we maintain that this sharing should be the result of negotiations leading to meaningful collaborative accommodations between hospitals and health centers. Instead, at this point, the State is proposing a regressive tax on health centers -- to the benefit of hospitals -- with no assurance that these funds will benefit the care of patients. In this letter, we will further comment on the practical affect this requirement will have on CHN, as we already have certain Level 1, Integrated Primary Care (IPC) VBP arrangements in place and are in the process of negotiating additional ones. The DOH's Update, if implemented, not only offers scant promise of improved care for patients, it threatens to undermine VBP arrangements already in formation.

From an implementation perspective, the proposed requirement is not practical; there is no apparent way to comply in notifying the appropriate downstream hospitals of VBP contracts. CHN's network covers four boroughs and we refer patients to all of the major hospital systems in New York. We have no way to identify the particular downstream hospitals (or hospital systems) which should be notified about our VBP arrangements.

More significantly, there is a risk that this requirement will make the build-out of care management within CHN unviable. The preliminary analysis of our VBP arrangements indicates that the financial return on any investment will be, at best, modest. Our intent is to test VBP throughout 2016, and refine the service mix (and associated expenses) needed to bring down overall costs and improve quality. To the extent we are required to share 50% of any savings with hospitals, we doubt that there will be enough revenue to support expanded care management. The practical result will be a necessary slowdown of our build-out of this function. We will be unable to enter these agreements, and we will be unable to invest in the arrangements that we're already party to. We will be forced to re-evaluate our

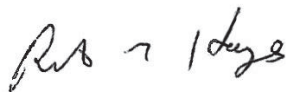
current strategy, perhaps wait for hospitals to build their infrastructure, and then determine if it can be leveraged for our patients. Ironically, through this de facto primary care tax, the Department will undermine its own goal of promoting the IPC model by driving providers like CHN away from meaningful engagement in this initiative. Further, recent research published in the New England Journal of Medicine has confirmed that accountable care provided by independent primary care groups provides greater savings than such care based on a hospital provider system. McWilliams, M., Hatfield, L., Chernew, M., Landon, B., and Schwartz, A., Early Performance of Accountable Care Organizations in Medicare. *The New England Journal of Medicine* (April 2016).

As you may know, to date no hospital has made or is making an ongoing, determined effort to engage CHN in managing the care of our patients. While relationships eventually may form through the DSRIP projects, no hospital has meaningfully responded to our requests to engage, on a site-by-site basis, on providing improved care to our shared patients. Notably, CHN joined PPSs led by NYC Health + Hospitals, Mt. Sinai, NewYork-Presbyterian, NewYork-Presbyterian Queens, and Bronx-Lebanon Hospital Center. There is a consistency to the hospital led efforts.

CHN would welcome real engagement from the City's hospitals, and would welcome arrangements that would result in sharing any savings with those hospitals. Hospitals, however, should be prodded to negotiate with FQHCs as partners, and not be given a State-backed guarantee that minimal efforts will result in 50 percent of all savings. A split of the savings should be a negotiation and result from true collaboration between a hospital and health center in a manner that supports our patients. The minor criteria identified by the State – data feeds that duplicate the RHIOs, palliative care, for example – are not ones that will further CHN's success in VBP.

We remain disappointed with the State's zeal to ensure that hospitals remain at the financial center of all health system transformation initiatives. Despite significant involvement in DSRIP activities, CHN has yet to receive a single dollar of the nearly \$1 billion DSRIP funds that have been distributed to date. The roadmap compounds our frustration, taxing CHN in an effort to direct more DSRIP dollars to New York City's hospital systems and ultimately away from the care that New York City patients need.

Sincerely,

A handwritten signature in black ink, appearing to read "Rob Hayes".

Robert Hayes, President and CEO
Community Healthcare Network



CPHS comments on the VBP Roadmap April 18, 2106

It clear that a change is overdue to how health care is delivered and reimbursement for care is done. CPHS does not disagree with the concept of Instead of providers being paid by the number of visits and tests they order (fee-for-service), their payments should be based on the value of care they deliver (value-based care). However, CPHS is concern how policies and mechanism put in place will drive improvement to the delivery of care by mandating better care at a lower cost. We are submitting a set of broad issues related to VBP and specifics regarding the roadmap.

Overall Issues of VBP to Raise

There are some very clear shared experiences from community based organizations and long standing issues that need to be addressed. CPHS partners and facilitates the Communities Together for Health Equity coalition. Through the participation of many diverse community-based organizations in that coalition, we are aware of the following:

1. There has not been a broad and comprehensive involvement of development of the VBP Roadmap. For example, a list of the membership was circulated to major health advocates in the borough of Brooklyn with a request to review the list for identification. The response was basically non-recognition, along with questions and concerns about how little representation there was of persons of color and immigrant communities. It is said that the committee membership was fluid and people could join by coming to the meeting. Knowledge of committees, and their meetings, was again limited and not generally known. Here is one specific comment.

On pages 11 of the Roadmap, it states "state aims to give PPSs, providers, and MCO's a comprehensive range of VBP options to consider". It is unclear if this means that the New York State DOH will create possible models that providers can choose to adopt. Or, providers can do this in a different way as long as they can show that the method they set up aligns with the goals of VBP. In either case, the possible models should be developed in consultation with community-based organizations working with communities that would possibly be targeted by the model.

2. Many CBO's have not received any resources in support or funding for implementation of DSRIP projects. Many are left out of the process and others involved are provided an unclear trajectory of their role. VBP maybe on a parallel but separate process from DSRIP program, but this very same problem will repeat itself in the VBP transition. Here are few specific comments
 - o On pages 16, it states possible contracting options at it relates to defining a contractor. It states "An entity that contracts VBP arrangement with an MCO, and can be an Accountable Care Organization (ACO), and Independent Practice Association (IPA) or an individual provider. If a PPS is not a legal entity, does that stop them from entering VBP contracts?"
 - o On pages 18-20, discusses an evaluation and assessment of progress regarding participating in a VBP contracting will be towards end of DSRIP year 3. This will be planned in 2016. We already in DSRIP year two, and in our discussion with some MCOs and PPS, they have no idea how to work with CBO's or pay for the services in a VBP model. CBO's have not had the time allotted and resourced to assess how they could participate in VBP contracting.
 - o On pages 33-35, discusses the Clinical Advisory Groups (CAGS). It states that these CAGS were chosen to represent diversity (upstate and downstate), and diversity of services provided (midwives

to neonatologists). There is no mention of indication of representation of diverse communities/populations.

- On page 45, very much to the end, we see the contracting with community-based organizations discussed. It states "...it is also critical that community-based organizations be supported and included in the transformation. There is a proposed requirement "...that starting in January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO. Tier 1 is defined as non-profit, non-Medicaid billing CBO's in social and human services. Tier 2 is defined as non-profit, Medicaid-billing clinical and clinical support services licensed by state agencies. It goes on with discussion of creating an independent retrospective review of the role of the CBO, to determine the VBP providers are adequately leveraging community based resources"

The first apparent issue that arises is contracting with one CBO. We can see an edge for larger, well-resourced and positioned, institutions being contracting over smaller, less resourced, but just as vital organizations. This could be avoided, if strategic planning dollars for CBO in the DSRIP process, as promised by the state, is released. These dollars could help with the beginnings of the analysis of capacity and participation in DSRIP and VBP transition. The second issues are the state's tinkering with a definition of CBO's, which woefully inadequate. . Finally why do other sections of the Roadmap point to on-going analysis and reflection? (I.e. pages 24-32). Retrospective review is critical for learning. However past experience with reforms and current experience with DSRIP, tells us that the communities served by CBO's are last in line of importance. Why not best practices that can be documented and discussed in real-time have and problems resolved before it happens.

3. Social, economic, environmental conditions that sustain high utilization of emergency rooms and hospitalization, also known as Social Determinants of Health are not being adequately incorporated in the plans. It is very troublesome that race, ethnicity, language spoken, immigration status and how these factors influence health care access and outcomes are being set aside. CPHS's Director was one of several non-members of a VBP committee established to address Social Determinants of Health and CBO engagement. We were appalled by the lack of community representation, where there was only one member of color attending the meeting. We also understood that the committee recommendations -- no matter how good they may be -- were subject to review by the larger body heavily populated by providers. Here are some specific comments:

- ✓ On pages 39, it points out that the document that is should be based on "outcomes", not "effort".
- ✓ And on page 40, states "the process of designing member incentives is complex and will need to consider underlying disparities and social determinants of health including community needs, and local planning efforts" It continues to state that "The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design".
- ✓ Page 41 begins to address the social determinants of health and calls for VBP contractors to be required "to implement at least one social determinant of health intervention." Contractors will be able to decide on the type of intervention. It also states that DSRIP would start build the infrastructure to take on determinants of health and VBP is the vehicle to maintain this infrastructure.

The critical factor to address for these three bullet point statements in the document, would be

- ✓ Who will be involved with these local planning efforts? This needs to be clearly described in collaboration with key diverse CBO's addressing various determinants of health (housing, food access, poverty, crime, violence)

- ✓ The experts already exist and working in the community. A plan of different types of inclusion and compensation for these groups, that include faith base and community based organizations has to be developed and agreed on. An agreement or guidelines developed with these experts that exist is best option, so that transparency and effectiveness is fostered. No need for over-reliance of outside consultants that could be more wasteful than productive.
- ✓ Although there are suggestions on what to consider in making decision of which determinant of health. What does not seem to be required is a discussion with and involvement of residents, houses of worship, community-based organizations to determine priorities. An unbalance can occur if one determinant has an edge of choosing over another. This happened with the scoring of DSRIP domains. The one selected social determinant of health may not address any of the most vital issues in the community and ideally the determinant selected should be based on a needs assessment of the community. More importantly, only requiring addressing one determinant of health seems almost a symbolic gesture. Why not incentivize with extra payment those providers trying to address more determinants for the good of the community?
- ✓ The state, PPS, and MCO plans have to clearly and specifically demonstrate how the CBO's will be involved. It can't be invitation to meetings and symbolic forums. They must show that the input translated into policies procedures, and implementation. State has to play a stronger role in enforcement and monitoring. This already is not occurring in DSRIP.

Other issues:

4. Academic Medical Centers and Large Hospitals have had for too long an unfair advantage over true public and community hospitals. Public tax-payer dollars are flowing unfairly to these providers. Transparency and critical review of any reimbursement model needs to occur, especially how it impacts medically underserved communities. Metrics and the terms and conditions should be reflected upon now and fixed to address these concerns. The state wants to DSRIP to succeed and in turn VBP be effective new tool. Therefore, if not resolved, inequities persist in funding and health outcomes in communities.
5. The very well documented of community-based primary care is indisputable, especially many communities that are under-served and are in need of additional services. The Roadmap is makes no clear path or prioritization for how to address this two widely recognized issues. The Federally Qualified Health Centers are a critical part of the delivery system. The FQHCs receive wrap-around dollars for the additional services. Will a transition to VBP ensure that they will keep this higher reimbursement to maintain the services they provide so well?
6. It is unclear if the Roadmap takes into account the differences in types of care for special populations that have historical disparities in access and quality of care (i.e. people with disabilities, formerly incarcerated, people who are homeless). Page 8 addresses it, but over-reliance on MCO's to do this, raises concerns on how funding will align with these differences in population. How people with special needs will be served in a VBP system?
7. The shifting of revenue mix will surely be a challenge and frankly it is scary to think what hospitals will do to tighten their margins. It has and will be disastrous if the hospitals and insurance companies see VBP solely as a financial model and not about improving outcome for patients, especially medically underserved communities.
8. Value-based payment contracts are in its very early stages, and most are structured according to a shared savings model. **Shared savings** arrangements differ, but in general they incentivize providers to reduce spending for a defined patient population by offering them a percentage of any

net savings they realize. The Medicare Shared Savings Program is the most well-known and standardized example of this new model.

9. Tracking performance in this kind of arrangement will be a significant challenge for health systems because it requires keeping track of two very different payment systems simultaneously. Medicare continues to reimburse health systems on a FFS basis; then, at the end of the year, shared savings bonuses are calculated.

Tracking shared savings requires health systems to be much more sophisticated in their accounting capabilities than most in NYC are today. It should be reliant on quality measures. For many years, providers have submitted quality measures for programs such as Hospital Inpatient Quality Reporting (IQR), Hospital Outpatient Quality Reporting (OQR), and Physician Quality Reporting System (PQRS). The fact that these measures are now tied to penalties and incentives will be new and most times patients don't benefit from hospitals trying to meet quality standards and cutting costs at the same time

Pages 26, discussed specifics such as establishing baselines, measuring growth trends, and adjusting for risk and performance adjustments. To do this, a Hospital needs to be able to measure performance on a continuous basis. Furthermore, if they aren't meeting quality standards, they need to be able to pinpoint the cause: Does performance differ by facility? Which providers are performing best and what can be learned from them? Page 26 continues with the state holding the right to changes these as lessons are learned through the implementation of this system. However, the effectiveness of this is impacted by the hospital or PPS not clearly developing a plan with or defines a "value" for community-based organizations in assisting in measuring performance and meeting the facilities quality standards. It's one thing to handle this level of performance analysis for a single patient population or a single quality measure. It's another story altogether when you consider how quickly the number of measures a health system must track is multiplying. CBO's, if well resourced and engaged could help with this. But currently can't if they are left out of the discussions and also do not have a clear define role in the process.

10. The transition to VBP is going to hurt. To meet value-based goals, hospitals are going to have to reduce utilization among their populations, which will reduce their procedure volume, which will reduce their revenue. The important question to answer is how does access to care and excellent care get assessed and evaluated in this transition. What is the impact to communities, especially low-income, immigrant, communities of color? We still don't see this being a critical component in the planning for the transition. There's no specific unit of time to mark the transition from fee-for-service to value-based reimbursement. Nobody knows yet how long this process will take. What we understand is that in pages 6 to 8, outlines 80% -90% of managed care payments to providers using VBP methodologies by the end of demonstration year 5 (DY5).

CPHS Comments are based on work with CBO's and advocates throughout New York City

Anthony Feliciano, Director, CPHS, 45 Clinton Street, NY, NY 10002, 212-246-0803



**COMMENTS REGARDING THE NYS DRAFT ANNUAL UPDATE TO
THE VALUE BASED PAYMENT ROADMAP**

*Submitted to New York State Department of Health
April 2016*

*Submitted by Cerebral Palsy Associations of New York State
3 Cedar Street Ext, Suite 2, Cohoes, NY 12047
518-436-0178*

Thank you for the opportunity to provide feedback on the Draft Annual Update to the Value Based Payment Roadmap. While we agree that in order for the DSRIP system changes to be successful and sustainable, there must be a change to the payment system as well, we want to ensure that the full spectrum of providers will be able to participate in this historic change. Community providers must be at the forefront of this endeavor in order to ensure their viability so that all Medicaid patients receive the services they need in the most appropriate and beneficial setting.

Following are our comments on specific aspects of the Roadmap:

The Roadmap should clarify that the Clinical Advisory Group report will be available to the public and that the public will have an opportunity to comment on the measures as well as other changes to the Medicaid Managed Care model contract. The Roadmap only indicates that the model contract would not be “posted until it is approved by CMS”. Public review and comments should be solicited prior to submission to CMS.

We are very pleased to see that DOH will be conducting VBP Pilots and Bootcamps. Both of these initiatives will help provide information and experience to providers and patients/consumers in the use of VBP. We would request, however, that more information about these initiatives be made available prior to their inception. We have not seen any information on these initiatives except for discussion in this update to the Roadmap.

CP of NYS would also request that DOH provide educational materials and technical assistance focusing on the role of CBOs (all three tiers) in VBP arrangements. CBOs will need to be an integral part of the VBP initiative in order to ensure adequate provision of services and many will require help in order to be prepared to be part of this initiative.

Again, we thank you for this opportunity to comment and for your consideration of our input. We await more detail in the next update to the Roadmap on how the specialty services we provide will be adequately brought into the value-based payment discussion. We are available for additional information, at your request and convenience.



NEW YORK CITY DEPARTMENT OF

HEALTH AND MENTAL HYGIENE

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April 1, 2016

New York State Department of Health
Medicaid Redesign Team
dsrip@health.ny.gov

Re: Draft March 2016 Updated Value Based Payment Roadmap

Dear Medicaid Redesign Team,

On behalf of the NYC Department of Health and Mental Hygiene, we thank you for the opportunity to provide feedback on the March 2016 Draft Value Based Payment Roadmap.

We have reviewed the March, 2016 version the Value Based Payment Roadmap, and have the following comments:

Improved metrics will be needed to ensure VBP investments lead to population health improvements, particularly for behavioral health

- We are concerned that the broad vision of population health and integration of care, including “social services” (on page 6 under *Sustainable Delivery Reform Requires Matching Payment Reform*) does not translate into value based payment arrangements if the outcomes focus solely on Quality Assurance Reporting Requirements (QARR) metrics.
 - Measures that incentivize this vision and lead to true integrated and recovery-oriented care need to include broader outcomes of well-being, functioning and other social outcomes (e.g. stable housing, employment and education, reducing criminal recidivism) that are inextricably linked to health outcomes.
 - A clear oversight/audit structure needs to be established to determine whether quality outcomes are improving.
- QARR metrics are also too limited to capture a full range of child and adolescent behavioral health outcomes in the immediate or long term.
 - Guidance is needed as to whether there is flexibility in bundled care to include social, non-clinical and/or community health worker (CHW) /peer services and measure broader functional well-being that may include non-health sector outcomes like housing, education and employment.
 - Particularly for young children, there should be inclusion of measures that reflect the future impact of investment in prevention and early intervention services.

Clear guidance is needed on how VBP contracting arrangements are expected to impact beneficiaries, especially those with mental illness and substance use disorders

- Clarity is needed on what VBP arrangements will mean for people with co-occurring mental and substance use disorders from their perspective, expectations, and experiences in a fragmented and long siloed system—the same is even more true for those with co-occurring physical and behavioral needs. The Roadmap provides a basic framework, but inadequate detail or evidence of connection of users' decisions about priority measures and goals.
- We are also generally concerned that diagnostic specific bundles are a credible approach for behavioral health issues. The “global care package” logic of HARP should be similarly applicable to establish a basic package of capabilities and services for all individuals with behavioral disorders. While there would likely be broader variation in intensity of need and full use of such a package, a definable package and spread should be similarly possible to project and implement.

Additional clarity is needed on how children's behavioral health providers are differentiated from adult providers for VBP purposes

- For example, clarity is needed as to whether school providers should be considered when forming provider networks in VBP arrangements, as well as how non-medical services impact outcomes for children in those arrangements.
- Primary sections that address bundles of care (page 13, 24-30) should also include guidance on whether children and adults can be part of the same bundle as with maternity care.
- DOHMH supports the recommendation (p.34) to form a CAG on “Special Needs Children” and requests further articulation of how each VBP arrangement (Total Care for the General Population, Integrated Primary Care, Selected Care Bundles, and Special Needs Subpopulations) can be adapted to accommodate the health care needs and developmental trajectories of children.

VBP framework should not discourage participation by small providers

- Small practices make up an important part of healthcare in New York City, and we recommend assessing the impact of this process on the overall community of small practices to ensure that a balance remains. Under the scheme proposed in the current Roadmap, small practices will be left behind because many may fit the definition of “financially challenged” and the recommendations are for them to be absorbed, transition to another licensure category/service line, or cease operations. Although small practices can work through an IPA to get additional resources, we don't know the market share for providers who are not in an IPA and will not choose to join one (or other affiliated entity to sustain operations) and would therefore be impacted.

VBP framework should not cause interruptions in care

- MCOs should make every effort possible to ensure that members have continuity of care with their existing PCP when attributing HIV/AIDS members to PCPs under VBP. Otherwise, this could lead to confusion and care gaps, which can negatively affect patient care, as well negatively impact retention and engagement in HIV Care.

Mechanism for deciding which services will be FFS under VBP should be clarified

- DOHMH agrees with the proposal to add FFS as a VBP payment mechanism for certain preventive activities which may not be incentivized appropriately through VBP because of the long delay between investment and return. We have observed the strategy of using FFS to drive preventive services in our quality improvement projects, including payers electing to move towards FFS for smoking counseling coding to increase rates within capitated contracts. As some would-be VBP contractors might otherwise forego certain preventive services because they're looking for more

short-term impacts, establishing FFS carve-outs for services with longer term population health impact are important.

- The roadmap states that fee-for service as VBP is applicable in cases where (1) Preventive activities that require widespread implementation whose impact will be mid- to long term (for example, immunizations and vaccinations) or (2) Preventive activities that are relatively high cost whose impact may well be felt outside the scope outside of the VBP contractor (for example, long-acting, reversible contraception). Both of these conditions are applicable to Pre-Exposure Prophylaxis (PrEP) for HIV. As such, we strongly recommend that PrEP for HIV medications and all applicable linkage and retention to PrEP activities be eligible for Fee-For-Service as Value Based Payment, as well as tobacco cessation services.
- As evidence of which services should remain as FFS may shift over time, we feel that it is important that the State clarify how these decisions will be made, and ensure a broad range of stakeholders, including from the public health sector.

The Roadmap should include an appendix illustrating individual patient use cases for VBP

- It will be helpful to have guidance on actions providers should take when a beneficiary is eligible for more than one bundle (e.g., diabetes and maternity care) and instances when a patient transfers from one provider in a Performing Provider System (PPS) to another provider in a different PPS.
- Additionally, we recommend that as services are defined for the various care models, all care models should include annually screening all women of reproductive age on pregnancy intention. Based on patient response, screening should be followed by counseling on preconception health and appropriate services and referrals or contraceptive counseling and services.

Timeline of bundled maternity care VBP arrangements should be extended

- We urge that the Maternity Care bundle be extended from the currently proposed first month of baby's care to at least 16 weeks post-partum (and ideally one year postpartum), to provide opportunity for a second post-partum visit and maternal depression screening at 16 weeks post-partum, as is now being recommended by the Maternal Depression Collaborative, an initiative of the New York City Department of Health and Mental Hygiene and the Greater New York Hospital Association. We additionally recommend that screening of mothers for maternal depression by pediatricians be included in the maternity care bundle or pediatric care model, in order to ensure that necessary screening occurs in the post-partum period.

The current Roadmap does not sufficiently address needs of CBO providers to participate in VBP

- We are concerned that the mechanism by which CBOs will be allocated funding isn't clear. We recommend that CBOs be given direct access to State funding to help them build infrastructure, resources, and legal expertise to prepare them for the transition to the VBP. Funding should also be put aside for continued technical assistance to the CBOs.
- Additionally, resources need to be allocated to educate CBOs to both help them understand the VBP process and clarify their specific role, as this lack of clarity has proven to be a significant barrier for CBO involvement in DSRIP implementation.
- There should also be a set mechanism whereby providers must attribute savings to CBOs and plans to ensure the CBOs receive continued funding as savings continue to grow.
- Successful community based prevention models for behavioral health issues and outcomes may require an opportunity for MCOs and provider networks to include the value of collaborations with not only smaller, community-based providers, but also non-clinical resources—from schools, to social networks and settings, and to other-sector CBOs all who can adopt "task-shifted" skills to screen, counsel, educate, or support.

- For the broad group of community resources needed to support quality behavioral health outcomes, the VBP roadmap does not clearly provide a pathway for exploring how to monetarily incentivize and capture the value of having such partners.
- Specific guidance and incentives should be established to allow and encourage exploring the full range of community-based providers and non-clinical partners where they appear to reduce costs and improve care and outcomes.
- The Roadmap should clarify and require that services contractually provided by community based organizations and other not-for-profit entities be paid for as invoiced by institutional partners, rather than via distribution of shared savings. These service providers often operate on a month-to-month basis, and ought not be expected to take on new and shared clients without receipt of up-front and regular funds with which to pay for the provision of those services.

VBP Maternity Care pilots should incorporate a group-based model

- We suggest that as the state considers applicants for the 2016 pilots in Maternity Care, that they select one group-based prenatal care model. Since the first implementation of group prenatal care in 1995, studies have found that compared to those who receive standard prenatal care, women assigned to group care have significantly better pre-natal knowledge, feel more ready for labor and delivery, are more satisfied with their care, are significantly less likely to have pre-term births, are more likely to initiate breastfeeding, are less likely to experience pregnancy-related distress in late pregnancy, and have lower postpartum depressive symptom scores and higher maternal functioning scores.

Timeline for submission of VBP growth plan should be extended

- We believe the timeline for submission by PPSs' of their proposed growth plans (by April 1, 2017) is too early for PPS to submit realistic plans; they are still in very early stages of integrating their networks and doing so in a step-wise way as a result of state reporting burdens, prioritizing short-term deadlines, not being paid as expected, difficulty managing large/complex projects, and duplicating efforts that could be centralized for more efficiency.
- Based on what we see from participation on two PPS IT committees, getting providers connected and sharing data is a slow process and PPSs are prioritizing groups of providers to start with before scaling out. They are choosing their high volume providers to maximize the effort but, but we are not sure how quickly widespread change will happen in this area.
- We recommend allowing PPSs another year to set up their infrastructure and get access to more actionable data so they can offer a more accurate growth plan of their network and develop a plan that is more likely to be operational.

An appendix illustrating individual patient use cases for VBP arrangements should be included

- It will be helpful to have guidance on actions providers should take when a beneficiary is eligible for more than one bundle (e.g., diabetes and maternity care) and instances when a patient transfers from one provider in a Performing Provider System (PPS) to another provider in a different PPS.

Privacy-related compliance issues must be addressed for VBP to succeed

- We agree that it is challenging for providers to understand and ensure compliance with the various privacy and security requirements, and these new health care structures in particular are raising new concerns about how information may be shared.
- We strongly advises against creating exceptions to NYS laws for certain providers in certain situations because these structures are shifting and adapting, and it will be challenging for providers and PPSs to ensure compliance during these changes. The Roadmap's proposed Option 2 and Option 3 rest on the unrealistic premise that little will change in the coming years, and it may be

unwise to make specific exceptions or laws that are not forward looking. However, we acknowledge that Option 3 may permit varying degrees of flexibility to accommodate changes in the coming years and advocates for flexibility to accommodate such change.

- Ultimately, we support Option 1, aligning NYS law with the federal HIPAA protocol. This will greatly simplify privacy and security management and will therefore reduce the amount of resources required to be dedicated to this effort. Moreover, this change will alleviate concerns particularly among small practices that are uncertain about how to ensure compliance. Finally, we acknowledge that mental and behavioral health and substance use information is more sensitive and may require stricter privacy regulations, however we suggest aligning these types of requirements with other federal requirements covering similar information.

Our agency has appreciated the opportunity to be involved in some of the VBP workgroups over the past year. As additional Clinical Advisory Groups and subcommittees are formed (especially around children and adolescents, data tracking around social determinants of health metrics, and a communications system workgroup around providers and community-based organizations), we would like to reiterate the expertise and public health perspective that DOHMH can contribute to these workgroups.

Thank you for your consideration of our comments on the VBP Roadmap, and we appreciate the opportunity to contribute our unique perspective in the development of New York State's transformation to value-based payment moving forward.

Sincerely,

A handwritten signature in black ink, appearing to read "Oxiris Barbot".

Oxiris Barbot, M.D.

To whom it may concern,

My name is Alec Feuerbach and I am currently working with the East Harlem Community Health Committee, Inc. (EHCHC) on a project to monitor the impact of DSRIP on East Harlem (Note that timing did not support an official review of these comments, or an official comment by EHCHC and that these are my personal comments). I am also involved with the advocacy group Communities Together for Health Equity and I am a medical student at Mount Sinai. I am writing today with comments mentioning several concerns about the issue of community engagement with regards to the "State Health Roadmap on Value Based Payments (VBP)." While these comments are sent on my personal behalf (and are not affiliated with the organizations mentioned above), they are informed by my experiences and the concerns that I have heard voiced during my work with such organizations, specifically the EHCHC and Communities Together for Health Equity. The first concern relates to the amount of public exposure and inclusion that has gone into creating this document and planning for the transition to VBP. The second is related to the role of community based organizations (CBOs) in this transition.

The first concern is related to page 57 of the document: "Stakeholder Engagement." In this section, it is stated that "Since 2014, New York State has been working diligently on involving various stakeholder groups in the policy development, design and implementation of VBP as outlined in this Roadmap. The level of engagement has been unprecedented" (57) claims the document. The Roadmap goes on to list the different groups that have been engaged. This list is extensive, and from this list alone, it seems that many groups have been engaged; however, first hand comments from people involved with this process have told a different story. Judy Wessler, a long time public health advocate and fellow member of Communities Together for Health Equity, sits on a DSRIP oversight panel. In comments (which she has prepared regarding this Roadmap) she explains what she sees as a lack of diversity and public involvement in the committees charged with planning the transition to VBP. A section of her comments, in which she speaks about her experience working with one of these committees, is included below:

"At one point, concerns were raised by community health advocates about what seemed to be missing from the considerations of the Social Determinants of Health—primarily missing was concerns about race, ethnicity, language spoken, and immigrant status and how these factors influence access to care and outcomes. The disparities and inequities in health care have a dramatic impact on people, yet these considerations do not seem to have been addressed. Several non-members of the committee were invited to attend a meeting to raise our concerns. The lack of community at the table was very disturbing, where there was only one person of color attending the meeting. We also understood that the committee recommendations—no matter how good they may be—were subject to review by the larger body heavily populated by providers." - Judy Wessler

While I have not personally been involved with these committees, I do find this firsthand experience described by Ms. Wessler disconcerting. In making a (much needed, admittedly) change to the way health care is delivered, voices that truly represent the community must be included. VBP has the potential to drastically shake up the way health care is, not only, delivered, but accessed as well. It is, therefore, of paramount importance that the community is made aware of these changes. Still, true community engagement must go beyond that. Successful engagement must not only educate, but also include, the community in the development of the proposed changes. Furthermore, the group of community members engaged in this dialogue and planning should represent the diversity of the communities where these changes will take place. While diversity includes more than just ethnicity—it includes diversity in thought, experience, position, and much more—it cannot be ignored that diversity of ethnicity and skin color play an important role in shaping the ability people have to access medical care and attention. In the past, our health care system has continually undervalued the voices—and bodies—of people of color. As stated in Ms. Wessler’s comments, “There is a pattern of public money flowing to Academic Medical Centers and large private hospitals, and much less to safety net providers, community based services, and public and community hospitals. This helps to create at least two classes of care with less funding traditionally being provided in low-income [communities], immigrant [groups], and communities of color” (Wessler). It is time for this to change. And the best way to drive this change is to include the voices of people and communities that have, in the past, been ignored. To do so, the committees planning this transition to VBP should aim to actively recruit diverse voices and people to not just inform them about the changes occurring, but to include them in planning these changes.

This brings me to my second point: the role of community organizations (outlined on pages 41-43 of the Roadmap in the section titled “Public Health and Social Determinants of Health”) in the planning—and future implementation—of VBP. What I find interesting, and disconcerting, about this section—which describes the vision of the State that culturally competent community organizations will contract with providers and health systems—is that there are no guidelines set up for how the providers will contract the community based organizations (CBOs). Rather, it is stated that 2-3 years down the road New York State will look at what has been done and decide whether or not it was effective. This retrospective analysis is, of course, important; however, I do not understand why this section on the involvement of CBOs is one of the only sections that relies simply on a retrospective analysis. For example, when the outline for the implementation of VBPs is laid out in this document, different guidelines and rules are provided. For example, on pages 24-30 of the Roadmap, specific percentage changes in “target budget setting” are laid out, and specific incentives (increased target budgets and decreased target budgets) are outlined for providers that are succeeding or failing (by falling within certain percentiles). This is done with the reasonable caveat that these percentages could change as the project is implemented; however, a model for quality and efficiency insurance is suggested and clearly outlined in extensive detail. Could not a similar model for community engagement be implemented, with a similar, reasonable caveat that the model be changed as best practices are identified? Without this, past history suggests that this engagement will not be successful. It is already clear with the example set by DSRIP over the past years of planning, that telling provider groups to simply contract with CBOs and include the community can result in a process in which CBOs and community members feel their voices are not being valued (among many other concerns). For this reason, the Roadmap to VBP should include a clear, process-oriented plan for CBO engagement. The creation of such a plan would have to rely on the input

from CBOs and other community leaders themselves. While there may be multiple ways to gather this input, a possible solution would be to contract a diverse team of these individuals that can outline a process for CBO and community organization engagement. This will not just benefit the CBOs and community groups. It will also benefit the providers by giving them a clear set of steps to follow to ensure that they are able to utilize the expertise of these community leaders. And, most importantly, it will benefit the community members whose social determinants of health are not going to be impacted by this VBP plan without meaningful and successful cooperation with community based organizations.

Finally, I want to thank you for the opportunity to comment on the “State Health Roadmap on Value Based Payments.” I hope my comments prove to be useful in highlighting several concerning areas of this Roadmap, specifically those areas related to community engagement. Our healthcare system is in drastic need of change. But it is important to note that it is not just the system that needs to be changed, but also the way that we, historically, have engaged in the process of designing and implementing such change. So as we continue to seek reform in the system, we must remember that reform of the process is just as important.

Thank you,

Alec Feuerbach

East Harlem Community Health Committee, Inc.

DSRIP Impact Analysis Project

VIA EMAIL TO: dsrip@health.ny.gov

Jason Helgerson
Deputy Commissioner, Office of Health Insurance Programs/Medicaid Director
NYS Department of Health
Corning Tower, Empire State Plaza, 14th Floor
Albany, NY 12237

Dear Mr. Helgerson,

Thank you for the opportunity to offer comments regarding the recently released annual update to the New York State Roadmap for Medicaid Payment Reform. EmblemHealth is the largest community-based nonprofit health plan in the country serving over 2.5 million people who live and work in New York. We are a market leader in value-based payment, serving commercial, Medicare and Medicaid enrollees, as well as a high proportion of municipal and union workers through a variety of products including HMO, PPO, and self-insured administrative arrangements.

EmblemHealth partners with AdvantageCare Physicians (ACPNY), the largest physician-led multi-specialty medical practice in the New York metro area. With over 450 doctors, ACPNY's 36 offices are located in Brooklyn, Manhattan, Queens, Staten Island, Nassau County and Suffolk County. ACPNY's medical and administrative professionals use a team approach to deliver coordinated care across a wide range of primary and specialty services. The EmblemHealth /ACPNY partnership gives us a unique perspective on the needs of different types of primary care provider practices and has informed many of our decisions about the best way to encourage and support value-based payment. We would like to share our thoughts on several aspects of the Roadmap for Medicaid Payment Reform and the annual update that was released in March of 2016.

Achieving meaningful risk sharing arrangements should be the definition of success: We remain concerned that defining payments made through level 1 value-based payment methods (e.g., fee-for-service or per member per month payments for specific care management functions) as success at meeting the goal of 80-90% of value-based payments to providers may actually impede progress to move Medicaid providers to robust risk sharing arrangements. EmblemHealth already has a significant value-based payment portfolio, with fully 64% of our HMO members in value-based payment arrangements. We will meet our own goal of having 100% of HMO members in robust risk-sharing arrangements well before 2020. We encourage the state to further define success as having moved 80% of managed care contracts into at least Level 2 VBP arrangements before 2020.

Increased clarity and flexibility around contracting arrangements: We recognize that the Medicaid Redesign Team seeks to find the correct balance between consistency and flexibility to allow for development of innovative and highly effective value-based payment arrangements. In particular, we appreciate the clarification that health plans are able to maintain flexibility not only to contract with different types of practices, including individual providers and IPAs, but also to continue to pursue innovative value-based payment contracting arrangements beyond those described in the Roadmap, as long as they reflect the

underlying goals of meaningful payment reform. This flexibility will be very important in preserving current progress in moving providers to robust value-based payment arrangements.

Contract review process: We are concerned that the contract review process outlined in this revision of the Roadmap will impede progress in swiftly moving payers and providers to robust value-based payment arrangements. In particular, we are concerned that the multi-agency review tier will create unnecessary duplication of regulatory function and consume dollars that could be allocated to program enhancements. A straightforward financial review and programmatic review by one agency is more than sufficient to assure that providers are taking on appropriate risk for their capabilities.

VBP Innovator Program: We are concerned that the VBP Innovator Program description continues to require that providers receive 90-95% of the dollars paid to MCOs. Such a requirement does not account for the on-going support and resources that health plans make available to providers in robust VBP arrangements.

Prioritization of selected care bundles: We are pleased that the state is adopting the recommendation of the Clinical Advisory Groups to concentrate efforts on the specific care bundles of maternity care and chronic care. We believe that the prioritization of these bundles and the elements included in them will allow payers and providers to focus efforts on these two important care spectrums and then apply successful care management and coordination strategies and best-practices realized through these bundles to other care spectrums and conditions in an effective manner. EmblemHealth has already begun work to implement these selected care bundles.

A core set of quality metrics should be coordinated across all public programs with flexibility to select subsets of those core metrics that can be tailored to communities and providers: We support the quality measurement metrics that have been selected but would ask that there be flexibility to allow payers to make adjustments in which metrics are used based on the quality improvement needs of a particular community. Although the choice of quality metrics should be flexible, all metric choices should be consistent across all state-funded government programs. We are committed to working with the state and other stakeholders to strike a balance between achieving measurement metric uniformity to reduce unnecessary burdens on providers, and flexibility to assure that measurement metrics are meaningful for specific populations and communities.

Quality Assurance Reporting Requirement (QARR) updates: The updated Roadmap states that the current QARR methodology will be adapted to optimally align with the Roadmap's core quality measures. We encourage the state as part of an updated quality reporting system to share the quality measurement metrics and methodology in advance each year rather than applying methodology and metric changes retrospectively as has been done in the past. Having prospective information on quality measurement information will allow providers and payers to adopt focused strategies to improve quality, efficiency and effectiveness of care.

New York State anti-kickback and self-referral law changes: We support the concept of aligning state and federal anti-kickback and Stark laws and putting safe-harbors in place for certain types of physician

integration activity because we find that clinical integration with primary care providers increases their success in transformation and ability to accept two-sided risk.

Alignment across all state programs and initiatives is critical for success: We remain concerned that although there is a stated intention for the state's Medicaid payment reform and state health plan innovation (SHIP) initiatives to work in concert, we note that there are several provisions of the Advanced Primary Care (APC) initiative that we believe are in conflict with the Medicaid reforms envisioned in the Roadmap. For example, although the newly-revised Roadmap recognizes the value of flexibility in design to allow for innovation, as described in the APC request for information, that program takes a "one-size-fits-all" approach that emphasizes up-front payments for care management services with little recognition of the impact that would have on the significant progress that has already been made to move providers to more robust risk arrangements. We have extensive experience with payment of care management fees and found that they not only did not encourage appropriate system transformation, but actually hindered our ability to move providers into risk sharing arrangements. We urge the Department of Health and the Department of Financial Services to better integrate statewide strategies to support substantive and meaningful delivery system reform.

EmblemHealth has demonstrated its full commitment to value-based payment. We are committed to serving New York's Medicaid population and to building a strong and sustainable high-quality health care system. We are happy to discuss our comments and to describe in more detail how we are helping to achieve the objectives of a value-based health care financing system.

Sincerely,



Scott Dickler
SVP, Government and Individual Programs





Family Planning Advocates of New York State

Comments on the 1st Annual Update to the Value Based Payment Roadmap April 18, 2016

Family Planning Advocates of New York State appreciates the opportunity to comment on the State's draft annual update to the Value Based Payment Roadmap ("the Roadmap"). The revised Roadmap charts a way forward, to continue the work already begun through the Delivery System Reform Incentive Program (DSRIP). The DSRIP process brought together stakeholders and fostered collaboration to integrate service delivery and reduce fragmentation of care. The Roadmap attempts to build on DSRIP progress to date, with innovative value-based payment approaches to achieve a health system that delivers better care and improved outcomes at lower costs.

Family Planning Advocates of New York State (FPA) represents the state's family planning provider network. Our provider members include the state's nine Planned Parenthood affiliates, hospital-based, county-based and freestanding family planning centers that collectively represent an integral part of New York's health care safety net for uninsured and underinsured individuals. Family planning centers provide critical primary and preventive care services such as family planning care and counseling, contraception, pregnancy testing, prenatal and postpartum care, health education, abortion, treatment and counseling for sexually transmitted infections, HIV testing and prevention counseling, as well as breast and cervical cancer screenings from funds that include the state's family planning grant, Medicaid and private insurance.

As a source of primary care for many women of reproductive age, family planning health centers are key drivers of quality and value for Medicaid. FPA's members in New York are engaged in numerous collaborations and partnerships to advance the Triple Aim of better care, improved quality and lower costs. For example, across the state, our Planned Parenthood members have contracted with Performing Provider Systems (PPSs) to perform Patient Activation Measure assessments, leading to improved primary care engagement for higher-risk patients served by their reproductive health centers. They are also actively engaging with community partners to connect patients with behavioral health services, based on screening and needs assessments. In the spirit of innovation and collaboration, many of our members are continuing to deepen relationships with all payers, partnering with providers, and identifying opportunities to demonstrate the value of their high-quality services in a transformed delivery and payment environment.

Building Out a Value-Based System

The revised Roadmap assigns a key role to managed care organizations (MCOs) and providers (including PPSs) while allowing for flexibility in value-based contracting. The State should ensure there is sufficient flexibility to enable community-based networks to develop financing and delivery solutions suited to the needs of communities and their unique patient populations. Much depends on the commitment of MCOs to implement truly value-based approaches.

We are particularly pleased to see the Roadmap's recognition of the impact of social determinants of health. By providing a bonus in Level 1 arrangements, and upfront funding in Level 2 and 3 arrangements, the State has tackled a financing challenge that has, thus far, prohibited integration of broad-based community solutions with health care delivery.

The Roadmap expresses a commitment by the State to build out a sustainable value-based payment system that will account for 80-90 percent of Medicaid payments by the beginning of the next decade. This is an ambitious goal. The Roadmap goes into detail on several important components to achieve this transformation, outlining a methodology for attribution and for setting target budgets, a state review process, integration with DSRIP and other important items.

One critical item missing from the Roadmap is an approach to linking total cost of care to quality measures and metrics. As set out in more detail below, FPA is especially concerned that the Roadmap does not adequately address how the value of preventive services - that are the foundation of providing quality care to women of reproductive age - will be addressed in a total cost of care model.

1.) Role of Preventive Care in Value-Based Purchasing

The proposal to "carve out" certain preventive services, including long-acting reversible contraception (LARC), is concerning. Under the approach set out, these preventive services would be paid on a fee-for-service basis yet considered value-based for the purposes of meeting the 80-90 percent goal. As presented in the Roadmap, this approach does not appear to be carefully thought through, particularly for a high-value preventive service like contraception, which is currently reimbursed at a low rate relative to its impact in preventing costly implications of unintended pregnancy.

In effect, MCOs would be encouraged to continue to pay for preventive services without regard to the value of these services and impact on total cost of care. On its face, this runs counter to the overall goals of value-based payment and delivery reform. For example, if prevention is not assigned sufficient value and reimbursed accordingly in a model that shares savings, how then would prevention be incentivized? Perhaps it is the intention that providers of preventive services may participate in shared savings programs, in addition to receiving fee-for-service reimbursement. If so, this should be made clear in a more detailed manner than offered by the Roadmap, including explanations of how payment levels for prevention will be determined and monitored for adequacy.

In the absence of this strategy, counting these fee-for-service payments as value-based in a reformed system sidesteps an important opportunity to evaluate and account for preventive services in a value-based system. It is difficult to imagine how value-based delivery and a robust primary care system can be sustained otherwise. The Roadmap (page 5) attempts to assure stakeholders that "value-based payment is not ... an attempt to make providers do more for less: In fact, the intent is the opposite. Under the state's value-based approach, reducing lower value care and increasing higher value care in equal proportions should lead to higher margins rather than lower margins."

Allowing an MCO to continue to pay fee-for-service rates for an intervention that the Roadmap has clearly identified as “high value” (e.g., LARCs) is clearly what the Roadmap says value-based payment should not be. Offering no additional payment – whether in the form of a bonus, an enhanced per member per month, or as part of shared savings, to name a few alternate payment approaches – is, in fact, making providers do more with less. Further, in doing so, we risk destabilizing providers in the primary and preventive care safety-net, whom the State is relying on in the achievement of reform initiatives. We agree with the Roadmap’s clear premise that value-based payment should increase higher value care and “should lead to higher margins...”

We would respectfully submit that preventive services, and LARC specifically, if reimbursed at current fee-for-service rates alone, should not be allowed to count as part of an MCO’s value based payment target. For a preventive service identified as high value care to “count” as value-based, MCOs should be required to provide enhanced payment, in some mutually agreed upon form, to the entity with which they are partnering to provide the service to the patient.

2.) LARC in Maternity Bundle

We would like to highlight our concerns with how the Roadmap treats LARC in the context of maternity care, which exemplifies the problematic approach discussed above through a bundled payment model. First, however, we note with favor that the list of relevant measures for the bundle includes uptake of LARC. We strongly agree that prevention of future unintended pregnancies should be considered a high-quality, high-value service component in a pregnancy episode. Research has long underscored a link between births resulting from unintended or closely spaced pregnancies and adverse maternal and child health outcomes. It is our hope that as the Roadmap evolves, a workable approach can be developed for ensuring appropriate payment for post-partum contraception.

The Maternity Clinical Advisory Group (CAG) considered the issue on August 11, 2015, and recognized that “LARC is a cost-effective, proven method to lengthen the interconception period but also to prevent e.g. teenage pregnancies.” The CAG concluded that “including the uptake of LARC as a quality measure would help the impact of the Maternity Bundle.” Further acknowledging that the relatively high cost of LARC could affect amount of available shared savings, the CAG recommended keeping LARC as a fee-for-service activity in order to stimulate its uptake in the post-partum segment of the episode.

However, the CAG did not determine, and could not have assumed, that reimbursing LARC providers for this high-value service based on current fee-for-service rates alone would be sufficient incentive to meet the quality goal. Further, it is important to note that not all hospitals nor stand-alone OB-GYN providers offer LARC insertion. Family planning providers will undoubtedly play a role in providing post-partum LARC insertion. While we understand the exclusion of LARC from the Maternity Bundle from a payment perspective, we do believe it is important that providers of LARC, be eligible for additional amounts, such as shared savings or reimbursement for participation, collaboration and data management in recognition of their contribution towards toward meeting the quality goals.

We also note that the CAG did not recommend counting LARC fee-for-service payments toward any applicable goal of value-based transformation. We reiterate our strong sentiment, expressed above, that fee-for-service LARC rates alone, should not be allowed to count as part of an MCO's value-based payment target.

An additional concern in the proposed maternity bundle is that LARC is the only contraception-related measure for post-partum care. *In order to promote patient choice, post-partum quality measures should include an option for a moderately effective method such as oral contraception.* Payment levels should accordingly incentivize services that promote informed patient choice.

3.) Flexibility in Allowing Models that Support Women's Reproductive Health Needs

As comments above highlight, the Roadmap to date fails to include a specific strategy to reimburse high-value reproductive health services to women. This is a glaring gap in a plan to transform a health care program that needs to serve a significant proportion of women of reproductive age.

Contraception and related reproductive health services have a high positive impact on quality and costs, particularly costs of unintended pregnancies, longer interbirth intervals and improved birth outcomes. Reproductive health providers in New York are based in diverse communities and, as DSRIP experience shows, are able to partner with other safety net providers to provide culturally sensitive services centered on women's needs and care-seeking preferences. Further, in many cases, reproductive health providers are the primary source of care for women in their reproductive years.

This unique population and the unique position of providers that meet women's needs should be prioritized in Medicaid transformation. Specifically, FPA would like to see a value-based payment model developed for women of reproductive age. Such a model should focus on and invest in services and delivery methods that promote equitable access and can eliminate health disparities among women of all races, ethnicities and socioeconomic status. Further, considering the quality and cost impacts over women's life spans and the strong roles of community-based approaches in achieving these impacts, more flexibility about use of shared savings would be appropriate. Overall, the model should capture and reinvest all savings among participating community-based providers to strengthen capacity to address social determinants of health.

4.) Critical Role of Quality Measures

Quality measures will inform how MCOs view and craft VBP arrangements with providers. It is imperative that the measures selected reflect key preventative health care services that bring value to the system at large and the diversity of care needs within the Medicaid population. The Roadmap articulates that for integrated primary care, quality measure development is occurring within the Advance Primary Care (APC) framework. We appreciate the quality measure selection process is complex, and weighs a series of factors regarding strength of particular measures, existing use, consistency in implementation and alignment with reform initiatives. In what we expect will continue to be an iterative process, we encourage the State to contemplate emerging quality measures that have the potential to address value in health outcomes for specific populations. New York ranks in the top three states for the highest rates of unintended pregnancy. Approximately 55% of pregnancies

are unintended, with public programs covering nearly 70% of all unplanned births.¹ It is estimated that only 5% of unintended pregnancies occur to those who are using contraception consistently and correctly.² It stands to reason, that assessing contraceptive adoption as a quality measure could bring value to both health outcomes, and costs of care. We applaud the State's participation in the CMCS's Maternal and Infant Health Initiative, which seeks to increase the rate and content of postpartum visits, and increase the use of effective methods of contraception among women in Medicaid and CHIP. We hope this engagement can inform and advance the future adoption of a contraceptive quality measure for the purpose of informing both quality and value-based care.

5.) Continued Transparency and Public Engagement

FPA applauds the State for their attention to stakeholder engagement in both the development and implementation of reform initiatives that have taken place to date. We urge the State to seize every opportunity to capture robust and diverse stakeholder feedback as transformation to our health care delivery system barrels forward. The Roadmap indicates the need for future revisions to the Medicaid Managed Care Model Contract. These revisions are an opportunity for further engagement, and should be subjected to a public comment period.

In conclusion, FPA appreciates your consideration of these comments and is at your disposal should you seek clarification or further discussion either on the points raised here, or other areas related to the provision of reproductive health care services in the state of New York

¹ The Guttmacher Institute. [State Facts About Unintended Pregnancy: New York](#). July 2015.

² Sonfield A, Hasstedt K and Gold RB, [Moving Forward, Family Planning in the Era of Health Reform](#), New York: Guttmacher Institute, 2014.



Comments on Value Based Payment Roadmap Annual Update April 8, 2016

Thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment Roadmap (the Roadmap). The Roadmap adds important new concepts that the Finger Lakes Health Systems Agency (FLHSA) fully supports, which are listed below. We have also commented on several areas, sometimes overlapping with those in the first category, in which the new language in the Roadmap raises some implementation concerns, which could be addressed by further explanation in this or a subsequent document. Finally, there are some concepts not included in the Roadmap which we strongly urge the Department to add.

I. Important New Concepts in the Update to the Roadmap

The Roadmap articulates this "Payment Reform Guiding Principle," which we support: "Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health." (p. 8)

We support the concepts articulated regarding "Incentivizing the Member," particularly the focus on positively incentivizing desired behavior and the clear statement that "burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option." (p. 38)

We support the State's plan to eliminate the \$125 incentive cap for incentive programs (the roadmap describes the current cap as applying to *preventive services*. We believe the reference should be to an existing cap on *incentive payments*). (p. 40)

We support the State's interest in measuring and encouraging creativity in incentive programs, specifically its plan to "analyze any collected data and identify best practices on, at least, an annual basis, and ... make this information publically available. We support the State's announced intent to convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design." (p. 40)

Recognizing that housing plays a critical role in a person's health, we support the Roadmap's commitment regarding the following:

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- The State's plan to collect standardized housing data for purposes of rate setting and appropriate intervention research and analysis
- The State's plan to ensure coordination with Continuum of Care (COC) entities when considering investments to expand housing resources
- The State's goal of leveraging the Medicaid Reform Team (MRT) housing workgroup money to advance a VBP-focused action plan and submit a New York State waiver application to CMS that tracks the *CMCS Information Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. (p. 39)

While we support the content of the box on Housing and Vocational Opportunities, (p. 39), we ask that this box be moved *from* Incentivizing the Member to Public Health and Social Determinants of Health (beginning p. 41). We would not want anyone to interpret the current placement to suggest that these programs should be used as patient incentives; rather, these are essential to achieving good health outcomes.

We support the Roadmap's plan that Level 2 and 3 VBP contractors should be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41). We agree that the selection of the type of social determinant intervention to be implemented "should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (p. 42). It is critical to be guided by individual members' own health goals and desires and community needs and resources.

We support the requirement that VBP "contractors should also create a report explaining a measureable reason why the SDH was selected, and identify metrics that will be used to track its success." We recommend that the process be similar to that used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics, and reports back to the State. (p. 42)

Finally, we fully support the State's insistence on including community based organizations in transformation, expressed by the following language: "Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO." (p. 42).

II. Concepts in Need of Further Explanation or Strengthening

As noted above, we applaud the new emphasis in the Roadmap on an expanded role for CBOs in VBP arrangements. We would urge further emphasis on the role for CBOs in specific programs whenever

possible. For example, the Roadmap states “VBP contractors who focus on health education, increased uptake of prenatal care, pre- and interconception counseling, adequate c-section rates and resource utilization, screening for post-partum depression and so forth have the opportunity to further improve maternity care outcomes while realizing shared savings.” (p. 13). The Roadmap should note that contractors/ subcontractors are likely be CBOs and could add reference to evidence-informed models utilizing CBOs in maternal/infant home visiting.

As indicated in the prior section, we strongly support the new requirement for a social determinant intervention. We are concerned, however, that requirements for professional-led VBP providers, such as safety net IPAs, to share large percentages of their savings with other providers, such as hospitals, may limit their capacity to invest in meaningful social determinant interventions. We would urge the Department to investigate this potential unintended consequence of required sharing of savings and explore alternative formulas.

As the Roadmap states: The selection of the type of social determinant intervention to be implemented “should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources.” (p 42). To make this meaningful, the Department will need to move forward with a plan to ensure that all members receive some type of SDH screening.

The State should also develop a process for the PPSs/hubs to utilize in developing the community needs and resource assessments required for selection of the social determinant intervention. Two points are important to keep in mind regarding the process for developing the community needs assessment:

- First, community needs assessments are best undertaken by neutral, independent entities that are not providing the services in question. Without neutrality, trust and community buy-in are difficult to develop and maintain. Without trust, reports on capacity and gaps in services may be less than complete and alignment between new initiatives and existing services will be difficult to achieve. Without community buy-in regarding priorities, social determinant programs will fail to capitalize on potential synergies and lack critical momentum.
- Second, VBP arrangements for Medicaid services will of necessity operate in close juxtaposition with VBP arrangements for Medicare and commercial payers. Unless clinical programs share goals and milestones across payers, progress will remain erratic and uncertain.

Thus, it will be critical for the PPSs/hubs undertaking community needs assessments and social interventions to coordinate with initiatives and planning efforts across payers, such as those generated by successful Population Health Improvement Programs (PHIPs).

The Roadmap states that: "After a period of two to three years, the State will create a process, which would include an independent review of the role of the CBO, to determine whether the VBP providers are leveraging community based resources, identify best practices and determine if future guidance or technical assistance is needed. (p. 42). We propose adding "or other resources," after the word "assistance," since additional resources may very well be needed. In addition, we recommend that the State urge PPSs/hubs to partner with independent community planning entities, such as the PHIPs, to perform the review of the role of the CBO.

The Roadmap indicates that the PPSs/hubs that are not contracting entities should maintain infrastructure for population health, patient-centered integration and workforce strategy. (p. 16). Non-contracting PPSs will be well-positioned to contribute reports on the impact of VBP arrangements. However, as mentioned earlier, community health planning is best suited to an independent entity and reports on the impact of Medicaid VBP arrangements will be most valuable viewed in the context of other payer initiatives, including Medicare VBP and commercial arrangements. We recommend that the State explicitly recognize PPSs population health assessments as taking place in collaboration with other state-funded entities conducting broader health planning activities that include Medicare and commercial VBP arrangements, such as PHIPs.

In the section on Quality Measures, the Roadmap references Category 1 and Category 2 measures, which have not yet been shared with the VBP workgroup. It is difficult to support this section of the Roadmap without having a sense of the measures that are being advanced by the CAGs in each category. (p. 34). It is important that quality measures capture the impacts of both under-treatment and over-treatment on health outcomes.

The Roadmap should clarify that the CAG reports on categorization will be shared with the VBP workgroup and that the public will have a chance to comment on the measures actually adopted for reporting in drafts of the new model contracts. For example, the Roadmap states that "measures focusing on rehabilitation and individual recovery including housing stability and vocational opportunities...are as yet underrepresented." The Clinical Advisory Group (CAG) on Behavioral Health has been working to identify metrics, both clinical and HCBS-related, but their work has not been integrated into the Update, and it is not clear if these essential metrics will be included in the revised model contract, the most definitive way to ensure MCOs are accountable for these metrics.

The Roadmap indicates that the state foresees including these metrics in the model contract, but fails to reference an opportunity for public comment on the model contract before it is finalized. Instead, the Roadmap states that the model contract "will not be posted until it is approved by CMS." In an earlier version of the recommendations from the Regulatory Subcommittee (SC), it stated that: "After consideration of the comments from the SC, DOH will share the updated Model Contract with the public and solicit additional comments before finalization. DOH will post all of the received comments on the DOH website prior to the adoption the Model Contract." We feel strongly there should be a public comment period on the model contract before it is finalized, so that stakeholders

have an opportunity to ensure the inclusion of metrics is representative of the successful work many are already engaged in.

The Roadmap states that a small number of CAGs will continue in Year 2, and new CAGs may be formed around additional priorities, such as Special Needs Children (p. 34). One or more CAGs focused on Special Needs Children is a good idea, but is not a substitute for a broader-focused task force that makes recommendations regarding value-based payment for children and adolescents.

The Roadmap makes reference to Patient Reported Outcomes (PROs) as a key missing link in assessing the outcomes of care for many health problems and conditions (p. 35). However a footnote to that reference appears to narrow use of PROs to FIDA, HARP and DISCO measures. The Roadmap's only other reference to PROs is in the section on social determinant interventions as a potential means of evaluating program success (p. 43).

PROs should not be restricted to social determinant programs or special populations. Validated PRO measures are now available in the public domain for use across a variety of clinical conditions and have shown success as a means of engaging patients in their care and informing care decisions. The footnote in the roadmap's should reflect the Advocacy and Engagement Subcommittee's recommendations that some form of PROs be considered by clinicians participating in VBP, and that VBP early adopter pilots serve as a vehicle for piloting the use of PRO measures in an assessment tool.

The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant in the VBP context. That is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it affects them. The Roadmap should reference some of the other important actions recommended by the Subcommittee that the State has committed to undertake, such as creating a workgroup to develop a communications strategy to ensure that the state, plans and providers communicate appropriate information to consumers, such as: an explanation of the difference in incentives that payment mechanisms generate; what is meant by a high value provider; consumers' right to question providers and seek a second opinion and the right to seek consumer assistance services.

The State's Independent Consumer Advocacy Network and any and all consumer assistance/ombuds programs should be equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment. More specifically, the State should expand the Ombuds Program for people with Medicaid Long-term care services to include Medicaid members enrolled in VBP.

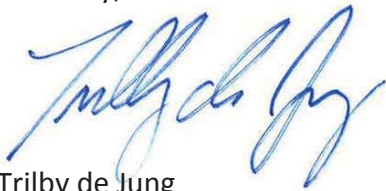
III. Important Concepts that Should be Added to the Roadmap

We urge the State to explore the development of payment methodologies that incentivize/reward providers for taking on patients with challenging social determinant of health barriers. The State should also invest in CBOs that show promise in helping to address social determinants of health. This investment could include infrastructure, data capacity, contracting, etc. State funding should be made available to help prepare these CBOs for their participation in VBP arrangements, including funding infrastructure and IT, measurement and data collection, and contracted services, such as fiscal and legal services. In addition, the state should consider establishing a loan fund to assist with cash flow issues that may arise if payment to CBOs in VBP arrangements is delayed.

Finally, the State should assess its economic development initiatives against health goals. A community thrives when its residents are healthy.

Thank you for this opportunity to comment and to participate as a workgroup member in this important undertaking. We look forward to future work with the State on these issues.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Trilby de Jung', is positioned above the printed name and title.

Trilby de Jung
CEO

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April
Six
2016

Jason Helgeson
State Medicaid Director, Deputy Commissioner
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1466
Albany, NY 12237

Dear Mr. Helgeson:

Thank you for the opportunity to comment on the first annual “Update to the Value Based Payment Roadmap” (Roadmap). We greatly appreciate the substantial work effort of DOH staff and consultants, the VBP workgroup, and the various VBP subcommittees over the past year in fleshing out the numerous open policy issues identified in the initial Roadmap. GNYHA strongly supports the State’s goal of increasing the percentage of value-based Medicaid managed care provider payments, and the updated Roadmap lays out a comprehensive strategy for doing so. There are, however, several key issues that we believe must be addressed prior to finalization of the updated Roadmap. We have also attached a copy of the Roadmap with suggested track-changed revisions as well as additional more technical comments.

VBP Options

The Roadmap outlines four categories of VBP arrangements – Total Cost of Care General Population, Integrated Primary Care (IPC), Selected Bundles and Special needs Subpopulations. For reasons we explain more fully in the sections that follow, we believe there should actually be three categories of VBP models, some with subcategories:

- Total Cost of Care Models
 - Total Cost of Care of the Total Population (TCTP)
 - Total Cost of Care of the General Population (TCGP)
 - Total Cost of Care of Subpopulations (TCSP)
- Integrated Primary/Chronic Care Bundle
- Discrete Episode Bundles
 - Maternity
 - Other



GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

Total Cost of Care Models

While the Roadmap envisions Medicaid Managed Care Organizations (MCOs) and providers entering into total cost of care arrangements either for the general population or for subpopulations, the most prevalent model today is total cost of care for the total population. Providers that already participate in shared savings or shared risk arrangements generally do not carve out subpopulations such as HIV or behavioral health. In fact, our understanding is that where VBP arrangements exist, the Health and Recovery Plan (HARP) population has largely just been folded in. Because the Roadmap's separation of the general population and subpopulations is causing confusion among providers and MCOs, we strongly recommend revising the Roadmap to specifically recognize three categories of total cost of care arrangements: Total Cost Care for the Total Population (TCTP), Total Cost of Care for the General Population (TCGP) and Total Cost of Care for Subpopulations (TCSP).

Integrated Primary/Chronic Care Bundle

We do not view IPC and the Chronic Care Bundle as two separate models as portrayed in the Roadmap. IPC arrangements are patient-centered medical homes (PCMH) or advanced primary care (APC) practices that enter managed care contracts based on savings and quality. As such, we believe the IPC in and of itself is really a *provider model* that then enters into a VBP arrangement—either Level 1 total cost of care or an Integrated Primary/Chronic Care Bundle (IPCCB). We recognize the importance of distinguishing between how primary care is generally provided today and the new model envisioned under APC or PCMH—with payment for care coordination and focus on measurable quality improvement—and we believe the Roadmap could include a section describing this model. But the APC or PCMH is really a *provider* that will enter into a VBP arrangement such as an IPCCB. Other providers, such as hospital systems, could also enter into a contract for IPCCB. We believe that reframing this by consolidating the IPC and Chronic Care bundles into one IPCCB model will greatly improve the clarity of the Roadmap.

Discrete Episode Bundles

Patients attributed to PCPs participating in an integrated primary/chronic care bundle will receive many services that would otherwise not be subject to value-based payment. While the Roadmap highlights the opportunity for providers to enter VBP arrangements for maternity services, we recommend that it specifically state that providers can enter arrangements for any discrete episode not covered under the integrated primary/chronic care bundle, even though DOH will not be able to support such episodes in the near term.

VBP Stimulus and Penalties

The Roadmap's stimulus adjustments are designed to encourage providers and plans to enter into VBP arrangements and to move into more complex Level 2 and 3 agreements. We believe these adjustments will be very helpful, but we disagree with providing higher stimulus adjustments to IPCCB or bundled arrangements for several reasons. We find it perplexing that the State

proposes to prioritize these models over total cost of care arrangements, as we believe it will be significantly harder to reach the 80% VBP goal through bundled payments. The Roadmap anticipates that for patients attributed to a bundle, services not included in the bundle will be contracted to another VBP contractor. While this might be easily accomplished for a maternity bundle, it is not clear that it will work for others. For example, for patients attributed to an Integrated Primary/Chronic Care Bundle, it seems unlikely that another provider would contract on a shared savings/risk arrangement for all the services not included in the IPCCB. Most savings will likely result from management of the bundle, not on the services outside the IPCCB (e.g. cancer, trauma). A more logical arrangement might be for a VBP contractor (IPA/ACO) to enter into a total cost of care arrangement and then provide incentives to physicians within the IPA/ACO around the bundles.

In addition, the rationale given for providing a larger stimulus for bundled arrangements is that they require more infrastructure and are likely to have a greater impact on efficiency and quality. It is not clear to us that this is the case. Since few bundles are likely to be prepaid, there do not appear to be significant infrastructure costs for the provider, and the relative impact of these models on quality and efficiency remains to be seen. Further, as described above, we believe it will be challenging to meet the VBP targets by prioritizing bundled arrangements. Instead, we recommend providing greater stimulus adjustments to total cost of care arrangements that incorporate one or more downstream bundles.

We are also concerned about the proposal to penalize plans that do not reach target percentages of payments under VBP and the suggestion that these would be passed on to providers if the providers are not willing to engage in VBP or progress to more advanced levels of VBP. Given the significant incentives under DSRIP to achieve VBP targets, we believe the proposed penalties are unnecessary. We also do not see how DOH could determine fault in whether or not a plan and provider reach agreement on a VBP contract. A provider may want to enter into a VBP arrangement, but not on the terms proposed by the plan – for example, a shared savings arrangement predicated on a reduction in the Fee-for-Service payment rate. And except in out-of-network situations, MCO payments to providers are subject to contract. In the absence of authorizing statute, we do not believe penalties could be passed on to providers unless the parties agreed to it in contract—something providers are unlikely to do.

Exclusions

While we have supported the exclusion for financially challenged providers, we believe it needs to be revisited in light of the evolving VBP-QIP program. The exclusion may no longer be necessary, and if it is retained the Roadmap should be clarified to indicate that VBP-QIP participants are not eligible for the exclusion, and that hospitals operated by public benefit corporations need not be excluded from participation in VBP even if they meet the financially challenged provider definition.

We also recommend that the permissible exclusion for high-cost specialty prescription drugs be expanded to permit exclusion of all drugs. While the cost of specialty drugs is a problem, there is also considerable concern about the rapidly rising cost of single source generics. In addition, MCOs have indicated that their premiums do not adequately support rising drug costs and that existing risk adjustment mechanisms do not adequately account for drug cost variances between plans. While these issues are being worked through, providers may be hesitant to take on risk for pharmacy costs, and we believe DOH should permit exclusion of these costs without such an arrangement being considered off-menu.

Model Contract Amendments

The Roadmap indicates that changes to the Model Contract will be negotiated with the plans and made public after approval by CMS. We had understood that providers would be able to see the proposed changes prior to submission to CMS. To the extent that any proposed changes impact providers entering into VBP arrangements, we strongly recommend they be shared with providers before finalization.

Performing Provider System (PPS) VBP Growth Plan

The Roadmap references a previously established DSRIP deliverable for PPSs requiring submission of a growth plan for achieving VBP contracting targets. It was our understanding that this deliverable would be modified given that PPSs will not be contracting entities. We believe that while PPS partners can commit to growing their VBP contracts, many, for competitive reasons, would be unable or unwilling to share their strategies or timeframes for doing so. As an alternative deliverable, we suggest requesting information from each PPS about how the PPS partners will contract (e.g., through a PPS-wide IPA or ACO, through hub IPAs, or as independent providers).

Off-Menu Options

We are concerned that by defining what can be off-menu, the Roadmap does not adequately allow for the flexibility in plan/provider contracting that we believe was intended and that was a core concern of GNYHA and many others during the VBP workgroup and subcommittee discussions. We strongly believe that as long as VBP arrangements meet Level 1, 2, or 3 criteria, they should be acceptable. We also believe that existing contractual arrangements that have worked well and qualify under these levels should be grandfathered. The Roadmap description of what the Medicaid VBP plan is *not* specifies that “*MCOs and providers can jointly agree to pursue different or ‘off-menu’ VBP arrangements as long as those arrangements reflect the Medicaid VBP principles*”. Consistent with this statement, we recommend the Roadmap focus on those principles and not include lists of what can and cannot be considered off-menu.

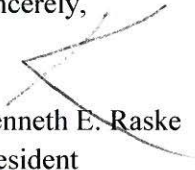
Sharing Savings Between Physicians and Hospitals

We suggest two clarifications to the criteria for sharing savings between hospitals and physicians where the hospital is not party to the VBP arrangement. First, direct data feeds for notifying

PCPs of patient hospital utilization is only possible where the IT connectivity to do so is in place and when the hospital can identify the patient's PCP. Many PCPs do not yet have this connectivity and State eligibility systems do not include a PCP identifier. We agree on the importance of getting this information to PCPs in a timely manner, but recommend allowing alternate mechanisms for providing it when necessary. Second, we think it would likely be impossible for hospitals to meet the requirement to collaborate with PCPs on *all* DSRIP domains 2 and 3 measures given the number of measures. We therefore recommend softening this requirement.

Thank you for your continued consideration of GNYHA's concerns and comments. We look forward to continuing to work with you on VBP implementation. [REDACTED]

Sincerely,



Kenneth E. Raske
President

Attachment

April 15, 2016

New York Department of Health
Delivery System Reform Incentive Payment Program
Corning Tower
Empire State Plaza
Albany, NY 12237

Submitted via email: dsrip@health.ny.gov

Re: Public Comments in Response to the annual update to the 2016 Value Based Payment (VBP) Roadmap

To Whom It May Concern:

GlaxoSmithKline (GSK) appreciates the opportunity to submit these public comments to the New York Department of Health regarding the Department's Delivery System Reform Incentive Payment Program (DSRIP) and the first annual update of the New York State Roadmap for Medicaid Payment Reform.

GSK is a science-led global health care company that researches and develops a broad range of innovative medicines and brands to help patients do more, feel better, and live longer. While GSK does not create quality measures, we have a committed interest in ensuring the robustness of quality that supports better care for individuals and improved overall population health within publically supported and market-based health care programs. The trends of linking quality to the value of care and using quality information to inform patient choices will continue to grow as they are critically important to assuring that health care reforms preserve and enhance patient outcomes. Evidence-based cost and quality measures will help the healthcare system evolve from one rewarded for the volume of services to one promoting the value of services.

GSK applauds the adoption of the New York State Roadmap for Medicaid Payment Reform as well as Department's efforts to improve health outcomes through Medicaid payment reform and the adoption of quality measures for each value based payment arrangement. A well-constructed quality strategy is of vital importance to achieving the goals outlined in the Roadmap. To that end, GSK supports the implementation of quality measures that meet the following characteristics:

- Endorsed by multi-stakeholder, evidence-based quality organizations, such as the National Quality Forum (NQF);
- Reflect higher performance in helping to achieve patient-centered outcomes;
- Based on evidence-based processes; and
- Aligned across multiple care settings and providers to harmonize the use of measures in various reporting programs to help reduce reporting burden and accelerate improvement.

GSK respectfully suggests that the Clinical Advisory Groups (CAGs) support the adoption of the following quality measures for the value based payment arrangements identified in the state's updated Roadmap:

HIV Quality Measures

HIV quality measures are critical to the care and treatment of people living with HIV. Approximately 1.2 million people are infected with HIV, and one in seven (14 percent) are unaware that they are infected. Despite groundbreaking treatments that have slowed the progression and burden of the disease, the pace of new infections continues at a high level, especially among certain demographic groups including Blacks/African Americans and Hispanics/Latinos.ⁱ Implementing the HIV viral load suppression quality measure would support public health priorities, such as reduced viral load, and the use of HIV Antiretroviral Therapy has been linked with improved overall health, quality of life, and decreased risk of HIV transmission.^{ii iii iv} GSK encourages the Department to implement the following measures:

- NQF #2082: HIV Viral Load Suppression (Clinician, Health System, Population)
- NQF #2083: Prescription of HIV Antiretroviral Therapy (Clinician, Health System, Health Plan, Population)

The Viral Load Suppression Measure has been nationally vetted and reported. In fact, the Centers for Medicare & Medicaid Services and America's Health Insurance Plans (AHIP) included NQF #2082: Viral Load Suppression, among other HIV measures, in their core measure set as a part of their broad Core Quality Measures Collaborative of health care system participants.^v The Core Quality Measures Collaborative, led by AHIP and its member plans' Chief Medical Officers, leaders from CMS and the National Quality Forum, as well as national physician organizations, employers, consumers, and patient groups worked hard to reach consensus on these core measure sets. The guiding principles used by the Collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost.

Immunization Quality Measures

During the 20th century, the life span of Americans has increased by more than 30 years in part because of the use of vaccines, and mortality from infectious diseases in the U.S. has been reduced 14-fold through the use of vaccines, according to the U.S. Department of Health and Human Services.^{vi} Approximately 4 million children are born in the U.S. each year, each of whom is vulnerable to vaccine-preventable pathogens.^{vii} The preventive nature of vaccines helps to improve patient outcomes and curtails treatment costs on the healthcare system. GSK recommends the following measures that support immunizations for routine use in children, adolescents, and adults and that have a recommendation from the Advisory Committee on Immunization Practices (ACIP).

- NQF #0038: Childhood Immunization Status (Health System, Health Plan)
- NQF #1407: Immunizations for Adolescents (Health System, Health Plan)
- NQF #0041: Influenza Immunization (Clinician, Health System, Health Plan)
- NQF #0431: Influenza Vaccination Coverage among Healthcare Workers (Health System)
- NQF #0043: Pneumococcal Vaccination Status for Older Adults (Clinician, Health System, Health Plan)
- NQF #1959: HPV Vaccination for Female Adolescents (Clinician, Health System, Health Plan)

GSK notes that despite ACIP recommendations and Healthy People 2020 targets, adult immunization rates remain low.^{viii} Quality measures have the potential to increase immunization rates.^{ix} Adult immunization quality measures currently focus on influenza and pneumococcal immunization. GSK supports the development of quality measures that increase adult immunization rates for ACIP recommended vaccines.

Respiratory Quality Measures

Asthma

At a cost of \$56 billion dollars a year,^x more than 25.7 million Americans suffer from asthma, including 7.7% of adults and 9.5% of children.^{xi xii} According to the CDC, in 2009 there were 2.1 million emergency room visits and nine deaths per day due to asthma.^{xiii} Lack of asthma control is costly to the healthcare system:

- In 2010, hospital inpatient costs due to asthma totaled \$1.9 billion.^{xiv}
- Uncontrolled patients cost approximately \$4,400 more in direct costs per year than their counterparts who have well controlled asthma.^{xv}

The following measures help support the heightened assessment of control and medication management, which are essential to improving patient outcomes and prevention of hospitalizations.

- NQF #0028: Tobacco Use Assessment and Tobacco Cessation Intervention (Clinician, Health System)
- NQF #1800: Asthma Medication Ratio (Schatz) (Health System, Health Plan)
- Optimal Asthma Care, Control Component: Minnesota Community Measurement (Clinician)
- NQF #0275: PQI 05: COPD or Asthma in Older Adults Admission Rate (Population)

- NQF #0047: Asthma: Pharmacologic Therapy for Persistent Asthma (Clinician)
- NQF #0283: PQI 15: Asthma in Younger Adults Admission Rate (Population)

COPD

Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in the U.S. and causes serious, long-term disability.^{xvi} As of 2011, 15 million Americans have been diagnosed with COPD; of this total, approximately 50% were not aware their lung function was not at full capacity, a primary symptom of COPD.^{xvii xviii} Therefore the number of Americans with COPD may actually be greater than 15 million, indicating an under diagnosis of COPD exists.^{xix}

A recent study conducted by the Centers for Disease Control and Prevention (CDC) shows the significant economic and quality of life impact that COPD is taking on the U.S. The research found that:

- In 2010, total national medical costs attributable to COPD were estimated at \$32.1 billion and total absenteeism costs were \$3.9 billion for a total burden of COPD-attributable costs of \$36 billion.
- An estimated 16.4 million days of work were lost because of COPD.
- Of the medical costs, 18% was paid for by private insurance, 51% by Medicare, and 25% by Medicaid.
- National medical costs are projected to increase from \$32.1 billion in 2010 to \$49.0 billion in 2020.^{xx}

GSK considers COPD disease management a significant component for better patient outcomes. GSK supports the inclusion of the following COPD measures as they focus on diagnosis and adequate treatment and exacerbation control and may possibly help impact quality of life and healthcare costs.

- NQF #0028: Tobacco Use Assessment and Tobacco Cessation Intervention (Clinician)
- NQF #0091: COPD: Spirometry Evaluation (Clinician)
- NQF #0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (Health System, Health Plan)
- NQF #0102: COPD: Inhaled Bronchodilator Therapy (Clinician)
- Former NQF #0549: Pharmacotherapy Management of COPD Exacerbation (Clinician, Health System, Health Plan, Population)
- NQF #0275: PQI 05: COPD or Asthma in Older Adults Admission Rate (Population)
- NQF #1891: Hospital 30 Day All Cause Risk-Standardized Readmission Rate following COPD Hospitalization (Health System)
- NQF #1893: Hospital 30 Day All Cause Risk-Standardized Mortality Rate following COPD Hospitalization (Health System)

Thank you for your consideration and the ability to participate in the transition process. GSK looks forward to working with the Department and other stakeholders to ensure that New York's public programs continue to ensure patients have access to quality care and to improve health outcomes.

Sincerely,



Tanisha Carino
Vice President, Public Policy
GlaxoSmithKline

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- ^{iv} World Health Organization (WHO). Adherence to long term therapies—evidence for action. 2003. http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf
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- ^{vi} The State of the National Vaccine Plan, 2013 Annual Report
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Jason Helgerson

State Medicaid Director, Deputy Commissioner

New York State Department of Health

Empire State Plaza, Corning Tower, Room 1466

Albany, New York 12237

Dear Mr. Helgerson:

Re: First Annual Update to the *Value-Based Payment Roadmap*

The Healthcare Association of New York State (HANYS), on behalf of our 500 non-profit and public hospital, nursing home, home health agency, and other healthcare provider members, appreciates the opportunity to formally comment on the first annual update to the state's *Value-Based Payment (VBP) Roadmap*.

The first annual update to the *Roadmap* includes additional and important VBP implementation details developed over the past several months by multiple state and stakeholder-led VBP subcommittees (SCs). The SCs focused on VBP technical design details, regulatory aspects of VBP, engaging patients in VBP models, and VBP's interaction with social determinants of health, among other issues.

HANYS is grateful to the Department of Health (DOH) and KPMG for actively engaging stakeholders and the healthcare community to refine key implementation details for providers and managed care organizations (MCOs) to engage in VBP arrangements, and looks forward to continuing distinct SC work outlined in the draft *Roadmap*.

Of utmost importance, as HANYS has urged, is that the current draft *VBP Roadmap* retains the needed flexibility for providers and MCOs to negotiate and engage in newly forming and relatively untested VBP care and payment models.

Flexibility has been a key HANYS theme from the beginning of the *Roadmap* development process. This theme was carried forward into the SC process, where HANYS advocated strongly for implementation details to take the form of *guidelines* as opposed to *standards*. HANYS appreciates that nearly all of the implementation details defined during the SC process and included in the updated *VBP Roadmap* are *guidelines*. The distinction between *standards* and *guidelines* will remain important as VBP arrangements are implemented and the *Roadmap* morphs to reflect provider and MCO experience in executing arrangements.

While the draft *Roadmap* is a consensus document, we believe important improvements and clarifications can be made while still retaining needed flexibility. HANYS looks forward to continuous engagement with the state on its developing VBP policies. Our detailed comments are below.

Criteria for Shared Savings in IPC and TCGP Contracting (Pages 12 and 68)

HANYS appreciates DOH's engagement throughout the Technical Design I SC process on defining policies around the criteria a hospital must meet for shared savings under Integrated Primary Care (IPC) or Total Cost General Population (TCGP) VBP arrangements where the hospital is not party to the VBP agreement. As identified in the *Roadmap*, this issue is critically important, as shared savings from these arrangements is typically tied to reducing hospital admissions and emergency room visits. HANYS had previously contested portions of this recommendation, focusing on needed improvements to the criteria hospitals must meet to secure shared savings and new components of the recommendations added outside of the SC process.

During the February 18, 2016 VBP Workgroup meeting, DOH accepted the SC recommendation without modification and has promised it will create a formal review and appeals process to monitor the implementation of this recommendation and assist in mediating any disagreements.

While HANYS still believes that some of the criteria outlined to achieve the equitable split of shared savings may not be practically achievable (i.e., "real time direct data feeds"), **HANYS is encouraged that this provision provides hospitals and professional-led VBP contractors with flexibility to agree on practical criteria to prove collaboration and achieve desired VBP outcomes. HANYS is optimistic about the DOH-promised review, appeals, and monitoring process and urges the agency to formally engage in an annual review of this *Roadmap* provision with stakeholders to ensure acceptable implementation, with appropriate adjustments if necessary.**

Contract Risk Review Process and Model Contract Updates (pages 22 and 47)

HANYS provided regular and ongoing comments as Chair of the Regulatory Impact SC. We appreciate having been appointed to this role, and the efforts by DOH and the Department of Financial Services to explore opportunities to streamline and alleviate regulatory hurdles associated with value-based contracting in New York State. **HANYS supports the new three-tier contract review process and believes it will ensure that there are appropriate safeguards in place to protect providers from taking on more risk than is financially sustainable.**

While HANYS supports these initial recommendations, we look forward to providing additional feedback as the state's VBP implementation work commences. We will also have additional comments on any proposed legislation that is introduced as a result of these recommendations. We hope that through its future meetings, the Regulatory Impact SC will continue to serve as a useful resource to the state as VBP is implemented and new priority areas are identified. **HANYS also looks forward to working with DOH on updates to the Model Contract that will support VBP implementation.**

Performance Adjustments and Aligning MCO Incentives (pages 26 and 44)

HANYs appreciates that the Technical Design I SC process resulted in a framework for establishing VBP target budgets that allows flexibility for negotiation after the state applies performance adjustments to MCO premium dollars based on quality, efficiency, and risk level.

Lack of Analysis to Support Adjustment Levels

HANYs is disappointed that the proposed VBP contractor performance adjustments for quality and efficiency and the stimulus adjustment lack data-driven results (dollar amounts). The adjustment levels outlined in the draft *Roadmap* give no indication of how much funding would be infused into the Medicaid system during 2016 (where only positive adjustments are applied for VBP contractor performance). In later years, when the adjustments are proposed to be both positive and negative, this transparency becomes especially important in order for VBP contractors, MCOs, and stakeholders to understand the magnitude of Medicaid funding that would be redistributed between and across providers and MCOs.

HANYs requests that DOH outline in the *Roadmap* a more defined process to work with stakeholder groups on an annual basis to develop and review performance-based premium adjustments prior to their proposal and application. Because the performance adjustments will adjust target budgets upward and downward, the implications of these adjustments are very real for providers to achieve shared savings. As such, the state must work through a transparent process with stakeholders to assess the appropriate level of these adjustments.

Stimulus Adjustment

HANYs supports the concept of a stimulus adjustment for movement to higher levels of VBP and subsequently higher risk. **Given the lack of debate during the SC process and lack of data-driven rationale, HANYs urges DOH to not adopt variable stimulus adjustments depending on type of VBP arrangement. Instead, in this version of the *Roadmap*, HANYs asks DOH to equalize the stimulus adjustments at 1% for all VBP arrangements until a more robust stakeholder review process can define a rationale for potential variations in the stimulus adjustment level.**

Clarity on Performance and Stimulus Adjustments and their Application

HANYs asks DOH to include a table in the *Roadmap* that clearly summarizes the financial incentives and penalties that are proposed within the draft *VBP Roadmap* along with which adjustments can be factored into negotiations and adjustments to the VBP target budgets.

This would include, but may not be limited to, the VBP contractor performance adjustment, MCO performance adjustment, risk-level stimulus adjustment, and MCO penalties for falling behind on VBP goals. **HANYs strongly believes that any MCO penalties assessed for not meeting VBP goals must not be considered as part of VBP arrangement negotiations between providers and MCOs.**

Clarity around the full scope of premium adjustments is critical for VBP contractors and MCOs to engage in productive negotiations around VBP arrangements. In that same context, **to support VBP negotiations between VBP contractors and MCOs, HANYs urges DOH to**

clarify in the *Roadmap* that it intends to make the aggregate dollar value of the final MCO premium adjustments in a given year completely transparent to the specific VBP contracting parties.

HANYS also asks DOH to provide additional details on the MCO-specific performance adjustments or signal when this information will be made available. These critical adjustments are not described in the draft *Roadmap* in any detail other than referencing that they would “closely follow” the VBP contractor adjustment methodology.

Transparency of Outcomes and Cost as the Foundation for VBP (page 29)

In the new VBP environment, data and information are essential to understanding and addressing performance and performance trends. HANYS appreciates that DOH is developing VBP analytic tools to support VBP contractor negotiations and performance improvement. **However, we once again urge DOH to expedite its ongoing process to make granular Medicaid claims data files available to Performing Provider Systems, providers, and others as soon as possible so that those ready to pursue VBP models can do so without delay.**

Data analysis that defines effective partners and target service areas is critical to the pursuit of risk-based payment. The sooner data are available for those ready to pursue VBP, the sooner state VBP goals can be advanced. **When providing or analyzing data for VBP contractors, MCOs, the public, or others, DOH must not reveal proprietary pricing information unless requested specifically by VBP contractors and MCOs to support and advance contracting.**

HANYS looks forward to formal or informal opportunities to discuss with DOH the most appropriate level of pricing information that could potentially be made broadly available—including “proxy” pricing information.

VBP Exclusions (page 30)

HANYS appreciates the thoughtful work of the Technical Design II SC on recognizing and defining which providers, services, and items could or should be excluded from VBP arrangements. **HANYS supports the current exclusions and supporting criteria and urges DOH to prioritize review of VBP exclusions on an annual basis using the Technical Design II SC or other appropriate workgroup.** Evaluating and defining emerging trends that support VBP inclusions/exclusions—such as changes in prescription drug prices and the interaction of VBP with financially fragile providers funded under special funding programs—will be important to measuring VBP progress and goals.

Quality Measures and Measurement (page 34)

HANYS applauds the state’s willingness to find a balance between measure flexibility and standardization; however we believe that the current approach to standardization does not adequately meet the intent. The following describes the recommendations for modifying the current process while maintaining provider flexibility.

Standardization

HANYS supports the Clinical Advisory Group (CAG) concept and the goal of thoughtful selection of quality measures. Given the broad scope of measurement across the healthcare continuum and the rapid change of the environment, HANYS supports DOH's plan to reconvene the CAGs on a regular basis to review and modify metrics.

However, HANYS has concerns about the effectiveness of the CAG process and recommends that DOH adopt a more formal process for future meetings. For example, we are concerned that the attendance at the past CAG meetings was often inconsistent and conclusions were reached by the group at hand. **HANYS suggests that DOH adopt a more formal member selection process that ensures the consistency of the CAG membership and is representative of the diverse state environment.**

HANYS also urges DOH to establish a process to promote alignment that extends beyond individual measure evaluation and selection and move toward consensus identification of a minimum number of representative measures. These measures should align with other state and national reporting expectations. This approach is especially important because VBP contractors are obligated to report on the entire set of quality measures recommended by the CAGs, regardless of individual contractual arrangements.

Since a key goal of the state is to “optimally align” with the Centers for Medicare and Medicaid Services (CMS), HANYS recommends the development of a crosswalk of the CAG quality measures with the newly released clinical group core measure sets. The core measure sets represent consensus from key stakeholders including physician groups and health plans, and are under consideration for future provider reporting (Medicare Access and CHIP Reauthorization Act/Merit-Based Incentive Payment System). Three of the nine CAG categories directly overlap with the CMS measure sets. Further aligning the CAG measures with the CMS measure sets prior to the VBP pilot work demonstrates the VBP model's responsiveness toward utilization of mutually effective and streamlined measures.

Flexibility

HANYS strongly urges DOH to clarify in the VBP Roadmap the level of flexibility with regard to quality measures selection that is permitted for VBP contractors. Given the significant variation in patient population and environment, having adequate flexibility in measures selection is key to enabling providers to focus their quality improvement efforts and resources on areas that are most important to patient care.

Performance

The *VBP Roadmap* does not clearly address how the quality measures will be incorporated into VBP contracts and shared savings/risk arrangements. **HANYS asks that DOH specifically clarify in the Roadmap that performance on the standard measure sets and how that performance factors into VBP agreements is fully negotiated between VBP contractors and MCOs.**

List of Prioritized VBP Arrangements (page 35)

The *VBP Roadmap* prioritizes the following VBP arrangements: Total Care for General Population, Total Care for Subpopulations, Episodic Care Services (Maternity Bundle and Chronic Care Bundle; and Integrated Primary Care). While there is much to learn about the practicality of how these models may or may not interact, HANYS generally supports their design as initial VBP arrangements come together and the beginning phases of Medicaid VBP start to take hold. Importantly, aligning with HANYS' theme of flexibility, the *Roadmap* allows VBP contractors and MCOs to negotiate VBP arrangements prioritized by DOH in the *Roadmap* and other "off-menu" arrangements mutually agreed to between VBP contractors and MCOs.

To bring clarity to the flexibility VBP contractors have outside of the VBP arrangements prioritized by DOH, HANYS asks that DOH consolidate the off-menu references throughout the document to the "Prioritized VBP Arrangements" section of the *Roadmap*. This will make clear the DOH preference and the flexible alternatives VBP contractors can pursue (i.e., episodic care bundles or total cost/total population models not prioritized).

Incentivizing the Member: Value-Based Benefit Design (page 38)

HANYS appreciates the flexibility included in the final Advocacy and Engagement SC recommendations and subsequently the updated *VBP Roadmap*.

During the SC process, HANYS continually raised concerns about adding new member incentive programs and measures to untested VBP models and instead urged that these programs be outlined as a guideline for VBP contractors to consider. **HANYS supports the *Roadmap's* view in not mandating member incentive programs, but rather urging VBP contractors to recognize the potential value of these types of programs and consider them when contracting for VBP.**

Additionally, during the SC process, HANYS recommended incorporating a guideline that would recommend the state inform and educate providers and MCOs regarding federal fraud laws to ensure incentive programs are not created in violation of those laws. **HANYS asks that a guideline regarding provider and MCO education on federal fraud laws be included in the updated *Roadmap* and/or be part of any continuing dialogue or agenda of the Advocacy and Engagement SC.**

HANYS looks forward to working with the state on patient engagement and public information programs as they continue to be developed and refined.

Public Health and Social Determinants of Health (page 41)

HANYS appreciates the flexibility included in the final SC recommendations and subsequently the updated *VBP Roadmap* related to social determinants of health. HANYS is pleased that, for the most part, this section of the *Roadmap* includes guidelines as opposed to standards—including recommendations for further state consideration. HANYS actively advocated throughout the SC process for guidelines as opposed to standards to ensure VBP contractors have maximum flexibility as they begin to explore and pursue new VBP-style care and payment arrangements. **HANYS continues to be concerned with the standard in the Community**

Based Organization (CBO) section that requires VBP contractors to contract with at least one tier 1 CBO under Level 2 and 3 VBP arrangements, despite the provision of financial incentives.

HIPAA and State Privacy Laws Brief (page 77)

HANYS is encouraged to see a new Health Insurance Portability and Accountability Act (HIPAA) and State Privacy Laws Brief section of the *Roadmap* and looks forward to continued Regulatory Impact SC discussion around the confluence of federal HIPAA laws and regulations and New York State privacy laws and regulations. Additional and overly burdensome restrictions can create an environment that prohibits providers from sharing information for the purpose of coordinating and evaluating care, and can potentially stifle VBP innovations. HANYS is grateful to the state for recognizing the importance of this issue and need for further discussions.

Innovator Program (page 84)

HANYS appreciates its role on the Technical Design II SC in developing the framework and design of the state's VBP Innovator Program. **HANYS fully supports the Innovator Program's design in the *Roadmap* and its role in advancing VBP in the state.**

HANYS appreciates the opportunity to offer comment on the first annual update to the *VBP Roadmap*. We look forward to continuing work with DOH and KPMG to help ensure that the VBP program is manageable for providers and contractors engaging in VBP arrangements.

Sincerely,



Dennis P. Whalen
President

DPW:lw



American Cancer Society ✕ Children's Defense Fund-New York ✕ Coalition for Asian American Children and Families ✕ Community Service Society of New York ✕ Empire Justice Center ✕ Make the Road New York Medicare Rights Center ✕ Metro New York Health Care for All Campaign ✕ New Yorkers for Accessible Health Coverage ✕ New York Immigration Coalition ✕ Public Policy and Education Fund of New York/Citizen Action of New York ✕ Raising Women's Voices-New York ✕ Schuyler Center for Analysis and Advocacy ✕ Small Business Majority

April 18, 2016

Jason Helgeson, Director
New York State Medicaid

Dear Director Helgeson:

Thank you for the opportunity to comment on the first annual update to the Value-Based Payment Roadmap. Health Care for All New York (HCFANY) is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected. Several of our members were represented on the value-based payment subcommittees. Please find our response to the Roadmap below.

Protection Against Under-Service and Patient Selection

Value-based payments will reduce incentives to over-treat and increase incentives to provide preventive and primary care services. However, because no quality measurement system will be perfect and because wide-scale use of value-based payments is still an untested way of providing care, the next Roadmap should include a robust plan for preventing, monitoring, and responding to new negative incentives. Risks to consumers include: (1) under-service by providers concerned about their financial exposure and (2) patient selection, when providers reject patients with complicated needs that may hurt their quality outcomes.

The Roadmap includes a fundamental protection against under-service, which is that plans and providers are disqualified from financially benefitting if their quality outcomes worsen overall (p. 20). Risk adjustment provides some protection against patient selection (p. 26).

The Roadmap also includes some discussion about protecting access to services that are clearly beneficial for patients but may not be cost-effective within the timeframe of a typical contract, such as vaccinations and long-acting reversible contraceptives. The Roadmap suggests the State will develop a list of those services, and count fee-for-service spending on them towards value-based payment goals (p. 32). The Roadmap also suggests that the provision of some of those services will be measured for assessing care quality.

The discussion provides a helpful description of a negative disincentive stemming from value-based payments, which is to avoid services that impose upfront costs without immediately

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producing savings or measureable quality improvements. However, the proposed strategy of separating those services from care bundles deserves more public discussion. It appears that this discussion took place either internally within the State or within the Clinical Advisory Groups, which did not include consumers or advocates.

Further, if a public discussion results in the pursuit of this strategy, developing the list of services and determining which should count as quality measures should also be a public process that includes consumers and consumer advocates. The Roadmap does not currently describe how the list would be developed, and it implies that quality measures have already been selected by the Clinical Advisory Groups (p. 11). HCFANY echoes the recommendations of Medicaid Matters New York and other advocates that the quality measures be made available for public comment before any final decisions are made.

The Roadmap does not include any of the recommendations made by the Advocacy & Engagement Subcommittee for informing members about their providers' incentives or educating consumer assistance programs about the repercussions of value-based payments. Consumers who understand their providers' incentives will be better equipped to identify instances where their care has been compromised. The next version of the Roadmap should include a plan for ensuring that consumers are aware of their rights and how to assert them regardless of how their care is paid for. It would be most appropriate for a new subcommittee to develop this plan. An example workgroup exists in Connecticut, where their Equity and Access Council released a report on safe-guarding patients under shared savings arrangements.¹

Additional protections will likely be developed as the State updates the Managed Care Bill of Rights (p. 43). The Roadmap does not describe the process, but it is important that consumers and consumer advocates are represented in that effort, as they were when the Bill of Rights was originally adopted under the Pataki Administration. Consumers and consumer advocates should be represented in proportion to other stakeholders, and should have a leadership role.

Quality Measures and Risk Adjustment

As mentioned above, there should be a public process for assessing the recommendations made by the Clinical Advisory Groups. The Roadmap says that playbooks with the quality measures per value-based payment arrangement will be released, but not that the measures will be publicly assessed (p. 13). It is appropriate to have heavy clinician input into the design of the bundles and their outcome measures, but it is important that patients and advocates have a chance to review their conclusions.

The Roadmap acknowledges that Patient-Reported Outcomes are a missing link (p. 35). Patient-Reported Outcomes are an important way of ensuring that consumers are truly benefitting from value-based payment. Clinical quality measures are vital, but they will never be able to perfectly capture all of the things that are important to consumers. As Medicaid Matters

¹ Connecticut State Innovation Model Equity and Access Council, "Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements," June 25, 2015, http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf.



New York and other advocates have also recommended, Patient-Reported Outcomes should be collected for all patients, not just subpopulations. Any development process for quality measures meant to capture patient's experience should include patients and advocates.

Moreover, the Roadmap does not guarantee that consumers will have access to any quality information, whether clinical or patient-reported. Consumers need that information to make good health decisions. Disseminating quality information in a way that supports decision-making should be addressed explicitly in the Roadmap.

Risk adjustment is important to protect providers who care for less healthy populations, and removes an incentive to avoid those patients. However it can also mask disparities. The Roadmap describes a continual improvement process for risk adjustment (p. 26). As this occurs, the State should ensure that risk adjustment does not mean disparities are going unmeasured. The National Quality Forum convened an expert panel on this topic and recommended that measures adjusted for socioeconomic factors be available for stratification to make disparities visible.² Their full set of recommendations should be reviewed for future Roadmap updates.

Member Incentives

The guidelines developed by the Consumer Advocacy & Engagement subcommittee are very important for protecting members from discriminatory incentive programs (p. 39-40). There was extensive discussion in that subcommittee about the appropriateness of member incentives, and the Roadmap includes positive provisions for designing culturally competent member incentives, measuring their outcomes, and ensuring that negative incentives like co-pays are not used. The discussions that were held in the subcommittee were a great first step.

However, the Roadmap does not fully reflect the reasons that some advocates are uncomfortable with the emphasis placed on member incentives as a way of making value-based payments work, which is the implication that poor health outcomes are predominantly the result of easily changed lifestyle choices. The overemphasis on member incentives is illustrated by the fact that the State will offer financial incentives to plans for developing member incentives but not for addressing social determinants of health. It is also illustrated by the fact that the subcommittee devoted to Consumer Advocacy & Engagement spent almost no time discussing consumer protections, instead focusing almost entirely on financial incentives to change consumer behavior. As New York City Health Commissioner Dr. Mary Bassett has argued, health disparities are not “about choice – it’s about the fact that people don’t have enough choice.”³ The lifestyle “choices” blamed for poor health outcomes are often the result of constraints imposed by poverty and disability. Similarly, member incentives for choosing high-value care are based on an assumption that members have good information and freedom to choose providers or services. This is frequently not the case.

² National Quality Forum, “Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors: Technical Report,” August 15, 2014, http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.

³ Mary Bassett, “‘Lifestyle Choices’ Doesn’t Explain Why Black Americans Are Dying Younger and in Higher Numbers,” <http://bigthink.com/videos/mary-bassett-on-new-york-city-health-disparities>.



The Roadmap states that this issue will be explored further in a workgroup, and HCFANY recommends that such a workgroup be led by consumers who have a realistic understanding of what choices truly exist for Medicaid managed care beneficiaries.

Public Reporting

The Roadmap says that the State will measure impacts on patient-centeredness, population health, and social determinants of health at the delivery-system level (p. 17). These, and other quality measures, should be publicly available so that there can be a public, informed discussion about the impact of value-based payments. As mentioned above, public reporting of outcomes is also an important part of consumer engagement in health care. Consumers cannot be asked to make better health decisions or to choose high-value providers based only on costs – they need access to accurate quality information about providers.

Stakeholder Engagement

The State is to be commended for undertaking such an extensive stakeholder engagement process and hopes that this will continue. For future workgroups and subcommittees, the appointment process should be very clear and membership lists and meeting minutes should be posted publicly. The value-based payment webpage provides a great amount of information, but adding those missing pieces would allow stakeholders not participating directly in the work to follow along. It is also important to increase the proportion of consumers and consumer advocates on these groups. An open process, for example with public postings for openings, would make it easier for consumer groups to organize and identify nominees with the right expertise to fully contribute.

Thank you for your attention to these comments. [REDACTED]

Sincerely,

Amanda Dunker, Policy Associate
Community Service Society of New York

I am writing to express my deep, deep concerns about the VBP plan. While it is written in a way that seems designed to be purposely confusing so that people can't truly comment, one thing is clear. This plan "includes" even less CBO and community participation than DSRIP. Why, with all the conclusive studies, NY State has to be told that most health does NOT take place in hospitals, is a mystery. But, until the state assures even the most basic CBO participation---just for a few examples, evidence-based education for chronic disease prevention and self-care, community-based care management----these VBP plan can only be seen as something that is purposely designed to allocate money to hospitals without getting the value for value-based health.

You need to have an overall plan of the place and value of community-based agencies in health BEFORE you can possibly work toward a "reformed" payment system.

Thank you,

Chris Norwood
Executive Director
Health People
552 Southern Boulevard
Bronx, NY 10455

www.healthpeople.org

*Preventing and managing chronic disease through sustainable peer outreach,
targeted education, and effective clinical partnerships*



HEALTH PEOPLE
Community Preventive Health Institute

April 8, 2016

Jason Helgeson
State Medicaid Director
Department of Health
Empire State Plaza
Corning Tower, Room 1466
Albany, NY 12237

Dear Mr. Helgeson,

Thank you for the opportunity to comment on the sixth draft of the State's Value Based Payment ("VBP") Roadmap. The New York State Conference of Blue Cross & Blue Shield Plans (NYSCOP) offer the following comments.

Contract Risk Review Process: P.22-23 and Appendix VI

The narrative on the Contract Risk Review Process on page 22 contains language that appears to differ from the Regulatory Impact Subcommittee recommendations. We suggest the following clarifying edits:

- Page 22, "Overview" Section: The first sentence of the third paragraph should be revised to make clear that Tier 3 only contains prepaid capitation arrangements that are currently subject to Reg 164. In this regard, the first sentence of the third paragraph of this section should be deleted in its entirety and replaced by the following:
 - "The third Tier will be comprised solely of prepaid capitation arrangements that are currently subject to DFS's Regulation 164, and will continue to be reviewed and approved by DFS in accordance with the terms of Regulation 164."
- Page 22, "Multi-Agency Review Tier (Tier 3)" Section: The references to Tier 3 containing fee-for-service arrangements is ambiguous and may be subject to varying interpretation. In addition, the types of prepaid capitation arrangements subject to Regulation 164 should be clarified. The Regulatory Impact Subcommittee did not discuss the DFS reviewing any arrangements other than prepaid capitation arrangements otherwise subject to Reg 164. As such, the inclusion of language allowing DOH to request DFS review for non-Reg 164 arrangements is inappropriate and should be removed. Related to this, we request that language that allows DOH to do its own

financial review in addition to DFS should be removed. Accordingly, to be more consistent with the recommendations of the Regulatory Impact Subcommittee, we request that the entire subsection called “Multi-Agency Review (Tier 3)” be revised as follows:

- “Multi-Agency Review (Tier 3)”

The Multi-Agency Review Tier (Tier 3) includes all contracts containing prepaid capitation arrangements currently subject to DFS review and approval pursuant to DFS’s Regulation 164. Consistent with Regulation 164, contracts containing prepaid capitation arrangements of less than \$1 million during any consecutive 12 month period are exempt from Regulation 164 and, therefore, not subject to Tier 3 financial review.

DFS shall conduct a financial review for all contracts in this Tier. DOH will conduct a programmatic review for all contracting arrangements within this Tier.”

- Page 22, “DOH Review Tier (Tier 2)” Section: The dollar thresholds (i.e., payments “less than \$250k” but “more than \$1M”) should instead read “more than \$250k” but “less than \$1M”. Also, the use of the term “fee-for-service payments” in conjunction with references to prepaid capitation are not correct. As such, we suggest that the first sentence of this section be revised as follows:

- “DOH Review Tier (Tier 2)”

The DOH Review Tier (Tier 2) includes VBP Level 2 contracting arrangements and VBP Level 3 contracting arrangement other than prepaid capitation arrangements (e.g., bundled payments) of more than \$1 million in annual payments where at least one of the following is true: ...”

New Chronic Care Bundle and Integrated Primary Care Definition: P.14, 37, 43

The new “all or nothing” approach to the chronic care bundle and Integrated Primary Care contract, that now requires that all fourteen bundles be contracted together under the chronic bundle and be offered under the IPC arrangement as well, will make contracting for chronic conditions and IPC exceedingly more challenging as many providers are unable to reasonably assume risk for all fourteen conditions. It is our view that it would be far more preferable for providers and plans to have the flexibility to enter into a VBP arrangement for one or a subset of the chronic conditions, consistent with the overall theme of the Roadmap until this recent update. Providers and plans should be free to work out mutually beneficial arrangements around one or more bundles without being forced to accept risk for all 14 simultaneously. This approach may lead to arrangements that take on more risk than providers are capable of assuming at this early stage.

P.84-Innovator Program-Participation Criteria-MLTC Subpopulation

We request that the MLTC sub-population recommended contract number be changed to 5,000 to make it consistent with the other sub-populations. It is not clear why there would be a

distinction among the sub-populations. At a minimum, this issue should be decided by the MLTC CAG. The Roadmap should not include a recommended “standard” number but leave it to the CAG to decide.

P.85-Innovator Program-Maintenance and Contract Termination/Program Exit Criteria

The Roadmap provides: “In a Level 3 arrangement, the VBP contractor will share in any costs or penalties imposed on the health plan, if the contractor’s failure to meet quality standards negatively affects the health plan’s quality scores. If a provider operates at a loss so that the costs exceed the percent of premium paid by a health plan, the provider will not have any recourse against the health plan or any of its members.”

- Comment: The Innovator Program should include a number of standard contract clauses including the provider assuming risk for poor QARR performance, with flexibility for the parties to negotiate the specific terms. Likewise, both MCO and member hold harmless clauses should be included in the contract, regardless if it is a level 2 or 3 Innovator arrangement. These points should be clarified in this section.

I hope you find these comments helpful. Thank you for the opportunity to provide feedback, Please feel free to contact me if you should have any questions.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Sean Doolan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Sean Doolan, Esq.

On Behalf of the New York State Conference of Blue Cross & Blue Shield Plans



Hospice & Palliative Care Association of NYS

2 Computer Drive W., Suite 105

Albany, NY 12205

Ph: 518-446-1483 ■ Fax: 518-446-1484

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HOSPICE AND PALLIATIVE CARE ASSOCIATION OF NEW YORK STATE

Comments on First Annual Update of the Value Based Payment Roadmap April 18, 2016

Thank you for the opportunity to offer comments on the First Annual Update of the Value Based Payment (VBP) Roadmap “A Path Toward Value Based Payment: Annual Update (June 2016: Year 2). The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the work of the Department of Health to develop an innovative approach to reforming the health care system. Hospice and palliative care embody the Triple Aim—patient-centered, quality, cost-effective care. Using an interdisciplinary model, hospice and palliative care provide case management and quality patient centered care—they are the perfect partners to help advance the DSRIP’s objectives, and they bring great value to the Performing Provider Systems (PPS’s). Indeed, 11 of the 25 PPS’s have chosen to include palliative care project.

In addition, it is reassuring to see that the Roadmap is beginning to see the value of including palliative care, especially under the “Chronic Care Bundle” section of the Roadmap. Quality palliative care to treat chronic illnesses such as Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure (CHF) can be extremely beneficial to patients and also very cost-effective in general. Coupled with hospice care, itself a “bundled care” model (interdisciplinary model of care) for patients at the end of life. While the Roadmap begins to incorporate hospice care, we continue to urge an increased incorporation of hospice care in the Roadmap in the future. New York State ranks 49th in the nation in the percentage of people who receive hospice care at the end of life. We outrank most states in health care costs in the last year of life, and in the percentage of persons with chronic diseases who are hospitalized each year. Taking steps to increase access to hospice and palliative care would help to address these distressing facts.

We understand that the Roadmap is intended to be a living document, and that many details will be added and changed moving forward. **Hospice and palliative care services can and should play a much larger role in improving the health care delivery system (than has so far been recognized by the DSRIP process).** We urge the New York State Department of Health to continue integrating palliative care and hospice into the Value Based Payment (VBP) Roadmap.

We stand ready to work closely with DOH and would appreciate having HPCANYS become a member of the VBP Workgroup moving forward. I would also be happy to meet with you to further discuss how hospice and palliative care providers can play a stronger role in achieving the goals of the DSRIP program. Thank you for your consideration.



Contact Information:

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www.facebook.com/HPCANYS

<https://twitter.com/HPCANYS>



MEMORANDUM

TO: Christina Papirnik
FROM: John Ruge
RE: 2106 VBP Roadmap Review
DATE: March 31, 2016

Christina—

I want to thank you, DOH staff, and the KPMG crew for providing the opportunity to review and comment on the draft VBP Roadmap that will be transmitted to CMS in June. Just to be clear, I have appreciated participating in the VBP Workgroup and can only marvel at how much I have learned by reviewing this new document. Let me proceed page by page with a set of comments, suggestions, and queries.

Page 5—At the bottom of this page, it is stated that a separate policy discussion will determine the future of payment reform concepts. By way of a query, has the locus for this policy discussion been determined? (This is a discussion I would not like to miss!)

Page 9—The chart at the top of this page labelled “New York State’s Vision on Advanced Primary Care” is outdated. The Integrated Care Workgroup has moved away from the concept of Premium APC and instead has a model with gateways and milestones. I am attaching a copy of the page that may be relevant for insertion in the roadmap.

Page 14—Here is a simple textual edit. I think the fourth paragraph should start with “As with IPC” rather than simply “With IPC.”

Page 18—The chart on Page 18 poses, at least for me, a brainteaser with respect to how VBP For Integrated Primary Care relates to that for Total Care for the General Population. In the earlier narrative, it is made clear that savings and rewards generated by IPC will derive from the impact on downstream providers. In this chart, however, Level 3 VBP payment for IPC indicates a PMPM capitated payment for primary care services. How, based on this description, are downstream savings to be calculated and distributed? It would seem that Level 3 payment for IPC is more confined and constricted than level 2.

Page 47—This page cites both VBP Pilots and the Innovative Program and specifically refers the reader to Appendix IX for a description of the “full design” of the Innovative Program. Nowhere can I find a similar overview or rounded description of the Pilot Program. Should not such a description be provided?

RE: 2106 VBP Roadmap Review

Page -2-

03/31/16

Finally, just to prove that I am a born copy editor, on Page 12 in the first line of paragraph four, “Advance primary care” should read “Advanced primary care.”

Let me close by again thanking everyone involved with the opportunity to weigh in.

John Ruge

Attachment



hrhcare.org

Executive Office
1200 Brown Street
Peekskill, NY 10566
914.734.8600

April 18, 2016

To Whom it May Concern:

I am pleased to submit comments on the Value Based Payment Roadmap on behalf of Hudson River Healthcare (HRHCare), a network of over 30 federally qualified health centers located throughout the Hudson Valley and Long Island that provide comprehensive primary, preventive, behavioral, and oral health care services to 150,000 patients annually. We commend New York State's vision for moving the vast majority of Medicaid payments to structures that incent value over volume and enhance the continuum of integrated services for patients.

HRHCare has attained 2014 PCMH Level 3 designations at all eligible sites, runs the largest Health Home in New York state, and is an active participant in New York state's only community health center-led Medicare ACO. Given our commitment to clinical innovation, experience supporting care coordination through the health home, and familiarity with value based payment, we believe our system is uniquely poised to participate in many of the models set forth in the roadmap. And while we applaud the overall direction the roadmap, we wish to raise several significant comments and concerns:

Integrated Primary Care

In addition to delivering primary care, HRHCare is in the process of implementing the IMPACT model for depression care at all sites. HRHCare is also a founding member of two IPAs that include joint governance between primary care and behavioral health providers as a means of deepening the collaboration that underlies integration approaches. While we think our network embodies the type of advanced or integrated primary care (IPC) the state is seeking to promote, we would need additional information to evaluate whether the reimbursement structure is feasible.

In particular, we believe it is of utmost importance to further define how participating entities would access savings associated with, "so-called 'downstream' costs: expenditures across the total spectrum of care that would be reduced when the PCMHs/APCs would be functioning optimally." As it is written we are uncertain if participating entities would receive a portion of shared savings associated with those reduced costs – our strongly preferred option if the portion is calibrated in a fair manner -- or simply bonus payments if ED/inpatient utilization rates are reduced.

We also question why the roadmap requires entities participating in IPC "to notify downstream hospitals of...intent to negotiate value based agreements with an MCO" and recommend removing this provision. We are concerned at

that hospitals bear no such notification responsibility to other health care entities in a geography. We also fear that this notification obligation before arrangements have been finalized confers a competitive advantage to hospitals that may be in the midst of their own negotiations with the same managed care entities.

Finally, the roadmap states that “as is the case today, IPC contracts...can tie additional rewards to progression towards APC status.” We believe that additional discussion and clarification should be offered on the alignment between integrated primary care and the APC paradigm. For example, what is the reimbursement level or type that would correspond to each of the APC gates being considered by the New York Department of Health Integrated Care Workgroup; how do the quality metrics under consideration by that group correspond to quality metrics that might mediate payments under value based models advanced in the roadmap?

Shared Savings with Hospitals

Several portions of the roadmap indicate that non-hospital entities that contract with managed care entities under integrated primary care arrangements, chronic bundled payments, and total cost of care arrangements must share a portion of any savings they attain with hospitals. We would point out that in similar value based payment arrangements at the federal level, such as the Medicare Shared Savings Program, there is no such requirement that providers much share savings with healthcare entities that are not a part of the participating provider network.

While we are troubled by the policy, we do applaud the fact that the roadmap will require hospitals to meet certain criteria to access savings, but suggest the following additions and modifications:

- **Clarify the definition of associated/downstream hospital for the purposes of accessing shared savings**
- **Enable value-based payment contractors to have flexibility in defining the thresholds for hospitals to meet in order to access shared savings** (for example, as written, there are several options to access shared savings related to palliative care, care transitions and we suggest that vbp contractors make the determination of what is most relevant)

Health Homes

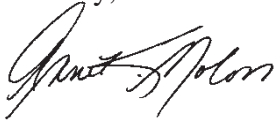
HRHCare is running New York State’s largest health home, the CommunityHealth Care Collaborative, and like many providers across the state has devoted significant resources to supporting this important program for coordinating the care for the most complex Medicaid beneficiaries. Given the focus of the Health Home program and the resources invested statewide, **we urge more affirmative guidance and commentary from New York state on how the Health Home model fits into the VBP models discussed in the roadmap.** Such clarity could involve discussing what the health home model is meant to reimburse for and any supplemental care management or disease management services outside of the health home model that typically undergird value based arrangements. We would also welcome thoughts on how within the VBP context, Health Home care management fees might be adjusted upward on the basis of

quality performance.

Thank you for your consideration. Should you have any questions, please feel free to contact me or my staff, Hope Glassberg, Vice President of Strategic Initiatives & Policy

[Redacted]

Sincerely,

A handwritten signature in black ink, appearing to read "Anne Nolon". The signature is fluid and cursive, with the first name "Anne" and last name "Nolon" clearly distinguishable.

Anne Nolon, MPH
President & CEO

My name is Kathryn Haslanger and I am the CEO of JASA, one of the region's leading non-profit providers of housing, home care, and community-based social services to 43,000 seniors in New York City and Long Island. JASA's mission is to enable older adults to remain in the community as they age, connected to the people, places, and activities that give them meaning.

Thank you for the opportunity to comment on this very comprehensive and sophisticated roadmap toward payment reform. We also appreciate the opportunity that has been provided for stakeholder involvement in developing and refining the roadmap.

My comments focus on one particular aspect of the roadmap: total care for special needs subpopulations, specifically the MLTC population. MLTC members are the people with whom we have the most direct contact and knowledge, and MLTC's are the aspect of the delivery system with which we have the most extensive interaction. JASA is involved in DSRIP and is aware of the PPS activities in our downstate service areas.

The roadmap asserts that it is building on the infrastructure that DSRIP puts in place, yet the MLTC population and key services have not been a focus of PPS efforts and we are already into DSRIP year 2. Long term care services have received very little investment. JASA's CRFP award, for which we are extremely appreciative, was one of the very few capital grants directed toward community-based services for the aging population. As a result, it is difficult to see what the DSRIP investments and related results are likely to be for this population and these services, since they have been largely left out of the DSRIP conversation up to this point (despite our attendance at countless hours of meetings and review of endless technical documents, none of which has been supported with implementation funding). If DSRIP is/was to be the source of the investments needed for VBP to succeed for MLTC providers and members, this gap presents a serious concern.

The roadmap's goal of rewarding MLTCs for their performance on potentially avoidable hospital use is important because as a policy matter it aligns incentives in a manner that can make a positive difference for MLTC members and addresses a key policy shortcoming of the partial capitation model. Yet, we are deeply concerned about how this will be operationalized, particularly as it is to be accompanied by "performance adjustments" in health plan premiums to reflect efficiency. It is positive that the Department plans to refine the current risk adjustment methodology for MLTCs because the current methodology does not adequately recognize and reward services to the most complex MLTC members with the most extensive needs. To avoid harm to New York's most vulnerable older adults, it is essential that the Department address shortcomings in this methodology affecting high-cost high-need members. Until the Department remedies this problem, we have serious reservations about plunging ahead into the further complexity of VBP and performance adjustments for this population.

Our concerns about the adequacy of MLTC premiums are compounded by the multiple and continuing delays in State payments for state and federally mandated cost increases for licensed home care agencies, which provide the lion's share of services to MLTC members. As I write this, JASA has yet to receive payments for the wage parity requirements which were authorized in 2014. We are a unionized agency meeting all of the requirements. We have just begun to

receive payments for the FLSA overtime and other requirements that went into effect in October 2015. We are unclear how and when rates will be adjusted to address the recently enacted increase in the state minimum wage. Together, these delays create financial stress and uncertainty in the very sector that is at the heart of policy changes intended to decrease institutional days and increase the number of good days that New York's aging adults are able to spend in the community.

The Roadmap calls for pilots that will not start before 2017. We urge the Department to address the underlying problems in home care and MLTC payment and to identify and adequately fund the necessary investment to support service delivery reform in this sector before embarking on VBP pilots. VBP can be a valuable tool in supporting quality care, but this promise can be realized only if it builds on a strong foundation and the current shortcomings are remedied.

Respectfully,

Kathryn Haslanger

--

Kathryn Haslanger
Chief Executive Officer
JASA
247 W. 37th Street
New York, NY 10018



www.jasa.org

Comments on the State Health Roadmap on Value Based Payments (VBP)
www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_workgroup.htm
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/roadmap_third_draft.pdf

Summary -- based on the concerns that are raised below and the great uncertainty about the VBP proposals in this document, the state should go back to the drawing board and expand the involvement in discussion and decision-making on a remodeled proposal that could meet the needs of all residents in the state, particularly the most under-served residents and communities. Although this complex proposal is not always clear, worries about the impact should be seriously considered.

Introduction

Thank you for the opportunity to comment on a very complex proposal that needs a great deal more exposure and explanation for the public to get a sense of and understand what is being proposed and what impact it will have on the person, the person's family, and the person's community. We understand that this proposal is the beginning of a proposal to dramatically change the way that health care providers will be paid for providing services. Such a dramatic change requires a great deal of public exposure and discussion before approving any parts of this proposal.

People have said that there was broad and comprehensive involvement in the development of this plan. This is true only if you are a regular Health Department person for appointment and/or an Albany insider. For example, a list of the membership was circulated to major health advocates in the borough of Brooklyn with a request to review the list for identification. The response was basically non-recognition, along with questions and concerns about how little representation there was of persons of color and immigrant communities. It is said that the committee membership was fluid and people could join by coming to the meeting. Knowledge of committees, and their meetings, was again limited and not generally known.

At one point, concerns were raised by community health advocates about what seemed to be missing from the considerations of the Social Determinants of Health -- primarily missing was concerns about race, ethnicity, language spoken, and immigrant status and how these factors influence access to care and outcomes. The disparities and inequities in health care have a dramatic impact on people, yet these considerations do not seem to have been addressed. Several non-members of the committee were invited to attend a meeting to raise our concerns. The lack of community at the table was very disturbing, where there was only one person of color attending the meeting. We also understood that the committee recommendations -- no matter how good they may be -- were subject to review by the larger body heavily populated by providers.

The concerns raised above are critical. The New York State history regarding development of reimbursement methodology for health care funding, is very troubling. There is definite discrimination, both intentional and perhaps unintentional, in the way that dollars are distributed within the health care field. There is a pattern of public money flowing to Academic Medical Centers and large private hospitals, and much less to safety net provider community based services and public and community hospitals. This helps to create at least two classes of care with less funding traditionally being provided in low-income, immigrant and communities of color - many of which are neighborhoods that are medically under-served and in need of more, not less, services. Therefore major changes in the way that

health care providers are reimbursed must be closely scrutinized and evaluated as to the impact on communities and people in need.

What are the federal requirements for VBP.

DSRIP, and therefore VBP, is subject to the Terms and Conditions negotiated by the State and the Center for Medicare and Medicaid Services (CMS) that allowed for New York State to embark on a major plan to transform the health care system, and reduce unnecessary hospitalizations and Emergency Room visits by 25% over a five year period. In developing the Value Based Payment system, the Terms and Conditions mention the following:

- 1 What approaches MCOs will use to reimburse providers to encourage practices consistent with DSRIP objectives and metrics, including how the state will plan and implement its stated goal of 90% of managed care payments to providers using value-based payment methodologies.
- 2 How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
- 3 How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.
- 4 How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
- 5 How the DSRIP objectives and measures will impact the administrative load for MCOs, particularly insofar as plans are providing additional technical assistance and support to providers in support of DSRIP goals, or themselves carrying out programs or activities for workforce development or expansion of provider capacity. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with DSRIP funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
- 6 How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
- 7 How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by DSRIP, including how up to date data on these matters will be incorporated into capitation rate development.

In reviewing the list above, and after reviewing the proposal, it is not clear that these conditions were met.

Specific Comments

Based on this report, it is very difficult to understand what is being proposed and how it would work. It appears that the HMO's will be the critical linchpin around which money and service delivery will meet. Much decision-making will be left to the HMO's. What accountability will there be in the delivery of care and the public reporting on the delivery of that care? We know from history that managed care is one way of limiting access to services, often but not always, unnecessary services. In for profit HMO's, will decisions be made by the market and the bottom line profit.

It is widely acknowledged that community-based primary care is the most important service that can be provided to many patients. We also know that there are many communities that are under-served and are in need of additional services. This report does not make clear that priority will be given to fostering and developing the needed services, particularly in the most medically under-served communities across the state. The Federally Qualified Health Centers are a critical part of the delivery system. In addition to focusing on providing

primary care, they are for the most part also more a part of their community and understand that the social determinants of health are an important part of their patients' lives and therefore provide broader services. The FQHCs receive wrap-around dollars for the additional services. Will this continue to ensure that they will keep this higher reimbursement to maintain the services they provide so well? Again this report is not clear. Many of the FQHC's incorporate working in their communities to address the social determinants of health and should be rewarded for this.

In the report, page 8 states: "Different types of patients require different types of care." We agree but it is not at all clear that this plan takes into consideration the differences. Relying on managed care organizations to be the pivotal organization in VBP, raises questions about caring for special and vulnerable populations. How will the funding be done to acknowledge different patient care needs? The state has spent years developing managed care programs for special populations and not all work. How will the special populations be served in a new VBP system?

Page 41 begins to address the social determinants of health and calls for VBP contractors to be required "to implement at least one social determinant of health intervention." Contractors will be able to decide on the type of intervention. Although there are suggestions on what to consider in making this determination. What does not seem to be required is a discussion with and involvement of residents, houses of worship, community-based organizations to determine priorities. The one selected social determination of health may not address any of the most crucial problems/issues in the community.

The very critical issue of contracting with community-based organizations finally appears on page 45 of this document. "...it is also critical that community-based organizations be supported and included in the transformation. There is a proposed requirement "...that starting in January 2018, all Level 2 and 3 VBP arrangements include a minimum of **one** Tier 1 CBO. Tier 1 is defined as non-profit, non-Medicaid billing CBO's in social and human services. Tier 2 is defined as non-profit, Medicaid-billing clinical and clinical support services licensed by state agencies.

Judy Wessler



April 18, 2016

Jason Helgerson
Deputy Commissioner and Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Albany, New York 12210

Marc Berg, M.D., Ph.D.
KPMG, LLP (US)
15 Broadway
Albany, New York 12207-2974

Via E-Mail

Re: Value-Based Payment Roadmap Update

Dear Messrs. Helgerson and Berg:

I am writing on behalf of LeadingAge New York to provide comments on the June 2016 Annual Update to the New York State Roadmap for Medicaid Payment Reform.

We commend the State for its comprehensive vision for transformation of the delivery system and the payment models that sustain it. We also appreciate the State's extensive efforts to engage stakeholders in the development of the Roadmap through subcommittees and clinical advisory groups (CAGs).

We are concerned that the unintended effect of the Roadmap, together with DSRIP Performing Provider System (PPS) funding priorities, is to further deplete funding of long-term/post-acute care (LTPAC) services. Clearly, the focus of State and federal Medicaid investments under DSRIP, and the reinvestment of Medicaid savings through value-based payment (VBP), is on primary, acute and behavioral health care services. With the benefit of upfront capital and infrastructure investments and incentive payments under DSRIP, the Roadmap creates feasible opportunities for providers of primary, acute and behavioral health care services to reap the rewards of reinvested savings. The same cannot be said of LTPAC providers.

While the State has moved quickly to address the infrastructure, capital and operating needs of primary, acute and behavioral health care providers, it has not invested resources to address the same challenges confronting LTPAC providers. The LTPAC sector is struggling to adapt to dramatic changes in the organization and financing of LTPAC services under both Medicaid and Medicare, in the face of flat funding, rising labor costs, and workforce shortages. LTPAC and senior services providers are expected to participate in a health care transformation, implementing innovative models of care and payment, and developing the physical, clinical, technical, and administrative infrastructure to do so. However, neither the State nor the federal government has made available the funding necessary to develop the infrastructure in the LTPAC and senior services sector to do so.

As you know, based on the funds flow projections submitted by each of the PPSs, only 4.2 percent of PPS payments are projected to be allocated to nursing homes over the five-year waiver period, and only 1.1 percent is expected to flow to hospice programs. Only 3.6 percent of the PPS payments is projected to be distributed to community-based organizations over five years – presumably a portion of these funds would be allocated to home care agencies.

Similarly, capital investment associated with DSRIP has been focused on the primary and acute care sectors, to the exclusion of LTPAC services. Only 1 percent of the Capital Restructuring Financing Program and Essential Health Care Provider grants were awarded to LTPAC providers.

The State's VBP Roadmap proposes to use payment reform to create a pathway for reinvestment of the savings realized by DSRIP in the delivery system. However, we are concerned that the payment models currently proposed will not result in the reinvestment of any savings in the LTPAC delivery system. In fact, they may result in further depletion of funding in LTPAC, if penalties are imposed on managed long term care (MLTC) plans that are not able to ramp up their VBP contracts quickly enough to meet the State's ambitious goals.

As we've noted previously, MLTC plans and their network providers play an important role in reducing avoidable hospital use and generating savings for the Medicare program. The best way to realize significant savings for reinvestment under current programmatic constraints is to pool Medicare and Medicaid dollars for duals in long-term care settings. Unfortunately, the Roadmap Update does not reflect progress on the State's proposal to align Medicare and Medicaid incentives and pool savings.

We appreciate the State's willingness to reward MLTC plans and providers for reducing avoidable hospitalizations through a pay-for-performance arrangement that would qualify as a Level 1 VBP arrangement. ***However, if the performance incentives are funded solely through withholds from rates, rather than new funding, the proposed arrangement will not create any new revenue for the LTPAC system and will not address existing funding shortfalls for the sector. Moreover, a VBP arrangement funded exclusively through withholds runs the risk of further destabilizing struggling providers, and runs counter to the basic assumption that VBP will make new revenues available for investment and operational support.***

We also appreciate the Roadmap's recognition that "[p]ayment reform principles should include operational feasibility." However, we question whether operational feasibility has been considered in the MLTC arena. As we've indicated to the MLTC CAG, by requiring that any on-menu VBP arrangement for MLTC plans include "[a]ll services covered by the associated managed care plans," the Roadmap demands that providers contract through a large, multi-specialty IPA or ACO that includes not just LTPAC services, but also dental, optometry, podiatry, and soon all Medicaid services. While IPAs and other affiliations are growing in the LTPAC sector, they typically do not involve the entire continuum of care. It is unlikely that such multi-specialty entities could come together and integrate sufficiently to engage in joint contracting for the entire benefit package within the three-year time frame anticipated, particularly in the absence of any public investment in this infrastructure.

Given the complexity of creating the on-menu options for MLTC plans envisioned by the Roadmap, we expect that providers and plans will advance off-menu proposals. This may result in administrative burdens for the State, providers, and plans and delay implementation of VBP arrangements.

With these fundamental concerns in mind, we would like to raise the following more granular issues:

- On page 18, the Roadmap contains a key chart describing the various VBP models and levels. The “Total Care for Subpopulation” row identifies “FFS with bonus/withhold for quality” should qualify as Level 0. However, in the box on page 19, the Roadmap states that pay-for-performance arrangements for reductions in avoidable hospitalizations would qualify as Level 1. These two pages are inconsistent, and our understanding all along had been that such MLTC payment arrangements with LTPAC providers would be treated as Level 1. Without this interpretation, the 80-90 percent VBP Level 1 penetration goal for 2019 appears to be unattainable.
- We appreciate the State’s commitment to transparency in the managed care contracting process. We assume that this commitment extends to the MLTC contracts as well. In addition, it is important to incorporate the lengthy CMS approval process in contract planning in order to avoid retroactivity and facilitate the attainment of VBP goals.
- The Roadmap references attribution of MLTC members to a home care provider or nursing home (depending on the residential status of the member). However, this anticipates a recommendation of the MLTC CAG, which has not yet issued recommendations. We recommend that MLTC VBP on-menu options permit attribution to adult day health care programs, as well as home care agencies, for members who live in the community. Once Assisted Living Program (ALP) residents are enrolled in MLTC plans, the home care agencies associated with ALPs should receive attribution of their residents as well.
- We are concerned about the proposed penalties on MLTC plans (which can be passed down to providers) for failing to meet threshold percentages of VBP payments at Level 2 or higher beginning in 2019 (we are assuming that pay-for-performance would qualify as Level 1). MLTC pilots are not anticipated until 2017. Given the complexity of the on-menu arrangements proposed, and the lack of public investment in the necessary infrastructure to date, it is unrealistic to expect significant engagement of MLTC plans and providers in risk-sharing arrangements by 2019.

Finally, we applaud the Roadmap’s recognition that housing is health care. The Roadmap’s commitment to offering a “stable, safe, and accessible housing environment” is commendable. In addition to prioritizing housing for homeless New Yorkers with mental illness, we ask that the State also commit to developing affordable housing with supports for senior citizens. With current waiting lists for affordable senior housing of 7 to 11 years in many communities, a substantial expansion of capacity is needed to address growing demand. Housing with supportive services for seniors can help seniors to age in place and delay or avoid nursing home placement.

We would like to reiterate the comments and regulatory reform recommendations we have advanced in the MLTC CAG and have attached them for your reference. Thank you for the opportunity to provide these comments. Please don't hesitate to contact Dan Heim or me with any questions.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'KLipson', with a stylized flourish at the end.

Karen Lipson
Executive Vice President for Innovation Strategies

cc: Mark Kissinger
Margaret Willard
Dan Heim
Sean Doolan



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April 18, 2016

MEMORANDUM

To: Christina Papirnik, Senior Associate, Advisory
KPMG LLP

From: Joe Baker, President
Krystal Scott, NYS Policy Director
Medicare Rights Center

RE: First Annual Update to Value Based Payment Roadmap

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to participate on the New York State Department of Health (NYSDOH) Value Based Payment (VBP) Workgroup and welcomes the opportunity to provide brief comments on the first annual update to the Value Based Payment Roadmap. While we understand that VBP arrangements are targeted for Medicaid providers and recipients, many of those individuals who currently have Medicaid either have Medicare coverage as well (i.e. the “dual eligibles”) or are nearing Medicare eligibility. As such, Medicare Rights finds it especially important that healthcare for dual eligibles and those Medicaid recipients nearing Medicare enrollment is improved as a result of the New York State VBP Initiative, and we are pleased to see that the Roadmap includes information related to how the State plans to coordinate VBP with Medicare.

Medicare Rights believes that the NYS VBP Initiative—if implemented with appropriate safeguards—can allow NYSDOH to test a model that achieves the triple aim of enhancing consumers’ health care experience, improving population health, and reducing costs. We have supported the recently announced Medicare Advantage (MA) Value-Based Insurance Design (VBID) demonstration model developed by the Centers for Medicare and Medicaid Services (CMS), and we believe both the federal VBID demonstration and the NYS VBS Initiative reflect careful consideration of many important consumer protections and have the potential for increasing quality of care for both Medicare and Medicaid enrollees.

Our comments below highlight the areas of the Roadmap that we support and identify opportunities for further strengthening consumer protections. These recommendations draw from our experience counseling New Yorkers who call our helpline with questions about their coverage, including their attributions to Accountable Care Organizations (ACOs), their decisions regarding sharing their personal health information to providers with the Delivery System Reform Incentive Payment (DSRIP) program, and their experiences navigating managed care. We also support comments submitted by both Medicaid Matters New York (MMNY) and Health Care For All New York (HCFANY).

Again, we thank NYSDOH for the opportunity to participate on the VBP Workgroup and provide comments on the Roadmap.

Coordination with Medicare

We are pleased that NYSDOH is committed to aligning payment reform efforts for Medicare to the NYS Medicaid Payment Reform Roadmap. We agree that this alignment may create opportunities for significant benefits, including increasing opportunities for shared savings and reducing risk of provider “distraction” caused by diverging payment models and incentives. Through our advocacy as the lead organization of the Coalition to Protect the Rights of New York’s Dually Eligible (CPRNYDE), we have seen where competing, albeit important care models, have contributed to the lack of provider participation on Interdisciplinary Teams within the Fully Integrated Duals Advantage (FIDA) program. Providers are increasingly required to choose how to divide time and resources between care models, and in our experience, providers and the health systems by which they are employed tend to devote more attention to models that increase quality for patients and involve shared savings, and less time on models that do not provide similar incentives. Based on our experience, we agree that coordinating Value Based Payment with Medicare could potentially be a good way to maximize efforts in FIDA and other programs for Medicare beneficiaries by aligning them with incentivized programs.

As the State continues to explore the framework for ensuring alignment of the goals for alternative CMS payment models in Medicare and Value Based Payments in Medicaid, we urge the State to consider the unintended consequence of reducing Medicare beneficiary choice and access to care by creating new and abstract “networks” in the Medicare program. Fee-For-Service Medicare beneficiaries are not held to a network of providers in order to access their healthcare services. And dually-eligible Medicare beneficiaries enrolled in managed care plans are afforded the ability to change those plan options on a monthly basis. As such, we believe Medicare beneficiaries should be informed when their participation in Value Based Payment may restrict their provider choice or cause them to go out of network. Whether beneficiaries are in Fee-For-Service Medicare or Medicare Advantage, we urge the State to ensure that all beneficiaries retain genuine access to providers of their choice.

To: Jason Helgersen, New York State Medicaid Director
From: Kate Breslin, President & CEO, Schuyler Center for Analysis & Advocacy
Charles King, President & CEO, Housing Works
Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services
Re: Comments on Value Based Payment Roadmap Annual Update
Date: April 8, 2016

Thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment Roadmap (the Roadmap). As you know, all three of us have participated actively in VBP deliberations and have chaired subcommittees – *Social Determinants of Health and Community Based Organizations* and *Advocacy and Engagement* -- supporting the VBP Workgroup.

The Roadmap adds important new concepts that we fully support, which are listed below. We have also commented on several areas, sometimes overlapping with the first category, in which the new language in the Roadmap raises some implementation concerns, which could be addressed by further explanation in this or a subsequent document. Finally, there are some concepts not included in the Roadmap which we strongly urge the Department to add.

I. Important New Concepts in the Update to the Roadmap

The Roadmap articulates this "Payment Reform Guiding Principle," which we support: "Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health." (p. 8)

We support several of the components of the section regarding "Incentivizing the Member," including the focus on positively incentivizing desired behavior and stating clearly that "burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option." (p. 38)

Recognizing that housing plays a critical role in a person's health, we support the Roadmap's commitment regarding the following:

- The State's plan to collect standardized housing data for purposes of rate setting and appropriate intervention research and analysis
- The State's plan to ensure coordination with Continuum of Care (COC) entities when considering investments to expand housing resources
- The State's goal of leveraging the Medicaid Reform Team (MRT) housing workgroup money to advance a VBP-focused action plan and submit a New York State waiver application to CMS that tracks the *CMCS Information Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. (p. 39)

While we support the content of the box on Housing and Vocational Opportunities (p. 39), we ask that this box be moved to a different section -- from *Incentivizing the Member to Public Health and Social Determinants of Health* (beginning p. 41). We would not want anyone to interpret placement to suggest that these should be used as patient incentives; rather, these are essential to achieving good health outcomes.

We support the State's plan to eliminate the \$125 incentive cap for incentive programs (the roadmap describes the current cap as applying to *preventive services*. We believe the reference should be to an existing cap on *incentive payments*. (p. 40)

We support the State's interest in measuring and encouraging creativity in incentive programs, specifically its plan to "analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publicly available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design." (p. 40)

We support the Roadmap's plan that Level 2 and 3 VBP contractors should be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)

The selection of the type of social determinant intervention to be implemented "should be based on information including (but not limited to): SDH **screening** of individual members, **member health goals**, the impact of SDH on their health outcomes, as well as an **assessment of community needs and resources**." (p. 42). We support this design - it is critical to be guided by individual members' own health goals and desires and community needs and resources.

VBP "contractors should also create a report explaining a measureable reason why the SDH was selected, and identify metrics that will be used to track its success. This could follow a similar process/procedure to that used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics, and reports back to the State." (p. 42) We fully support this.

"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO." (p. 42)

"The Advocacy and Engagement and Social Determinants of Health Subcommittees also recommended the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: a **taskforce focused on children and adolescents in the context of VBP...**" (p. 59). We strongly support a separate process to consider how to measure value for children, in the context of value-based payment. Though

there has not been discussion of the unique needs of children in VBP, the approaches being considered would be applicable to payment for services for children. To the extent that system transformation efforts currently underway aim to fundamentally change New York's health care delivery system, it is critical that we look closely at value from a pediatric perspective or risk creating a system that, by design, ignores the developmental trajectory of children.

II. Concepts in Need of Further Explanation or Strengthening

"VBP contractors who focus on health education, increased uptake of prenatal care, pre- and interconception counseling, adequate c-section rates and resource utilization, screening for post-partum depression and so forth have the opportunity to further improve maternity care outcomes while realizing shared savings." (p. 13). The Roadmap should note that contractors/subcontractors may likely be CBOs and could add reference to evidence-informed maternal/infant home visiting.

The Roadmap indicates that the PPSs/hubs that are not contracting entities should maintain infrastructure for population health, patient-centered integration and workforce strategy. (p. 16). Non-contracting PPSs will be well-positioned to contribute reports on the impact of VBP arrangements. However, reports on the impact of Medicaid VBP arrangements will be most valuable viewed in the context of other payer initiatives, including Medicare VBP and commercial arrangements. It will be important for the State to ensure that PPS reports and population health planning activities are integrated into broader community assessment and planning efforts, such as those generated by successful Population Health Improvement Programs (PHIPs). We recommend that the State explicitly recognize PPSs population health assessments as taking place in collaboration with other state-funded entities conducting broader health planning activities that include Medicare and commercial VBP arrangements.

The selection of the type of social determinant intervention to be implemented "should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (p 42). To make this meaningful, the Department will need to move forward with a plan to ensure that all members receive some type of SDH screening.

The State should also develop a process for the PPSs/hubs to utilize in developing the community needs and resource assessments required for selection of the social determinant intervention. Two points are important to keep in mind regarding the process for developing the community needs assessment. First, community needs assessments are best undertaken by neutral, independent entities that are not providing the services in question. Without neutrality, trust and community buy-in are difficult to develop and maintain. Without trust, reports on capacity and gaps in services may be less than complete and alignment between new initiatives and existing services will be difficult to achieve. Without community buy-in

regarding priorities, social determinant programs will fail to capitalize on potential synergies and lack critical momentum.

Second, as mentioned earlier, VBP arrangements for Medicaid services will of necessity operate in close juxtaposition with VBP arrangements for Medicare and commercial payers. Unless clinical programs share goals and milestones across payers, progress will remain erratic and uncertain. Thus, it will be critical for the PPSs/hubs undertaking community needs assessments and social interventions to coordinate with initiatives launched across payers.

“After a period of two to three years, the State will create a process, which would include an independent review of the role of the CBO, to determine whether the VBP providers are leveraging community based resources, identify best practices and determine if future guidance or technical assistance **or other resources** are (added) ~~is~~ needed to maximize utilization of community resources” (p. 42). We propose adding “or other resources.” In addition, we recommend that the State urge PPSs/hubs to partner with independent community planning entities, such as the PHIPs, to perform the review of the role of the CBO.

In the section on Quality Measures, the Roadmap references Category 1 and Category 2 measures, which have not yet been shared with the VBP workgroup. It is difficult to support this section of the Roadmap without having a sense of the measures that are being advanced by the CAGs in each category. (p. 34). It is important that quality measures capture the impacts of both under-treatment and over-treatment on health outcomes.

The Roadmap should also clarify that the CAG reports on categorization will be shared with the VBP workgroup and that the public will have a chance to comment on the measures actually adopted for reporting in drafts of the new model contracts. For example, the Roadmap states that “measures focusing on rehabilitation and individual recovery including housing stability and vocational opportunities...are as yet underrepresented.” The Clinical Advisory Group (CAG) on Behavioral Health has been working to identify metrics, both clinical and HCBS-related, but their work has not been integrated into the Update, and it is not clear if these essential metrics will be included in the revised model contract, the most definitive way to ensure MCOs are accountable for these metrics.

The Roadmap indicates that the state foresees including these metrics in the model contract, but fails to provide an opportunity to comment on the model contract before it is finalized, stating that that the model contract “will not be posted until it is approved by CMS.” In an earlier version of the recommendations from the Regulatory Subcommittee (SC), it stated that “after consideration of the comments from the SC, DOH will share the updated Model Contract with the public and solicit additional comments before finalization. DOH will post all of the received comments on the DOH website prior to the adoption the Model Contract.”

There should be a public comment period on the model contract before it is finalized, so that stakeholders have an opportunity to ensure the inclusion of metrics is representative of the successful work many are already engaged in.

A small number of CAGs will continue in Year 2, and new CAGs may be formed around additional priorities, such as Special Needs Children (p. 34). One or more CAGs focused on Special Needs Children is a good idea. This should not, however, substitute for a broader-focused task force that makes recommendations regarding value-based payment for children and adolescents.

The Roadmap makes reference to Patient Reported Outcomes (PROs) as a key missing link in assessing the outcomes of care for many health problems and conditions (p. 35). However a footnote to that reference appears to narrow use of PROs to FIDA, HARP and DISCO measures. The Roadmap's only other reference to PROs is in the section on social determinant interventions as a potential means of evaluating program success (p. 43).

PROs should not be restricted to social determinant programs or special populations. Validated PRO measures are now available in the public domain for use across a variety of clinical conditions and have shown success as a means of engaging patients in their care and informing care decisions. The footnote in the Roadmap should reflect the Advocacy and Engagement Subcommittee's recommendations that some form of PROs be considered by clinicians participating in VBP, and that VBP early adopter pilots serve as a vehicle for piloting the use of PRO measures in an assessment tool.

The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant in the VBP context. That is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it affects them. The Roadmap should reference some of the other important actions recommended by the Subcommittee that the State has committed to undertake, such as ensuring that plans and providers communicate information to consumers that explains the difference in incentives that payment mechanisms generate and the workgroup that will be created to develop a larger communication strategy. Consumer education and patient activation are needed around what is meant by a "high value provider," as well as their right to question their providers, seek a second opinion, and obtain consumer assistance/ombuds services. The State's Independent Consumer Advocacy Network and any and all consumer assistance/ombuds programs should be equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment. More specifically, the State should expand the Ombuds Program for people with Medicaid long-term care services to include all Medicaid members in VBP initiatives.

III. Important Concepts that Should be Added to the Roadmap

The following recommendations were included in the approved subcommittee reports. We endorse them and would like to see them reflected in the Roadmap:

In New York State, current contracts that are in place between the providers and MCOs provide a strong incentive for the MCOs to offer technical support to the provider, given the potential financial benefit to both parties. In addition to the support that MCOs can provide, healthcare

providers participating in DSRIP have the ability to use program funds to employ third party services for further education and technical support on VBP arrangements. Providers may also seek assistance within their PPS. Though the development of a standard or guideline is not recommended at this time, the State, PPSs, MCOs and providers will collectively monitor whether action or additional guidelines may become necessary in the future.

The State and/or a third party should develop educational materials on VBP that focus on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks and MCOs. Additionally, the State and/or a third party should provide technical assistance for the providers/provider networks and MCOs (non-CBO) contracting entities on how to work effectively with CBOs needing assistance. In addition, the State should explore mechanisms for how it could assist and support CBOs if payment or cash flow issues arise.

The State should create a "design and consultation team" of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support in a way that is affordable to CBOs who are either involved or considering involvement in VBP.

The State should invest in CBOs that show promise in helping to address social determinants of health. This investment could include infrastructure, data capacity, contracting, etc. State funding should be made available to CBOs to help prepare them for their participation in VBP arrangements. CBOs will need funding for: infrastructure development, including IT systems; ability to do measurement and data collection to demonstrate their value; contracted services, such as fiscal and legal expertise; among other things. In addition, the state should establish a loan fund to assist with cash flow issues that may arise if payment to CBOs in VBP arrangements is delayed.

The State should explore the development of payment methodologies that incentivize/reward providers for taking on patients with challenging social determinant of health barriers.

Finally, the State should assess its economic development initiatives against health goals. A community thrives when its residents are healthy.

We would also like to endorse the recommendations submitted by CHCANYS. Thank you for this opportunity to comment and to participate as a workgroup member in this important undertaking.



Additional Comments Regarding the Draft Annual VBP Roadmap

On behalf of the New York Association of Psychiatric Rehabilitation Services (NYAPRS), I'd like to thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment Roadmap (the Roadmap).

While our comments are included in the document sent to you from SCAA and Housing Works, I'd like to give special emphasis to the following. We strongly support:

- the inclusion of financial incentives to both providers and beneficiaries, in the latter case removing the \$125 cap and encouraging creativity in the scope and nature of such incentives.
- the underscoring of employment as well as housing as key factors to achieve improved population health
- the requirement that Level 2 and 3 contractors implement at least one intervention to address a social determinant and that managed care organizations (MCOs) share in the costs and responsibilities of the investment.
- the expectation that the State will create a process, which would include an independent review of the role of the CBO, to determine whether the VBP providers are leveraging community based resources, identify best practices and determine if future guidance or technical assistance is needed. *We propose adding "or other resources," after the word "assistance," since additional resources may very well be needed. In addition, we recommend that the State urge PPSs/hubs to partner with independent community planning entities, such as the PHIPs, to perform the review of the role of the CBO.*

Items that Should be Clarified or Added to the Roadmap

- The Clinical Advisory Group (CAG) on Behavioral Health has been working to identify metrics, both clinical and HCBS-related, but their work has not been integrated into the Update. It is essential that these critically important metrics be included in the revised model contract, the most definitive way to ensure MCOs are accountable for these metrics.
- PROs should not be restricted to social determinant programs or special populations
- The State should expand the Ombuds Program for people with Medicaid long-term care services to include Medicaid members enrolled in all current or emerging VBP initiatives.
- It should be clear that MCOs should offer technical support to CBOs and that healthcare providers participating in DSRIP have the ability to use program funds to employ third party services for further education and technical support on VBP arrangements. Providers should also be able to seek assistance within their PPS.

- The State and/or a third party should develop educational materials on VBP that focus on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks and MCOs. Additionally, the State and/or a third party should provide technical assistance for the providers/provider networks and MCOs (nonCBO) contracting entities on how to work effectively with CBOs.
- The State should create a "design and consultation team" of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support in a way that is affordable to CBOs who are either involved or considering involvement in VBP.
- CBOs will need funding for infrastructure development, including IT systems (e.g. ability to measure and collect data to demonstrate their value), contracted services (e.g. fiscal and legal expertise), and other areas needing assistance. In addition, the State should explore mechanisms for how it could assist and support CBOs if payment or cash flow issues arise.
- The State should ensure that information concerning VBP and how it varies from FFS is communicated effectively to Medicaid members. The State should communicate general information about new structures and incentives under VBP. MCOs or ACOs should communicate more specific information about VBP and FFS programs their members are enrolled in.
- Community needs assessments should be undertaken by neutral, independent entities that are not providing the services in question.

Thanks very much for the opportunity for me and our NYAPRS board members and staff to participate on the various work groups and Steering Committee and to offer these comments.

Harvey Rosenthal
Executive Director



April 8, 2016

NYS Council Comments on Value Based Payment Roadmap Annual Update

The NYS Council for Community Behavioral Healthcare appreciates the opportunity to submit comments on behalf of our members on the Value Based Payment (VBP) Roadmap Annual Update.

Our organization is a statewide non-profit membership association representing the interests of 100 behavioral health (mental health and substance use) prevention, treatment and recovery organizations across New York. Our members include free standing community-based agencies, general hospitals, and counties that operate direct services.

The NYS Council and its members support New York's transition to VBP to improve access to, and coordination of, care for people with serious mental illness (SMI) and chronic substance use disorders (SUD). We have offered comments throughout the VBP process and are encouraged by the State's willingness to consider our suggestions. This version of the Roadmap adds important new concepts that we fully support and detail at the end of our comments. We begin by offering our comments on areas where we feel the language in the Roadmap raises some implementation concerns and/or where we strongly believe issues need to be added or expanded further.

METRICS

Our first concern is regarding the issue of performance metrics; we believe they are critical to the success of VBP for community-based behavioral health (BH) providers. If managed care organizations (MCOs) are held accountable for metrics that are reflective of the work done by BH providers, MCOs and VBP contractors will be incented to prioritize the work of the BH field in VBP arrangements, and the value added by BH providers will be recognized and rewarded. *It is essential that all Medicaid managed care products are held accountable for these performance metrics, not just HARP products.*

The structure indicated by the June 2016 update takes this into account, but does not offer sufficient detail to assuage any concern about the inclusion of these metrics, and in fact the document explicitly recognizes this shortcoming. "Measures focusing on rehabilitation and individual recovery including housing stability and vocational opportunities...are as yet underrepresented." The Clinical Advisory Group (CAG) on Behavioral Health has been working to identify metrics, both clinical and HCBS-related, but their work has not been integrated into the Update, and it is not clear if these essential metrics will

be included in the revised model contract, the most definitive way to ensure MCOs are accountable for these metrics.

The Update does indicate that the state foresees including these metrics in the model contract, but there is no assurance that they will be, nor that they will be satisfactory to the community BH sector when they are. Unfortunately, the state does not indicate that there will be an opportunity to comment on the model contract before it is finalized, and, in fact, indicates just the opposite, that the model contract will not be posted until it is approved by CMS.

In an earlier version of the recommendations from the Regulatory Subcommittee (SC), it stated that “after consideration of the comments from the SC, DOH will share the updated Model Contract with the public and solicit comments before finalization. DOH will post all of the received comments on the DOH website prior to the adoption the Model Contract.” *We believe there should be a public comment period on the model contract so that we will have an opportunity to ensure the inclusion of metrics representative of the work our members do—in the contracts for all managed Medicaid products—before the model contract is finalized.*

SOCIAL DETERMINANTS OF HEALTH (SDH)

Much progress has been made with respect to SDH in the Update. We support the Roadmap’s plan that Level 2 and 3 VBP contractors should be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)

The selection of the type of social determinant intervention to be implemented “should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources.” (p. 42). We support this design - it is critical to be guided by individual members’ own health goals and desires and community needs and resources.

VBP “contractors should also create a report explaining a measureable reason why the SDH was selected, and identify metrics that will be used to track its success. We support this requirement and recommend that it follow a similar process/procedure to that used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics, and reports back to the State.” (p. 42)

“Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO.” (p. 42)

“The Advocacy and Engagement and Social Determinants of Health Subcommittees also recommended the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: a taskforce focused on children and adolescents in the context of VBP...” (p. 59)

We are concerned, however, that the SDH metrics included in the Update are process measures, not outcome measures, and while it’s a positive movement, it leaves quite a long way yet to go; SDH interventions should be incented by outcomes, not tacked on as process measures.

The BH CAG has identified SDH-related outcome measures, including measures related to housing, criminal justice, employment and education. The problem is not that SDH-related outcome measures are inconceivable, but that they are not included in clinical or claims data. The Update indicates that “the State will evaluate the feasibility of incorporating SDH measures into Quality Assurance Reporting Requirements (QARR) performance measures.” *This is a positive step, but we believe there should be a commitment to include SDH in QARR measures.*

RESOURCES FOR COMMUNITY BASED ORGANIZATIONS (CBOS)

There are a number of recommendations included in the Update for supporting CBOs in making the transition to VBP. They include “creating a self-assessment process for groups to assess their readiness for VBP participation; State funding and the creation of additional workgroups to address the capacity, monetary, and infrastructure deficits impacting numerous organizations; convening a team of experts with whom CBOs could consult on VBP participation; and evaluating the feasibility of creating a bi-directional system for provider/provider network and CBO communication.”

While we support these recommendations, we also remain concerned about provider’s current issues of continuing to provide quality services while participating in transformation initiatives, including payment reform. The community based health care providers have not had access to the same amounts of funding that other providers have had access to. CBOs will need funding for: infrastructure development, including IT systems; ability to do measurement and data collection to demonstrate their value; contracted services, such as fiscal and legal expertise; among other things. To that end, we *recommend a clear and transparent process for determining the extent of the resources being considered, especially financial resources, who is eligible for them, and how they are allocated. We also recommend that the state establish a loan fund to assist with cash flow issues that may arise if payment to CBOs in VBP arrangements is delayed.*

We are encouraged by the idea of realizing savings from the work that is occurring in the community based health care providers but believe this savings should be shared among all participating providers. The fact that a provider is unable to take risk shouldn’t determine their ability to share in savings. *If their investment and participation in the VBP arrangement generated savings, then this savings should be returned to them for future investment.*

ATTRIBUTION

The question of to whom members with chronic behavioral health conditions should be attributed has not been adequately addressed in the Update. Attribution is in part about risk and it doesn't preclude VBP participation in any way. For the BH-related chronic conditions (bipolar disorder, depression and anxiety, and substance use disorders) attribution continues to be the Primary Care Physician (PCP), and HARP members continue to be attributed to the MCO assigned Health Home. We believe that in both instances, it makes more sense to default to a behavioral health provider.

There is movement in a positive direction, because "an MCO and VBP contractor may deviate from this guideline and agree on a different type of provider to drive the attribution on the condition that the State is adequately notified." Nonetheless, the default continues to be misaligned from the provider who is best positioned to impact the course of a person's illness. *For people with chronic BH disorders (or at the very least for HARP members), attribution should be to the housing provider, or to the multi-service BH provider from whom the client currently receives care.*

HOUSING

There are some good ideas about housing contained in the Update, including prioritizing NY/NY housing for people eligible for HARP, collecting standardized housing data, seeking CMS approval to use Medicaid more flexible for housing, leveraging MRT housing workgroup money to advance the VBP agenda, and coordinating with the Continuum of Care. They are, however, somewhat uncoordinated. *We believe a Service Advisory Group (SAG) for housing (analogous to the CAGs)—and perhaps a SAG for employment—would be beneficial to the VBP infrastructure.*

TIMING

Throughout the document there are challenges created for providers by the fact that key information is not yet available. These mis-aligned timelines are a serious impediment to providers planning appropriately and entering into relationships based on sufficient information to make informed decisions. Some of the most challenging instances of this are:

- The Clinical Advisory Groups have done significant work, but have not yet reached consensus on some important issues and therefore there are meaningful gaps throughout the Update. Statewide definitions and quality measures "will be made available."
- That "the State is currently developing risk adjustment methodologies for both HIV/AIDS and HARP."
- That "in the first half of 2016, the State will make the total risk-adjusted cost of care available per PPS and MCO for the total population, as well as per integrated care service delineated above (Maternity Bundle, Chronic Bundle, Integrated Primary Care, HIV/AIDS, HARP)."
- Baseline survey results will be "the starting point for NYS Medicaid VBP," but they are not available.

- “There remain a few outstanding considerations that DOH will further evaluate, including contractual safeguards that may need to be included around prompt payment in the VBP environment.” Issues around prompt payment should really be resolved prior to anyone entering into VBP arrangements.

ENFORCEMENT AND CLARITY

There are a number of places where the state indicates what “ought” to be, or what PPS’ or MCOs “should” do. It is unclear how these areas will be monitored and/or enforced. Some important instances of this are:

- Because of the importance of maintaining the population health-focused infrastructure, patient-centered integration and workforce changes that are being purchased with DSRIP funding, “the PPS or its hubs will have to submit a plan outlining how this infrastructure will be maintained.” How this will be enforced, or even incented, is unclear.
- The guidelines for distribution of shared savings amongst providers are an excellent example of this.
 - “Savings should be allocated appropriately among providers; especially behavioral health, long term care, and other community based providers should not be disadvantaged.” We couldn’t agree more, but if/how that will be either monitored or enforced is not clear.
 - The guiding principles for the distribution of shared savings delineated on pp 20-21 speak to the importance of fairness, equity and protection of small providers, but offer no actual protection.
- MCOs will be penalized for failure to achieve VBP targets from 2018 on. At that point, they “may pass on such penalties to incentivize providers that can reasonably be expected to make this transition to work with the plans towards realizing these common goals.” We believe there is a lack of clarity here that will impact providers. Who determines which providers can be “reasonably expected to make this transition?” On what basis?
- “Smaller, less prepared providers may need access to resources and support to develop the sophistication to succeed, and DSRIP funds are explicitly intended to facilitate this progress.” If DOH expect PPS’ to use their DSRIP funds to support small provider preparedness for VBP, a mechanism for enforcing that expectation would be useful.

INTEGRATION OF REPORTING AND POPULATION HEALTH

The Roadmap indicates that the PPSs/hubs that are not contracting entities should maintain infrastructure for population health, patient-centered integration, and workforce strategy (p. 16). Non-contracting PPS’ will be well-positioned to contribute reports on the impact of VBP arrangements. However, reports on the impact of Medicaid VBP arrangements will be most valuable viewed in the context of other payer initiatives, including Medicare VBP and commercial arrangements. It will be important for the State to ensure that PPS reports and population health planning activities are

integrated into broader community assessment and planning efforts, such as those generated by successful Population Health Improvement Programs (PHIPs). We recommend that the State explicitly recognize PPS' population health assessments as taking place in collaboration with other state-funded entities conducting broader health planning activities that include Medicare and commercial VBP arrangements.

EDUCATION AND TRAINING

We recommend that the State and/or a third party develop educational materials on VBP that focus on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks and MCOs. Additionally, the State and/or a third party should provide technical assistance for the providers/provider networks and MCOs (non-CBO) contracting entities on how to work effectively with CBOs.

In order to ensure that information concerning VBP and how it varies from FFS is understood, we suggest that it be communicated effectively to Medicaid members. The State should also communicate general information about new structures and incentives under VBP. MCOs or ACOs should communicate more specific information about VBP and FFS programs their members are enrolled in.

We also recommend that the State create a "design and consultation team" of experts from relevant State agencies, advocacy and stakeholder groups, to provide focused consultation and support in a way that is affordable to CBOs who are either involved or considering involvement in VBP.

VBP AND CONSUMERS

The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant in the VBP context. This is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it affects them. The Roadmap should reference some of the other important actions recommended by the Subcommittee that the State has committed to undertake, such as ensuring that plans and providers communicate information to consumers that explains the difference in incentives that payment mechanisms generate; the workgroup that will be created to develop a larger communication strategy.

Consumer education and patient activation are needed around what is meant by a "high value provider," as well as their right to question their providers, seek a second opinion, and obtain consumer assistance/ombudsmen services. The State's Independent Consumer Advocacy Network and any and all consumer assistance/ombudsmen programs should be equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment.

ADDITIONAL COMMENTS

The NYS Council supports the following new concepts included in the Roadmap Update:

The Roadmap articulates this “Payment Reform Guiding Principle,” which we support: “Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health.” (p. 8)

We support several components of the section on “Incentivizing the Member,” including the focus on positively incentivizing desired behavior and stating clearly that “burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option.” (p. 38)

We support the State’s plan to eliminate the \$125 incentive cap for incentive programs (the roadmap describes the current cap as applying to preventive services. We believe the reference should be to an existing cap on incentive payments). (p. 40)

We support the State’s interest in measuring and encouraging creativity in incentive programs, specifically its plan to “analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publically available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design.” (p. 40)

Thank you for the opportunity to provide comments on the Value Based Payment Roadmap Annual Update. [REDACTED]

Sincerely,

Lauri Cole

Lauri Cole
Executive Director

To Whom It May Concern:

A few items particularly stand out in regard to the VBP Proposal, and the opportunity for public comment is appreciated.

Most concerning I believe is the proposal that Hospitals and Community Based Providers share equally in cost savings. The cost of primary care transformation is already a growing concern for those of us who have embraced the PCMH model and continue to work at implementation and refinement. No hospital has assisted us with this effort; in fact, the hospitals only stand to gain from our efforts, yet at this point, unless the state underwrites the formation of large, multispecialty corporations wherein specialty and primary care are part of one single system, Primary Care will remain in a position of disadvantage from a financial standpoint, unless hospitals are also required to share their cost savings equally with their Community Based Providers.

The requirement that contractors notify downstream hospitals of their intent to negotiate VBP agreements with an MCO seems unreasonable.

Ultimately, the state should focus on regulation of the payers' practices, in addition to that of providers and hospitals, but given the current health care environment, this requirement sets up the opportunity for hospitals to compete or leverage potential contract stipulations in their favor.

Social Determinants of health are an essential piece of health outcomes. Again, it puzzles me as to why the state and other politicians do not focus on welfare reform, and instead create overly complex rules about how healthcare organizations address this multi-layered problem. It amazes me when I see that for many of my patients who must choose between a job that provides costly insurance versus public assistance, the incentive is often to find whatever way possible to remain on or apply for Medicaid, especially if they have conditions requiring long term medication, for example Multiple Sclerosis. I am proud to be part of a safety net for the disenfranchised of our society, yet my cynicism increases as I observe incentives for patients that do not help them to become independent, self-managing individuals, but create dependence on "the system".

That being said, from a clinical perspective, one would at least hope that clinical programs which account for social determinants of health would relate those determinants to specific clinical outcomes that are readily apparent to all, and that the measures and goals would be consistent across all payers.

Thank you again for the opportunity to comment.

Nancy Ciavarri, MD
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Office of Mental Health

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MARTHA SCHAEFER
Executive Deputy Commissioner

Office of Mental Health Value Based Payment Roadmap Comments as of April 14, 2016

General High Level Comments

- OMH and OASAS support and advocate for an advisory group to help ensure proper implementation of VBP, with robust participation from OASAS and OMH, particularly on matters relating to Behavioral Health (BH) and BH populations.
- OMH and OASAS, as Executive branch agencies charged with the oversight and service provision for the BH population, have deep professional expertise related to BH Medicaid data analytics, including partnerships with Columbia University and NYU. It is critical this expertise be used in development of analytics and risk adjustment as it relates to BH involvement with Value Based Payment. We have developed specific comments on this, please see #s 3, 6, 7, 14 below for more detail.
- The transition years will be critical for our specialty provider systems, including treatment providers and HCBS. Adequate supports and safeguards need to be in place to prevent outsized adverse impacts on those systems and the vulnerable populations they serve. A data-driven 'early warning system' to monitor these fragile, sometimes newly developed specialty service providers would help assure the populations they serve are not inadvertently harmed in this transition. Please see #s 5 and 11 below for more detail.
- Investment in rehabilitation services, i.e., the movement of dollars from inpatient to rehabilitation is crucial. VBP arrangements should incentivize these in early years in order to develop appropriate rehabilitation measures. See point #7 below for more detail.
- As stated in our MOU with DoH, any BH related changes contemplated for the Model Contract, including those related to VBP, must first be reviewed and approved by OASAS and OMH.
- VBP must address and comply with the new Mental Health parity rules.



Office of Mental Health

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ANN MARIE T. SULLIVAN, M.D.
Commissioner

MARTHA SCHAEFER
Executive Deputy Commissioner

Page Specific Comments

1. Pg. 15: OMH understands the logic of attributing individuals to only one subpopulation. The three HIV-SNPs in NYS also have members who are enrolled and/or eligible for HARP. If the HIV SNP develops a Total Care for Subpopulation, OMH and OASAS need to be involved to be sure metrics meet HARP criteria.
2. Pg. 22: Where BH is involved, that is, in HARP or BH episodes within the chronic bundle, OMH and OASAS should be involved in the programmatic review of contracts. See also page 75.
3. Pg. 26: OMH and OASAS need have input into KPMG's HARP risk-adjustment process.
4. Pg.30: OMH and OASAS need access to the Baseline Survey sent to MCOs and PPSs on 2/12/16.
5. Pg. 32: Observation – a point is made that there are certain activities whose impact may be felt outside the contract. One example given is LARCs. A similar point could be made for BH rehabilitation and recovery. Access to BH rehabilitation is a relatively new addition to the Medicaid benefit package. The CMS directive for MH parity is recently stated. In addition, the value-based impact of investing in these rehabilitation services may go beyond VBP contract period. Therefore, OASAS and OMH would like to discuss with DOH the merit of developing FFS or alternative approaches to investing in rehabilitation services in the early years of VB contracting, until the network for these services mature and their impact can be effectively measured.
6. Data access and validation comments:
 - Pg. 24, 29, 35, 52, 53 and others: It is imperative that the BH data analytics benefit from OMH and OASAS expertise. As such, OMH and OASAS need full briefings on and access to the data and validation techniques used through the 3M Grouper, the HCI3 Grouper and any other performance data development and platforms.
 - Pg. 29: OMH and OASAS need to have early input on the approach to risk adjustment.
 - Pg. 29: OMH and OASAS need full access to the “Total risk-adjusted cost of care available per PPS and MCO for the total population”.
 - Pg. 30: OASAS and OMH need full access to the State's analytic platform.
 - Pg. 67: “The State's Medicaid Performance Portal will use the ‘on-menu’ options to create overviews of total cost of care, outcomes, shared savings possibilities and so forth for the MCOs and Providers alike.” OMH and OASAS need access to this data.
7. Pg. 35: In order to develop appropriate rehabilitation measures, there must be an investment in rehabilitation services, i.e., the movement of dollars from inpatient to rehabilitation. VBP



Office of Mental Health

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arrangements should incentivize these in early years. Robust incentives and safeguards should be in place to prevent systemic underinvestment in these services.

8. Pg. 42: As described in regard to developing Social Determinants of Health metrics using “a similar process/procedure used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics and reports back to the State”, it may make sense to develop a similar approach on HARP pilots wherein OMH and OASAS work with the Plans and providers in developing rehabilitation and recovery metrics for the pilots.
9. Pg. 42: In the early years of VBP deployment if there is not close monitoring of proper incentives in maintaining the CBO safety net, a retrospective review in 2-3 years may be too late. There may be irreparable damage to the CBO safety net and access to services in the system of care. Continuous monitoring will be required, including regular transparent reports. The advisory body should play a central role.
10. Pg. 48: Regarding, “the State will not enforce how MCOs and VBP contractors set the target budgets, what quality measures they reward, and whether they reward actual performance or improvement” OMH raises the concern that there are few measures currently related to BH in QARR and HEDIS. There are indications from other states that without proper oversight when the BH benefit is moved into Managed Care BH spending declines and access may be negatively impacted. Therefore in the early years of VBP the State may need to take a more direct role in overseeing the design of the BH contract guidelines.
11. Pg. 54: Regarding, “The State will monitor this development and, where necessary, develop additional approaches to ensure the inclusion of providers who demonstrate successful performance.” OMH and OASAS advocate a proactive tracking and oversight process to ensure high-performing BH providers new to VBP arrangements are included.
12. Pg. 54: BH rehabilitation and recovery measures are not adequately developed yet, therefore intermediate measures are needed. Quality measures and standards should be developed using an iterative approach wherein measures are developed, tested, and refined over time, and involving the State, Plans, and Providers to ensure maximum clinical efficacy and buy-in.
13. Pg. 67: “Integrated Primary Care without behavioral health care would equally not fulfill this criterion [off-menu option for integrated care].” OMH and OASAS fully support this approach.
14. Pg. 83: Clinical Relevance #2 states, “For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcomes measured.” OMH and OASAS will want to discuss our agencies’ position on process measures for achieving rehabilitation and recovery outcomes within the context of criteria articulated in Appendix VIII.

Primary Care Development Corporation Comments on New York State Roadmap for Medicaid Payment Reform: Annual Update, March 2016 Draft

Thank you for the opportunity to comment on the New York State Roadmap for Medicaid Payment Reform March 2016 draft. The Primary Care Development Corporation (PCDC) is a nonprofit organization whose mission is to expand access to quality primary care in underserved communities. We have helped hundreds of primary care practices (community health centers, hospital-based and private practices) transform into patient centered medical homes, and we are deeply aware of their challenges and opportunities as our payment system undergoes a major shift toward value.

Changing how we pay for care is essential to changing how we deliver care, and we support New York State's value based payment (VBP) approach that incentivizes providers to deliver more effective care at lower costs. However, primary care has historically been undervalued and underfunded, and increasing spending on primary care is essential to reducing costs elsewhere in the health care system. Because VBP relies so heavily on "Integrated Primary Care" (IPC), a continued lack of investment could seriously undermine the role of primary care in VBP, and thus threaten the success of VBP itself. We must also remember that primary care is a basic right and necessity for all New York State residents. Sufficient investment is essential to ensure that it we have enough high quality primary care providers (PCPs) to serve New York State's communities.

We approach the Roadmap from the perspective that high-quality primary care is essential to successful value-based payment models. Likewise, value based payment must support the long term sustainability of high-quality primary care. The comments below are not meant to be comprehensive, but to identify key issues we believe should be prioritized as VBP moves forward.

Measure and publicly report spending on primary care across all MCOs and in all value based payment arrangements – Understanding how VBP impacts primary care spending is essential to public policy decisions, yet information about primary care cost and utilization is not publicly available, either at a plan level or as a share of total health care spending in New York State. To the extent that primary care cost and utilization data is being collected and reported, it is unclear if primary care is being defined uniformly, and what services within the primary care category are measured and reported.

Recommendation: All Medicaid managed care organizations (MCOs) engaging in VBP contracts should publicly report the amount of spending on primary care using a common definition. This information will help all parties better understand the level and type of primary care investment being made and which strategies are likely to have the greatest impact on cost and quality.

Ensure sufficient investment in primary care as a share of overall spending – New York State’s overall spending on primary care is insufficient. All MCOs must invest adequately on primary care as a share of total health care spending – there can be no “free riders.” We need the level of investment to reflect the value that primary care brings to individual and community health, the health care system and payers’ networks. Sufficient investment is essential to fostering MCO partnerships with primary care providers and building strong primary care networks that have the infrastructure to share data, coordinate patient care, improve individual and population health and generate savings in overall health care costs.

Recommendation: New York State should require a minimum level of primary care spending as a share of overall spending across all MCOs and in all VBP contracts.

Require minimum prospective or fee-for-service payment for primary care: Sufficient and timely reimbursement prospectively or at the time of care is fundamental to effective prevention and high performing primary care. We support the IPC approach that provides for fee for service (FFS) plus a per-member per-month (PMPM) payment, with the possibility of additional compensation through shared savings. The FFS and PMPM payment should combine to fully compensate the PCP for the cost of operating the practice and delivering and managing care as a Patient Centered Medical Home/Advanced Primary Care practice (PCMH/APC). While shared savings programs or bonus programs may incentivize the practice to earn additional compensation, they should not be structured such that that failure to earn savings puts the practice at risk of reducing access to services, undue financial distress or closure.

Emerging evidence supports this approach for PCMH/APC,ⁱ and these models are increasingly demonstrating reductions in cost and utilization.ⁱⁱ Recent analysis is also beginning to identify the considerable costs of maintaining a PCMH/APC model,^{iii iv} and the disproportionate reporting costs borne by PCPs.^v

Finally, national payment policy is moving in this direction. The Medicare Payment Advisory Commission (MedPAC) recommends a monthly per beneficiary per month to replace the 10% Medicare bonus payment for PCPs (which expired in 2015).^{vi} Further, CMS is signaling to the health insurance market that significant prospective and FFS payment for primary care is likely

to be part of its VBP policy. CMS's recently released "Comprehensive Primary Care + (CPC+)," is a Medicare-led multipayer model that will support practices with FFS plus a care management PMPM fee between \$6 and \$33 (depending on program track), with complex patients eligible for a \$100 PMPM and upfront quality incentives that are reconciled retrospectively.^{vii} CPC+ requires all payers to use this payment structure (albeit not necessarily the same compensation amounts).

Recommendation: A minimum level of support for primary care through prospective or fee-for-service payments should be established across all VBP contracts to ensure sufficient upfront and ongoing investment.

Alignment with other NYS and national efforts (Page 61): We are encouraged that the Health Care Payment Learning and Action Network APM framework aligns with those in the NYS VBP Roadmap. CMS is expected to release the Final Rule on MACRA for comment in April 2016, and New York State should to continue to align the VBP roadmap on alternative payment models (APMs), Merit-Based Incentive Payment System (MIPS) measurements on quality, resource use, clinical practice improvement and Meaningful Use, and CMS initiatives like CPC+.

New York State should establish internal alignment on primary care transformation and the PCMH/APC model. A very significant barrier to adoption of PCMH/APC is the multiplicity of projects (most funded by CMS) that aim to achieve transformation to VBP. Practices with several payer contracts are faced with multiple measure sets, payment models and reporting requirements. This creates considerable inefficiencies for the practice and payer alike, and may lead to providers deciding not to participate in VBP arrangements until there is a clear pathway for the majority of their patient's payers.

Recommendation: Establish a New York State industry-wide set of primary care-related process and outcome measures, reporting requirements and payment methods for all payers to minimize complexity and allow practices to focus on patient care.

Sharing savings between PCPs and hospitals (Page 68): We remain concerned with the provision that "earned savings should be shared evenly between professional-led practices and associated hospitals, provided that the hospitals work cooperatively with the practices to better manage their patient populations." Our concern is twofold.

1. While hospitals that fully participate in VBP should share in the savings their efforts produce, requiring professional-led VBP contractors – the very providers that have been

historically undervalued in the healthcare system – to pay a set portion of shared savings to hospitals seems to run counter to the principles of VBP, where payment is tied to value.

2. We are encouraged that criteria have been included for hospitals to receive shared savings from professional-led VBP contractors. However, the criteria should be more specific, meaningful and well documented to recognize that primary care providers are at a significant disadvantage with regard to data sharing, collaborative care planning and other key elements of transformed care that create value and reduces cost.

Recommendation: Eliminate the requirement that professional-led VBP contractors “share evenly” in earned savings with hospitals, and require greater levels of documented engagement between to trigger shared savings compensation between professional-led VBP contractors and hospitals.

Fee for Service as Value Based Payment for Preventive Services (P 38): We support continuation and expansion of FFS to support high value, and often high cost or time-intensive, preventive services that are recommended by the US Preventive Services Task Force and required by the Affordable Care Act to be provided without cost to the patient, such as LARC, tobacco and alcohol use screening, counseling and treatment, obesity and nutrition counseling.

Incentivizing the Member: Value Based Benefit Design (Page 37): PCDC supports the inclusion of patient incentives in VBP plan benefit design. We recognize that member incentivization is a relatively new and unstudied concept, and support the flexible approach being taken. The guiding principles outlined are appropriate, as is providing financial resources to VBP Contractors who undertake member incentivization and eliminating the \$125 cap on incentives in MCO Model Contracts. As evidence grows, we encourage New York State to disseminate best practices to MCOs and VBP contractors so they can adapt their programs member incentive programs accordingly.

Addressing Social Determinants of Health (Page 41)– PCDC recognizes that measuring impact of social determinants of health (SDH) interventions is inherently challenging, and we are encouraged that New York State is committed to making this an important part of the VBP roadmap.

Conclusion

We applaud New York State’s efforts to improve care and outcomes by redesigning and aligning incentives to achieve higher value. Implementing VBP is a challenging road, but thankfully New

York State is not walking it alone. Ultimately, we believe success will be determined by how substantially and effectively we invest in primary care and other parts of health care system that have the ability to create the greatest value, and how well our efforts are rationalized and aligned across payers. We are committed to working with New York State and all stakeholders to ensure New York's success in developing and implementing an effective value based payment system.

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ⁱ Edwards, S. T., A. Bitton, J. Hong, and B. E. Landon. "Patient-Centered Medical Home Initiatives Expanded In 2009-13: Providers, Patients, And Payment Incentives Increased." *Health Affairs* 33.10 (2014): 1823-831. Web. <http://content.healthaffairs.org/content/33/10/1823.full.pdf+html> Accessed 4/15/16

ⁱⁱ Nielsen, M. Buelt, L. Patel, K., Nichols, L. "The Patient-Centered Medical Home's Impact on Cost and Quality Annual Review of Evidence 2014-2015." Patient Centered Primary Care Collaborative. February 2016 <https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf> Accessed 4/15/16

ⁱⁱⁱ Magill, M. K., D. Ehrenberger, D. L. Scammon, J. Day, T. Allen, A. J. Reall, R. W. Sides, and J. Kim. "The Cost of Sustaining a Patient-Centered Medical Home: Experience From 2 States." *The Annals of Family Medicine* 13.5 (2015): 429-35. Web. Accessed 4/15/16

^{iv} McKinsey analysis: January 11, 2016 State Health innovation Plan Integrated Care Workgroup presentation, Slide 47 https://www.health.ny.gov/technology/innovation_plan_initiative/docs/2016-01-11_integrated_care_presentation.pdf Accessed 4/15/16

^v Casalino, L. P., D. Gans, R. Weber, M. Cea, A. Tuchovsky, T. F. Bishop, Y. Miranda, B. A. Frankel, K. B. Ziehler, M. M. Wong, and T. B. Evenson. "US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures." *Health Affairs* 35.3 (2016): 401-06. Web. Accessed 4/15/16

^{vi} Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission. March 2016. Page 113. <http://medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2> Accessed 4/15/16

^{vii} Comprehensive Primary Care Plus Fact Sheet. Center for Medicare and Medicaid Services. April 2016. <https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus> Accessed 4/15/16

To whom it may concern,

Thank you for the opportunity to comment on the State Health Roadmap on Value Based Payments (VBP).

As Radical Health, an organization committed to challenging the current state of health care in underserved areas of New York City, we believe that a systematic approach, especially one that does not embrace the cultural and indigenous practices of the community it is intended to serve, will not bring a holistic approach to person-centered care.

We recommend that the State work directly with community based organizations (CBOs) to design methods for working together. The partnerships provide components of integrated physical and behavioral primary care. We need to address the following concerns:

- How will CBOs be compensated for providing vital social services and community-based prevention activities?
- What strategies are in place for CBOs to be incorporated into the legal entities led by health care providers entering into VBP contracts?
- What resources will the State provide to CBOs for strategic planning to enter into VBP contracts?

We strongly recommend that all VBP arrangements, not just Level 2 and Level 3 VBP, address social determinants. This would also promote inclusion of CBOs in all arrangements.

A complete remedy for health requires thoughtful inclusion of social determinants from the start. We look forward to more opportunities to contribute to the NY DSRIP program and shape the future health of New Yorkers.

Sincerely,
Radical Health

Ivelyse Andino
Founder | CEO
Isabella Leung
Partner | Chief Policy & Strategy Officer

--

Radical Health
(347) 433-6471
www.radical-health.com



April 18, 2016

Jason Helgeson
Medicaid Director
NYS Department of Health

Dear Mr. Helgeson:

Thank you for the opportunity to comment on the first annual update to the Value-Based Payment Roadmap. Raising Women's Voices-NY ("RWV-NY") is the New York affiliate of [Raising Women's Voices](#), a national initiative working to ensure that the health care needs of women and our families are addressed as the Affordable Care Act is implemented. RWV-NY is also a member of the steering committee of the Health Care for All New York (HCFANY) coalition, which is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers.

Ensuring Access to High Value Care

Value-based payments can help eliminate incentives to over-treat and increase incentives to provide preventive and primary care services. However, because no quality measurement system will be perfect and because wide-scale use of value-based payments is still an untested way of providing care, the next Roadmap should include a robust plan for preventing, monitoring for, and responding to new negative incentives.

In this new payment model, risks to consumers include under-service by providers concerned about their financial exposure. The Roadmap includes some discussion of protecting access to services that are clearly beneficial for patients, but may not be cost-effective within the timeframe of a typical contract, such as long-acting reversible contraceptives (LARCs). The Roadmap suggests the State will develop a list of those services, and count fee-for-service spending on them towards value-based payment goals (p. 32). The Roadmap also suggests that the provision of some of those services will be measured for assessing care quality.

RWV-NY is concerned that there is no clarity of whether providers of certain preventive services can participate in the shared savings programs, in addition to receiving fee-for-service reimbursement. If the goal is to incentivize high-value care such as LARCs, fee-for-service reimbursement alone does not accomplish this. RWV-NY recommends that if preventive services - especially LARCs - are reimbursed at current fee-for-service rates alone, those services should not count towards part of a managed care organization's value based payment target. Alternatively, if fee-for-service preventive services do "count" as value-based, managed care organizations should be required to provide an additional payment, in some mutually agreed upon form, to the provider with which they are partnering to provide that preventive service.

Quality Measures and Public Reporting

The Roadmap says that the State will measure impacts on patient-centeredness, population health, and social determinants of health at the delivery-system level (p. 17). RWV requests that these, and other quality measures, should be publicly available so that there can be a public, informed discussion about the impact of value-based payments. The Roadmap implies that quality measures have already been selected by the Clinical Advisory Groups (p. 11). RWV-NY echoes the recommendations of Medicaid Matters New York and other advocates that the quality measures be made available for public comment before any final decisions are made.

Stakeholder Engagement

RWV commends the State for undertaking such an extensive stakeholder engagement process and hopes that this will continue. For future workgroups and subcommittees, RWV recommends that the appointment process should be transparent and membership lists and meeting minutes should be posted publicly. It is also important to increase the proportion of consumers and consumer advocates on these groups, particularly those who represent the interests of women and LGBT people. An open process, for example, with public postings for openings, would make it easier for consumer groups to organize and identify nominees with the right expertise to fully contribute.

Sincerely,

A handwritten signature in black ink that reads "Kyle Marie Stock". The signature is written in a cursive, flowing style.

Kyle Marie Stock, Model States Policy Manager
Raising Women's Voices-New York

MEMORANDUM

To: Jason Helgeson, New York State Medicaid Director
From: Kate Breslin, President & CEO
Re: Comments on Value-Based Payment Roadmap Annual Update
Date: April 18, 2016

Thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment (VBP) Roadmap (the Roadmap). The comments below focus on the implementation of value-based payment as it relates to children. By definition, VBP for children must address the needs of their families and services in their communities, as children's health and well-being are shaped by those around them.

We strongly support a separate process and workgroup to consider how to assess/measure value for children, in the context of value based payment. The Roadmap includes a recommendation regarding the development of workgroups to dig deeper into a number of critical issues, including a **taskforce focused on children and adolescents in the context of VBP...** (p. 59). This should be focused on the broad, population-oriented preventive and primary care needs of all children.

Though there has been little discussion of the unique needs of and approaches for children in New York's health system transformation, the approaches being considered would be applicable to payment for services for children. To the extent that system transformation efforts currently underway aim to fundamentally change New York's health care delivery system, it is critical that we look closely at value from a pediatric perspective or risk creating a system that, by design, ignores the developmental trajectory of children.

The Roadmap suggests that a small number of Clinical Advisory Groups (CAGs) will continue in Year 2 and that new CAGs may be formed around additional priorities, such as **Special Needs Children** (p. 34). One or more CAGs focused on Special Needs Children is a good idea. This, more narrow focus should not substitute for a workgroup or task force described on page 59 of the Roadmap (and supported above) that will make recommendations regarding value-based payment and the broad, population-oriented preventive and primary care needs of **all** children.

The Roadmap articulates a guiding principal of financially rewarding, rather than penalizing, providers and plans who deliver high value care through emphasizing **prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health** (p. 8). We strongly support this principal and note that, for children, addressing underlying social determinants of health will include focusing on the family.

We support the Roadmap's plan that Level 2 and 3 VBP contractors be required to implement at least one intervention designed to address a **social determinant of health** and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)

We support the Roadmap's statement that providers and plans that focus on health education, increased uptake of prenatal care, pre- and interconception counseling, adequate c-section rates and resource utilization, screening for post-partum depression and so forth have the opportunity to further improve maternity care outcomes and generate savings (p. 13). We welcome this focus on prevention and maternal mental health and note that contractors/subcontractors in this field may be community-based organizations (CBO) and that evidence-informed maternal/infant home visiting is among the strategies for successfully improving prenatal and post-partum outcomes as well as child health and well-being.



Safety Net Association of Primary Care Affiliated Providers of WNY

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Frank Azzarelli, Ex Officio
Associate Vice President
People Inc. Elmwood Health
Center

Comments on the 1st Annual Update of the NYSDOH Value Based Payment Roadmap April 18, 2016

Thank you for the opportunity to comment on the New York State Department of Health's Draft Annual Update of its Value-Based Payment Roadmap. The Safety Net Association of Primary Care-Affiliated Providers (SNAPCAP) of Western New York represents the majority of the primary care providers that primarily serve the Medicaid beneficiaries in the eight westernmost counties of the state. Member organizations are all NYSDOH-certified Article 28 primary care clinics spanning Federally Qualified Health Centers, hospital systems, and free-standing provider groups, and are therefore at the very center of delivery system reform efforts.

These healthcare providers and the patients they serve are projected to experience the biggest impact of the reforms explained in the Value-Based Payment Roadmap. In respect of this, SNAPCAP encourages a state Value-Based Payment strategy which reflects the nuances of the responsibility entrusted to care for this population. A summary of SNAPCAP suggestions to incorporate these principles into the first annual update to the Roadmap is as follows:

SNAPCAP supports the following components included in the revised Roadmap:

- The 1% stimulus adjustment available to VBP contractors with Integrated Primary Care contracts, reflecting the high cost of infrastructure costs and care transformation needed to realize improvement in cost and quality outcomes. Primary care providers have been at the forefront of this resource-intensive process for a number of years, and the onset of VBP is expected to accelerate these efforts even further. (Page 29)
- A commitment from NYSDOH to streamline measurement and reporting requirements across DSRIP, QARR, and VBP contracting arrangements. This promise will ensure safety-net primary care providers will be better equipped to provide time-intensive high-quality care specific to patient needs rather than driven by onerous and duplicative reporting requirements. (Page 52)

• Ensuring the integrity of partnerships with downstream providers in Integrated Primary Care contracting. SNAPCAP supports the requirement of downstream hospitals to demonstrate sufficient cooperation in data management, data sharing, innovation and care redesign, and quality and engagement prior to receipt of shared savings payment. This is crucial to ensuring effective partnership among providers across the continuum of care. Of special importance is the emphasis on real-time direct data feeds. This is currently a critical technological deficit and will strengthen primary care providers' ability to monitor attributed patients hospital visits and provide supportive services when needed. (Page 68)

SNAPCAP points to the following components in the revised Roadmap that need further explanation, revision, or strengthening:

- Reliance on MCO-assigned primary care provider for VBP contracting attribution and analysis. There is a high degree of discrepancy between MCO-assigned primary care provider and the actual primary care provider ultimately involved in a patient's care, particularly for the safety-net population. The reliance on this flawed methodology presents a high risk of invalid outcomes measurement and distribution of shared savings/losses. SNAPCAP strongly

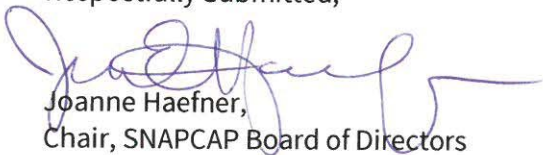
encourages a collaborative attribution process created in partnership with the MCOs and the VBP contractor which enables a better capture of actual care provided, and by whom, and better tracks the resultant outcomes within an attributed population. (Page 24)

- NYSDOH lack of commitment to provide analytics for alternative patient attribution arrangements. While the Roadmap encourages MCOs and VBP contractors to explore alternate patient attribution methodologies, it follows directly with stating that the Department of Health will not provide the analytics essential to evaluation and shared savings/risk distribution specific to contracts with these alternate attribution methodologies - rendering them essentially useless. SNAPCAP reiterates the aforementioned risk of invalid reporting and requests clarity on this matter. If NYSDOH is supportive of alternate attribution arrangements, the Department should provide sufficient support to enable their inclusion in contracting. (Page 24)
- Determination of eligibility for target budget increases or decreases based through the relative (i.e. percentile-based) ranking of VBP contractors on efficiency and quality metrics rather than achievement of objective, standardized performance goals. This places VBP contractors in direct competition with each other in a way that will widen the gaps in quality and cost-effectiveness across the state and reward already-successful contractors by way of disinvestment in those which need assistance the most. The potential risk of widening patient health disparities through this payment practice must be explored, and NYSDOH must consider objective achievement goals as an alternative. (Page 27)
- NYSDOH lack of commitment to enforce whether MCOs ultimately pay the shared savings due to VBP contractors. While SNAPCAP ultimately respects NYSDOH flexibility in guidelines for individual MCO-VBP contractor negotiation and arrangement design, safeguards must be in place to ensure that sufficient reimbursement and incentives for services rendered will be provided to all who have earned them. SNAPCAP requests clarification and further attention to this matter. (Page 48)

SNAPCAP encourages the inclusion in the Roadmap of the following recommendation:

- The expansion of Medicaid Analytics Performance Portal (MAPP) access outside of the PPS entity. Due to the volume of VBP contractors which are anticipated to exist outside of the PPS and its staff, SNAPCAP encourages expanded access to MAPP to enable non-PPS data and analytics workforce to use the tool, facilitating broader access to actionable quality and cost outcome data. (Page 29)
- Greater transparency surrounding the measurements currently considered by Clinical Advisory Groups (CAGs) as Category 1 or Category 2 measures. It is difficult to support this section of the Roadmap without having a sense of the measures that are being advanced by the CAGs in each category. (Page 34)

Respectfully Submitted,



Joanne Haefner,
Chair, SNAPCAP Board of Directors



Christine Kemp
SNAPCAP Administrative Director

The New York Self-Determination Coalition is an independent, statewide group of parent volunteers dedicated to promoting participant-directed services as an option for persons with developmental disabilities served by NYS OPWDD.

As representatives of families and individuals using Medicaid-funded services, we applaud DOH's robust involvement of consumers and advocates in the move to Value Based Payment. Our experience in reviewing the 3-way FIDA/IDD contract showed us how consumer input can result in meaningful changes that help assure intended outcomes. We strongly recommend that the Roadmap specify that drafts of future Medicaid Managed Care model contracts be shared with the public in a timely way to allow for reflective comment.

It is essential that consumers be given information that will help them understand the implications of Value Based Payments on their care. The VBP Roadmap must:

Assure that those involved in New York's Independent Consumer Advocacy Program and other ombuds programs are trained in the concepts of VBP, and can communicate needed information clearly to consumers.

Require that plans and providers provide clear information to consumers that explain the incentives generated by different payment mechanisms, as well as their consumer's right to ask for second opinions and seek help from consumer assistance and ombuds services.

We are looking forward to upcoming discussions on how VBP will be adapted to the DD population, and want to flag an issue that will arise as OPWDD develops a VBP Roadmap. During this process, Fiscal Intermediaries must be included as CBOs and incentivized under VBP methodology to take on challenging individuals, including those with high levels of need for LTSS, so that all individuals served by OPWDD have the option to self-direct their services.

Sincerely,

Susan Platkin, Shelley Klein, Maggie Hoffman
New York Self-Determination Coalition

RE: Comments on NYS DOH MA Value Based Payment Plan - 2016 Update

UJA- Federation of NY ("UJA") is one of the nation's largest local philanthropies. Central to UJA's mission is to care for people in need. UJA gives millions of dollars in grants and services each year to a network of over 80 NYS nonprofits that serve the vulnerable and build communities.

New York State Department of Health, as part of the Federal Center for Medicaid Services Value Based Payment Roadmap approval, has committed to an annual Roadmap update process, including a 30 day public comment period. UJA is submitting this email in response to this opportunity to comment.

UJA acknowledges and supports the Plan's recognition that Social Determinants for Health are the health promoting factors that provide foundational ability to shift population health (pages 41- 44). Human service nonprofits, such as those in the UJA-Federation of NY network, provide critical interventions, services and therapies to address these determinants.

UJA-Federation of NY is concerned that the 2016 Value Based Payment Plan does not include enough genuine accountability for assuring that the Managed Care Organizations actually engage with existing, effective human service nonprofit organizations for use of their services, which are integral to achieving the State's goals. UJA notes that these non-profit community service providers have spent many years establishing trust and rapport within their communities, connecting to the hard-to-reach populations that are the focus of the MA payment transformation, and providing excellent quality services, often through competitively procured Government contracts. It is UJA's opinion that it is essential that the State require definable and measured engagement of these human service providers.

UJA is concerned that this Plan may allow the Performing Provider System networks to create their own human services instead of engaging and using services from existing human service nonprofit entities. Should this occur, NYS would both be losing quality and expertise that the Government has invested in (as Government contracts a majority of human service nonprofits) and increasing inefficiency (through creation of secondary human service provision). Further, not mandating that the PPS must engage with existing human service nonprofit experts could result in the permanent loss of these important nonprofit providers.

While UJA recognizes that the Plan subscribes to the concept of use of existing non-profit service providers, UJA strongly suggests that the VBP Plan set a mandate for engagement and accountability for integration between PPS and human service nonprofit providers throughout the entire plan.

Thank you for your consideration.

Edie

Edie Mesick
State Government Relations Executive
UJA-Federation of New York
Albany Office





ACL's Comments on the First Annual Update of the Value Based Payment Roadmap

April 11, 2016

Thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment (VBP) Roadmap. ACL is a membership organization of more than 100 non-profits that provide community based services to people with serious and persistent psychiatric disabilities.

ACL appreciated our inclusion in the Subcommittee on the Social Determinants of Health. Our two overarching interests are for the state to make a long term commitment to securing Community Based Organizations' (CBO) ongoing input into the transition to a VBP structure, as well as to ensure that they have the resources they need to be partners in VBP arrangements.

We make the following points that ask for clarity, change or strengthening.

Payment Reform Guiding Principles (page 8): As explained in this annual update, these principles were developed by the MRT Payment Reform and Quality Measurement workgroup in 2012, before DSRIP and the transition to Managed Care. Although they appear to be in alignment with VBP, we would like to see more added in the way of protections for populations and providers during transitions. Principle 1 and 8 are critical in that transparency and access to services in the appropriate setting (#1) and financial reward to providers emphasizing "prevention, coordination and optimal patient outcomes" (#8) represent important contributions made by CBOs.

VBP Contractor Definition (page 11): A VBP Contractor is defined on page 11 as *"an entity that contracts VBP arrangements with an MCO, and can be an ACO, an IPA, or individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers). Multiple providers can contract a VBP Level 1 arrangement by cooperating clinically and operationally, and making individual shared savings agreements with the MCO. Jointly, VBP contractors and MCOs can create arrangements around:*

- *Total Care for the General Population (TCGP); and/or*
- *Integrated Primary Care; and/or*

- *Selected care bundles; and/or*
- *Special needs subpopulations.”*

In addition, the Roadmap provides that “[p]roviders and MCOs are, however, free to jointly agree to other types or ‘off menu’ versions of VBP arrangements, including existing arrangements, as long as those arrangements reflect the underlying goal of payment reform as outlined above, and sustain the transparency of cost versus outcomes as detailed in Appendix II.”

This definition appears to be limited to entities that are driven by acute care systems and structures that reflect Medicare efforts. It remains unclear what standards, if any, apply to an “individual provider.” Does the parenthetical phrase apply only to “individual provider” or to all on the list, i.e., ACO, IPA, etc.? In addition, the definition seems to leave out an entire group of providers unless they invest in the formation of IPAs, as they cannot become an ACO under Federal requirements. ACL’s members are suited to create VBP arrangements for either specific care bundles or special needs subpopulations (i.e. specifically HARP), however it is unclear from reviewing the document, as well as Appendix II, if it would be possible.

We encourage that the entities allowed to enter into VBP arrangements include providers of all types.

Total Care for Special Needs Subpopulations (pages 14 and 15): In the description of “Total Care for Special Needs Subpopulations” the document indicates that “a capitated model (per member per month PMPM payment) is best suited.” It also states that “[a]s part of the movement towards managed care, the State has already identified several special needs subpopulations which have their own dedicated managed care arrangements.”

ACL is primarily interested in the HARP population. While the transition of the HARP population statewide to managed care should be complete by July, it is only partially a PMPM arrangement because the actual HARP services (HCBS) are still in a FFS structure. Moreover, the ramp up for HCBS has been very slow with little evidence that it will pick up substantially in the first year or two. It seems that there has been no actual evaluation of the benefits of a PMPM for this subpopulation.

In addition, the attribution model used for the HARP population is the MCO assigned Health Home, however individuals in HARPs can choose not to participate in a Health Home so this attribution may be compromised.

We encourage the State to review closely the impacts of the managed care transition so that those providers/CBOs serving the HARP population can effectively participate in VBP arrangements.

Possible Contracting Combinations (page 16): The section on Possible Contracting Combinations is confusing. It seems to identify a set of possibilities and then identifies all the exceptions and possible “pitfalls” of those possibilities. The section includes discussion of “various arrangement options for MCOs to choose when contracting with a VBP contractor” - this implies that the arrangements will be driven by MCOs, however the document is filled with references to the VBP contractor being an equal partner since the goal is shared risk for some populations or bundles of care. The state should be clear about which entities are really in the “driver’s seat”.

This section also introduces the PPS as a potential partner in the VBP arrangement but states that “the PPS would have to evolve to one of the first two options above in order to contract on behalf of the entire PPS.” This indicates that a PPS must become an ACO or an IPA in order to do this, however the PPS provider network includes all types of providers which may not be eligible for ACO designation (which is a Federal process under Medicare). An ACO does not include downstream providers/CBOs like ACL’s members and it would certainly be difficult to include all the providers/CBOs in the PPS provider networks in an IPA.

The State should clarify this section so that there is greater engagement from all provider types.

Target Budgets (pages 25 and 26): Establishing Target Budgets is critical as this is the financial baseline from which VBP arrangements’ “success” is determined.

The document states that the “Target Budget” is based on historic claims data with “risk adjustment and growth trend” included. However, ACL members’ programs have experienced no risk adjustments or growth trends over the lives of their programs. ACL providers start at a disadvantage because their services are budget based, running approximately 40% behind inflation compared to 25 years ago. This represents a hazard for ACL members as the existing claims data available does not reflect actual cost.

ACL members’ Medicaid programs are residential. We recommend that the State look at these rates and make adjustments before VBP is fully implemented.

Financially Challenged Providers (page 31): Financially Challenged Providers who, by definition, can be excluded from the ability to participate as a VBP contractor or be part of a VBP arrangement beyond Level 1, are defined in the following ways:

- Less than 15 days of cash and equivalents
- No assets that can be monetized other than those vital to the operations; and
- The provider has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

This definition may significantly reduce the opportunities for participation by ACL members. Nonprofits that contract with the state exclusively do not have the ability to create reserves so

that most don't have much cash or cash equivalents because they must use or lose all of their government contract dollars. Licensed residential programs that bill Medicaid and surpass their occupancy targets are allowed to keep only 50% of any revenue that represents more than the state sanctioned budget even though they provided full services. If they were able to keep 100% of the dollars that they earn, they would be in a better financial position today. We recommend that the state allow residential providers/CBOs to keep all of the revenue that they earn under Medicaid so that they have at least one mechanism to create reserves. This would require a legislative change. We also recommend that state contracts be adapted so that as long as providers spend 95% according to contract guidelines they are allowed to keep the remainder. Moreover, we recommend that the State explore the development of payment methodologies that incentivize/reward providers for taking on patients with challenging social determinant of health barriers.

Housing and Vocational Opportunities – Boxed Item (page 39)

This boxed item on page 39 includes a number of initiatives.

The Roadmap includes amending the State and NYC's eligibility by prioritizing homeless persons who meet HARP eligibility criteria in existing NY/NY Agreement projects. Rather than amend existing hard fought agreements, we recommend that homeless persons who meet Health and Recovery Plan (HARP) eligibility criteria be given priority access to the new 20,000 supportive housing units to be developed under the 2016 Housing New York Plan.

The Roadmap also suggests that the state seek a waiver to CMS requesting the restrictions on rent in the context of VBP be removed. We recommend that this be discussed further with housing providers, MCOs and PPSs before spending considerable resources in a waiver application. Certain issues must be clarified on all sides, for example: housing providers'/CBOs' readiness to bill within VBP arrangements for rent. Moreover, will arrangements like this put rents at risk if targets are not met? If housing providers/CBOs do not meet targets, will payers want to move their rent payments to different providers/CBOs? If yes, providers/CBOs could be left holding leases for which they cannot meet payments. There are many questions that need to be discussed and clarified before a waiver for the payment of rents is considered.

The Roadmap suggests coordination with Continuum of Care (COC) entities when considering investments to expand housing resources. We do not think this is a good fit. There are not COCs in every part of the state. HUD housing carries very different obligations and eligibility criteria from the myriad of NYS housing for special needs populations. It would be counterproductive for COC members, who are primarily experienced in HUD criteria, to have an outside role in deciding investments if NYS dollars in additional housing. Moreover, COCs are specifically designed to support HUD's investments and are only open to HUD housing providers so that a parallel process that is more inclusive would have to be created. Because it

would be critical for a different and more inclusive process to be developed anyway, ACL recommends that this be removed from the Roadmap. Alternatively, an ad hoc committee of housing providers, senior state staff, and COC representatives should be convened to discuss.

The Roadmap also suggests that MRT housing money be leveraged to advance a VBP-focused action plan. We strongly urge the state to fully vet this with the MRT housing sub-committee.

The Roadmap also refers to the State exploring the option to submit a waiver to CMS that tracks the *CMS Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. Seeking to pay for services with Medicaid dollars in Supportive Housing carries some level of risk related to client care, provider fiscal health, client interest in Medicaid services v more flexible as needed services, and the ability to continue to serve all tenants in Supportive Housing settings. We appreciate that there are savings to be had whenever Medicaid is brought in but in some situations it is not the right thing to do. We urge the State to form a committee to explore the issues related to this action before submitting a waiver.

Finally, we suggest that this be moved from the section headed “Incentivizing the Member” to “Public Health and Social Determinants of Health.” None of the content reflects patient incentives, but rather are clearly in the category of social determinants.

Public Health and Social Determinants of Health (pages 41 and 42): The Public Health and Social Determinants of Health section states that Level 2 or 3 VBP contractors will be required to implement at least one social determinant of health intervention. It indicates that Providers/provider networks/MCOs *“may also contract with CBOs to satisfy this recommendation. Contracted CBOs should expect the inclusion of a value based component in the contract, such as pay for performance, and be held to performance measure standards.”* *Model Contracts will include specific parameters for bonus for Level 1 or a funding advance for Level 2 and 3. Finally there will be a requirement that starting in January 2018 that all Level 2 and 3 VBP arrangements must include a minimum of a Tier 1 CBO.”*

While this appears to be an opportunity for reinvestment there should be greater specificity on the level of requirements and what types of financial benefits would flow to CBOs.

Further, the Tier 1 CBO definition is a NFP, non-Medicaid billing community based social and human services organization that operates housing and other services while Tier 2 includes NFP Medicaid billing providers. Some housing providers operate both Medicaid reimbursed housing programs and non-Medicaid reimbursed housing programs so that they are able to meet the requirements of a Tier 1, but could be considered a Tier II.

Because they operate the programs used as examples in the Tier I description, we recommend that certain Tier II CBOs be listed as both Tier I and Tier II so that they can be counted towards the minimum of one Tier 1.

Medicaid Managed Care Model Contract (page 44): The vehicle for making these significant shifts in the Medicaid program will be through updates to the Medicaid Managed Care Model Contract. The pace of changes starts with 2017 rate setting for MCOs. Penalties to MCOs are designed to start in 2018 if less than 10% of total MCO expenditures are captured in VBP Level 1 or above arrangement with increasing requirements and penalties thought 2020. In addition, there are indications that there will be a variety of statutory and regulatory changes.

At this time the critical work to amend the contract is not completed. There does not seem to have been legislative progress on the statutory changes identified and the regulatory changes remain under the review of various workgroups. This always puts providers/CBOS at risk as the underlying program and financial standards will continue to apply to operations.

The Roadmap should have time frame contingencies built in if the regulatory and statutory changes are not made in a timely manner.

Assuring that Providers Successful in DSRIP are included in Networks (page 54): We are heartened that the Roadmap includes DSRIP funds earmarked to facilitate the process for smaller, less prepared CBOS to access resources and support to develop the sophistication to succeed in this new environment. In particular, the State should invest in CBOs that show promise in helping to address social determinants of health. State funding should be made available to CBOs to help prepare them for their participation in VBP arrangements. CBOs will need funding for, among other things: infrastructure development, including IT systems; ability to do measurement and data collection to demonstrate their value; and contracted services, such as fiscal and legal expertise. In addition, the state should establish a loan fund to assist with cash flow issues that may arise if payment to CBOs in VBP arrangements is delayed.

Medicaid

Medicaid Matters New York

Matters

Comments on the 1st Annual Update of the Value Based Payment Roadmap April 11, 2016

Thank you for the opportunity to comment on New York State's Draft Annual Update to the Value Based Payment Roadmap. Medicaid Matters New York (MMNY) was pleased to have been involved in the process of revising the Roadmap through representation on the VBP Workgroup and the Subcommittees on Advocacy & Engagement, and Social Determinants of Health & Community-Based Organizations. As the statewide coalition representing the interests of consumers served by New York's Medicaid program, we applaud the State for seating these two subcommittees that were dedicated to discussing issues particularly relevant to consumer and community interests. It is through the recommendations advanced by these two subcommittees that consumer and community interests are being recognized in the move to a value-driven payment system.

The level of stakeholder engagement in this process has been unprecedented in many ways. As referenced below, MMNY recommends that the Roadmap reflect a continued commitment to maintaining robust stakeholder engagement that includes the voices of consumers and their advocates. In this vein, it is particularly important that the process to revise the Medicaid Managed Care Model Contract be as transparent as possible, as so many components of the State's move to a value-based system will be implemented through that contract.

MMNY supports the following new components included in the revised Roadmap:

- Addressing social determinants of health, particularly through the following Payment Reform Guiding Principles: "Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health." (pg. 8)
- The section "Incentivizing the Member," which reflects the extensive discussions of the Advocacy and Engagement Subcommittee and includes the guiding principles advanced by that group (pg. 38-40). The focus on positively incentivizing desired behavior and stating clearly that "burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option" is an important point to emphasize. (pg. 38)
- Also regarding patient incentives, the State's interest in measuring and encouraging creativity in incentive programs, specifically its plan to "analyze any collected data and identify best practices on, at least, an annual basis, and will make this information

publicly available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design.” (pg. 40)

- The recommendation that Level 2 and 3 VBP contractors be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations (MCOs) share in the costs and responsibilities of the investment (pg. 41). MMNY supports this recommendation, as achieving good outcomes (“value”) is not possible without addressing social determinants of health.
- Basing the selection of the type of social determinant intervention to be implemented “on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources.” (pg. 42). The inclusion of individuals’ own goals and desires, as well as an assessment of community needs and resources are critical aspects of determining appropriate interventions.
- The requirement that VBP contractors provide “a measureable reason why the SDH was selected, and identify metrics that will be used to track its success.” The emphasis on metrics is critically important in making efforts to address social determinants of health meaningful and effective. (pg. 42)
- The requirement that “starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO” (pg. 42). MMNY joined many other voices throughout this process to consistently highlight the importance of supporting community-based organizations and emphasizing their role as critical to reaching intended outcomes.
- Inclusion of the Advocacy & Engagement, and Social Determinants of Health & CBOs Subcommittees’ recommendation to develop several workgroups to dig deeper into a number of critical issues (pg. 59), including:
 - children and adolescents in the context of VBP;
 - how to reliably track metrics related to social determinants;
 - development of a communications system for providers and CBOs to better address SDH needs;
 - updating the current Managed Care Bill of Rights to include information relevant to VBP and to provide information on VBP to Medicaid beneficiaries; and
 - examining and tracking the use of patient incentives, including particular focus on ensuring cultural competency in patient incentives (mentioned above).

MMNY points to the following components in the revised Roadmap that need further explanation, revision or strengthening:

- In the Quality Measures section (pg. 34), the Roadmap references Category 1 and Category 2 measures, which have not yet been shared with the VBP Workgroup. It is difficult to support this section of the Roadmap without having a sense of the

measures that are being advanced by the Clinical Advisory Groups (CAGs) in each category.

- The Roadmap should also clarify that the CAG report will be shared with the VBP Workgroup and that the public will have a chance to comment on the measures adopted for reporting in drafts of the new Medicaid Managed Care model contract. The Roadmap indicates that the state foresees including these metrics in the model contract, but fails to provide an opportunity to comment on the model contract before it is finalized, stating only that the model contract "will not be posted until it is approved by CMS." In an earlier version of the recommendations from the Regulatory Impact Subcommittee, it stated that "after consideration of the comments... DOH will share the updated Model Contract with the public and solicit additional comments before finalization. DOH will post all of the received comments on the DOH website prior to the adoption of the Model Contract." MMNY feels strongly that there should be a public comment period on the model contract before it is finalized, so that stakeholders have an opportunity to ensure the inclusion of metrics is representative of the successful work many are already engaged in.
- The Roadmap makes reference to Patient Reported Outcomes (PROs) as a key missing link in assessing the outcomes of care for many health problems and conditions (pg. 35). However, a footnote to that reference appears to narrow use of PROs to FIDA, HARP and DISCO models. The Roadmap's only other reference to PROs is in the section on social determinant interventions as a potential means of evaluating program success (pg. 43). PROs should not be restricted to social determinant programs or special populations. Validated PRO measures are now available in the public domain for use across a variety of clinical conditions and have shown success as a means of engaging patients in their care and informing care decisions. The Roadmap should reflect the Advocacy and Engagement Subcommittee's recommendations that some form of PROs be considered by clinicians participating in VBP, and that VBP early adopter pilots serve as a vehicle for piloting the use of PRO measures.
- While MMNY supports the content of the box on Housing and Vocational Opportunities (pg. 39), the box should be moved from "Incentivizing the Member" to "Public Health and Social Determinants of Health" (beginning pg. 41). This should be done to avoid any suggestion that housing and vocational opportunities be used as patient incentives; rather, these are essential to achieving good health outcomes.
- MMNY supports the State's plan to eliminate the \$125 incentive cap for incentive programs. The language in the Roadmap, however, describes the current cap as applying to *preventive services*. The reference should be to an existing cap on *incentive payments*. (pg. 40)
- As it relates to the responsibility of VBP contractors to assess community needs and resources in the selection of the social determinant intervention (pg. 42), it is critical that any community needs assessments be done by neutral, independent entities that

are not providing the services in question. Without neutrality, trust and community buy-in are difficult to develop and maintain. Without trust, reports on capacity and gaps in services may be less than complete and alignment between new initiatives and existing services will be difficult to achieve. Without community buy-in regarding priorities, social determinant programs will fail to capitalize on potential synergies and lack critical momentum. In addition, as mentioned earlier, VBP arrangements for Medicaid services will by necessity operate alongside VBP arrangements for Medicare and commercial payers. Unless clinical programs share goals and milestones across payers, progress will remain erratic and uncertain. Thus, it will be critical for the VBP contractors undertaking community needs assessments and social interventions to coordinate with initiatives launched across payers.

- The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant to VBP (pg. 43). That is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it may affect them. The Roadmap should reference some of the other important actions recommended by the Advocacy and Engagement Subcommittee that the State has committed to undertake, such as:
 - ensuring that plans and providers communicate information to consumers that explains the incentives that different payment mechanisms generate;
 - providing consumer education and promoting patient activation around what is meant by a “high value provider,” as well as the right to question their providers, seek second opinions, and obtain consumer assistance/ombuds services;
 - making sure the State’s Independent Consumer Advocacy Network (ICAN) and any and all consumer assistance/ombuds programs are equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment; and
 - expanding the ICAN program to include Medicaid members enrolled in VBP.
- MMNY applauds the level of stakeholder engagement achieved through this process, as referenced on page 57. The openness to having anyone interested in serving on a subcommittee welcome at the table is unprecedented. The Roadmap should indicate very clearly that this openness will continue.

MMNY urges inclusion in the Roadmap of the following recommendations, which were approved in the reports from VBP Workgroup Subcommittees:

- The State and/or a third party should develop educational materials on VBP that focus on both CBOs’ role in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers, provider networks and MCOs. Additionally, the State and/or a third party should provide technical assistance to providers, provider networks and MCOs’ (non-CBO) contracting entities on how to work effectively with CBOs needing assistance.

- The State should create a “design and consultation team” of experts from relevant State agencies, advocacy and stakeholder groups to provide focused consultation and support in a way that is affordable to CBOs who are either involved in or considering involvement in VBP.
- The State should invest in CBOs that show promise in helping to address social determinants of health. State funding should be made available to CBOs to help prepare them for their participation in VBP arrangements. CBOs will need funding for, among other things: infrastructure development, including IT systems; ability to do measurement and data collection to demonstrate their value; and contracted services, such as fiscal and legal expertise. In addition, the state should establish a loan fund to assist with cash flow issues that may arise if payment to CBOs in VBP arrangements is delayed.
- The State should explore the development of payment methodologies that incentivize/reward providers for taking on patients with challenging social determinant of health barriers.



The Supportive Housing Network of New York (SHNNY) appreciates the opportunity to offer comments on New York State's Draft Annual Update to the Value Based Payment Roadmap. Housing is a perfect example of how social determinants of health are important to providing better health and curbing Medicaid costs. If Medicaid recipients don't have stable housing they are far more likely to overutilize institutional care and settings.

Supportive housing – permanent, affordable, nonprofit-operated rental housing linked to on-site services – has proven to be the commonsense, humane and cost-effective housing option for people with a variety of special needs who are typically the most 'frequent users' of expensive emergency services like hospitals, emergency rooms, residential treatment and hospital detoxification programs, psychiatric centers, prisons and shelters.

The relatively low-cost intervention of providing **permanent housing combined with on-site person-centered care** has been proven to significantly reduce the number and length of hospital stays; the number of emergency room visits; and the number of psychiatric hospitalizations. It has allowed the State to reduce psychiatric inpatient beds and shelter usage, and decrease spending on expensive emergency Medicaid spending. By targeting chronically homeless individuals who are frequent users of emergency rooms, hospitals and medical detox programs, supportive housing can reduce inpatient Medicaid spending substantially. Multiple national studies have found reductions in emergency department and inpatient costs averaging 60%, with overall Medicaid savings ranging from \$1,130 to \$17,625 per person per year.

As a result, the Supportive Housing Network and our members played a key role in crafting the Medicaid Redesign Team's Affordable Housing Workgroup's action plan which recommended that the state invest in supportive housing for homeless high cost/high need Medicaid recipients. Under the leadership of the Department of Health, the state has expanded the availability of supportive housing to serve high cost Medicaid users significantly, investing over \$500 million for supportive housing programs throughout the state over the last five years.

The Roadmap currently recommends amending the three NY/NY Agreements retroactively to prioritize individuals who are eligible for HARP benefits, a recommendation we hope to see amended to prioritizing homeless High Cost Medicaid Users as a priority population for the New York State Governor's recently-announced commitment to creating 20,000 units of supportive housing over the next fifteen years.

The Roadmap is also recommending that CMS lift restrictions preventing Medicaid funding's use for rent, a recommendation the Network heartily supports.

Additionally, the Roadmap recommends utilizing Medicaid to pay for services in supportive housing, which are currently funded through City, state and, to a lesser extent, Federal service contracts that allow providers to provide accessible, flexible, person-centered services as needed as long as the tenant is housed. It is this third recommendation that concerns the Supportive Housing Network of New York.

The supportive housing model – independent affordable rental housing linked to accessible comprehensive support services was born out of years of trial and error following the advent of widespread homelessness in the late 1970s and has been evolving continually since. It is the unique blend of housing and voluntary services that have proven successful in helping even the hardest-to-serve stabilize in the community. It is precisely because the services in supportive housing are voluntary, person centered and delivered by individuals with whom tenants have strong relationships that the model remains attractive to multiply-challenged individuals and families who chafe against restrictions and programs. It should be noted that at supportive housing's birth an estimated 30% of beds in residential settings with stringent program requirements remained empty, with multiply-challenged individuals preferring to live on the streets than in these settings.

As the membership organization that both represents the supportive housing model, 50,000 units of which have been created in New York State, and the 200+ nonprofits that have created and run this housing, the Supportive Housing Network seeks to ensure that the core components of supportive housing services, those that have made the model the only intervention yet devised that successfully stabilizes the most vulnerable people in the community – remain intact.

COMPONENTS OF THE MODEL

NYS supportive housing follows two basic models: on-site service programs in buildings that have dedicated housing units for one or several at risk populations often mixed with non-special needs individuals and families; and housing case managers or multidisciplinary teams supporting individuals in rent-subsidized scatter site community apartments.

Supportive housing programs offer a core set of services to individuals living in designated units and to a lesser degree to low income tenants in mixed use buildings. Whether services are delivered by staff based in a building's on-site office or by staff who travel to scatter-site rental apartments, there are six critical service components that make up this successful model:

- **Housing and services are permanent.** Once an individual is placed in supportive housing, services are available for the duration of tenancy, which in many cases can be for the rest of a tenant's life, due to the chronic nature of the individual's health and social risk factors. As tenants' needs change, the intensity of services are modified, but services are always available.
- **Services are accessible, flexible and integrated,** available when an individual wants or needs these services based on the person's priorities and delivered on the tenant's timetable. To be effective, services must be available in "real time" requiring service availability 24/7. Further services need to be integrated to optimize tenant outcomes.
- **Services are offered by trusted individuals with whom tenants have built a relationship and with whom they are working to address tenants' goals.** Relationships

are built through staff's continual availability to individuals when they want and need assistance.

- **Client-driven priorities** relate to tenants' housing stability, life goals and increasing independence. Pursuing activities that lead to better health status may or may not be a priority at different points in tenants' lives.
- **Consistent staffing model.** The combined requirements of accessible, flexible services and the need for caregivers with whom tenants have relationships means that the model must provide consistent staffing available as needed and as wanted by tenants.
- **Non-stigmatizing approach** in buildings with a mix of supportive and affordable units, where all residents are encouraged to ask for help from the supportive service team. While in reality the individuals in the supportive units are the main focus of the service team, low income tenants experience housing and health instability with some frequency. Building operations depend on the support team being able to provide safety net services and linkage to community providers for all tenants, to both stabilize the building as a whole and ensure that service provision is not visibly limited to special needs tenants and therefore stigmatized.
- **Services are voluntary.** A core principle of supportive housing is that tenancy is not contingent on service acceptance. While service providers are required to provide services to tenants, tenants do not need to accept services in order to remain housed.

Supportive housing programs are funded by numerous federal, state and local contracts, often in a single building. Supportive housing is not licensed and the services are virtually all funded through contracts with NYS or the locality, with a few receiving federal grant support. A single building may have multiple city, state and federal service funding streams serving distinct populations. They are not Medicaid billable programs.

CONCERNS WITH USING MEDICAID FUNDING TO PAY FOR SERVICES IN SUPPORTIVE HOUSING

The Supportive Housing Network is concerned about the unintended consequences of shifting supportive housing services from contract funding to Medicaid funding. The model's unique success in providing stability to those with the most complex challenges requires that the core components of supportive housing remain intact. Below are the key challenges to replacing contract funding with Medicaid funding that must be addressed in order to continue to achieve the model's successful tenant outcomes.

Ensure Service Model is Maintained. The state must ensure that all services that are currently offered in supportive housing that enhance tenants' lives and stability be deemed Medicaid-reimbursable or ensure that state funding is continuously available to cover services that are not covered by Medicaid and that these services may be easily integrated into the service model. While the recent CMS Bulletin attempts to clarify housing related activities and services for individuals with disabilities that would be covered by Medicaid, it is our estimate based on several cross walks that have been done across the country that only approximately 80% of existing services "might" be eligible for reimbursement. The state must ensure that if the funding source for services changes, the actual services funded would not change and the following model components are able to be preserved:

- Building trusting relationships:** At its heart, what make supportive housing services successful is that they are delivered by individuals tenants know and trust. The tenants of supportive housing have generally lost ties to friends and family and their recovery is often tied directly to case managers. This trust is built on case managers' ability to offer assistance to tenants based on tenant goals when the tenant needs or wants it, in a manner that when and at what level is useful to the tenant and the open door approach for on-site programs and the timely assistance from field staff supporting people in scatter site housing. There is little precedent that we can find of Medicaid funding that supports a sustained relationship with housing-based service providers. The Medicaid model is rather structured to encourage a sustained relationship with the primary care provider and with a long term services and supports provider for older and disabled people. For supportive housing services to continue to deliver good outcomes for people while being supported with Medicaid funding, NYS would need to develop a model that is structured to support the building of trusting relationships between tenants (Medicaid beneficiary) and their supportive housing staff over time and in periods when the Medicaid beneficiary may be relatively stable.
- Client-driven priorities:** To effectively engage individuals with supportive services, supportive housing case managers work with at risk clients to develop a service plan with goals that are meaningful to them and activities to accomplish said goals. Goals and priorities change over time as the individual gains experience with mastering skills and achieving goals. Supportive housing service teams need the flexibility to engage individuals where they are and focus on goals of importance to them. Evidence based practices are utilized to engage individuals who may have behavioral health disorders, and/or have endured homelessness, domestic violence and/or other traumas. In a Medicaid model, services are provided based on care plans that specify the type and quantity of services needed to address functional deficits, symptoms and disorders. Individuals do have input, but priorities driving the care plan may largely emphasize the clinical goals important to the payer such as reducing hospital use or evidence based protocols for treating the illness, rather than the individual's goals that may lead to the same outcome but not as directly. Care plans that are narrowly focused on addressing health-related issues could have unintended consequences of undermining the engagement of supportive housing residents in beneficial services, and, if insisted upon, lead to wholesale noncompliance..
- Consistent Staffing Model:** Since the success of supportive housing lies in its offer of voluntary and easily accessible services delivered by staff known and trusted by tenants, Medicaid funding must flow in such a way as to ensure consistent staffing. Thus once tenants are deemed eligible for services, those services will be available to that tenant for the entire year (and for the duration of their tenancy which in most cases is permanently), allowing providers maintain appropriate staffing levels. Predictable and consistent funding enables supportive housing services to be offered on most days of the week for many hours a day supplemented by housing front desk services 24/7. Medicaid payments from a case rate or FFS funding model would result in unpredictable service payments based on each tenant's evolving care plan. Providers faced with significant income variations could not support consistent staffing during extended days/hours on-site in the field to effectively address both routine and crisis management issues for the supportive housing population in their program. Consistent staffing is behind the outcomes that NYS values from supportive housing.
- Permanency:** Once an individual is placed in supportive housing, services are available for the duration of tenancy, which in many cases can be for the rest of a tenant's life, due to the chronic nature of the individual's health and social risk factors. Medicaid-funded services are

typically tied to medical necessity and/or functional impairment with time-limited episodes of care to address care plan goals. Many services in supportive housing are services that are not tied to medical necessity, but rather tied to housing stability. Additionally, Medicaid typically funds service interventions, not service programs. It would be challenging to impossible to maintain a supportive housing program based on fee-for-service or case rate funding for time limited interventions for eligible building residents. If funded by Medicaid, the state would need to ensure that the services provided were for the duration of the tenancy, not time limited. This is the very essence of the model.

- **Real-time service availability:** Supportive housing services are effective because they are available both when and where very vulnerable individuals and families are in need and prophylactically – catching and addressing issues before they become crises. In order to remain effective, services funded through Medicaid must continue to be offered in this way: both immediately responsive to tenants’ needs and as a prophylactic, preventing health and behavioral health issues from reaching crisis levels. Typically, Medicaid-funded services require lengthy chains of administrative approval, which would prove not just unproductive, but counterproductive for very vulnerable tenants, endangering both the health and well-being of affected tenants but others in the community as well.

Establish systems whereby non-licensed providers need not develop Medicaid billing capacity nor hew to current licensing requirements in order to keep the model ‘non-medicalized’. If providers have to comply with resource-draining documentation and billing requirements linked to FFS or case rate Medicaid funding, service capacity will be diluted and/or service costs will need to rise significantly to maintain current levels. Also, the vast majority of supportive housing providers do not have the infrastructure or systems in place to bill Medicaid.

Ensure adequate and uniform rates for services across all MCOs. If housing benefits are managed by the multiple Plans that manage health benefits, it would be a crushing administrative burden for already thinly funded programs, diverting resources from direct services, and not likely to support the service model that is needed to address tenant needs effectively.

Ensure provider reimbursement for service provision regardless of changes in MCO coverage. MCOs typically see 25% turnover in membership each year. In order to ensure consistent staffing and reimbursement, the State will need to fund any and all budget deficits resulting from tenants’ change of coverage.

Ensure all units receive access to services. Currently in New York, all new supportive housing residences must serve a mixed tenancy of individuals and/or families with special needs as well as non-special needs individuals and/or families. This model promotes integration and supports the State’s Olmstead Plan. This requirement coupled with the need to provide services through an ‘open-door’ system means that all tenants of a supportive housing residence may have access to some level of services including building-wide activities. Because Medicaid funding for supportive housing services could only be used for the targeted beneficiaries, it would eliminate activities in single site buildings that are community-building and support a stable tenancy in the building.

At stake is not just very vulnerable people’s housing and health, but the billions invested in congregate buildings and surrounding neighborhoods. If supportive housing no longer proves successful because services are not adequate to meet the needs of very vulnerable tenants, the impacts will be devastating.

As NYS explores how to utilize Medicaid reimbursement to sustain current supportive housing services, as well as expand access to additional at risk Medicaid beneficiaries, the Supportive Housing Network of New York respectfully asks the state to initiate a thoughtful planning process with supportive housing providers to ensure that a model is developed that does not damage the long-term safety net that many housing-linked support programs offer individuals, especially tenants living in permanent housing. A Medicaid model that supports the supportive service program, not just time-limited person-centered interventions, is essential in order to utilize housing-linked services to improve population health.

April 18, 2016

Jason Helgeson
Deputy Commissioner,
Office of Health Insurance Programs,
NYS Medicaid Director
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: March 2016 Update to the Value Based Payment Roadmap

Dear Deputy Commissioner Helgeson:

On behalf of Montefiore Health System (Montefiore), I am writing to offer comments on the draft March 2016 Updated Value Based Payment Roadmap. Montefiore is at the forefront of delivery system reform and value-based reimbursement with government and commercial payers, with approximately half of our total operating revenue generated through performance or risk-based contracts. As such, Montefiore wholeheartedly supports New York State's move to value-based payments. Our comments provided below are offered in this spirit.

Thank you for the opportunity to provide this input. [REDACTED]

Sincerely,



Lynn Richmond
Executive Vice President
Montefiore Health System

Value Based Payment Options

From Shared Savings towards Assuming Risk (p. 18):

We applaud the State for mirroring CMS's Next Generation ACO in developing the financial methodology. Such standardization is crucial to reducing unnecessary administrative burden as providers implement new payment models. However, in further examination of the guidelines provided for Level 2 arrangements (p.20), there are areas in which there should be greater alignment between the Next Generation ACO and the State's methodology. Specifically, the VBP Roadmap deviates from the Next Generation ACO model when it comes financial incentives related to quality, and to shared savings/risk thresholds. **We recommend that the State reflect with the Next Generation ACO methodology related to quality performance and levels of savings, in which every point below 100% results in a 0.1% decrease to the benchmark, up to 1.0%. Further, we recommend the State mirror the Next Generation ACO Arrangement A which provides a cap in total savings (80%) and in maximum liability (15% corridor).**

Innovator Program

Minimum attributed population (p. 84, Section 3.3):

The updated VBP Roadmap states that "VBP contractors [in the Innovator Program] should have a minimum number of 25,000 Medicaid members (excluding dual eligible members) attributed for a TCTP contract." We support setting a minimum population for the Innovator Program; **however, the minimum threshold should be applied in the aggregate across all contracts, so that plans that have smaller footprints in certain geographies are not unintentionally excluded.**

Premium enhancements (p. 85, Section 5):

In the first version of the VBP Roadmap, plans participating in the Innovator Program would receive immediate premium enhancements: "Plans that are leading the way in VBP initiatives will be rewarded by having immediate access to the premium increases associated with VBP contracts. (p. 30)"

We have not found similar language in the updated roadmap. Instead, certain plans (not just those participating in the Innovator Program) are eligible receive a "Stimulus Adjustment" in 2018. **Plans must receive the immediate premium enhancement for the Innovator program. Such funding is crucial in order to establish the administrative infrastructure necessary to support Innovator arrangements and to encourage such arrangements between plans and providers.**

Network adequacy (p. 84, Section 3.1):

Because patients will still have access to the full MCO network, patient access will not be impacted if the Innovator network doesn't meet standard MCO network adequacy requirements. Recognizing that an Innovator must have sufficient depth and breadth of providers within its network to successfully implement population based care, **we request that the Department confirm that the Innovator would not be expected**

to meet the standard MCO NYS network adequacy requirements addressing: numbers of providers per specialty, and any time and distance requirements of providers relevant to the enrollee address.

Plan negotiations and partner selection:

We request that the Department confirm our ability to identify the plans with which we will pursue under the Innovator Program, and independently under “Off Menu” arrangements. Certain existing arrangements may not need to be changed and should not be required to change. Further, certain plans may not have sufficient premium or infrastructure in place to allow for sub-capitation arrangements as an initial step. Providers will be assessed by the State before they qualify for participation in the Innovator Program; however, no such assessment is in place for plans. Allowing providers flexibility to identify which plans with whom to enter into the Innovator Program is crucial in the absence of such an assessment process.

Premium adequacy for sub-capitation arrangements:

CRG Scores: Smaller plans may have inadequate premiums to cover medical costs due to CRG values. Further, many health plans are unable to isolate a network’s CRG scores to accurately pass the appropriate premium for the attributed population. These plans may not be immediately suitable for sub-capitation arrangements, or they may require additional premium enhancements until which time the premium is sufficient to cover medical costs. **For such plans, we recommend that arrangements can still be classified under the Innovator Program even if the first few years of the arrangement are not under the Level 3 TCGP model. Plans and providers should be allowed to start their arrangements under the lower TCTP Level configurations until the premium levels are adequate. This will allow plans and providers to build a glide path to Level 3 TCGP over a multiple year arrangement.**

Quality Scores (p.86, Section 6): QARR scores, which are currently measured at the plan level, have a significant financial impact on premium. **Providers assuming financial risk through a TCTP arrangement should be measured by their quality scores, not the plan’s overall QARR score. Conversely, plans should be responsible for their own quality scores and should not be permitted to reduce payments to providers for deficiencies that are not due to provider activity.**

Measurement of Success: **The performance of providers in the Innovator Program should be measured based on the actual quality and CRG scores of the population attributed to the provider.**

Proposed Changes to New York State Law (p. 48)

We applaud alignment of State and Federal fraud control laws generally. This would allow for more flexibility in provider arrangements as we move towards a value-based system.

We support the development of the recommended ongoing regulatory workgroups on HIPAA/privacy, Program Integrity, and Regulatory Reform, and we volunteer to participate.

We further recommend the development of a system to waive fraud and abuse (and perhaps other) State laws in order to advance VBP arrangements, similar to the Federal waivers developed for the MSSP/ACO program. This recommendation was raised in the regulatory reform workgroup, and we support it. We volunteer to participate in any work group or discussion that would help develop such a waiver system.

Value Based Payment Roadmap Comments

- The model incentivizes performance and outcomes and will ensure that the highest performing providers are reimbursed for success. This will allow providers to structure care in a way that emphasizes prevention and whole health.
- Interim Support- It is critical that throughout the DSRIP demonstration years PPS are incentivized in meaningful ways to financially support downstream providers to prepare for the transition. The transformation requires significant infrastructure changes that without financial support many downstream providers caring for the highest cost members will not be able to survive.
- Behavioral health providers are critical to improving medical outcomes. In the current structure of the “bundles” it does not seem to allow behavioral health providers to be rewarded for improvements in their clients’ physical health outcomes. Integration is an important part of the transformation and will be an important part of improving care and the structure of the bundles may continue to silo this care.
- Depression, anxiety, and bipolar have their own subgroups in the chronic care bundles. This excludes many other chronic SMI diagnoses. How will this be managed (not all individuals with those diagnoses will necessarily be HARP eligible it seems).
- How will Medication Assisted Treatment for addiction be managed in the pharmacy bundle?
- Much of this work will involve data sharing to be effective. In order for community providers to be a part of this transformation we will likely need to connect to multiple RHIOs. This will be a significant cost to organizations. What is the state considering to improve data sharing through a smaller number of HIEs? Also to ensure care is tracked across more than one borough.
- Behavioral Health organizations (particularly Substance Use Disorder) are currently limited in sharing information with RHIOs due to 42CFR. What work is being done to support RHIOs in ensuring they work to develop methods to share information.
- The roadmap incentivizes the provider to address the Social Determinants of Health and it is important to keep the requirement to contract with CBOs.
- How will this impact the PPS rate of FQHCs?

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