

March 30, 2015

VIA ELECTRONIC SUBMISSION

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

**RE: New York State Value-Based Payment Roadmap—Third Draft Version
March 2015**

Acting Commissioner Zucker:

The Biotechnology Industry Organization (BIO) is pleased to submit the following comments regarding New York State's Value-Based Payment (VBP) Roadmap (the "Roadmap") released by the Department of Health for New York State (the "Department") in March 2015.¹ 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 Roadmap document released earlier this month, 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 particularly 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. While the goals of the DSRIP program focus more specifically on decreasing unnecessary hospitalizations and increasing care coordination, the current structure of the Roadmap may allow participating MCOs and Performing Provider Systems (PPS) to broaden efforts beyond these DSRIP goals in pursuit

¹ New York State Department of Health (March 2015). *VBP Roadmap—Third Draft Version March 2015*, Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/roadmap_third_draft.pdf.

of the achieving the triple aim. In fact, the Department identifies that the Roadmap is meant to outline “what the state and its stakeholders consider to be the payment reforms required for a high quality, financially sustainable Medicaid delivery system.”² Given this scope, BIO asserts 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 measures to prevent 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 models 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 model in which their provider participates.

BIO agrees with the Department’s broad approach of surveying existing payment and delivery of care models to ascertain lessons learned that may improve the development and implementation of the Roadmap. For example, the Roadmap identifies the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation’s (CMMI’s) Bundled Payment for Care Improvement (BPCI) Initiative as a recently developed model that shares many of the same aims—including to improve primary care and care coordination—as the Roadmap, and even the broader DSRIP. BIO cautions the Department that this model was built for a different population with potentially different clinical care needs, and thus, should not be emulated in its entirety. Nonetheless, several lessons learned from the implementation of the BPCI to date that may be relevant for the Department’s development of the Roadmap include:

- Normalizing random fluctuations in baseline prices;
- Removing expenditures associated with new technologies from the benchmark until these costs are adequately captured in the baselines;
- Making initial performance period one-sided risk while methodologies are refined, with the option to transition to a two-sided risk model after the initial performance year; and
- Using local/regional benchmarks (or a blend of historical benchmarks and community rates) rather than individual benchmarks so as to attract/reward efficient providers and avoiding cherry picking, transitioning to healthier case mix, and/or stinting on care over time in order to achieve savings.

Bearing in mind both these lessons learned and the potential 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 establish an Advisory Team specific to the implementation of the Roadmap;
- 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.

² VBP Roadmap at 5.

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 Models.

The Roadmap identifies four potential alternative payment and delivery-of-care models from which an MCO and the PPS with whom it contracts can choose. However, given the broad language that prefaces the description of the models in the Roadmap; the scope of the health outcomes, services, and technologies that each model can target; the resulting potential impact of these models on patient access to needed care, is unclear.^{3,4} 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, like cancer, 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 all providers they see, the MCO that manages their health care, or the chosen VBP model.

Although details regarding how innovative drugs and biologicals will be incorporated into the four VBP models are currently not sufficient for BIO to offer detailed comments, in developing and refining those details, we urge the Department to consider that the inclusion of drugs and biologicals in a bundled or episodic payment model is complicated. This is because any such model 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 seriously 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—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.

Therefore, in determining the appropriateness of including drugs and biologicals in any bundled or episodic payment model, the Department must consider the extent to which the choice of therapies is driven by a patient’s individual clinical presentation for a given disease or condition (or a specific stage of patient care), as well as the extent to which the choice of therapies impacts the overall costs of care. 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. Additionally, questions of true therapeutic equivalence for biologicals are multi-faceted. Thus, any VBP model included in the Roadmap must be structured in such a way 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.

To the extent that drugs and biologicals are ultimately included in a bundled payment model, BIO urges the Department to incorporate safeguards in the structure of all such

³ VBP Roadmap at p.5.

⁴ 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 p. 23.

models—in the form of accounting for individual patient severity and the heterogeneity of a patient population—to protect against creating treatment “winners and losers” within such an episode wherein decisions about cost have the potential to undermine appropriate care.

If the Department decides to allow Roadmap participants to establish VBP models—whether those described in the current version of the Roadmap or any others—such that they do not carve out drugs and biologicals entirely, it must at least consider a system in which drug and biological costs are partially carved out from the bundled payment. Under this system, a certain amount of drug costs would be included in the bundle, but the remainder of the cost of a therapy would be paid separately. This would still give providers the incentive to consider alternative treatments, but would mitigate their risk if patients require drugs and biologicals that exceed the budget target established for providers participating in the model.

Equally important to ensuring patients’ timely access to appropriate care is the need for the Department to ensure that any VBP model 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. In the end, it is important that the Department’s approach when implementing the Roadmap 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 appreciates the Department’s focus on improving integrated, high-quality care for Medicaid patients. We agree that VBP models included in the Roadmap that result in increased integrated care for this population have the potential to decrease overall costs of care—for example, through reducing avoidable hospital use—while improving patients’ experience within the healthcare system. Additionally, we appreciate the Department’s recognition that “one size does not fit all” in the case of reforms to the payment for and delivery of care to different patient populations. This recognition is evidenced in the multi-option approach that the Roadmap lays out, including models that focus on the total cost for total population (TCTP), integrated primary care, selected care bundles, and special needs subpopulations. This structure is intended to afford MCOs and PPS, or groups of their constituent providers, the opportunity to identify and develop contracting arrangements that are most appropriate based on the healthcare needs of specific patient (sub)populations.

While BIO appreciates the importance of providing such flexibility, we also urge the Department to establish standard beneficiary protections that apply across the Medicaid MCO population. First, given the many complexities involved in designing and implementing

VBP reforms, we believe that MCOs should be required to provide patients with a thorough, intelligible understanding of the structure of the VBP model in which their provider(s) participate and how it may impact their care. Additionally, the Department should specify protections for both patients and providers with regard to transitioning from the current system to the VBP models envisioned by the Roadmap. Patients included in any VBP model established under the Roadmap should retain, at a minimum, existing protections, such as those already included in the Medicaid program under both state and federal law. For example, the Department should build on the Medicaid managed care requirement for grievance and appeals processes,⁵ and other reviews of patients' access to medical technologies, to ensure patients are afforded robust and timely access to the most appropriate drugs and biologicals. We also urge the state to build upon these requirements. The potential to create a carve-out for drug and biological therapies (described previously) will help, but other protections may be needed. For example, we urge the state to ensure that patients are able to access needed therapies, including those that are newly prescribed, for the entire time a grievance or appeal is pending.

In considering beneficiary protections, we appreciate the Department's discussion in the Roadmap of the potential to explore beneficiary attestation as part of the attribution determination.⁶ BIO supports any effort on the part of the Department in implementing the Roadmap to ensure beneficiaries are well-informed about the various types of payment and delivery-of-care models that may guide their individual care, and 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.

BIO also appreciates that the Department intends to look to refine the Roadmap, at least annually, through collaboration with stakeholders. However, we ask that more information be provided on how stakeholder feedback—including input from patients and their representatives—is incorporated into this process. For example, we note that a final version of the Roadmap must be submitted to CMS by April 1, 2015, but the public comment period the Department established only closes on March 30, 2015. Thus, it is unclear how this round of stakeholder feedback will contribute to the Department's refinement of the Roadmap. In future years, we ask that this process be clarified to ensure efficient communication between the Department and interested stakeholders.

In addition to seeking stakeholder feedback, we also urge the Department to conduct its own monitoring activities. Specifically, the Department should actively monitor patient

⁵ See 42 C.F.R. § 438.402, *et seq.*

⁶ VBP Roadmap at p. 22.

feedback and work with stakeholders representing the patient community to ensure the VBP models 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. Establishing an Advisory Team Specific to the Implementation of the Roadmap.

BIO reiterates our appreciation of the opportunity to provide comments specific to the third version of the Roadmap. Input from a diverse group of stakeholders is important as these stakeholders are often in possession of information to which the Department itself may not have access or may not have considered, including how certain changes to the delivery of and payment for care may impact beneficiaries and/or certain subpopulations of beneficiaries. Moreover, stakeholders interact with the realities of operationalizing these reforms and will be on the front lines of their implementation. While the Department notes that annual refinements to the Roadmap may be made available for public comment—a structure to the process of refinement that BIO stridently supports—we also recommend that the Department consider establishing a specific advisory team to support the efforts around refining and implementing the Roadmap. The expertise of such an advisory team would be valuable to the Department both in assessing the progress of the Roadmap and in considering refinements even before they are released for public comment. We urge that any such team include robust provider representation, be formed through a nomination and confirmation process that is transparent and open to public comment, and have responsibilities that include a review and assessment of the operation of the Roadmap with regard to how well it is meeting its goals and the goals of the broader DSRIP program.

IV. Providing Additional Details around the Attribution Methodology to Ensure Patient Access to a Range of Providers.

The Roadmap notes that both the TCTP and the Integrated Primary Care value-based arrangements will require an attribution model to track provider progress on meeting established cost and quality-of-care benchmarks. The Roadmap does not include a detailed attribution methodology for stakeholder feedback; however, it is not clear whether the Department intends to utilize a methodology, or a version of a methodology, currently utilized by other DSRIP programs. Thus, we ask that the Department include additional details specific to the attribution methodology that will be employed for the implementation of the Roadmap in the next Roadmap version. In establishing such a methodology, we also ask the Department to consider three specific issues.

First, a standard attribution methodology should be applied across all MCO/PPS contracts to help prevent against the establishment of perverse provider incentives, such 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).

Second, the attribution methodology should be able to clearly identify that a particular provider is responsible for the care provided during the measurement period. Provider attribution must be 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. Thus, BIO urges the Department to consider focusing on only those diseases for which this interaction of providers, and its impact on patient care, is well-characterized to avoid creating incentives that could result in fragmented patient care. 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 the care offered by other types of providers.

Third, we also ask the Department to be aware of the potential that incentives for providers may become distorted because of how costs are assigned within or outside of a bundled payment. Such may be the case if the cost of certain interventions is included in the cost of care provided within an institution rather than assigned to a specific PPS, group of providers, or individual providers (e.g., as is the case for drugs and biologicals administered during acute care hospital stays). In these cases, providers in a VBP program may be incentivized to over-admit patients who receive high-cost drugs or biologicals so that the cost of the drugs are assumed by the institution and not recorded as costs incurred by the provider. BIO urges 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.

V. Establishing a Detailed Benchmark Methodology to Promote Evidence-Based Decision-Making around Budget Targets.

In the benchmarking section of the Roadmap, the Department distinguishes between its role—to provide the MCOs and PPS/combinations of providers with the benchmark data—and that of the MCO/PPS—to set the target budgets for groups participating in a model option that requires a bundled payment (e.g., TCTP, integrated primary care). BIO appreciates this clarification and agrees that a standard methodology to establish risk-adjusted benchmarks should be used across all participants. As long as the data sources and methodology used to calculate these benchmarks is standard, the individual MCO/PPS decisions around target budget will be utilizing data based on the same assumptions.

While a standard benchmarking methodology is envisioned, the Roadmap does not provide specificity around that methodology. We ask that the Department provide more information so that stakeholders, many of whom may have experience establishing benchmark methodologies for the purposes of alternative payment models, can provide meaningful input. In the absence of such detail, BIO, nonetheless, would like to raise two key considerations for the Department with respect to establishing benchmarks.

First, BIO appreciates the Department's cognizance of the potential disincentives to a participating provider that may occur if the payment baseline is continually reset downwards once savings have become commonplace. In fact, the Roadmap identifies concerns with "a gradual downward trend in the overall provider reimbursement" in the context of the integrated primary care model. BIO is similarly concerned that the lower a provider's benchmark is set, the greater the incentive the provider may have to stint on necessary care or use strict utilization-management techniques in order to meet the established benchmark. In working to address these concerns, we urge the Department to broaden its focus from the integrated primary care model to all potential shared savings and bundled payment model designs. We believe a specific focus on this issue across all models is critical to achieve savings through improvements in the coordination and quality of care, without placing limits on beneficiary access to needed care.

Second, in the Roadmap, the Department also notes its intent to publish potential (shared) savings of MCO/PPS participants, estimated by benchmarks on potentially avoidable complications. BIO appreciates this commitment to transparency, and believes that these data will help ensure that stakeholders are able to provide thorough, meaningful feedback

to the Department on the implementation of the Roadmap. Nonetheless, we urge the Department to ensure that any release of data is accompanied with sufficient context to allow stakeholders to understand what the data represent, and equally importantly, what is not represented in order to avoid misinterpretations that could negatively impact VBP model refinement under the Roadmap.

VI. Accurately Accounting for the Risk Associated with the Underlying Health of Patient Populations and Subpopulations.

While the Roadmap references the need to ensure that benchmarks, and the target budgets that are developed based on them, take into account the underlying health of a patient population or subpopulation, it does not specifically propose a risk-adjustment methodology. In the absence of the ability to offer feedback on such a methodology, BIO would nonetheless like to raise two key considerations that we ask the Department to keep in mind as a specific risk-adjustment methodology is developed.

First, we ask that a standard risk-adjustment methodology is used across all VBP model contracts under the Roadmap. As long as the data sources and methodology used to calculate provider risk are standardized, the individual MCO/PPS contracts will be utilizing data based on the same assumptions.

Second, we note that many common risk-adjustment methodologies, like the CMS-Hierarchical Condition Categories (HCC), suffer from a number of shortcomings. For example, risk-adjustment methodologies that are prospective, rather than concurrent, predict future spending rather than measure current patient needs or reflect current patient health problems. Additionally, these methodologies do not sufficiently account for changes in clinical evidence regarding patient care. Thus, based on the need to ensure accurate comparisons between providers participating in VBP programs, BIO urges the Department to develop and continue to refine a risk-adjustment methodology that takes these issues into consideration.

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

The 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 models 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 Roadmap, the Department specifically notes that “a minimum number of patients per PPS/provider combination per integrated care service is required for these [VBP]

arrangements to become meaningful.”⁷ 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.

VIII. Establishing Robust, Meaningful, Specific Quality Measures.

Throughout the Roadmap, the Department notes that the VBP model options require practices to meet both cost and quality targets. In several contexts, certain quality metrics are identified as part of those targets, including potentially avoidable (re)admissions, Emergency Department visits, and “other potentially avoidable complications, as well as patient experience” and “a broader range of project-specific process-and outcome measures.” The Roadmap also mentions the potential that “Patient Reported Outcome Measures (including quality-of-life metrics)” will be employed.⁸ While BIO appreciates the Department’s reflection of the broader DSRIP program goals, we note that the structure of the Roadmap, as currently drafted, can afford MCO and PPS participants the flexibility to target quality and cost measures beyond just the DSRIP program goals. Given this flexibility, BIO recognizes that there is not sufficient detail on the quality measures that participants will utilize for us to provide specific feedback on their potential inclusion. Nonetheless, we agree that now is an ideal time to test new scales for Patient Reported Outcomes, and would welcome the opportunity to discuss this further with the Department. BIO also strongly urges the Department to consider the following issues in developing, utilizing, updating, and assessing participants’ use of quality of care measures across the implementation of the Roadmap.

BIO believes that any quality measures used in the Roadmap’s models must meaningfully evaluate whether the patient is receiving the most appropriate course of treatment, and serve as a bulwark against the perverse incentives that can be brought about by a solitary focus on cost-containment, namely under-utilization of appropriate and medically necessary care. We therefore urge the Department to consider whether, for a specific patient population or subpopulation:

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.

First, it is not the case that existing quality measures are always appropriate for every provider. For example, a quality measure may be benchmarked to a different population (e.g., one that is inherently healthier) than the patient population being treated by a specific provider, especially if that provider is a medical specialist. Heterogeneity of patient

⁷ VBP Roadmap at p. 24.

⁸ Id. at p. 20.

populations with complex, chronic diseases, or those with rare diseases, may render such a quality measure invalid, and unduly penalize their providers based on the underlying disease severity of their patients, rather than the quality of the care they provide.

Second, even where quality measures appropriate for specialized care do exist, not all measures are created equal. Thus, to ensure the validity of available quality measures for purposes of the demonstration, the Department should require that MCO/PPS contracts utilize measures that are endorsed by the NQF or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures. Moreover, to ensure that applicable quality measures are appropriate for the episode-based model in question, we urge the Department to ensure that any such measures:

- Are based on appropriate timeframes for the conditions being treated;
- Are appropriate for the procedure or condition;
- Are meaningful to patients and provide actionable results;
- Are appropriate for the type of provider;
- Encourage coordination between specialty care and primary care providers; and
- Where possible, include outcomes-focused and patient-reported measures, instead of relying solely on process-focused metrics.

While BIO believes each of these characteristics is important, we draw the Department's attention specifically to the issue of the timeframe covered by a measure. Because the impact of many interventions on patient outcomes or total cost of care may not be apparent for several weeks or months (or even years), it is crucial that a measure (or measures set) be both actionable and able to capture these downstream effects to avoid incentivizing short-sightedness in the provision of care. The Department should also ensure that each measure can be accurately assessed within the timeframe assigned to the episode of care. This is especially crucial in chronic and severe disease management where care is provided over the course of several years.

Additionally, we would like to highlight that, where possible, the Department should aim to employ a balanced set of quality measures that are both outcomes-focused and process-focused, where appropriate. While process-focused measures may be appropriate to measure preventive services (e.g., percentage of a population that has received a recommended vaccines), they are not always indicative of a causal change in health outcomes based on an intervention. While process-related outcomes are an important start to understand how a standard of care is implemented, in certain cases outcomes-measures may more directly link the care provided with a specific health outcome. Since the ultimate aim of alternative payment models is to maintain or improve quality of care, it is preferable to include actionable measures that balance and help to assess actual changes in health outcomes instead of relying on the interpretation, or likelihood, that changes in process will directly affect outcomes. Especially in the case of complex and chronic diseases, it is imperative to assess many different factors beyond the process of care which can influence longer-term health outcomes.

Third, for reasons articulated previously, we urge the Department to consider how the applicable quality measures will take into account factors outside of an individual provider or PPS's control. For instance, the Department could adjust performance on quality measures in each of the VBP models described in the Roadmap to account for factors such as a patient's pre-existing medical condition(s), disease severity, and co-morbidities. We strongly urge the Department to take into consideration the degree to which a patient's

outcomes—and a specialty care provider’s performance on the corresponding quality measure—are impacted by the care rendered by other provider types not included in model’s evaluation.

Fourth, 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. Furthermore, BIO urges the Department to carefully evaluate quality measure-containing cost components given the inherent incentives of a bundled payment model and to place excessive emphasis on costs. 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.

IX. 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. Please feel free to contact me at (202) 449-6384 if you have any questions or if we can be of further assistance. Thank you for your attention to this very important matter.

Sincerely,

/s/

Erin Estey Hertzog, J.D., M.P.H.
Director
Reimbursement and Health Policy

Comments on Value Based Payment Roadmap- Third Draft

The Community Health Care Association of New York State (CHCANYS) respectfully submits these comments in response to NYS' Third Draft Value Based Payment (VBP) Roadmap dated March 2015. As a member of the Value Based Payment Work Group, we appreciate the opportunity to comment on the document.

What New York State's Medicaid VBP plan is not

The inclusion of this text box on page 5 in this third revision of the VBP Roadmap is a great attempt of easing some of the tension providers are experiencing as the VBP program evolves. With regards to the third bullet addressing "adequate reimbursement for FQHCs", it is our assumption that this addresses the commitment by New York State to continue the FQHC Medicaid Managed Care Shortfall ("wraparound") program as VBP is implemented. To provide more clarity to the FQHC industry, the following phrase should be appended to the last sentence of this bullet – "and consistent with Federal statute".

Role of PPS in off-menu contracting

While we appreciate that DOH clarified what Value-Based Payment "is not", including that it is not an attempt to make PPS leads responsible for PPS providers' contracting, other sections of the Roadmap do not support this sentiment as strongly as we would like and may even contradict this language.

For example, on pages 15-16, you write, "[T]here is a risk that PPSs that do not contract either the total care for their population or integrated primacy care at the PPS level end up jeopardizing the population-health focused infrastructure, patient-centered integration, and associated overall workforce strategy that DSRIP sets out to build. In these cases, the PPS and the MCO will have to submit a plan outlining how the value-based arrangements that they opt for will be sustained." This language seems to indicate that if the PPS does not contract directly with the MCO for Integrated Primary Care services, then the PPS and MCO needs to submit a plan to the State explaining how the efforts of DSRIP will be sustained. How will this arrangement affect alternative contracting arrangements in which the PPS is not the lead? Will providers need permission from the PPS to enter into alternative arrangements?

We are concerned that this requirement may create a disincentive (monetary or otherwise) for such off-menu contracting. Despite the assurance that VBP will not automatically make PPS leads the arbiters of PPS provider contacting, it is not clear to us that provider groups and MCOs can contract without the PPS blessing or meeting the PPS framework for outside contracting. We request that there be further clarity on the parameters of the role of the PPS in off-menu contracting situations and the ability for groups of providers to contract directly with the MCOs without the PPS' approval.

PPS v. Providers within a PPS

As we have stated in our comments on previous drafts of the Roadmap, the State should provide clarity around how VBP contracting would work between a payer, a PPS and/or the subsets of PPS providers. If subsets of providers are free to enter into their own agreements, then that would potentially prohibit, dilute, or disrupt any PPS-wide VBP agreement or proposal. To avoid this, the PPSs may try to lock in their providers into a PPS-wide VBP model. How does the State plan to disincentivize such behaviors?

Furthermore, the draft does not outline what constitutes a sub-group of providers within a PPS? The Roadmap seems to anticipate that all of a type of provider within a PPS would constitute a subgroup. Clarity is required on this point because there may be any number of reasons like types of providers may join a PPS but not find it desirable, feasible or practical to form sub-groups with all other similar providers. Rather, the providers should be given flexibility to form a sub-group with only some of their partners. Additionally, some providers may be part of a larger affiliation of providers, some of whom may be in the PPS and some who may not. Could the entire provider group participate as or part of a sub-group even if not all of them are in the PPS? Could the provider as part of the larger affiliation contract both as part of the affiliation and as part of the PPS?

These issues still have not been addressed in any of the Roadmap drafts and in fact, this version seems to heighten the importance of contracting through the PPS. The Roadmap simply allows for proposing alternatives for “off menu” contracting, and does not guarantee that these types of alternative arrangements will be permitted. It is very important that the flexibility for providers to contract within *or* outside of a PPS is maintained. This will permit providers to build on previously existing successful relationships between entities.

Additionally, the following previously submitted comments have not yet been addressed:

Use of DSRIP incentive payments

We applaud the VBP Roadmap’s approach to allowing combinations of providers to contract directly with MCOs for VBP for appropriately selected bundles of care without the PPS’ involvement. That being said, groups of downstream providers who are potentially able to directly contract with an MCO for a bundle of care fear that the PPS Lead agencies may use the DSRIP incentive payments as a “stick” to force providers within their PPS to join a PPS/MCO VBP arrangement. To prevent this from happening and to ensure that the DSRIP incentive payments work their way down to the providers responsible for accomplishing the goals of DSRIP, the VBP Roadmap should provide for protections to ensure that the DSRIP incentive payments are not unduly utilized by a PPS to force the MCO contracting efforts of its downstream providers.

Management of Chronic Disease

In your definition of Integrated Primary Care on page 10, you include “effective management of chronic disease” as a component of providing primary care services. Later, on page 23, seven

diseases are listed in the Integrated Primary Care bundle, including diabetes, asthma, hypertension, depression, chronic heart failure, coronary artery disease, and COPD. By including each of these diseases in the Primary Care bundle, it appears that providers would need to manage each one as part of a VBP model. While the first few diseases are typically managed effectively by primary care physicians, the last three- chronic heart failure, coronary artery disease, and COPD- require coordinating care with specialists, who may or may not be on staff at a health center. We request further discussion on inclusion of specific chronic diseases in the Integrated Primary Care bundle.

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A non-profit tax-exempt organization representing
New York City's community-based behavioral
health sector

Coalition Comments on Value Based Payment Roadmap

Thank you for the opportunity to comment on the Value Based Payment (VBP) Roadmap. While the outline for the long term plan is clear, there are many questions that need to be addressed prior to achieving the goals outlined.

The Coalition of Behavioral Health Agencies (The Coalition) supports the concept of payment methodologies that incentivize paying to keep people healthy. Behavioral health services frequently reduce the total cost of care and produce better outcomes for individuals with mental health and addiction issues.

One fundamental concern that the Coalition has with the VBP Roadmap is that the Roadmap is not clear about how far downstream Value Based Payment will penetrate. The overall financial relationship between the community based behavioral health provider community and the Performing Provider System (PPS) is uncertain and the Coalition is concerned that many providers may not be included in the payment structures that get developed. While the PPS may enter into a VBP relationship with an MCO, it is not clear whether the PPS is then required to replicate the incentives with downstream providers. This potentially would negatively impact community based organizations (CBOs) that serve both adults and children.

The Coalition is also concerned that VBP will replace current requirements that MCO reimburse outpatient behavioral services at rates equivalent to the current Medicaid Fee for Service (FFS) rates. The Coalition would urge 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.

Similarly, mental health parity is at a critical juncture in its implementation. Hopefully, VBP will encourage access to behavioral health services. However, if VBP were to create incentives to reduce access to behavioral health care, there could be a significant issue regarding compliance with federal and state statutes.

It is also unclear how providers that primarily serve children will be incorporated. While many PPSs have included children in some of their discussions, this is not a group that is well represented within the metrics that were developed. Overall, a discussion about children

with special needs must occur. The timeframe for children's managed care transitions is on a different trajectory than adults, and VBP requirements should reflect this alternative schedule so that these providers can meaningfully participate.

The Coalition is also concerned about the feasibility of achieving VBP goals by 2019. Provider participation in PPSs is continuing to evolve. It is necessary to ensure that behavioral health partners have access to funds to invest in their infrastructure to allow them to meaningfully participate and transition with the rest of the health care ecosystem.

An additional area where The Coalition believes some greater detail and clarity is required concerns the New York State oversight of the VBP financial relationships that are developed among MCO, PPS and community based providers. NYS should exercise appropriate oversight regarding issues such as the minimum Medical Loss Ratio associated with relationships, stop loss arrangements with downstream providers and willingness to contract with quality community based providers.

The New York State roll out of VBP payments includes a number of initiatives that The Coalition supports and is looking forward to seeing greater detail on their proposed implementation. These include positive incentives for consumer lifestyle changes, the risk pool for providers who become financially distressed due to VBP and the transparent use of PPS data to inform VBP discussions.

Lastly, the VBP roadmap has raised a number of additional open issues that require more guidance, including:

- As noted above, it is unclear how far downstream value-based payments go. In addition to relationships between a PPS and individuals partners, there is a lack of clarity regarding whether an IPA that contracts with a PPS-MCO would need to replicate value based arrangements among its members.
- Throughout the roadmap, reference is made to PPS-MCO. The Coalition would like to better understand what form this joint entity might take. As we understand it, PPS entities distribute DSRIP funds while MCOs pay for services. In NYC, most PPS will have attributed members that belong to multiple MCOs. In such a complex environment, it seems like community based organizations might be faced with multiple VBP methodologies that could stretch their administrative capacities.
- There should be more specificity regarding how carved out services or individuals would be handled in the context of VBP. For example, behavioral services remained carved out for dual eligible individuals.
- Home and Community Based Services (HCBS) for individuals with behavioral needs are an exciting new expansion of services. Given that such services are in

developmental stages, special consideration should be given to supporting such services independent of VBP while experience is gained with the program.

- Many MCOs are utilizing Behavioral Health Organizations (BHO) to manage behavioral benefits. This can be a fragmented approach to managing an individual's total health care needs. Such relationships, that focus entirely on the behavioral health spend of an individual appears to be inconsistent with VBP approaches.
- Social services are an important component of the total cost of care for an individual with behavioral health needs. Such services appear to be outside the scope of VBP.
- Historically, community based agencies have made capital expenditures based upon financial assumptions regarding Medicaid rate support for such expenditures. Some consideration should be made to support such expenditures or allow for their transition in a VBP model.

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

March 31, 2015

BY E-MAIL

Jason Helgeson
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
99 Washington Avenue
Albany, NY 12210

Re: Third Draft of the Value-Based Payment Roadmap

Dear Jason:

On behalf of the Coalition of NYS Public Health Plans and the NYS Coalition of Managed Long Term Care and PACE Plans, thank you for the opportunity to provide feedback on the third draft of the Value-Based Payment Roadmap. As we have expressed to you in feedback on previous drafts of the roadmap, Medicaid managed care organizations, including both mainstream and long-term care plans, see real value in shifting from fee-for-service to value-based payment models. We hope that the following comments will help the Department of Health and the Value-Based Payment (VBP) Workgroup and its Subcommittees further fine-tune the state's approach to value-based purchasing during DSRIP and beyond. Understanding that this roadmap is a "living document," we look forward to providing more feedback on future iterations of the roadmap and to participating in VBP Workgroup and Subcommittee meetings moving forward.

The Need for Flexibility

VBP Innovator Program

For several key reasons, the Coalitions urge the State to reconsider the VBP Innovator Program as described in the third draft of the roadmap.

The State should encourage providers to attain maximum sophistication in population health management through mechanisms other than mandated business relationships with plans. The Innovator program as drafted has a high potential of disrupting existing, effective VBP arrangements and interfering with market-based business relationships that best serve Medicaid clients. Contractual relationships between plans and providers—many of which already contain a number of VBP arrangements that may not be catalogued by the State—are important, complex, and part of the overall economy of the plan and delivery system worlds. Creating a

requirement, or even an expectation, that any provider certified as an “innovator” will receive a particular type of payment is potentially disruptive to members and destructive of important provider relationships. For example, a plan may already have a total-cost-of-care arrangement in place with a provider system that includes individual and other providers with their own surplus sharing or partial risk arrangements. If, under the VBP Innovator Program, one or more of these provider groups is certified as an “innovator” (thereby creating an expectation of an entitlement to receive approximately 95% of the dollars paid by the State to the plan for the care it provides), should the existing total-cost-of-care arrangement be undone so that the innovator group of providers could take the position at the top of the premium chain (i.e., to be paid directly by the plan)? Such an example (notably of just one plan and one provider group within one VBP arrangement) highlights how disruptive enforcement of the VBP Innovator Program would be, as written. Presumably, this is not the State’s intent.

It would be more effective to offer “carrots” to providers by, for example, excusing them from posting certain levels of reserves or providing them with various other kinds of regulatory relief that are current barriers to assuming risk. The Coalitions do not believe the State should insert itself into the relationship between plans and providers in this fashion and that it should consider other incentives to motivate innovation at the provider level without disrupting existing arrangements—some of which already meet the VBP objectives laid out in the draft roadmap.

The VBP Innovator Program interferes with partnership among plans and providers. The State’s VBP strategy should incentivize plans and providers to have market-based relationships that are also partnerships. To maximize value and achieve the triple aim, plans’ and providers’ interests should be aligned. A plan must be confident that its provider systems can deliver quality, access, and member satisfaction; a provider system must be confident that it can rely on its plans for needed information, support, and consultation to manage care and reconcile finances. The mandatory and prescriptive nature of the VBP Innovator Program disrupts this alliance, which the Coalitions believe will be essential to the long-term sustainability of DSRIP and to maximizing the value of care provided to the State’s Medicaid members.

As emphasized above, a pass-through of a premium percentage should not be mandated; should the State advise on one, however, 95% is far too high. To the extent the State weighs in on an appropriate percentage of premium to be passed down through a total-cost-of-care arrangement or other VBP arrangement, the figure included in the draft roadmap—95%—is much too high. Plan administrative expenses range from 7-8% of premium up to 12-15% of premium. No plan can survive on 5% of premium to administer the program and fulfill the State’s solvency, reserve, or Medicaid managed care contract requirements. It should be noted that the administrative component of plan rates also does not include funding of statutory reserves. Regardless of what is shared with a provider system, plans also have insurance and regulatory requirements related to appeals and grievances, member complaints, network adequacy beyond the “innovative” providers, quality assurance, prompt payment to providers,

pharmacy benefit management and other critical functions, many of which are mandated by the State. Plans ultimately bear legal responsibility for the myriad of requirements related to being an HMO or PHSP and under the Medicaid managed care program.

To the extent the State wishes to move in a proscriptive way with a VBP Innovator Program—which we oppose—it would need to increase its “innovator” certification criteria. In this program, the State essentially eliminates the normal interplay of market forces between providers and plans *and* removes the plan’s traditional role of assessing provider readiness and capabilities for ensuring access, quality, and contribution to the goals and requirements of the Medicaid managed care and MLTC programs. The more proscriptive the State’s innovator qualifications are, the less able plans will be to assess, make judgments about, and fine-tune the arrangement with such provider entities to ensure that their members receive the services they should be receiving.

In a similar vein, not all plans have the same capabilities and their arrangements with providers would also have to be fine-tuned to maximize value to both sides. If the State removes the usual, market-driven back-and-forth that plans and providers do to strike the best balance in the interest of their members, the State should ensure that “innovators” are prepared out of the gate to fulfill program requirements. For example, the State should conduct access and availability audits of a proposed “innovator” to ensure they meet State requirements, and assess their quality results against the requirements of the State’s Medicaid managed care quality incentive program. As currently imagined, an “innovator” certified by the State would have an entitlement to run the Medicaid managed care program for some segment of the population without the involvement of the plan. Accordingly, the “innovator” should meet relevant program, quality, and access requirements specified for plans.

Rewarding Plans with Flexibility

Plans—especially those that have demonstrated competence in efforts similar to DSRIP’s objectives—should generally be afforded flexibility and not be required to diverge from the very efforts that have proven effective and are consistent with the spirit and intent of DSRIP. In many ways, overly prescriptive programs like the VBP Innovator Program would disrupt the arrangements most in line with DSRIP’s aims. To prevent this, the State should consider giving plans with a record of effective and innovative alternative reimbursement strategies greater flexibility to achieve the goals of the roadmap.

Plan-Provider Contracting

The third draft of the roadmap indicates that in cases where plans and PPSs or providers cannot agree on the terms of a VBP arrangement, “the State will develop a process consisting of plan and provider representatives to assist in addressing the impasse.” While the Coalitions appreciate the State responding to plans’ concerns about the lack of incentive for providers to

participate in value-based purchasing (and plans' subsequent inability to meet the State's VBP milestones), we do not believe that the proposal included in the latest roadmap would work. In contemplating this issue further and recognizing that DSRIP is a five-year demonstration, the Coalitions support an assessment of the market toward the end of DSRIP Year 3 of provider interest/participation in VBP contracting as well as of market dynamics that may disincentivize provider participation. With more information and several years of DSRIP implementation completed by that time, plans and the State will be better equipped to address any problems that arise as value-based purchasing accelerates.

In addition to removing language relating to contracting impasses between plans and providers, the Coalitions recommend that the State include language that more explicitly affords both plans and providers expansive flexibility to develop their contractual arrangements. The boundaries—especially those related to metrics and targets—within which plans and providers must work should not be overly prescriptive. Each iteration of the roadmap signals that the State is moving closer to this principle, but the Coalitions request that this flexible approach be included more explicitly in the next draft of the document.

Other Opportunities for Flexibility

- *Attribution methodology.* The Coalitions recommend that plans and providers be afforded flexibility—and encouraged by the State—to pursue negotiations with one another on attribution methodology.
- *Assessment of workforce.* The draft roadmap indicates that “the State will ensure that sufficient measures are in place to assess the competence and stability of the workforce upon which patient access and quality services depends.” The Coalitions recommend leaving the assessment of workforce competence to the plans and providers, as we will be assuming the financial risk.

Risk Mitigation

The VBP Roadmap contemplates creating a risk mitigation program for providers participating in risk-based arrangements. The Coalitions support the creation of such a program as long as it is not funded by reducing health plan premiums. The Coalitions understand that such a proposal has been considered in which health plan reserve requirements would be reduced resulting in lower premiums for the MCOs. This “savings” would be used to fund the risk mitigation pool for providers. Given the razor thin margins and new complex populations in managed care, the health plans do not support any more reductions in plan premiums even if there is a reduction in reserve requirements. Instead, the plans would support the State creating a new risk mitigation pool, funded by the State or provider contributions, similar to the model currently used by Medicaid managed care plans.

Prescription Drugs

Prescription drugs should be included in total-cost-of-care arrangements, but doing so underscores the need for the Department of Health to pay an adequate, risk-adjusted pharmacy rate to plans, so that they can in turn compensate providers fairly.

Requests for Clarification

Preventative Care Activities

According to the draft roadmap, “purely preventative activities” will continue to be reimbursed on a fee-for-service basis. The Coalitions recommend that the State clarify how this will be factored in to the requirement that 80-90% of plan payments be value-based by the end of DSRIP Year 5. For example, will these preventative services be counted toward a plan’s percentage of VBP? Will they be considered Level 1 VBP?

State Methodology for Payments to Plans to Incent Higher Levels of VBP

The draft roadmap indicates that “the State plans to increase the managed care rate for those plans that capture more provider payment dollars in VBP arrangements.” The Coalitions request more information on the State’s methodology for determining the additional revenue to be paid to plans with more VBP. We understand that the State is currently in discussions with its actuary on this issue; we urge the State be as transparent as possible on this issue and include plans in the discussion, wherever possible. Moreover, the Coalitions would object to using the Medicaid quality incentive pool for this or other DSRIP payment reform purposes, such as risk mitigation or other possible provider needs. The quality incentive pools are among the most important mechanisms the State employs to ensure that members receive the care they should. This should remain the focus of the quality pools and payment and delivery system reform should be funded from other dedicated sources.

Sharing of Savings in Certain Contracting Arrangements

To the extent possible, we request that the roadmap clarify (perhaps as an example or in a text box) how the sharing of savings may be achieved when a plan contracts directly with providers within a PPS, rather than with the PPS itself. Will the plans be responsible for including language in their contracts that accomplishes sharing across multiple entities (e.g., among hospitals and primary care provider groups) or might such shared savings be accomplished through inter-organizational arrangements within the PPSs? How would such arrangements be operationalized if plans are unable to negotiate contracts with all providers in the PPS?

Credentialing

The draft roadmap states that “safety-net providers that are just now transitioning into managed care should not have to be unduly concerned that credentialing would remain a barrier to care when VBP is being rolled out.” The Coalitions request clarification on the implications of this for plans and members. For example, does this mean that plans will be required to relax their credentialing standards for providers transitioning into managed care? If so, how will the plans be indemnified against any legal/financial penalties imposed upon them as a result of the relaxation of standards and what are the implications for members, whom the credentialing requirements are meant to protect in the first instance? Has the State considered the impact of such relaxed standards on each plan’s NCQA or URAC accreditation status?

VBP Subcommittees

Community Based Organization (CBO) Subcommittee

The draft roadmap states that the CBO Subcommittee “will be focused on identifying the needs of CBOs so they can fully participate in VBP.” Plans are interested in more information on how exactly CBOs will fit into the managed care environment. Several initial questions for the subcommittee include:

- Since funding for CBOs does not, for the most part, currently come from plan premiums, how exactly does the State envision them participating in VBP?
- How might the CBOs be expected to share in savings generated by PPSs and other providers?
- Is it anticipated that existing CBO funding streams will be modified to flow through plan premiums?

Social Determinants of Health Subcommittee

According to the draft roadmap, the VBP and Social Determinants of Health Subcommittee “will focus on the inclusion of social determinants of health in both the payment mechanisms (i.e., paying for housing) as well as outcomes measurements.” The Coalitions support such efforts, which are in line with DSRIP’s overall goals. Similar to our previous comment, as this subcommittee begins to meet, plans are eager to learn how such efforts may be funded (e.g., whether plan premiums will be increased to fund these payment mechanisms or whether such funding is expected to come from savings generated under VBP).

Coalition plans remain interested in participating in the forthcoming workgroups and subcommittees, and look forward to continuing the dialogue on VBP with you and the provider

and stakeholder communities. We thank you for the opportunity to comment. If you have any questions about these comments, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Anthony J. Fiori". The signature is fluid and cursive, with the first name being the most prominent.

Anthony J. Fiori

cc. Marc Berg
Jim Lytle
Health Plan CEOs

March 31, 2015

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

Dear Mr. Helgerson,

Thank you for the opportunity to comment on the most recent draft of the State's Value Based Payment ("VBP") Roadmap. We appreciate your responsiveness and flexibility in responding to many of our prior comments. In many respects, the document is vastly improved. However, in other respects, some more recent changes have raised significant concerns. Specifically, the New York State Conference of Blue Cross & Blue Shield Plans (NYSCOP) offer the following comments:

The VBP Innovator Program Should be Revised to: 1) Provide for Voluntary Participation by Plans; 2) Establish Specific Criteria for Eligibility; and, 3) Require "Total Population" Participation

The most recent draft of the Roadmap prescribed a dramatic departure from the original concept behind the VBP Innovator Program. In its' current form, we strongly oppose this component of the Roadmap and encourage the state to refine its approach so the Innovator Program serves as the "aspirational program" that was described at the second meeting, instead of what appears in our estimation to be a construct designed to benefit a select group of large hospital systems that will provide inappropriate incentivization and rely on regulatory mandates to force plans to enter agreements that will neither benefit their members nor the health care system overall.

Specifically, we are adamantly opposed to any program that would force managed care plans to enter into any innovator arrangements which are dictated by providers. Such an approach seems completely inapposite to the marketplace balance and flexibility that has been espoused by both plans and providers. It is unclear what benefit the state will derive from this policy other than to drive existing off-menu VBP arrangements dictated by certain hospital systems. The VBP Innovator Program, much like VBP arrangements overall, will be a success if plans and

providers are given the flexibility to craft the risk sharing arrangements collaboratively and are both permitted to participate in arrangements of their choice. This will ensure appropriate marketplace balance for all sides and that arrangements are reached that are mutually beneficial and capable of surviving DSRIP. To force plans to participate in the Innovator Program will only permit large hospital systems, which already enjoy near monopolistic powers, to dictate the terms and conditions of the entire risk arrangement. If the State is desirous of the hospital system assuming such a degree of risk and mandating all plan conditions of participation, perhaps the more appropriate course is to simply require the hospital system to obtain a managed care plan or insurer license and they can eliminate the need for plan participation. If there is a desire to have plans participate in such an arrangement, the State should provide voluntary incentives, such as an Innovator Premium, (as discussed at previous Workgroup meetings) and make participation a collaborative effort by all parties.

The Roadmap should establish specifically identified criteria for provider eligibility and require “total population and total care management” as elements of the Innovator Program. It was our understanding that the original purpose of the VBP Innovator Program was to serve as a model that would allow a few, *select PPSs* who could meet clearly established heightened solvency requirements and had a clearly identifiable level of readiness, to enter into VBP Level 3 arrangements to manage the total health needs across their entire populations. Under such circumstances, the Innovator would receive certain assurances and guarantees for their willingness to invest resources and take on an elevated level of risk. In contrast, the current Draft offers little in terms of financial accountability, and allows providers the flexibility to only enter into these arrangements for partial populations or partial benefits. Without any defined criteria for participation, Innovators will now include providers with potentially limited upside/downside risk management experience who seek to take advantage of this program’s rich incentives and State-provided downside protection.

Likewise, allowing the provider to select the partial populations and care they desire to be subject to the Innovator Program, will inevitably lead to adverse selection or “cherry picking” of favorable risks or limited risk by the provider resulting in disproportionate “upside” for the provider. This policy will disincentivize providers/PPSs from pursuing total population health management arrangements under capitation (CMS’s ultimate goal), since all of the benefits of the program can be achieved through less risk. Inevitably, providers will seek limited scope Level 2 or 3 arrangements, leaving care and services for the most complex patients and expensive services outside of innovator arrangements. As you know, managed care entities that operate under full capitation are responsible for all populations and services, and manage care by successfully spreading risk across their entire population of members. If specific services and populations can be picked off by providers, they will receive a windfall via excessive capitation that was designed to incentivize broad population service management, while making it exceedingly more difficult for plans to manage remaining services left out of innovator arrangements.

Under the current construct, there will also be more failed arrangements as it will be more difficult to discern which providers are capable of entering Level 2 arrangements. There is a much clearer demarcation between PPSs who are ready to pursue Level 3 total population health management arrangements, vs. providers who may be in between Level 1 and 2 capability. If the providers only need to manage upside/downside for a small subset of the population to partake in the innovator program, there will be many more providers eager to participate, and what was intended to be a model program will be inundated with premature entrants, which provider groups have noted could stymie overall progression to VBPs, not to mention cost to the state to bail them out.

VBPs and the VBP Roadmap Should Discuss Additional Contractual Flexibility for Different Sectors

We request that the State include additional detail regarding flexibility that will be available for plans (both mainstream managed care, as well as MLTC and FIDA) and providers for agreements that relate to settings within the health care landscape that may not be fully represented under the existing roadmap. This includes, for example, contracts for long term care services. There was some discussion at the last meeting that there may be different parameters for agreements between plans and nursing homes and other providers. We would request that the State provide additional detail in this area so both sides can begin to assess what it will mean for their agreements going forward.

Attestation of Compliance for Off-Menu VBP Arrangements

We are supportive of using a provider/plan attestation to jointly certify that an off-menu payment arrangement complies with the requirements of VBP reform.

The Need for Price Transparency and Closer Analysis of Provider Pricing Before Implementing VBPs

Finally, we look forward to the discussion of cost transparency once the Catalyst for Payment Reform's Survey is complete and how this will be incorporated into VBP arrangements going forward. We think it is critical to take steps to ensure that increased provider margins achieved through VBPs will benefit the health care system through a direct linking of higher costs and enhanced quality. There is no evidence to suggest that higher provider margins necessarily add value to anything but provider profits. In fact, there is ample evidence to suggest the contrary, that there is already little correlation between the "price" paid by payers and the actual "cost" of services. This is particularly true in New York, where price transparency ranks among the worst in the nation, and especially so in New York City, which continues to have the highest cost differentials for identical procedures performed in the country. The issue of transparency is as critical in the Medicaid program as it is on the commercial side especially as reimbursement evolves into value based. As VBP arrangements established under DSRIP naturally extend beyond Medicaid and into Medicare and commercial insurance, it will be integral that the State use this reform to begin the process of assessing and redefining what the cost of typical services are and what reasonable cost should be.

Thank you for the opportunity to comment.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Sean Doolan". The signature is fluid and cursive, with a large initial "S" and "D".

Sean Doolan, Esq.

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

4813-9977-1938, v. 3

VBP Roadmap – ~~second~~ Third draft

Version ~~February-March 31~~6, 2015

For discussion in ~~Second Value-Based Payment Work Group Meeting~~

~~Albany February 2~~ March 4, 2015

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Introduction

On April 14, 2014, the State of New York and CMS reached agreement for a groundbreaking waiver that allows the state to reinvest \$8 billion dollars for comprehensive Medicaid delivery and payment reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program promotes community-level collaborations and aims to reduce avoidable hospital use by 25% over five years while financially stabilizing the state's safety net. Safety net providers have come together in 25 Performing Provider Systems (PPSs), covering the whole State, to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on performance linked to achievement of project milestones.

To ensure the long term sustainability of the DSRIP investments in the waiver, the Terms and Conditions (§ 39) state that the State must submit a multi-year roadmap for comprehensive payment reform before April 1st 2015, including how the States will amend its contracts with Managed Care organizations. The T&Cs mention the following specific topics to address:

- 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.
- 8 How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

In what follows, ~~we~~ the roadmap will address each of these issues in turn.

Importantly, this Roadmap is designed as a living document. It is not a blueprint; it rather attempts to demonstrate the State's ambition and the outlines of what the state and its stakeholders consider to be the payment reforms required for a high quality, financially sustainable Medicaid delivery system.

Working intensely with the Managed Care Organizations, Providers, Beneficiaries and other stakeholders, many details will be added and changed over the next months. In addition, the State will work with CMS to optimally align these efforts with the Medicare Value-Based Payment Goals recently announced.¹ ~~Over the next five years, many lessons will be learned from DSRIP and the emergence of PPSs, which we will similarly want to be included in this Roadmap so as not to be 'locked in' a process that requires adjustment. Therefore, fulfilling CMS' request, t~~

~~This Roadmap will be updated yearly throughout the DSRIP period, incorporating lessons learned in New York state and elsewhere.~~

What New York State's Medicaid Value-Based Payment plan is *not*

During the development of the Roadmap, stakeholders have expressed concerns related to the pace and scope of the change that Value Based Payment could represent. Throughout a series of detailed stakeholder discussions, it became clear that there were some misperceptions related to the intent of the State's Roadmap. As such, the State has explicitly outlined what is not included in VBP, to address the roadmap's intention and to ensure all stakeholders understand the true direction of the course that the State is undertaking.

What New York State's Medicaid VBP plan is *not*:

- **A new rate setting methodology:** *the state will show benchmarks and give guidance, but it will not set rates for value-based payment arrangements*
- **One size fits all:** *there is a menu of options to choose from, and many details to negotiate between MCOs and providers. Also, MCOs and providers can jointly opt to propose 'off-menu' value-based payment arrangements. In addition, the state's VBP goals will be measured at the state's level, not at the individual PPS level, allowing for differences in adaptation between PPSs.*
- **The state backing away from adequate reimbursement for FQHCs and other community-based providers:** *as outlined in the Figure on p.6, the state is committed to ensure adequate reimbursement aligned with the value provided for the Medicaid population*
- **An attempt to make providers do more for less:** *in fact, the intent is the opposite. Reducing lower value care and increasing higher value care in equal proportions should lead to higher revenues-margins rather than lower margins-revenues.*
- **An attempt to make PPS leads responsible for all PPS providers' contracting:** *what responsibilities providers delegate to their PPS is decided by themselves through the emerging PPS governance structure. Delegating contracting responsibility to the PPS is an option, but by no means the only one.*

¹ Burwell, S. M. (2015). "Setting Value-Based Payment Goals - HHS Efforts to Improve U.S. Health Care." N Engl J Med.

1. Towards 90% of value-based payments to providers

Issue 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 **80-90%** of managed care payments to providers using value-based payment methodologies **by end of DY 5**.

Sustainable Delivery Reform Requires Matching Payment Reform

DSRIP is a major collective effort to transform the NYS Medicaid Healthcare Delivery System from a fragmented system, overly focused on inpatient care, to an integrated and community-based system focused on providing care in or close to the home. Where the delivery system is currently predominantly re-active and (acute) provider-focused, DSRIP aims to create a more pro-active and patient-focused system, with a vibrant workforce emphasizing population health and closely involving social services.

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes: *value*

These objectives have broad stakeholder support and are made measurable by a set of DSRIP metrics on potentially avoidable (re)admissions, ER visits and other potentially avoidable complications, as well as patient experience. Underlying these overall outcomes is a broader range of project-specific process- and outcome measures.

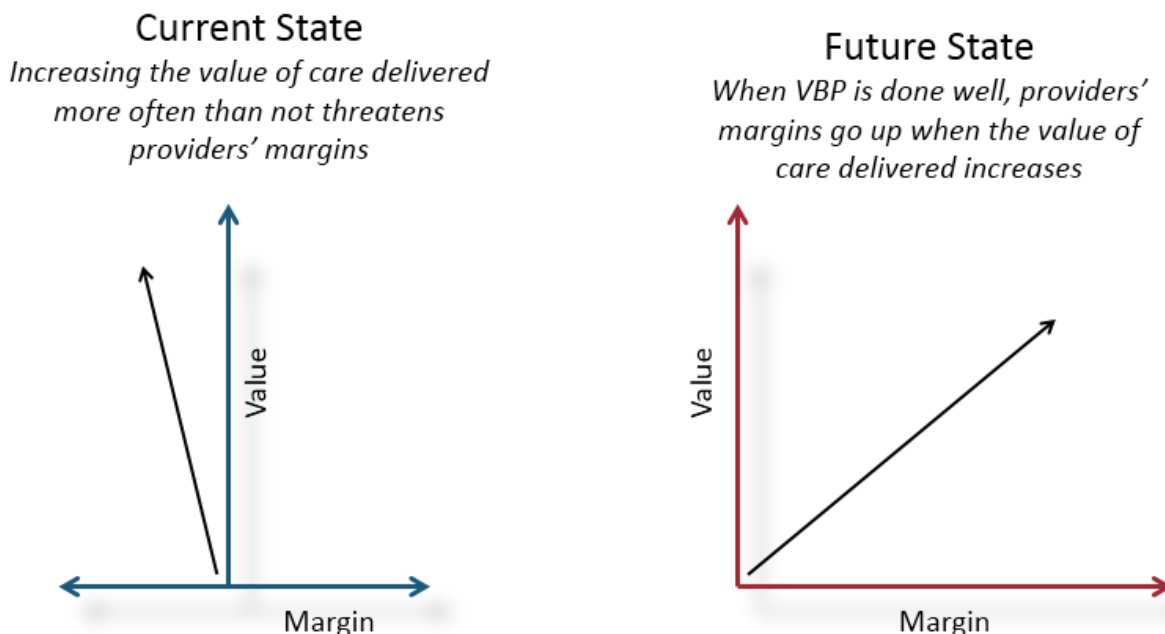
Reducing avoidable (re)admissions, ER visits and other potentially avoidable complications will further stabilize overall Medicaid expenditures. This will allow NYS to remain under the Global Cap, without curtailing eligibility, while strengthening the financial viability of the safety net and continuing to invest in innovation and improving outcomes.

Such a thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well. Many of the Medicaid delivery system's problems (fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration) are rooted in how providers are reimbursed. In most cases, siloed providers are still being paid Fee for Service (FFS) by their MCOs, incentivizing volume over value, and creating a focus on inputs rather than realizing adequate outcomes. To this day, an avoidable readmission is usually rewarded more than a successful transition to integrated home care; likewise, prevention, coordination or integration activities are rarely reimbursed sufficiently, if at all.

In addition, the current FFS system, and the diversity of contracting regimes between individual providers, individual MCOs and other, non-Medicaid payers, creates an administrative burden on providers that would be unfathomable in any health care sector in the world – or in any other US industry. Often, payment reform initiatives initially seem to increase the administrative burden: they necessarily constitute a change from the way current administrative processes and systems operate. Yet well-executed payment reform can significantly reduce this complexity by reducing the need for micro-accountability (such as the need for utilization review throughout the care process), standardizing rules and incentives across providers, and increasing transparency.²

² Cutler, D., E. Wikler and P. Basch (2012). "Reducing administrative costs and improving the health care system." *N Engl J Med* **367**(20): 1875-1878.

In essence, the state's Medicaid Payment reform attempts to move away from a situation where increasing the value of the care delivered (preventing avoidable admissions, reducing administrative waste) has a *negative* impact on the financial sustainability of providers towards a situation where the delivery of high value care can result in *higher* margins (see Figure below).



Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period, such that patient educational engagement and care coordination activities, including peer based activities, can be reimbursed, that value-destroying care patterns (avoidable (re)admissions, ER visits) do not simply return when the DSRIP dollars stop flowing, that a stable and well-trained primary and community based workforce is maintained ~~healthcare workers' careers within the Medicaid delivery system become more fulfilling and rewarding~~, and that dollars currently lost in non-value added administrative processes become available for patient care. Importantly, payment reform is equally essential to ensure that the savings realized by DSRIP can be reinvested in the Medicaid delivery system. Without payment reform, savings would accrue to MCOs, whose yearly rates would in the current payment system subsequently be revised downwards. In fact, many PPSs are already actively discussing the importance of payment reform as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits).

Payment Reform Guiding Principles

The roadmap is built upon the foundation already put in place by the MRT Payment Reform & Quality Measurement Work Group. In 2012, that Work Group concluded that innovative payment reform and quality initiatives should:

1. Be transparent and fair, increase access to high quality health care services in the appropriate setting and create opportunities for both payers & providers to share savings generated if agreed upon benchmarks are achieved.
2. Be scalable and flexible to allow all providers and communities (regardless of size) to participate, reinforce health system planning and preserve an efficient essential community provider network.
3. Allow for flexible multi-year phase in to recognize administrative complexities including system requirements (i.e., IT).
4. Align payment policy with quality goals
5. Reward improved performance as well as continued high performance.
6. Incorporate strong evaluation component & technical assistance to assure successful implementation.
7. Engage in strategic planning to avoid the unintended consequences of price inflation, particularly in the commercial market

New guiding principle:

8. Financially reward rather than penalize providers and plans that deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes including interventions that address underlying social determinants of health.

Starting point: how should an integrated delivery system function from the consumer/patient's perspective

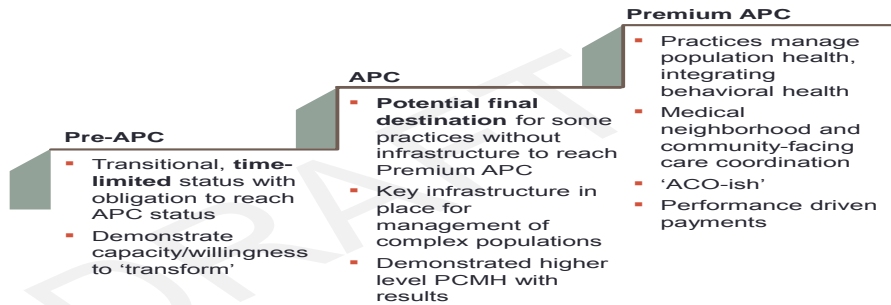
Different types of patients require different types of care. As foreseen in DSRIP, a high performing care delivery system encompasses three types of integrated care services, with optimal coordination between them:

- **Integrated Primary Care** (including behavioral primary care, effective management of chronic disease, community based prevention activities and clear alignments with social services (Patient Centered Medical Home (PCMH)/Advanced Primary Care (APC) models)). This type of care is continuous in nature, strongly population-focused, based in the community, culturally sensitive, oriented towards primary and secondary prevention, and aims to act as the primary source of care for the majority of everyday care needs. (See textbox for a discussion about NYS's vision on Advanced Primary Care).

New York State's vision on Advanced Primary Care

Advanced Primary Care (APC) plays a core role in NY's State Health Innovation Plan (SHIP) as well as within DSRIP. The below Figure briefly explains how NYS sees the progression from 'pre-APC' status towards 'Premium APC' status, which fully aligns with DSRIP's end goals for Integrated Primary Care. (See the SHIP plan for more details).

SHIP Advanced Primary Care (APC) Model



A critical goal of design and implementation is for multi-payer alignment on this multi-tiered model coupled with payment support for transformation, care management AND value based payment.

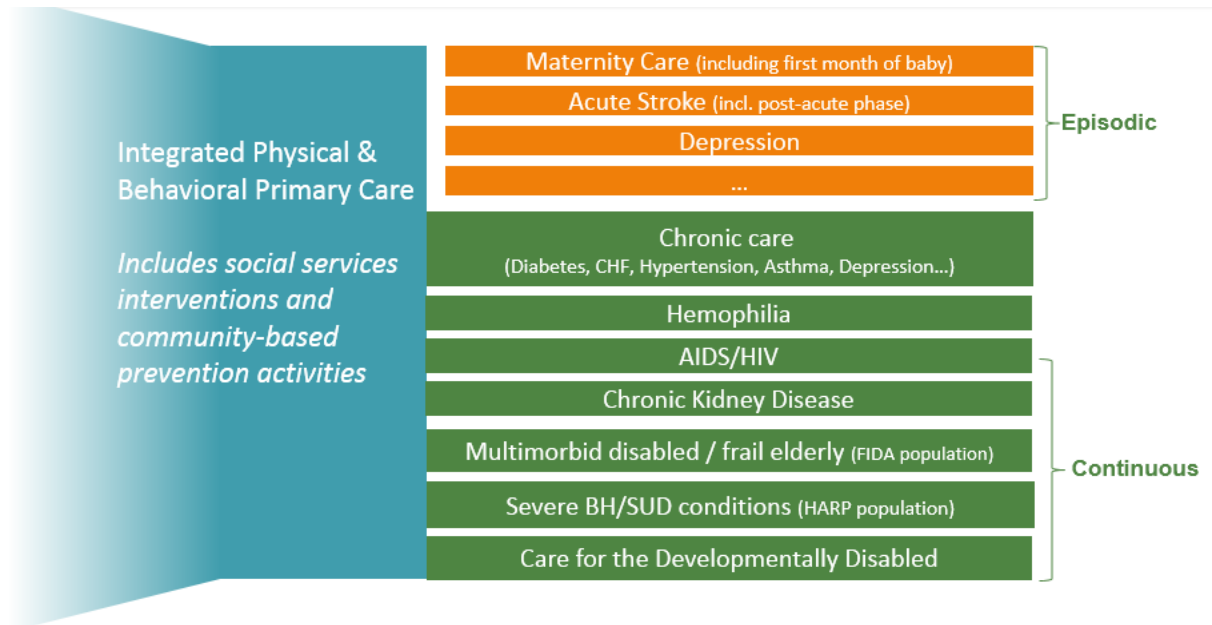
NYS has extensive experience with what will later be described as Level 0 Value Based Payments, FFS with quality bonus payments, during the early and ongoing support of the PCMH model through its Medicaid program, and its involvement in medical home demonstrations in a variety of settings across the state. As these initiatives have progressed, it has become clear that transformation of primary care practices to an APC model will include three broad phases, during which the practices require different types of financial support as follows:

- Initial investment in practice transformation, including support for technical assistance, and for the costs of new programs and staff (or re-training existing staff).
- Interim Support. Support for increased operating costs for a period of time (experience indicates 2-3 years), as practices improve quality and population health, but before realizing reductions in preventable utilization and other costs needed to support 'shared savings' payment. In the early years of the APC's operation, providers will be taking on new functions and costs, improving quality, patient access and experience, but not (yet) generating cost savings.
- Ongoing support. Once the APC model has begun to have a measurable impact on total cost of care and to generate measurable savings, the practice and payers may choose to reduce the basic program support and shift compensation to shared savings and/or risk sharing.

From the perspective of Medicaid, phase 1 and 2 will be funded through DSRIP; phase 3 is the transition towards Level 1 (and higher) Value-Based Payment for integrated primary care as discussed in this Roadmap.

- **Episodic care services** are utilized for circumscribed periods of time when people require more specialized services for a specific health problem or condition, for circumscribed periods of time. Within the Medicaid population and DSRIP, maternity care may be the best example; for elderly patients, hip and knee replacement episodes are the most prevalent examples. These services should be tightly integrated, with multidisciplinary teams working with evidence-based care pathways, organized around these patients' specific needs and cultural sensitivities.

- **Specialized continuous care services** are required for those individuals which require ongoing, dedicated specialized services for their health problem(s) or condition(s). This type of care can involve both evidence-based specialty care for individual conditions (HIV/AIDS, hemophilia, advanced kidney disease, serious behavioral health conditions, significant developmental disabilities) as well as care for severely co-morbid populations (e.g. the HARP and FIDA populations). For the latter groups of patients, personalized goal setting and intensive care coordination become more dominant than disease management per se. In both, a focus on maximizing a patient’s capabilities for self-management and personal autonomy is central.



Facilitating the Development of an Optimally Functioning Delivery System through Value-Based Payments: A Menu of Options

Following the spirit of the DSRIP program, NYS does not foresee one single path towards payment reform. Rather, NYS aims to give PPSs, their providers, and MCOs a Menu of Options to consider. This allows providers and MCOs to select those types of value-based payments that fit their strategy, local context and ability to manage innovative payment models, which has been proven a critical success factor in successfully realizing payment reform.³

Jointly, PPSs (or combinations of providers within the PPS) and MCOs can create value-based payments arrangements around:

- Total care for total population and/or
- Integrated primary care and/or
- Selected care bundles and/or

³ Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." *Health Aff (Millwood)* **32**(5): 929-934; Miller, H. D. (2009). "From volume to value: better ways to pay for health care." *Health Aff (Millwood)* **28**(5): 1418-1428.

- Special needs subpopulations

At any given time, providers and MCOs are free to jointly propose 'off menu' versions of Value Based Payment arrangements, including currently existing arrangements. These VBP arrangements would be accepted by the state will accept these proposals when as long as these 'off menu' versions by evidence that the alternative arrangement has a high likelihood of success and they support the underlying goals of the payment reform as outlined above and sustain the transparency of costs vs outcomes.

Total care for the total population

In this model, the MCO contracts a value-based payment arrangement with the PPS (or with 'hubs' within the PPS) which considers total PMPM (per member, per month) expenditure for the total attributed population (global capitation), and overall outcomes of care (potentially avoidable ER visits, hospital admissions, and the underlying DSRIP Domain 2 and relevant Domain 3 metrics). Although there is less experience with these types of models in Medicaid than in Medicare or in the commercial plan market, the opportunities are widely deemed to be significant. Aligning pre-existing Medicare ACOs with a comparable model in Medicaid, moreover, would greatly reduce both costs and risks for the providers involved.⁴

Integrated Primary Care

In this model, the MCO contracts Patient Centered Medical Homes (PCMHs) or Advance Primary Care (APC) arrangements with the PPS or the PCMHs/APCs in the PPS to reimburse these PCMH/APCs based on the savings and quality outcomes they achieved. The savings here would be focused primarily on so-called 'downstream' costs: expenditures across the total spectrum of care that would be reduced when the PCMHs/APCs would be functioning optimally. Avoidable ER visits and hospital admissions for conditions such as diabetes and asthma are good examples; cancer care costs, on the other hand, would not be included when calculating potential PCMH/APC downstream savings. Likewise, the quality outcomes would be those DSRIP Domain 2 and 3 metrics attributable to integrated primary care, including the behavioral health, diabetes, asthma and cardiovascular health metrics.⁵

Leveraging such savings can substantially increase funding to PCMHs/APCs, because the potential downstream savings are much larger than the total current revenues of the PCMH. This addresses two key issues that have been identified as limiting the potential impact of emerging integrated primary care delivery models: lack of funding to sustainably enhance both staffing and infrastructure of integrated primary care⁶ and a lack of adequate incentives for primary care providers to truly impact overall costs

⁴ Kocot, S. L., C. Dang-Vu, R. White and M. McClellan (2013). "Early experiences with accountable care in Medicaid: special challenges, big opportunities." *Popul Health Manag* **16 Suppl 1**: S4-11.

⁵ Using potentially avoidable hospital (re)admissions and ER visits as outcome indicator for primary care is an approach also used in Colorado's Accountable Care Collaborative: <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20Annual%20Report%202013.pdf>. See also Kocot et. al. op. cit. footnote 4.

⁶ Nocon, R. S., R. Sharma, J. M. Birnberg, Q. Ngo-Metzger, S. M. Lee and M. H. Chin (2012). "Association between patient-centered medical home rating and operating cost at federally funded health centers." *JAMA* **308**(1): 60-66; Landon, B. E. (2014). "Structuring payments to patient-centered medical homes." *Jama* **312**(16): 1633-1634; Weissman, J. S., M. Bailit, G. D'Andrea and M. B. Rosenthal (2012). "The design and application of shared savings programs:

of care.⁷ DSRIP will work closely with the State Health Innovation Plan Integrated Care Workgroup on the development of the Advanced Primary Care model that promotes high value care and is better integrated across the spectrum; that promotes and supports primary care providers and that assures a more efficiently operating health delivery system that promotes optimal health and well-being for all.

Bundles of care

In this model, the MCO contracts specific, patient-focused bundles of care (such as maternity care episodes or stroke) with the PPS or (groups of) providers within the PPS. Here, the cost of a patient's office visits, tests, treatments and hospitalizations associated with a specific illness, medical event, or condition are all rolled or "bundled" into a single, episode-based total cost for the episode.⁸ Because variations in utilization and potentially avoidable complications are linked to the specific episodes, this model has shown much promise in stimulating patient-focused, integrated care delivery teams to substantially increase the value of care delivered from a wide range of conditions.⁹

This model has also proven useful for chronic care, as highlighted by the inclusion of chronic condition in the CMS Bundled Payments for Care Improvement (BPCI) Initiative¹⁰. Whereas the BPCI program's care bundles (for now) start with a hospital admission, NYS will follow the internationally emerging consensus to treat chronic conditions as full-year-of-care bundles (emphasizing the continuous nature of this care), including all condition-related care costs.¹¹ Those chronic conditions whose effective management is integral to New York's Advanced Primary Care model will in principle be part of the Integrated Primary Care contract.

Total care for special needs subpopulations

For some specific subpopulations, severe comorbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care costs are included in the full-year-of-care bundles. At this point, this becomes similar to a capitated model (a PMPM for a specific special needs

lessons from early adopters." *Health Aff (Millwood)* **31**(9): 1959-1968; Edwards, S. T., M. K. Abrams, R. J. Baron, R. A. Berenson, E. C. Rich, G. E. Rosenthal, M. B. Rosenthal and B. E. Landon (2014). "Structuring payment to medical homes after the affordable care act." *J Gen Intern Med* **29**(10): 1410-1413.

⁷ Nielsen, M., J. N. Olayiwola, P. Grundy and K. Grumbach (2014). The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013, Patient-centered primary care collaborative.

⁸ Sage, W. M. (2014). "Getting The Product Right: How Competition Policy Can Improve Health Care Markets." *Health Aff (Millwood)*; Mechanic, R. E. and S. H. Altman (2009). "Payment reform options: episode payment is a good place to start." *Health affairs (Project Hope)* **28**: w262-271.

⁹ Miller, D. C., C. Gust, J. B. Dimick, N. Birkmeyer, J. Skinner and J. D. Birkmeyer (2011). "Large variations in medicare payments for surgery highlight savings potential from bundled payment programs." *Health affairs (Project Hope)* **30**: 2107-2111; Struijs, J. N. and C. A. Baan (2011). "Integrating Care through Bundled Payments — Lessons from the Netherlands." *New England Journal of Medicine* **364**: 990-991; Bach, P. B., J. N. Mirkin and J. J. Luke (2011). "Episode-based payment for cancer care: a proposed pilot for Medicare." *Health Aff (Millwood)* **30**(3): 500-509.

¹⁰ Bailit, M., M. Burns and J. Margaret Houy (2013). Bundled Payments One Year Later: An Update on the Status of Implementations and Operational Findings. *HCI3 Issue Brief*, June 2013; <http://innovation.cms.gov/initiatives/bundled-payments>.

¹¹ de Bakker, D. H., J. N. Struijs, C. B. Baan, J. Raams, J. E. de Wildt, H. J. Vrijhoef and F. T. Schut (2012). "Early results from adoption of bundled payment for diabetes care in the Netherlands show improvement in care coordination." *Health Aff (Millwood)* **31**(2): 426-433; De Brantes, F., A. Rastogi and M. Painter (2010). "Reducing potentially avoidable complications in patients with chronic diseases: the Prometheus Payment approach." *Health Serv Res* **45**(6 Pt 2): 1854-1871; xx.

population). As part of the development towards Managed Care, NYS has already identified several special needs subpopulations for which contracting total costs of care will be an option (see further).

Fee-For-Service remains a Value-Based payment mechanism for preventive care activities. Because of the importance to stimulate reaching out to the whole population, purely preventative activities (such as immunizations or evidence-based screening activities) will remain reimbursed on a Fee for Service basis. Combined with adequate quality measurement (% of eligible patients having received breast cancer screening, for example), FFS incentives volume where needed.^{12,13}

Possible contracting combinations

The MCOs and the PPSs/Providers may opt to either contract the total care for the total population (ACO model), or create combinations of the value-based payment arrangements discussed. Some MCOs may prefer to contract for integrated primary care (PCMH or APC) separately to optimize the chances of successful primary care reinforcement; some PPSs may want to specifically contract for fragile subpopulations and the maternity care bundle.

When combinations of integrated care services are contracted separately, it has to be clear what happens when a beneficiary requires two (or more) services. The table below outlines how these interactions would play out:

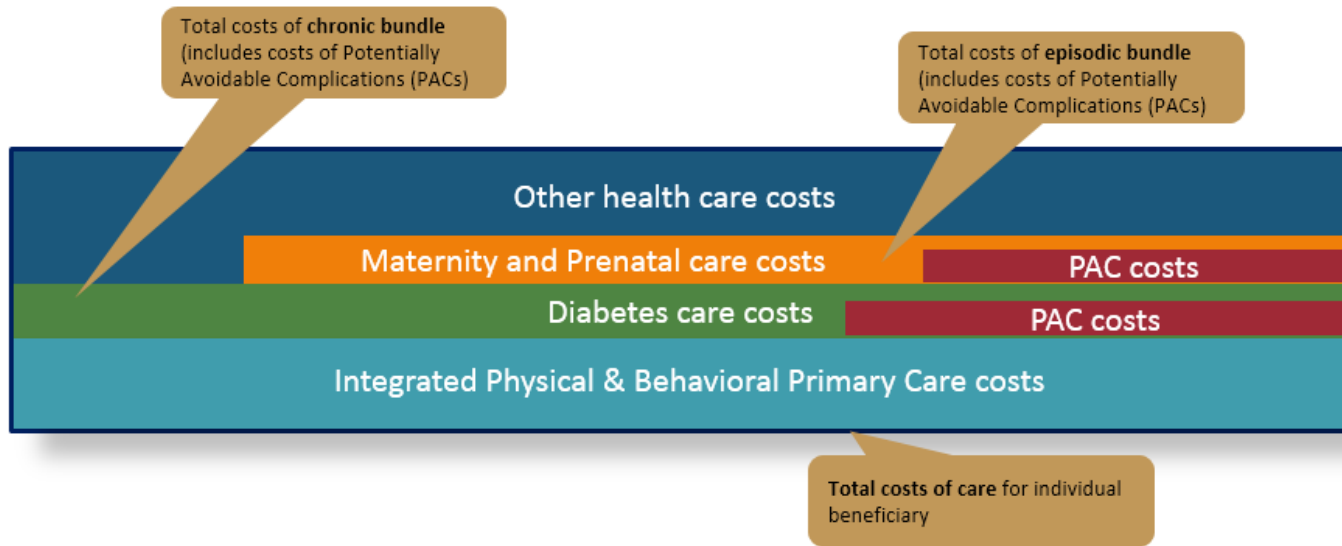
Integrated Primary Care	A beneficiary can only be attributed to one IPC provider at a time		
Episodic Bundle/ Specialty Chronic Care bundle	A beneficiary will be expected to keep IPC services (for e.g. non-related preventive activities or e.g. diabetes treatment) during the duration of an episodic illness / specialty chronic condition	A beneficiary may receive two or potentially more episodes simultaneously. <i>In some cases, a second episode ('stroke') will be deemed to be a potential complication of a first episode ('pregnancy & delivery')</i>	
Sub population	This type of care is so comprehensive that a distinctive IPC role is difficult to carve out	TBD on the basis of the analyses. Some episodes (e.g. Maternity Care) may be so distinctive that they could be 'carved out'	A beneficiary can only be attributed to one sub-population at a time
	Integrated Primary Care	Episodic Bundle/ Specialty Chronic Care Bundle	Sub population

¹² Miller, H. D. (2009) op.cit. fn. 2319; Chien, A. T., Z. Li and M. B. Rosenthal (2010). "Improving timely childhood immunizations through pay for performance in Medicaid-managed care." *Health Serv Res* 45(6 Pt 2): 1934-1947.

¹³ The state will work with stakeholders to define the activities that fall under this category, including the associated quality measures.

Calculations cost of care

When multiple care services are involved, calculating the total cost of care involves adding the costs of the individual integrated care services, as illustrated below.



In addition, MCOs do not necessarily have to contract these value-based payment arrangements with the PPS: they may also contract provider-combinations¹⁴ within the PPS for total care for the total population, integrated primary care, care bundles or specific subpopulations. Both providers and health plans have suggested that although joint contracting at the PPS level for the most vulnerable, multi-morbid subpopulations could be highly beneficial, joint contracting at the PPS level for more circumscribed and prevalent types of care – such as maternity care - would stifle competition. Also, some PPSs might consist of 2-3 hubs that would prefer contracting the total care for the total population separately rather than as a single PPS.¹⁵ Likewise, in some cases contracting at the PPS level for integrated primary care may be the best answer to rapidly develop region-wide APC capabilities, while in other cases it would rather disrupt locally grown collaboration patterns that require differential treatment to truly blossom.¹⁶

This leads to the following possible options:

¹⁴ Because advanced primary care, or the care for a pregnant woman (including the delivery) requires the cooperation of and coordination between different professionals and types of providers, contracting for these types of integrated care services will more often than not involves different providers within the PPS. These providers will have to contractually agree to jointly deliver these services with the MCO and/or amongst themselves. Much like the emergence of a more integrated governance structure at the PPS level, experience shows that providers involved in jointly delivering and contracting integrated care services often tend to evolve towards having one single point of contact with the MCO. (See e.g. Bailit, M. (2014). Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments. [HCI3 Issue Brief](#), May 2014).

¹⁵ Importantly, when the total care for the total population is contracted at the level of a hub (or other entity) rather than the PPS, the total PPS attribution is divided over these hubs. In other words, no beneficiaries can be 'left out'.

¹⁶ What care the PPS can actively contract for on behalf of the providers in the PPS is decided through the governance structure the PPS has put in place.

Contracting at the PPS level (no in-PPS competition)	A value-based arrangement (e.g. integrated primary care, total care for the total population, a bundle of care, care for a specific subpopulations) is contracted between MCO and PPS. All providers within the PPS delivering this care are held to that arrangement.
Contract with PPS provides for direct MCO- Provider contracting (in-PPS competition)	The PPS works with the MCO <i>how</i> to contract with providers within the PPS on a value-based arrangement. Within that framework, MCOs can contract directly with combinations of providers to deliver that care.
No contract at PPS level	The PPS has no responsibilities for the contracting of a value-based arrangement. MCOs contract that care directly with combinations of providers within the PPS.

When MCOs, PPSs and providers contract primary care, bundles and/or subpopulations, they may not be able to reach the minimum of 80-90% value-based payments by end of DY 5. In those instances, the MCO and the PPS (or its hubs) will need to contract a total care for the populations and care services *not* covered by the integrated primary care, care bundles and subpopulations contracts. (In other words, a ‘total care for the total population’ arrangement from which the otherwise contracted populations and services are carved out).

Although both providers and MCOs have stressed the importance of flexibility in contracting options, they have also stressed the enormous benefits of a reduced administrative burden when contracts with MCOs would be more aligned. Especially smaller providers will benefit greatly if PPSs and MCOs can agree on a similar set of rules and conditions to which they will be held accountable – whether that is arranged through a single MCO-PPS contract or through the MCO and the PPS agreeing on the framework how to contract directly with groups of providers.

In addition, to further reduce administrative burden for both MCOs and providers, and to allow for transparency in performance between PPSs, the state will work in close collaboration with the stakeholders to standardize the definitions of the integrated care services, building upon what is already outlined in DSRIP:

- the delineation of the PCMH/APC care, care bundles and specific subpopulations;
- the outcome measures to be used (payers/providers are of course free to add additional measures)
- cost of care (total PMPM, per bundle, subpopulation) methodologies will be standardized, including required risk-adjustment methodologies¹⁷

The state will provide MCOs and providers with extensive information detailing their data and performance (see further).

Finally, the Integrated Delivery System that DSRIP aims for can take many shapes and forms: virtual or not, centered in a strongly developed Advanced Primary Care concept or more diffusely embedded throughout the entire care delivery network. Yet there is a risk that PPSs that do not contract either the total care for their population or integrated primary care at the PPS level end up jeopardizing the population-health focused infrastructure, patient-centered integration and associated overall workforce

¹⁷ Standardization required to reduce administrative load for Providers, but also to allow realizing state-wide information support strategy for providers and payers to facilitate VB Contracting as well as state-wide transparency and cost- and outcomes-reporting.

strategy that DSRIP sets out to build. In these cases, the PPS and the MCO will have to submit a plan outlining how the value-based arrangements that they opt for will ensure that these gains will be sustained. In addition, PPS level measures on patient-centeredness and the workforce will remain in place after the DSRIP funding stops, and will be considered a component of the overall outcomes of care contracted within the different VBP arrangements.

From Shared Savings towards Assuming Risk

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs/providers can choose different *levels* of Value Based Payments. (Assuming risk is a fundamental step; it goes without saying that PPSs should focus first on building out the DSRIP projects and strong networks before focusing on potential risk-sharing arrangements.)

Together, this creates the following Menu of Options:

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population*	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Episodic Care	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Integrated primary care, shared savings and assuming risk

As mentioned above (p. ~~1140~~), in the context of integrated primary care, 'shared savings' and 'assuming risk' takes on a somewhat different meaning. In the case of the other value-based payment arrangements, 'total cost of care' refers to the total costs of care of the total population, the subpopulation, or the care included in the bundle. In the case of integrated primary care, however, (the considerably larger) *downstream costs* are included in addition to the costs of the primary care itself.

Costs that are largely outside of the sphere of influence of a well-functioning PCMH/APC will be excluded, such as costs for trauma, cancer, ~~AIDS/HIV care~~ and other conditions requiring highly specialized treatment. Also, to avoid double-counting of savings/losses, and to fairly attribute shared savings/losses to those who have realized them, once in a PPS bundles or subpopulations are subcontracted in Level 1 arrangements or higher, the PCMH/APC can no longer receive shared savings for reductions of average cost per episode or PMPM per subpopulation patient. It can, however, still realize shared savings by *avoiding* an episode or a patient becoming eligible for a special needs subpopulation. The inverse is similarly true for incurred losses.^{23,49} Following the same principle, if a PPS contracts total cost of care in addition to one or more integrated primary care contracts, the PCMH/APC will similarly not be accountable for average costs per episode or subpopulation for *all* care bundles/subpopulations tracked by the state that are included in the total care for total population arrangement.

For integrated primary care, the 'upside' percentages are as described, which can help further generate the substantial additional income required to further implement the infrastructure and staff required for a full-blown APC. Because the downstream costs are relatively high compared to these providers overall revenue, and the influence primary care providers can exert on that care is necessarily limited, the stop loss per patient will be set lower, at e.g. one standard deviation above the set budget benchmark. Alternatively, PMPM payments could be reduced by an agreed-upon percentage (e.g. 2-3 * percentage benchmark downstream costs are exceeded).

Level 0 is not considered to be a sufficient move away from traditional fee for service incentives to be counted as value-based payments in the terms of this Roadmap. Because of the need to incentivize cross-organizational coordination and integration of care, shared-savings payments to individual providers that do not or cannot take responsibility for the integrated care services described above are equally counted as 'level 0'.

Level 1 consists of 'upside only' shared savings arrangements. Here, the capitation and bundled payments exist only virtually. When the accrued Fee-for-Service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the providers ('retrospective reconciliation').¹⁸ Potential provider losses are not shared; providers are not 'at risk' in Level 1. If a PPS or a combination of providers meets >90% of its contracted quality outcomes, for example, MCOs can return between 50-60% of the savings; when fewer goals are met, the shared savings percentage is reduced. When less than 50% of the outcomes are realized, no savings are shared.^{19,20}

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¹⁸ Alternatively, shared savings can be distributed through inter-organizational arrangements within the PPS/between the involved providers. In practice, however, Level 1 and 2 arrangements usually leave the distribution of savings/losses to the payer (based on pre-agreed sharing formulas).

¹⁹ The percentages are set high so as to create a true economic incentive to deliver high quality care (and thus avoid the common mistake that the financial incentives to improve outcomes are insufficient). See: McKethan, A. and A. K. Jha (2014). "Designing Smarter Pay-for-Performance Programs." *JAMA*; Ginsburg, P. B. (2013). "Achieving health care cost containment through provider payment reform that engages patients and providers." *Health Aff (Millwood)* **32**(5): 929-934'.

²⁰ Savings should be allocated appropriately among providers; especially behavioral health and other community based providers should not be disadvantaged.

Level 2 consists of upside and downside risk sharing arrangements. Again, the capitation and bundled payments exist only virtually, and only when for example > 50% of the contracted quality outcomes are achieved will potential savings be shared. When the accrued Fee-for-Service payments are higher than the virtual PMPM or bundle budget, these excess expenses will be compensated through reductions in the reimbursement payments to be made in the subsequent year to the PPS/providers. In level 2, because the providers share in the risk, if a PPS or a combination of providers meets >90% of its contracted quality outcomes, the MCOs can return 90-100% of the savings. Conversely, if a PPS or a combination of providers exceed the virtual PMPM capitation or bundle budget, and fewer than 50% of outcome goals are met, then these providers are responsible for 95% of this difference (see Table below).²¹

To reduce unwarranted insurance risk for providers, there the state is considering to put will be two types of stop-loss put in place:

- (per episode/subpopulation patient): a stop loss of two or three standard deviations above the set budget benchmark
- (total assumed risk for PPS/combination of providers): a stop loss of 8% (to be determined) of the *total* Medicaid payments received by the contracting PPS or combination of providers.²²

The percentages mentioned here, including the stop loss limits, are tentative, and will be further defined in close collaboration with the stakeholders during DY 1 (2015) to find the optimal balance between incentives and risks for the PPS, actuarially responsible risk for the MCO and the desired overall outcomes for the state. The state will likely set ranges within which MCOs and providers can realize in their contracts; it may also consider varying percentages over time. For example, to stimulate providers to move towards Level 2 VBP arrangements, the shared savings percentage may be lowered by e.g. 5-10% each year a Level 1 arrangement is extended. Similarly, to reduce real or perceived risk, the aggregate stop loss in the first year of a Level 2 arrangement may be set low – say at 2-3% -, and gradually set to increase over the years. (In those cases, an aggregate ceiling for total shared savings would also be put in place). The definite choices will be made in close collaboration with stakeholders and will be presented to CMS in the state’s next update of this Managed Care DSRIP plan, early 2016.

Pharmaceutical costs and the role of the Pharmacist

Costs for drugs and the dispensing of drugs (including adequate pharmaco-therapeutic management) are included in the value-based payment arrangements described. Pharmacists can add great value in managing polypharmacy, for example, or in enhancing proper medication usage and compliance. State of the art Medication Therapy Management (MTM) can improve outcomes and reduce overall costs, and many innovative contracting models are available for MCOs as well as PPSs to incorporate the benefits that MTM can bring into the value-based arrangements discussed here.

²¹ There is no minimum savings/losses threshold foreseen before savings/risk sharing begins.

²² The State will set minimum and maximum sharing percentages for both shared savings and losses.

²³ This responsibility for the PCMH/APC not only incentivizes the primary care providers to reduce morbidity, but also effectively limits the volume-risk that can still be associated with the use of bundled payments. Miller, H. D. (2009). "From volume to value: better ways to pay for health care." *Health Aff (Millwood)* **28**(5): 1418-1428.

In Level 3 the underlying Fee-for-Service payment system is largely replaced by PMPM and/or single bundled payments. No retrospective reconciliation is necessary. The Level 2 stop loss arrangements would remain to prevent providers from inadvertently taking on insurance risk. In situations where MCO and PPS/groups of providers intend to contract using value based payment arrangements but cannot reach an agreement, the State will develop a process consisting of plan and provider representatives to assist in addressing the impasse.

Outcome Targets % Met	Level 1 VBP	Level 2 VBP	Level 2 VBP
	Upside only	Up and downside <i>When actual costs < budgeted costs</i>	Up and downside <i>When actual costs > budgeted costs</i>
> 90% of Outcome Targets met	50-60% of savings returned to PPS/ Providers	90-100% of savings returned to PPS/ Providers	PPS/ Providers responsible for 50% of losses. For Stop Loss see text. For Integrated Primary Care see IPC textbox.
50 90% of Outcome Targets met	Between 10 – 50/60% of savings returned to PPS/ Providers (gliding scale in proportion with % of Outcome Targets met)	Between 10 – 90/100% of savings returned to PPS/ Providers (gliding scale in proportion with % of Outcome Targets met)	PPS/ Providers responsible for 50%-95% of losses (gliding scale in proportion with % of Outcome Targets met). For Stop Loss see text. For Integrated Primary Care see IPC textbox.
< 50% of Outcome Targets met	No savings returned to PPS/ Providers	No savings returned to PPS/ Providers	PPS/ Providers responsible for 95% of losses. For Stop Loss see text. For Integrated Primary Care see IPC textbox.

This table will be used as input for the Technical Design Workgroup to further flesh out (changing, adding, or reducing details) during the course of calendar year 2015.

Transparency of outcomes and cost as the foundation for Value Based Payments

The NYS DSRIP program is geared towards the realization of outcomes (reduced potentially avoidable (re)admissions, visits and complications; better patient experience, reduced number of uninsured and beneficiaries not using preventive and primary care services); PPSs that do not realize their goals receive less DSRIP performance payments. The NYS Medicaid Payment Reform strategy embraces these same goals, structurally rewarding outcomes over inputs. As said, the outcomes to be contracted for the different VBPs will directly aligned the DSRIP measures: the Domain 2 and 3 measures that have been selected for the DSRIP program will form the starting point. Measures outside of the DSRIP core measures, that do not align with these goals will be addressed and retired when possible. Additional measures will be added when it is deemed that outcomes of care are not optimally captured for specific care bundles or subpopulations. One key goal is the inclusion of Patient Reported Outcome Measures (including quality of life metrics), a key missing link is truly assessing the outcomes of care for many health problems and conditions. Similarly, measures focusing not so much on ‘cure’ but on rehabilitation and individual recovery, as well as cultural competency and penetration of specific minority groups, are

as yet underrepresented. ²⁴ Finally, the State will ensure that sufficient measures are in place to assess the competence and stability of the workforce upon which patient access and quality services depends. While the State aims for consistency in the metrics and measures used for VBP, as measures are approved over time or additional information and objective require modifications or changes, the State will adjust accordingly.

Over 90% of these measures is based on claims data, or on other data (such as surveys) that are owned by or primarily available to the state (CAHPS, UAS-NY, ...). The state will make the scores of these measures available to the PPSs and the MCOs during DY 1 (2015), with the opportunity to compare between PPSs and regions, to identify providers responsible for high or low scores, and to explore some of the common drivers of better or lesser performance. In DY 2 (2016), the State will also make the total risk-adjusted cost of care available per PPS for the total population, as well as per integrated care service delineated above (Maternity care, Diabetes care, APC/PCMH care, etc; based on the average of the involved providers' historical data over the previous 2 years). Potential (shared) savings, estimated by e.g. benchmarks on potentially avoidable complications, will be publically provided as well at both the total population level as per care bundle and subpopulation. Having these costs and the outcomes of these services available and transparent is crucial for any transformation towards payments based on value rather than volume.²⁵

For the population-based total cost of care calculations, the state will rely on 3M CRG risk adjustment methodologies to create comparability between PPSs/providers and to adjust for shifts in attribution profiles within a PPSs/provider group over time.²⁶ For the care bundles (including chronic care), the most recent version of the open source Evidence-informed Care Rate (ECR) risk-adjustment methodology will be used, developed by the Health Care Incentives Improvement Institute.²⁷ As with the measures, as adjustment methodologies improve over time (including e.g. better sensitivity to pre-existing disparities), the State will adjust accordingly.

Establishing Benchmarks, Setting Rates and Rebasings

To determine whether savings or losses are made in Level 1 and 2 arrangements, a 'virtual budget' needs to be agreed upon for the PMPM or bundle. Using the risk-adjusted cost information, the benchmarks and the potential for shared savings, the MCOs and PPSs/combinations of providers can negotiate target budgets per arrangement to disincentivize above-average avoidable complication rates, for example, or rather invest additionally in underserved areas of care.²⁸ The state, in other words, provides information and benchmarks, but does not intend to set these target budgets, nor does it intend to set the PMPM or bundle rates once Level 3 arrangements come into view.

²⁴ NQF (2013). Patient Reported Outcomes (PROs) in Performance Measurement. For especially the FIDA, HARP, and DISCO subpopulations measures will be developed which reward quality of life and rehabilitation outcomes. These measures will help New York State achieve Olmstead, Americans with Disability Act and Home and Community based setting requirements.

²⁵ Watkins, L. D. (2014). Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative, Milbank Memorial Fund.

²⁶ For some of the selected subpopulations, 3M CRG-based rate adjustment methodologies have already been developed that will form the basis for the risk adjustment for provider payments for these subpopulations.

²⁷ <http://www.hci3.org/content/ecrs-and-definitions>

²⁸ In projecting historical costs forwards, a price-index adjustment will be included

A common concern in shared savings arrangements is downwards resetting of the baseline once savings have become commonplace, leading to a gradual downward trend in overall provider reimbursement. As the Figure on page 6 illustrates, however, the state aims to link the realization of high value care to *increased* provider margins rather than to reduced margins. So while the reduction of rates of costly avoidable complications may lead to downward rebasing within a single bundle, investments in primary and secondary prevention may lead to upward rebasing. Similarly, those PPSs or combinations of providers that already deliver high value care (good to excellent outcomes and little opportunity in terms of savings) should be rewarded for doing so, while those PPSs or combinations of providers that reap significant savings because their potentially avoidable complication levels were high can expect some downward rebasing until the value they realize is in line with the reimbursements received.

Again, as long as the total statewide yearly growth rate remains within NYS' Medicaid global cap, the state will not force either way; it will merely provide the transparency for MCOs and providers to compare the total risk-adjusted costs of care per bundle and per (sub)population, including the virtual budgets, and present that information linked to the outcomes realized.

As said at the beginning of these section: at any given time, providers and MCOs are free to jointly propose 'off menu' versions of Value Based Payment arrangements. The state will accept these proposals when these 'off menu' versions support the underlying goals of the payment reform and sustain the transparency of value as outlined above (costs vs outcomes).

Attribution

Both the Total Care for Total Population as the Integrated Primary Care value-based arrangements require a clear definition of 'attributed lives'. DSRIP's attribution for performance mechanism will be the starting point for these purposes, which is updated monthly and also used for calculating the DSRIP outcomes of care for the overall DSRIP targets as well as for the selected projects.

Lessons learned during DSRIP that could further improve this attribution methodology will be incorporated. One improvement could be having members select a PPS at the time of enrolment, much like members currently choose a PCP. The state will investigate this possibility, which would have the PPS serve like a 'preferred provider network' for the patient (without restricting access to the plan's entire network). This approach could also facilitate the realization of across-PPS information sharing and patient consent.

For the care bundles and subpopulations, patients need to be attributed to the contracting PPS (or the

Dual Eligibles

The dual eligible population may seem relatively small (some 15% of Medicaid beneficiaries are also eligible for Medicare), but these 700,000 individuals comprise 27% of total Medicaid spending. Because of these high costs, NYS intends to integrate the NYS Fully-Integrated Dual Advantage (FIDA) program in this VBP program. (For purposes of determining the '80-90% of total costs' goal, however, Medicare dollars will not be included).

The FIDA program is a relatively new effort in NYS, and while the program gains momentum, the State will focus its efforts on including the Managed Long Term Care (MLTC) payments in the progress towards VBP. Preventing avoidable hospitalizations and improving palliative care, for example, can greatly enhance the quality of care for these patients. Even if the savings would primarily accrue to Medicare, NYS will not pass on the opportunity to make significant strides in meeting the needs of this part of the Dual population.

(See p.3635 on the overall alignment with Medicare).

PPS with which the contracting providers are affiliated), and need to fulfill standardized diagnostic criteria.

Goals

- A Statewide goal of 80-90% of total MCO-PPS/provider payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs at end of DY5. Fee-For-Service payments for preventive activities, aligned with quality measures, will be counted as VBPs.
- The State recognizes that providers throughout the State are at varying levels of readiness to begin transitioning to VBP. As such, the State will plan to develop expectations and evaluations of progress into VBP in three distinct categories:
 - Leading PPSs/Groups of Providers: These providers are ready, willing and able to enter into VBP arrangements, likely building upon current experience in VBP arrangements with payers.
 - Learning Providers: These providers are willing to enter into VBP arrangements, but may require more time and additional technical assistance to be fully prepared to enter into agreements with payers.
 - IAAF Providers: Providers who receive Interim Access Assurance Fund (IAAF) support, will be allowed to undergo the required significant restructuring before VBP steps will need to be made.
- To optimize the incentives, and allow providers to maximize their shares in realized savings so as to build towards a financially stronger Medicaid delivery system, the state aims to have $\geq 70\%$ ²⁹ of total costs captured in VBPs has to be in Level 2 VBPs or higher. The target here is not the percentage per se but the goals the state, the providers, MCOs and beneficiaries collectively want to achieve through payment reform. In that light, the State will incentivize responsibly moving towards Level 2 and higher, and yearly readjust this target in the light of the realization of ~~our~~the overall goals.

Pending: Textbox describing current MCO VBP Landscape

In this textbox, a brief description will be given of the current landscape of VBP use by MCOs in NYS. To be realized before 3/24.

Exclusions

In principle, the state does not want to wholly exclude any cost categories from the VBP arrangements.

²⁹ Ibid.

2. Ensuring alignment between DSRIP goals and value based payment deployment

Issue 2: How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures

Selecting integrated care services

As discussed in the previous section, sustaining the achieved DSRIP goals is the starting point for the design of this payment reform. The overall aim to increase population health, individual health outcomes and reward high value care delivery is similar, and the outcome measures to be used in the different VBP arrangements will directly build upon the DSRIP measure set. In addition, the DSRIP objectives and measures play an important role in the selection of the care bundles and subpopulations to be prioritized. The following criteria have been used:

1. The proportion of total Medicaid costs

Focusing on those care bundles and subpopulations with the largest spent is the best way to realize maximal impact while keeping the number of care bundles and subpopulations within reason.

2. The number of Medicaid beneficiaries included in these integrated care services per county/PPS

A minimum number of patients per PPS/provider combination per integrated care service is required for these value-based payment arrangements to become meaningful. When numbers are too low, after all, it becomes impossible to reliably measure outcomes of care. In addition, the lower the number of patients per care bundle or subpopulation, the higher the risk that natural variation will inadvertently cause significant gains or losses unrelated to the quality or efficiency of the care delivered.³⁰

The care bundles and subpopulations with the highest numbers of patients will be prioritized. Minimum numbers for contracting will be established in 2015.

3. Cost Variation

Variation in cost per integrated care service can be due to three factors³¹:

- Quantity of services delivered: the more admissions or expensive diagnostic tests, the higher the cost per care bundle/patient
- Mix of services: selecting more costly diagnostic tests, prescribing specialty rather than generic drugs or opting for inpatient rather than outpatient treatment modalities drives up cost per care bundle/patient
- Price per unit of service (this variation will be low within the Medicaid domain)

Large variations in costs per care bundle or subpopulations is indicative of potential waste and thus savings, and these care bundles or subpopulations will thus be prioritized.

³⁰ Mechanic, R. and C. Tompkins (2012). "Lessons learned preparing for Medicare bundled payments." *N Engl J Med* **367**(20): 1873-1875; Weissman, J. S., M. Bailit, G. D'Andrea and M. B. Rosenthal (2012). "The design and application of shared savings programs: lessons from early adopters." *Health Aff (Millwood)* **31**(9): 1959-1968.

³¹ de Brantes, F. and S. Eccleston (2013). Improving Incentives to Free Motivation, Healthcare Incentives Improvement Institute and Robert Wood Johnson Foundation.

4. Rates of potentially avoidable complications

Because the core goal of DSRIP is reducing potentially avoidable (re)admissions and ER visits, identifying those care bundles and subpopulations with the highest rates of overall potentially avoidable complications is a crucial criteria for prioritization.

5. Prioritized within DSRIP

To ensure alignment with the DSRIP objectives, the integrated care services selected within the DSRIP program will be prioritized as well.

Applying these criteria, the following selection of integrated care services emerges (see Appendix II for the quantitative analyses underlying this selection):

Integrated Primary Care, including integrated care for:

- Diabetes
- Asthma
- Hypertension
- Depression
- Chronic Heart Failure
- Coronary Artery Disease
- COPD

Care Bundles – Episodic:

- Maternity Care
- Stroke
- Depression³²

Care Bundles – Specialty Chronic:

- AIDS/HIV
- Hemophilia
- Chronic Kidney Disease

Total Care for Subpopulations

- Multimorbid disabled / frail elderly (MLTC/FIDA population)
- Severe BH/SUD conditions (HARP population)
- Care for the Developmentally Disabled (DISCO population)

[this section to be developed further once analytics are done.]

The total dollar amount associated with these care services is xx\$, thus covering approx. xx% of the total payments between MCOs and PPSs/providers (excluding the Medicare component of the FIDA payments).

This initial selection will be tested, refined and expanded further during the remainder of 2015 through further data analysis and discussions with stakeholders.

³² Depression can be an episodic but also a chronic condition.

Incentivizing the Patient: Value Based Benefit Design

Payment reform is incomplete without considering the financial incentives for patients in both lifestyle choices (leading to future health care costs) but also provider choices (choosing for either higher or lower value providers). Financial incentives for the former (stimulating behavior that will lead to healthier lives) are becoming common. Incentives to stimulate high-value care utilization, however, are less widespread. Yet the problems DSRIP set out to address have their roots in inadequate financial incentives for beneficiaries as well. Absence of coverage, leading to ER use as the only realistic location for care, is the most obvious one, and is being addressed by New York's Medicaid expansion, amongst others. Yet once a patient is enrolled in a Medicaid managed care plan, indiscriminate choices of providers and persistence of using the ER as the first line of care are more often than not similarly covered as judiciously selecting a primary care physician and high value care. If these behavioral patterns are not addressed, if providers' *and* patients' financial incentives are not fully aligned with the value of health care services, the chances that DSRIP sustainably realizes its goals will be reduced. Value-based benefit design is an important part of this and should thus be a core aspect of any payment reform.³³

In NYS Medicaid, however, adding financial burdens by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option. On the other hand, *positively* incentivizing desired behavior, including allowing access to previous inaccessible high-value care benefits (such as joint weight reduction programs, smoking cessation, post-acute care activation programs, or programs to teach healthy and affordable cooking habits and wellness management skills) can be a very powerful tool. The state will stimulate MCOs as well as PPSs and other provider combinations to introduce ~~both types of~~ positive incentives:

- Wellness or Lifestyle incentives, where the state can build upon its experience with its MIPCD (Medicaid Incentives for the Prevention of Chronic Disease) program. Any program that has been proven effective can be implemented by MCOs as part of their larger VBP approach. Plans are required to coordinate the approach with the PPSs to whom their populations are attributed.
- Patient incentives to make optimal health care choices, such as:
 - Actively and meaningfully using PCPs and preventive care
 - When indicated: Engaging in early Maternity care
 - When indicated: Engaging in chronic care
 - Adherence to treatment
- Using care In Network (ie., within IDS) rather than out-of-network (unless explicitly indicated).


In line with the levels of VBP described above, and learning from the rapidly growing experience in incentivizing patients/consumers, the state aims to maximally focus here as well on *outcomes* rather than efforts or process-steps. In this view, patients could be incentivized, for example through cash payments or ~~housing~~ subsidies, for meeting life style choices that are proven to improve health and


³³ Thomson, S., L. Schang and M. E. Chernew (2013). "Value-based cost sharing in the United States and elsewhere can increase patients' use of high-value goods and services." *Health Aff (Millwood)* **32**(4): 704-712; Choudhry, N. K., M. B. Rosenthal and A. Milstein (2010). "Assessing the evidence for value-based insurance design." *Health affairs (Project Hope)* **29**: 1988-1994; Antos, J., K. Baicker, M. Chernew, D. Crippen, D. Cutler, T. Daschle, F. d. Brantes, D. Goldman, G. Hubbard, B. Kocher, M. Leavitt, M. McClellan, P. Orszag, M. Pauly, A. Rivlin, L. Schaeffer, D. Shalala and S. Shortell (2013). *Bending the Curve. Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth*. Washington DC, Brookings Institute.

reduce downstream costs, or truly choosing high value care. Any incentive, regardless of its form, would not impact a member’s Medicaid or other State Health or Human Service (e.g. SNAP or TANF) eligibility status with regards to income or asset thresholds. This would be a form of ‘inclusive shared savings’, where patients’ incentives to choose wisely become fully aligned with professionals and providers aiming to reduce avoidable hospitalizations and improve population health. Any incentives offered to consumers need to be culturally competent not only in terms of geographic, linguistic, and normative preferences, but also needs based on disability status, employment, and transportation. It is important to note that the process of designing patient incentives is complex and will need to consider underlying disparities and social determinants of health including community needs, local planning efforts, and should not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and supports.³⁴

Public health and social determinants of health

Given the importance of the social determinants of health for the realization of the state’s goals, its definition of Integrated Primary Care and its vision for the role of the PPS is explicitly population-health focused, reaching out into the community to stimulate community-based prevention activities and aligning itself with available social services. Concurrently, the framework for value-based payment will maximally incentivize providers to push the envelope in focusing on the core underlying drivers of poor health outcomes – whether traditionally within the medical realm or not.³⁵

Housing 

Offering a stable housing environment can be a highly efficient and outcomes-improving intervention for vulnerable, homeless Medicaid beneficiaries. DSRIP explicitly stimulates investing in tailored housing solutions, and this VBP Roadmap aims to maintain that opportunity also after the end of the DSRIP program. 

Capturing Savings across all areas of Public Spending

Addressing the social determinants of health is a critical element in successfully meeting the goals of NYS DSRIP and Health Care reform more broadly. The State is fully committed to exploring ways to capture savings accrued in other areas of public spending when social determinants are addressed. These might include e.g. reduced cost of incarceration and shelter care for homeless people.

Given the current state of primary care and IDS development in the state, however, and the difficulty to truly move the needle on a population-wide basis within a few years, the DSRIP Domain 4 population health measures are Pay for Reporting only. In the near future, however, the state foresees culturally competent community based organizations actively **aligning contracting** with PPSs and/or Advanced Primary Care organizations to take responsibility for achieving the state’s Prevention Agenda. DSRIP starts to build the infrastructure to take on housing, job placement and

³⁴ Thomson et al. op.cit. 3328; Schmidt, H. and E. J. Emanuel (2014). "Lowering medical costs through the sharing of savings by physicians and patients: inclusive shared savings." JAMA Intern Med **174**(12): 2009-2013; Baicker, K. and M. Rosenthal (2014). "Shared savings, shared decisions, and incentives for high-value medical care." JAMA Intern Med **174**(12): 2014-2015.

³⁵ See e.g. Doran, K. M., E. J. Misa and N. R. Shah (2013). "Housing as Health Care — New York’s Boundary-Crossing Experiment." N Engl J Med **369**(25): 2374-2377.

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incarceration pathways as levers to increase population health, and the state foresees VBPs (for PPSs as a whole or for integrated primary care) to become a vehicle to maintain this infrastructure. Specifically, the state aims to introduce a dedicated value based payment arrangement for pilot purposes in DY 3 to focus specifically on achieving Prevention Agenda targets through CBO-led community-wide efforts.

Immediately after DY 5, the state intends to turn the Pay for Reporting measures into Pay for Outcomes measures, making a part of overall PPS reimbursement dependent on the achievement of specific public health goals as identified by these measures.

[A dedicated group will be established to focus on these issues \(see p. 3435\).](#)

3. Amending contracts with the MCOs to realize payment reform

Issue 3: How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform

Aligning incentives

The state will add the following incentives and regulations in its contracts with MCOs to stimulate MCOs towards adapting VBPs:

- The state plans to increase the managed care rate for those MCOs that capture more provider-payment dollars in VBP arrangements. It is exploring enhancing the existing quality incentive pool to reward those plans for engaging in VBP levels 1, 2 and 3. The state is currently in discussions with its actuary in order to determine the best method to implement these actions.
- Part of this increase will be paid to providers as a stimulus for engaging in higher level VBP contracts. This is one of the mechanism by which the state will ensure that financial resources for providers are 'depleted' when savings start to accumulate.
- Additionally, the State will need to formulate a methodology to evaluate the different levels of plan and provider value based payment arrangement. This method in turn would be basis for the distribution of additional quality pool funding related to this initiative.
- The state intends to include a provision that further incentivizes plan/provider arrangements that focus on integrated care services (APC/PCMH, care bundles or total care for selected subpopulations) rather than those that focus on total cost of care for the total population because a) infrastructure costs for these former arrangements will be higher and b) the State believes the total impact on quality, efficiency and sustainability of the Medicaid delivery system to be higher when a more differentiated VBP approach is taken.
- Starting DY 4, quality pool incentives for non-VBP payment rates from MCO to provider are no longer allowed without explicit permission by the state. This includes payments for achieving quality goals in Level 0 VBP arrangements. Permission will automatically be granted for services that are foreseen to remain part of the 10% non-VBP payments after DY 5. The funds saved through this measure will be utilized by the state to continue and/or further augment payment to MCOs through the quality incentive.

- The state will assure that it will not hold MCOs accountable when providers, to no fault of the MCO, run into financial difficulty because of underperformance on a Value Based Contract. To be able to give this guarantee, and as an additional layer of protection for the state’s safety net infrastructure, the state will create a dedicated statewide fund / risk pool for distressed safety net providers that are too essential to allow to fail. The funding mechanism for this pool is still under development.

VBP Innovator Program

In addition to the incentives discussed above, the state will implement a VBP Innovator Program. This program will support multi-year agreements between plans and providers for those PPSs or combinations of providers that aim to lead the way in embracing the opportunities and flexibility that come with fully-fledged Level 2 or 3 value-based arrangements. In cooperation with MCOs, the Department of Health and the Department of Financial Services will work together to jointly set criteria to ensure the providers are ready to take on this risk, and that the Program does not inadvertently hamper existing leading initiatives. In addition, DOH and DFS will monitor performance and provide required oversight on an ongoing basis. The PPSs or provider combinations that meet these criteria will receive approximately 95%³⁶ of the dollars paid by the state to the MCO for this care. Plans will not be expected to cover any potential losses incurred by providers that participate in the Innovator Program. In addition, plans that are leading the way will similarly be recognized through a VBP innovator premium.

Specific regulatory amendments

Successful transformation of the existing payment system will require restructuring of contractual arrangements which clearly define metrics and the ability to share savings and risk. Such Value Based Payment reform would necessitate changes in State statute to recognize integrated delivery systems and to promote arrangements that impact the provision of services. Additionally, the existing regulations within the Department of Health and the Department of the Financial Services (DFS) will be thoroughly reviewed and amended as necessary to reflect changes necessitated by the adoption of the value base payments. While NYS has a regulatory framework for the review and approval of certain risk arrangements, additional regulations may be promulgated in order to effectively implement. Any new or revised regulations would also be promulgated in collaboration with the DFS and health care provider industry.

Changes to the Medicaid Managed Care model contract and the internal policies guiding the risk sharing arrangements with MCOs and downstream providers will also be evaluated and if necessary amended to promote value based contracting. Successful implementation of this new payment reform will ensure that existing provider and patient protections continue to be honored and provision of services to needy is not inadvertently disrupted.

To date the State has identified the following required amendments;

- **Changes to Statute** -- The Governor’s FY 2016 Executive budget includes language that authorizes the Commissioner of Health, in consultation with the Superintendent of the Department of Financial Services, to require value based payments and set the framework for regulatory reform, as needed. In addition, it authorizes managed care organizations to contract with PPSs for the provision of

³⁶ DOH, DFS, and stakeholders will determine what constitutes an appropriate capitation amount when they develop the parameters of the program.

services, and requires that all value based arrangements be reviewed and approved by the Department. This language is included in Appendix X.

- **Regulatory Changes** – The DOH will engage and work collaboratively with the newly established PPSs, Provider Advocacy Groups and the Managed Care Industry along with the DFS to develop regulations guiding value based payment arrangements. It is envisioned that regulations will be promulgated to address: issues relating to reimbursement methodologies, approving discrete levels of value based arrangements, reserved requirements and risk transfers to ensure that the arrangements are sustainable for both MCOs and providers.
- **Model Contract and other Policy changes** -- The Department of Health has included language in the Medicaid Managed Care Model contract which begins to evaluate the baseline for current alternate value based payment arrangements in order to monitor the transition of payments from fee-for-service to value based over the next five years.

Medicaid managed care plans will be required to increase the percentage of value based payments each year and must submit an annual report to the Department identifying which providers will be impacted by alternate payment arrangements and the percent of provider payments impacted. Current MCO/Provider and Independent Practice Association (IPA) Guidelines as well as the Management Contract Guidelines will be modified accordingly and applied to all contracting arrangements with plans and providers. The contract modifications will have to be realized before the start of DY 3 (2017) (see also the Timeline section)

These initial regulatory implications have been identified, however the State plans to convene a Regulatory Work Group during 2015 with the charge of identifying additional regulatory challenges related to implementing VBP, and suggested solutions for resolving these issues. As wethe State moves towards full Medicaid managed care coverage and value-based payment, for example, safety-net providers that are just now transitioning into managed care should not have to be unduly concerned that credentialing would remain a barrier to care when VBP is being rolled out. In addition, this Regulatory Work Group will also examine current rules and regulations that may no longer be required in the future including for example detailed monitoring and rate setting.

4. Amending contracts with the MCOs: collection and reporting of objectives and measures

Issue 4: How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.

The state currently includes quality and efficiency incentives in contracting with MCOs that are directly aligned with DSRIP. Many of its QARR metrics, for example, are identical to the metrics selected for DSRIP. In addition, 2015 will be the first year the State works with Efficiency Measures for MCOs, which are aimed at reducing ER visits and avoidable admissions through the same measures used within DSRIP. This further aligns MCO's incentives with DSRIP's desire to realize a lasting, sustainable transformation of the Safety Net system. In DY 1 the State will work with MCOs to finalize the streamlining of the overall MCO quality and efficiency frameworks with the payment reform proposed here. During that year, the

state will involve multi-stakeholder groups to discuss the inclusion of additional outcome measures where necessary (see section on ‘Transparency of Outcomes’ above, p. 20).

5. Creating synergy between DSRIP objectives and measures and MCOs efforts

Issue 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

Currently, the base administrative per member per month (PMPM) amounts are calculated for each of the State’s nine managed care rating regions using plan Medicaid Managed Care Operating Reports (MMCORs). The regional PMPM amounts are calculated by dividing the total allowable administrative cost for each plan in a given region by the plan reported member months. Each plan PMPM amount is then subject to the Department’s administrative PMPM cap and adjusted down if necessary. Additionally, the Department of Health (DOH) also incorporates an administrative component into premiums for all new populations and benefits moving into the benefit which are not reflected in the two year MMCOR base. This additional administrative component is developed by the State’s actuary. The administration component is then adjusted by a plan specific risk score.

As with all new requirements, the Department and its actuary will review what will be expected of plans under DSRIP with regards to provide technical assistance/support, new activities, workforce development, etc. to achieve waiver goals. This analysis will also take into account activities already being accounted for in plan rates to ensure duplication of payment is avoided. Ultimately, the State’s actuary will certify an actuarial sound rate range that takes into account the factors above which the State will pay for within the range to meet Federal requirements.

It is anticipated that the new requirements under DSRIP may result in additional administrative costs for the plans which will need to be evaluated by the State and its actuary. Two specific areas where this will likely occur are: 1) *workforce planning* where, under the waiver, plans are responsible for developing and implementing various workforce strategies and 2) *value based payment* requirements which will necessitate plan/provider contract modifications. While there will likely be increases for these items, the Department believes they will not be excessive as it intends to set benchmark payment levels for use by plan/provider. Further, it is not the intention of the State to exclude plans that have been proactive and have already made investments to develop VBPs from this additional support.

6. Assuring that providers successful in DSRIP are contracted

Issue 6: How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks

VBP is not designed to limit patient options or to “lock” providers out. The state will maintain current managed care network requirements which both ensure adequate patient choice and provider inclusion. The state will also work with PPS to enhance their networks as needed to ensure that all vital providers are included. While there is no requirement for a provider to join a PPS network many already have during DSRIP which positions the state to ensure that VBP will be applied widely. Because high performing (combinations of) providers will be visible to both providers, MCOs and the public alike, it is highly unlikely that (combinations of) providers that are successful in delivery high value care would not be contracted by MCOs. In addition, the State will look to develop approaches which ensure the inclusion of providers who demonstrate successful performance. It is likely that some providers may need assistance engaging in value based payment. Smaller, less prepared providers may need access to resources and support to develop the sophistication to succeed. DSRIP funds are explicitly intended to facilitate this. In addition, the State intends to form a workgroup during calendar year 2015 explicitly focused on ensuring that Community Based Organizations can fully participate in VBP.

Over time, the state will also explore the possibility of having Medicaid members select a PPS at the time of enrollment much as they do their PCP. For PCPs included in only one PPS, members would be automatically enrolled in that PPS to assure attribution alignment. If a PCP was in more than one PPS a member would be entitled to select one of the PPS. Such an option would help better connect a member with his or her preferred provider group from the beginning of Medicaid eligibility which should ensure better care coordination especially for complex patients. Such a selection process would also enhance attribution for performance measurement purposes. The state doesn’t envision a member being limited to the providers within the selected PPS network. Individuals would still have access to all providers within the managed care network. All current rights Medicaid members enjoy relative to provider access would be maintained within a VBP environment.

7. Amending contracts with the MCOs: adjusting Managed Care rates to improved population health and care utilization patterns

Issue 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

Under the Department’s Mainstream Managed Care risk adjusted rate methodology, all plans are paid at the same regional average premium, adjusted by a plan specific risk adjustment factor that accounts for differences in enrollee acuity across plans. The regional premiums are developed using two years of plan reported MMOR data. Using collected encounter data, risk scores are calculated using 3M’s Clinical Risk Group (CRG) model and cost weights developed by the Department. In simple terms, these two pieces are multiplied together to get plan specific risk adjusted rates. The Department and its actuary incorporate changes in case mix, utilization and cost of care on an annual basis as the data becomes available to incorporate in rate development. The inclusion of DSRIP into this process will be a continuation and expansion of the work already being done. Furthermore, as the Department implements its “Care Management for All” initiative and new populations and services (esp. for chronic conditions including the long term care, behavioral health and developmentally disabled populations) move into managed care, it has engaged 3M and plans to make refinements to the current risk adjustment methodology. This effort is also a significant element of the CMS/DOH Fully Integrated Dual

Advantage (FIDA) Demonstration. Ultimately, the goal is to have one risk adjustment system that incorporates the needs of the entire Medicaid managed care population.

8. Amending contracts with the MCOs: ensuring alignment between DSRIP objectives and measures and MCO rate setting

Issue 8: How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year

As noted above, the state’s actuary currently develops actuarially-sound rates for the state. Any new expectations or tasks associated with DSRIP that the plans will be required to undertake will be incorporated into the development process. Similarly, as new populations and services have moved into managed care the State has and will continue to deploy risk mitigation strategies such as stop loss, medical loss ratios and/or risk corridors to ensure that appropriate reimbursement is being made. The State also places a premium on timely and accurate plan encounter submissions. This information is used to not only monitor the implementation of “Care Management for All” but also as a means to measure plan profitability and rate adequacy. Furthermore, as mentioned above, the Department will include core DSRIP metrics into plan specific reimbursement to optimally align payers’ and providers’ incentives. Through the transparency program described above, the Department will report outcomes of these metrics to both plans and providers on which PPSs and provider-combinations are achieving or underperforming on each of the measures.

Stakeholder Engagement

In support of the State’s efforts to create a comprehensive roadmap a series of Stakeholder Engagement Interviews were conducted to share preliminary VBP concepts the State was considering, discuss key themes with regard to achieving a VBP model, identify and outline key challenges anticipated and request feedback and suggestions for the State’s consideration. Stakeholder’s engaged during the preliminary interview process included New York State Health Plans, managed care organizations, representative organizations including the Health Plan Associations, Hospital Associations, legal firms specializing in health care contracting, New York State Health and Human Services Agencies, community based providers, patient advocates, and Performing Provider Systems and other industry experts including national experts in VBP.— All of the key themes and challenges identified during this stakeholder engagement have been documented and addressed through the drafting of the Roadmap.

In addition, the State has created a formal group of Stakeholders, an expansion of the Medicaid Reform Team’s Global Cap Work Group, to serve as the Value Based Payment Workgroup. The VBP includes representatives from other State Agencies, payers, providers, advocacy groups, and labor. A list of the members included in this group is attached in Appendix X. This group will continue to be engaged throughout the development and implementation of this Roadmap, ~~and the State also plans to expand~~

~~this group and engage them in the process of all payer payment reform in coordination with the State's Health Innovation Plan (SHIP).~~ In addition, members of the VBP workgroup will serve in leadership roles to support the detailed work which will commence after CMS approval to operationalize the roadmap. These workgroups are outlined in the Next Steps Section.

Timeline

- In DY 1 (2015), the Medicaid VBP approach will be finalized and refined, including a detailed scoping of the required information infrastructure to support the statewide realization of this approach.
- In DY 2 (2016), every MCO – PPS combination will be requested to submit a growth plan outlining their path towards 90% value-based payments. All growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population). MCOs with more ambitious grow plans will receive a bonus on their PMPM rates from DY 3 (2016) on.
- End of DY 3 (2017), every MCO – PPS combination will have at least a Level 1 VBP arrangement in place for PCMH/APC care and one other care bundle or subpopulation (a Level 1 arrangement for the total cost of care for the total population would count as well). PCMH/APC care is selected here because of its vital role in realizing the overall DSRIP goals.³⁷
- End of DY 4 (2018), ~~every MCO – PPS combination will have~~ at least 50% of ~~its the state's MCO payments care-costs~~will be contracted through Level 1 VBPs. This aligns with the aim to have 50% of Medicare payments tied to quality or value through alternative payment models by the end of 2018. The state aims to have ≥ 30% of these costs contracted through Level 2 VBPs or higher at this time, yet this aim may be moved up- or downwards depending on the overall trend towards financial sustainability and high value care delivery as measured through overall DSRIP measures and cost of care measures for bundles and (sub)populations.
- End of DY 5 (2019), ~~≥80-90%~~ of ~~the state's~~ total MCO-PPS payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs. The state aims to have ≥ 70% of these costs contracted through Level 2 VBPs or higher at this time, yet this aim may be moved up- or downwards depending on the overall trend towards financial sustainability and high value care delivery as measured through overall DSRIP measures and cost of care measures for bundles and (sub)populations.

Next Steps

As discussed above, this Roadmap has been conceived as a living document. It is not a Blueprint; but rather attempts to demonstrate the State's ambition and the outline of what the state and its stakeholders consider the payment reforms required for a high quality, financially sustainable Medicaid delivery system.

Upon CMS approval of the Roadmap, the work of operationalizing this vision for payment reform at a more detailed level will commence. Fundamental to the success of the efforts outlined in this Roadmap is consistent and meaningful engagement of ~~our the State's S~~ stakeholders to harnessing their expertise and enlist their assistance in making these ambitions a reality.

³⁷ ~~The contract does not have to include the PPS as contract partner.~~

The State intends to leverage the VBP Workgroup to create a number of sub-committees whose tasks will center on taking this roadmap and developing detailed implementation plans for the work ahead. The State currently envisions six main areas of focus which will be supported by an ongoing team of data and analytics staff:

1. *VBP Technical Design*

Utilizing a diverse group of stakeholders, this sub-committee will be focused on the detailed design of the State's vision for VBP. This would likely include content areas related to the technical design, for example shared savings limits, stop loss thresholds to prevent insurance risk from transferring to providers, threshold savings and losses levels to ensure payment models are tenable for all providers and minimum beneficiary assignment levels for MCO VBP agreements.

2. *Integrated Care Services*

For each of the integrated care services that are identified through the analytical assessment, groups of clinicians, providers, payers, and State staff will work in teams to fully define that service area. This would likely include the development of appropriate parameters for each bundle, ensure outcome measures are well aligned and comprehensive, and identify any regulatory changes required to allow implementation.

3. *VBP and Social Determinants of Health*

This sub-committee will focus on the inclusion of social determinants of health in both the payment mechanisms (i.e., paying for housing) as well as outcomes measurement. Amongst others, this sub-committee will:

- Integrate rewards and incentives based on utilization and outcomes related to best practices in cultural competence;
- Evaluate the reporting requirements for DSRIP leads, PPS providers, and managed care companies in terms of social determinants;
- Suggest how to evaluate and measure the effectiveness of Evidence Based practices for cultural groups based on their correlative impact on social determinants of health.

3.4. *Regulatory Impact*

The group will focus on identifying and problem solving regulatory and contractual barriers to the implementation of the scope of VBP. In addition, this group will review the current mandates required and assess the need for them to continue in the future state of VBP in NYS.

5. *Community Based Organization Workgroup*

This group will be focused on identifying the needs of CBOs so they can fully participate in VBP. The state recognizes that these providers play a critical role in the desired health care delivery system, however CBOs are very diverse in their ability to fully take on VBP. The group would make recommendations to the state and draft an action plan designed to make available the technical assistance and training necessary to bring the CBOs up to speed.

4.6. *Communications*

The implementation of the VBP Roadmap, along with the significant delivery systems reform underway in DSRIP requires a thoughtful and strategic approach to communicating to both Stakeholders and Members. This group, in close collaboration with consumer advocates, will assist in developing a communications strategy that will adequately address the complexities of these envisioned changes.

It is the State's hope that this planning process to occur over the next 10-12 months will ensure the State's commitment to Stakeholder engagement, transparency and coordination with other Health and Human Services programs in New York State

Coordination with Medicare

As referenced above, CMS has announced the goal to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, the CMS target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. As CMS embarks down the path of VBP for Medicare with explicit goals for alternative payment models and value-based payments New York State is committed to ensure coordination between both VBP programs. The State will actively engage with CMS so as to maximize synergy and benefit between the programs and minimize complexity for beneficiaries, providers and plans.

Conclusion

Providers and PPSs in successful DSRIP programs will see a significant shift in reimbursement dollars. DSRIP funds will allow them to compensate for lost revenues while investing in new infrastructure; similarly, DSRIP funds will be used to pay for currently non- or underfunded care activities when innovative, outpatient- and community-focused care models are being introduced. As quality outcomes improve, and avoidable admissions and visits are reduced, the current fee-for-service model will be increasingly ill-fitted to sustain the new delivery models. After five years, when the DSRIP funding stops, gains realized will be impossible to maintain unless significant steps are made to align payment mechanisms with these new care models. Importantly, without payment reform, improved outcomes and efficiency will lead to reduced reimbursements, and a downward rebasing of MCO rates, reducing Medicaid dollars and weakening rather than improving the viability of the safety net.

Building upon the infrastructure that DSRIP will help put in place, this roadmap outlines a gradual transformation towards payment reform which:

- Aligns the payment incentives with the aims and goals of DSRIP and population health management
- Rewards value over volume
- Ensures reinvestment of potential savings in the delivery system
- Allows for reimbursement of innovative care models currently not or underfunded
- Allows for increased margins for providers when delivering value and an increased viability of the state's safety net
- Allows for more sustainable workforce strategies
- Reduces the percentage of overall Medicaid dollars spent on administration rather than care

The state realizes that this plan is ambitious, yet without this ambition, these aims, vital to the beneficiaries, the provider and plans community, and the Medicaid delivery system as a whole, cannot be realized. It is encouraged to see its ambitions reflected in the recently released Medicare VBP plan and in the feedback of many leading providers and MCOs. The state looks forward in working closely with CMS and stakeholders to further build out and jointly realize this plan over the next five years.

Appendix I: T&Cs Par. 39

In recognition that the DSRIP investments represented in this waiver must be recognized and supported by the state's managed care plans as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of DSRIP in managed care contracts and rate-setting approaches. Prior to the state submitting contracts and rates for approval for the April 1, 2015 to March 31, 2016 contract cycle, the state must submit a roadmap for how they will amend contract terms Recognizing the need to formulate this plan to align with the stages of DSRIP, this should be a multi-year plan, and necessarily be flexible to properly reflect future DSRIP progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for managed care contracts for the 2015 state fiscal year. The state shall update and submit the Managed Care DSRIP plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the Managed Care DSRIP plan will also be included in the quarterly DSRIP report. The Managed Care DSRIP plan should address the following:

- 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.
- How and when plans' current contracts will be amended to include the collection and reporting of DSRIP objectives and measures.
- 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.
- How alternative payment systems deployed by MCOs will reward performance consistent with DSRIP objectives and measures.
- How the state will assure that providers participating in and demonstrating successful performance through DSRIP will be included in provider networks.
- 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.
- How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with DSRIP that the plans will undertake, and how the state will use benchmark measures (e.g., MLR) to ensure that payments are sound and appropriate. How plans will be measured based on utilization and quality in a manner consistent with DSRIP objectives and measures, including incorporating DSRIP objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

- How the state will use DSRIP measures and objectives in their contracting strategy approach for managed care plans, including reform.

Appendix II: Value Based Payments and the Forestland PPS in 2019

During the DSRIP application process, the State facilitated the creation of a Prototype application, designed to provide emerging PPSs with an example of what a successful DSRIP application would look like. To create this prototype a fictional PPS “Forestland” was created. Building upon this narrative, the following provides an example of what the future state of VBP in the fictional Forestland PPS could look like. (It is not necessary to have read these earlier Forestland materials).

The Forestland PPS has been a successful PPS. It has met the bulk of its performance targets over the DSRIP years, and has been one of the State’s most successful PPSs in addressing diabetes and cardiovascular disease related hospital admissions, leading to several high-performance fund payments. While thinking through its Value-Based Payment strategy in 2015, the Executive Body of the Forestland Health Provider Partnership (FHPP, the NewCo created during those last hectic months of 2014) decided that it would not attempt to create one integrated contracting entity for the total PPS. Big is not always beautiful, they had argued. Their MCOs, with whom they had always had a good relationship, had also been clearly concerned about having to negotiate with such a unified group of providers. In addition, there had always been a natural distinction in culture, focus and also patient populations between the east and the west parts of the Forestland providers.

In East Forestland, home of the poorer parts of this geographical area and two of the PPSs three hospital systems, the providers and MCOs had decided during 2016 to focus on their significant HARP and [MLTC](#)/FIDA populations for value-based payments. Analysis of the outcome versus cost measures (that had become available and comparable statewide that year as part of the state’s VBP Roadmap) had shown them that potential improvements in both quality and overall costs were significant. Maternity care, on the other hand, was selected because their outcome versus cost measures showed what they had thought all along: they were one of the best performers statewide. In the FFS system, however, they were still losing money on maternity care, and a contract that focused on value could be the solution.

The pre-existing Health Home had linked up with the other Advanced Primary Care initiatives that were expanding in the region, and had proposed to contract Integrated Primary Care including its chronic bundles throughout most of East Forestland. They had been impressed with the potential reduction in potentially avoidable complications that the data had shown, especially with those patients that weren’t quite ‘HARP eligible’, but whose combinations of behavioral and physical chronic conditions led to poor outcomes overall.

For Maternity Care, the two hospitals joined forces with the obstetricians and with community-based providers, and opted for a Level 1 arrangement in 2017. This increased the dollar amount available for this care (based on their high performance statewide, and on the state’s incentive for MCOs and providers to move to higher levels of VBP arrangements). Because this bundle also included the care and costs of the first month of the baby, significant savings were realized by a further reduction of the already low NICU admission rates. With the 50% of these savings that the MCO returned to them based on the Level 1 contract, improvements were made in the ability of community-based providers to reach out to the most underserved populations, which helped reduce smoking and other substance abuse during pregnancy. The shared savings helped the hospital as well, and was a welcome addition to the obstetricians’ income.

Inspired by this result, they agreed to move to Level 2 in 2018 so as to be able to capture 100% of the shared savings, and profit from the further increase in VBP incentive dollars). The hospitals and the obstetricians formed a Maternity Care LLC, aimed at ultimately taking full risk. The obstetricians pushed to hire midwives to further decrease overall cost of care, safely increase the percentage of homebirths, and increasing the overall ‘hands-on’ time that delivering mothers would experience. Increased patient satisfaction led to an influx of patients from the wider region, which further helped stabilize the financial results for the hospital, which was now receiving its Maternity care related income through a contract with the Maternity Care LLC. Sensing the alignment of their own

professional drives with the new financial incentives, and witnessing the disappearance of prior authorizations and MCO's utilization reviews, morale surged amongst the staff members.

The Health Home and the other Advanced Primary Care practices had realized that if they would maximally strengthen the synergies between the different projects they had selected (IDS (2.a.i), medical village (2.a.iv), ED (2.b.ii), readmission reduction (2.b.iv), their 'project 11' (2.d.i), and their Domain 3 and 4 projects), all these projects would help drive the same results: an improved focus on housing, adequate nutrition, smoking cessation and obesity prevention throughout the community, improved adequate utilization of primary and preventive care, improved disease management and care coordination. One of their magic bullets, they had decided, was to build upon the success of their Health Home. Its focus on and infrastructure for care management and physical and behavioral care integration was the platform upon which they 'rolled out' their approach to first the HARP population and subsequently the broader 'at-risk' population. A second magic bullet had been the idea to work closely together with the home health care and visiting nurse providers, which greatly improved their ability to be pro-active in terms of addressing patients' problems and allow these patients to live more independently, reduce hospital use, and overall consume less costly care resources. This cooperation subsequently proved highly successful for the FIDA population as well, reducing the need for inpatient long term care, and improving quality of life.

They moved to Level 1 for Integrated Primary Care in 2017, including the associated chronic bundles, and did so for the HARP population as well. Getting a good grip on the HARP population proved harder than expected, and not much difference in outcomes or costs was realized in 2017. Their integrated approach, however, was highly successful in reducing admissions for especially diabetes and all cardiovascular chronic conditions that were being measured statewide: hypertension, angina/coronary artery disease, chronic heart failure (CHF), but also arrhythmia. Contrary to their expectations, 2017 saw a drop not only in the admissions for CHF and uncontrolled diabetes, but also in long-term complications: diabetic lower-limb amputations and cardiovascular events, especially myocardial infarctions and strokes.

The savings resulting from fewer such potentially avoidable complications were significant. Following the state's guidelines, they had agreed to split these savings 50/50 with the hospitals within their PPS, helping them further reduce inpatient capacity to the newly modeled demand. For the Health Home and the Advanced Primary Care practices, even 50% of 50% of savings amounted to a significant increase in revenue. They used this to fulfill some long-standing desires: increase payment levels for the primary care docs and the home care organizations; expand their use of visiting nurses to further prevent hospitalizations in at-risk individuals; invest in new staff across all levels (some of which were transferred from inpatient care organizations through the DSRIP workforce retraining programs they had put in place). Building upon the DSRIP programs, they paid much attention to ensuring cultural competency within their staff, adequately reflecting the cultural and ethnic diversity of the populations they served.

They moved to Level 2 in 2018 for Integrated Primary Care, with an increased stop-loss provision just to 'get used to the risk', as they called it. They moved to Level 1 for the MLTC/FIDA/MLTC population that year, and remained in Level 1 for the HARP population. When their interventions for the HARP populations seemed to bear fruit throughout 2018, they shifted to Level 2 for that population as well. For the remainder of the care within the PPS, a Level 1 Total Cost for the Total Population arrangement was agreed upon in 2018 that would suffice until further notice. There was no risk involved in such an arrangement, and the MCOs had agreed to simply distribute potential savings (according to overall involved Medicaid dollars) amongst the East Forestland PPS providers, with the option to negotiate different arrangements in the future.

In West Forestland, the Forestland Hospital Center and its neurologists had realized its potential to be an early adopter of integrated Stroke care. It had long been a center of excellence for stroke care, and its own analyses showed that optimizing the acute phase of stroke care, starting rehabilitation during day one, and working with a select group of specialized post-acute rehabilitation and home care providers would yield significant

improvements in mortality and long term outcomes. They were aware that the bulk of costs of stroke care, when seen across the total cycle of care, were long term care costs. Improving quality of acute stroke care, they were convinced, would improve the number of stroke patients recovering fully and thus reduce the number of patients left with impairments and corresponding life-long care dependency. Their own analyses had shown them that much of these potentially avoidable 'downstream costs' were incurred outside of their PPS: nursing homes, other post-acute care providers and hospitals that were not part of their PPS.

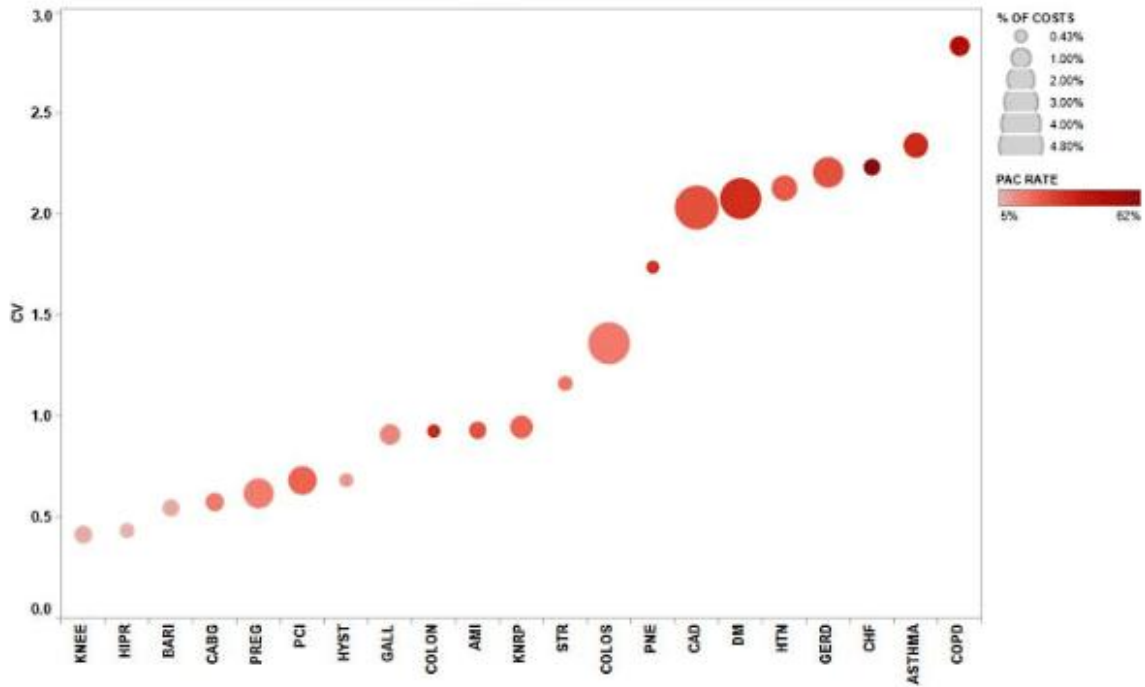
They decided to opt in the VBP Innovator program, moving immediately to a fully-fledged Level 2 model. The incentive associated with this Innovator program was significant, but – as they had predicted – the savings that they were able to realize, largely without impacting any of their PPS provider colleagues, were greater. The public attention their work received led to an increase of patients being brought to them for acute stroke care, including Medicare and commercial patients. In 2018, Forestland Hospital Center was the first organization in the state to enroll in the aligned Medicaid-Medicare stroke bundle, which extended the 'rules of engagement' of the Medicaid bundle to the duals and the Medicare FFS population. This was part of a broader alignment between CMS and New York State on the Medicaid and Medicare payment reform, which allowed for adaptation of New York State's Medicaid VBP models in Medicare, and selected Medicare Innovation Models within Medicaid.

Contrary to East Forestland, there initially was not much focus on value based payment arrangements in the remainder of the West Forestland provider community. Triggered by the success of the Stroke Program, and the bristling of activities in their sibling 'hub' within the PPS, they decided to 'try out' a Level 1 Total Care for the Total Population program in 2018 (which excluded only stroke care). Because they were successful in meeting most of their DSRIP goals, overall costs of care dropped somewhat, which became an unexpected source of additional revenue (they had booked a significant sum of 'lost revenue compensation' within the DSRIP funds for 2018). Emboldened by that result, and perhaps also somewhat driven by competition with the West Forestlanders, they moved to Level 2 in 2019, while planning to realize an integrated Medicaid-Medicare ACO in 2020.

Appendix II: Quantitative Analysis per Integrated Care Service

[forthcoming: analysis showing per integrated care service the total costs associated with that care, the # of Medicaid patients, cost variation and potentially avoidable complications.

Example of visualization to be used (showing combination of cost variation (vertical axis), total costs (size of bubble) and % of costs associated with potentially avoidable complications (hue of bubble). (example derived from output from HCI3 grouper).]





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Schenectady, NY 12305
mvphealthcare.com

cc: Peggy Chan

Meghan Gleason
Marie Berg

RECEIVED

MAR 23 2015

NYS DOH-OFFICE OF HEALTH INSURANCE PROGRAMS

M-111

March 19, 2015

Via Email: [redacted]
and First Class Mail

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

Dear Mr. Helgerson:

Thank you for the invitation to comment on the progressive initiatives that NYS is undertaking in partnership with the provider and payer community to transform the care delivery and payment system for the benefit of our patients and all New Yorkers. This type of collaborative spirit will no doubt be tapped many times in the coming years as we face and overcome the challenges before us.

As you well know, the health and social care delivery system is in the preliminary stages of transition from many decades of fee for service to a more value-oriented approach that is consistent with the triple aim that we all espouse. There are both broad and deep implications for both providers and payers if we are to better activate and serve our patients.

After processing the VBP roadmap in the context of MVP Health Care's participation in several collaborative agreements as well as conversations and interactions over the past several months with both the larger provider community and our government leaders, it seemed best to categorize and summarize comments into three general areas for your consideration:

1. **Narrow the focus** to the key objectives of DSRIP
2. **Maximize existing assets** during this evolution
3. **Invest in experimenting and learning** as organizations, processes, and uses of technology transform

Narrow the Focus

The DSRIP program promotes collaboration, seeks to financially stabilize the state's safety net, and aims to achieve a very tangible and important goal of reducing credibly avoidable hospital use by 25% over five years. This intended reduction merits a laser focus as successfully addressing avoidable admissions, readmissions, and inappropriate emergency department use would be an incredibly impactful transformation. Our concern is that with so many projects and so many objectives and measures, this overarching goal could be lost.

Advanced primary care, behavioral health providers, and health plans are in an excellent position to assist in achieving this 25% reduction. Our initiatives and conversations with hospitals suggest that the highest levels of leadership believe in value-based care, but the larger the organization, the more pervasive and entrenched the fee for service mindset is amongst management and staff. For example, we see that as hospital systems consolidate or otherwise affiliate, they are inclined to use this as a point of leverage to increase fee for service rates. The purpose of the consolidation was likely to create a more integrated system to deliver value-based care, but the culture of fee for service is deeply ingrained.

The migration away from incentives that encouraged higher utilization of facility-based services to a more holistic, population management perspective (sometimes crassly referred to as “filling the beds” versus “emptying the beds”) will take time, but will require constant vigilance. Services such as diagnostic imaging and laboratory testing that were viewed as profit centers are now cost centers, while other services, such as home care, become more strategic to success. It is heartening to now participate in conversations with hospitals that are just beginning to recognize the need to take advantage of the improvement in outcomes that home care can facilitate.

We appreciate the aspirational desire to have 80% of payment become value-based by 2018. It seems aggressive given the current state, and it is measurably different than some other well-regarded groups such as Catalyst for Payment Reform whose goal is “20% of payments proven to provide value by 2020”. Like New York State, this not-for-profit organization is committed to a higher-value health care system, and its members include progressive employers and purchasers such as GE, Boeing, and CalPERS. In either case, these metrics might be better viewed as a means to an end. Achieving the 25% reduction in credibly avoidable hospital use should be the central theme, and it will require a coordinated effort by all stakeholders to reach it.

Maximize Existing Assets

We are, thankfully, at a historic time for partnership between providers and payers after decades of often unnecessarily adversarial perspectives brought about by the economics of fee for service healthcare. As a not-for-profit regional health plan, we are increasingly welcomed by (and are welcoming of) providers who embrace the notions of value-based care and improving the health of our communities. During the course of these interactions, we work to understand the capabilities of each organization, determine what we are better off delegating to one party or another, and what responsibilities we will share. We are expert at managing and distributing payment, assessing financial risk, conducting outreach, and servicing subscribers. At MVP, we hold quality as a fundamental underpinning of creating healthy communities, and have care management and quality improvement programs in place to support this. The provider system or PPS is expert in providing care, and many are making great strides in integrating health and social care. They are in varying stages of addressing the health and well-being of populations, using care management and quality programs to drive improvements in key measures.

For example, in a recent conversation with a leading health system, we shared our focus on quality as evidenced by our leading Medicaid satisfaction scores in the Hudson Valley and our 4.5 STARS rating for our Medicare offering. We then described efforts to improve Medicaid quality scores in the community we jointly serve. The CEO responded by asking “what can we do to help get you to 5 STARS for Medicare and address those Medicaid results?” We agreed to break out a workgroup to leverage our care management and quality improvement teams to drive improvements by integrating data into the workflow in a timelier manner. This is an excellent example of how assets can be maximized.

We harbor a concern that DSRIP may have the unintended consequence of encouraging providers to become insurers, thrusting upon them a need to build new competencies from scratch rather than applying resources and energy to leverage their strengths with ours for the benefit of New Yorkers. Some responsibilities such as credentialing, utilization management, and quality management may ebb and flow over time, but should be approached synergistically versus in a manner that adds more system cost through efforts that are at best duplicative, and at worst at cross purposes. We are already seeing competition in some markets for human resources, causing a rise in salaries. Maximizing existing assets and capabilities during this delivery system transformation is the better way.

The state also has significant assets and capabilities to contribute, such as the data it collects for risk adjustment and quality measurement. There is an opportunity to improve the timeliness and availability of the data to both providers and health plans. It may require more coordination amongst agencies, and new processes or technologies, but this is quite similar to the changes needed amongst providers and health plans.

Invest in Experimenting and Learning

To support the experimentation and learning associated with DSRIP, both providers and payers must make investments in their technology infrastructures to enable new care provision and payment models, and, perhaps even more importantly, to bi-directionally share claims, clinical, and other data to harvest value. DSRIP provides funding for providers to improve their capabilities, but does not proactively recognize the significant technology investments needed by payers to support any number of value-based models, as well as the ability to bi-directionally exchange data with providers. It is mentioned as part of an overall recognition in the context of rate setting, but a more proactive/leading investment for payers would actually offer *providers* the best opportunity to successfully aggregate and normalize data coming to them from multiple payers. Existing payer systems were designed and built with a traditional fee-for-service care delivery and payment model in mind. As the roadmap suggests, there will be a portfolio of risk arrangements to accommodate, and this requires a new level of technical flexibility. Investing in both provider and payer data management infrastructure is necessary to have the right data available to the right person at the right time to drive the right action. Using incentives rather than mandates increases the probability of success.

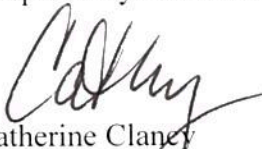
The VBP roadmap allows for a variety of approaches. It will be important to share not only the successes and challenges in New York, but what is working in other states or countries.


Anecdotal sharing is often helpful but formal study of interventions by health services researchers would be beneficial. For example, there is a good deal of discussion and experimentation around bundles of care to address variation in services and readmissions over time, but bundles by themselves do not address the necessity of the service. Bundles also raise significant challenges in terms of distribution of payments amongst providers. Would reference pricing and shared utilization management be a quicker path to both clinical and economic outcome improvement?

The cycle of experimentation, learning, and application must also be condensed if we are to reach our goal of 25% reduction in credibly avoidable hospital use by 2018. In some cases, smaller intra-PPS efforts would be a better path. The time to implement is shorter as would be the ability to analyze results before bringing to scale. Using focused experts to study and share these efforts would augment the benefits of discussing these in committees or workgroups.

In closing, we are appreciative of the collaborative umbrella under which we can share our experiences and recommendations. We believe that care delivery transformation is best enabled by maximizing existing assets, maintaining a narrow focus, and investing in experimentation and learning. We look forward to the opportunity to maintain an open, productive, and continuous dialogue with you.

Respectfully submitted,


Catherine Clancy
Executive Vice President,
Medicaid & Operations


Karla Austen
Chief Financial Officer
Executive Vice President, Network Management

cc: Denise V. Gonick,
President and CEO

March 30, 2015

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New York State Department of Health
Delivery System Reform Incentive Payment Program (DSRIP)
Value Based Payment Reform (VBP)

**Comments of the New York State Nurses Association
Draft VBP Roadmap**

The New York State Nurses Association is the largest union representing registered nurses in New York State, with over 37,000 members engaged in direct patient care. We are firmly committed to promoting quality health care, attaining universal access to care and increasing the role and voice of nurses and other healthcare workers, patients and impacted communities in healthcare decisions that directly affect us.

We have reviewed the proposed DSRIP Value Based Payment “Roadmap” and have the following comments and concerns:

1. Value Based Purchasing is based on an unproven “Pay for Performance” Model

The VBP Roadmap aims to move away from “fee for service” provider payment structures and to have 90% of Medicaid payments tied to value based purchasing contracts by year 5 of the DSRIP program.

The draft VBP Roadmap is premised on a “Pay for Performance” (P4P) model that is empirically questionable and unsupported by significant data or evidence that it will produce improved health outcomes or better quality of care.

Under P4P models, it is assumed that the offer of economic rewards and the imposition of economic penalties will force healthcare providers to improve their practices and result in improved patient care and health outcomes.

There is, however, little or no evidence that the P4P model has had any measurable effect on quality of care or health outcomes. Analyses and studies of the issue show negligible short term improvements or no improvements at all in actual patient outcomes where pay for performance models have been

employed.¹ In a study of hospital mortality rates, there was no difference in results between hospitals that were reimbursed with a P4P model and those that were not.²

Other studies indicate that the use of financial incentives can actually have negative effects by weakening or “crowding out” the positive role of normative or other personal motivation to provide high quality health care services.³

Given the lack of clear evidence that the provision of financial incentives and penalties will have a sustained positive effect on quality of care and patient outcomes, the emphasis on this model in the payment reform effort being undertaken in DSRIP would seem to be a dangerous gamble to take with our safety net system.

We are concerned that the reliance on pay for performance market incentives in the “Roadmap” will be ineffective in improving care and is being driven not by evidence based practices but by predetermined ideological preferences.

2. Market Based Incentives Will Result in Market Manipulation in Pursuit of Higher Profits

Another core premise of the VBP Roadmap is its reliance on the financial self-interest of providers, operating in a healthcare “market” environment, to improve health outcomes through the mechanism of monetary incentives or penalties.

This approach creates a tension between the two aspects of healthcare provider organizations (whether they are hospitals, PPS systems under DSRIP, doctor’s practice groups, corporate providers, capital investors, etc.). On the one hand each of these entities is a business and as such is motivated by an integral need to generate revenues and profits. On the other hand, each is also a provider of health care services and such services form the basis for its revenue and profit streams.

Under the VBP model being proposed, competitive pressures, coupled with the inherent drive to increase revenues and profits, will likely lead to increasing reliance on sophisticated strategies to manipulate the incentive payment schemes being envisaged in the “Roadmap.”

Larger, more profitable providers will likely seek to create algorithms or other techniques to “slice and dice” their Medicaid populations in order to make marginal gains in their “scoring” that will then be translated into higher incentive payments and profits. These higher revenues will not result from improving care but by manipulating the actuarial demographic of their Medicaid patient pools.

This approach will take the form of using marketing and other competitive practices to maximize enrollment of discrete sub-sections of the general population of patients that are healthier or will be

¹ See: New York Times, “The Problem with ‘Pay for Performance’ In Medicine,” Aaron E. Carroll, July 28, 2014, and studies cited; <http://www.nytimes.com/2014/07/29/upshot/the-problem-with-pay-for-performance-in-medicine.html?mwrsm=Email&abt=0002&abg=1>

² “The Long-Term Effect of Premier Pay for Performance on Patient Outcomes,” Ashish K. Jha, M.D., M.P.H., Karen E. Joynt, M.D., M.P.H., E. John Orav, Ph.D., and Arnold M. Epstein, M.D. N Engl J Med 2012;366:1606-15; <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1112351>

³ “Will Pay for Performance Backfire? Insights from Behavioral Economics,” Steffie Woolhandler and Dan Ariely, <http://healthaffairs.org/blog/2012/10/11/will-pay-for-performance-backfire-insights-from-behavioral-economics/>

easier to treat than their cohorts⁴ or to manipulate coding practices to make their patients appear to be sicker than they are.⁵

Providers that wield these techniques effectively will appear to be producing better quality care and patient outcomes and will qualify for incentive payments that are not warranted. At the same time, they will be avoiding the responsibility and risk of caring for sicker patients or groups of patients within the broader population.

The provision of monetary incentives to “improve” care at reduced costs will provide many self-interested providers with an actual incentive to game the system and thus to undermine the purposes of the DSRIP program and the “Triple Aim.”

3. Core Safety Net Providers will be vulnerable to unwarranted penalties and risk of failure

The VBP Roadmap further provides that when value based purchasing is fully implemented, providers will be faced with increasing risk of penalties for failure to meet metrics regarding quality and patient outcomes. Though the Roadmap provides for a “stop loss” mechanism to cap these penalties, the proposal does create a very real threat to the viability of “core” safety net providers.

Under DSRIP guidelines the number of hospitals that met the relaxed DSRIP “safety net” definition amounted to 147 out of 187 statewide. Within the safety net category, however, there are wide variations in payer mix and in the relative share of Medicaid populations in each hospital’s total patient populations. HHC hospitals, for example, have Medicaid patient populations that are in the 75-85% range, treat large numbers of uninsured patients and have relatively small numbers of privately insured patients. The result is that HHC and many other “core” safety net providers are under constant financial pressure as a matter of design.

These “core” safety net providers, already laboring under strained finances, are to receive extra support in the DSRIP program in order to allow them to make necessary adjustments and transition to the VBP system.

The VBP Roadmap further recognizes the importance of non-clinical social factors in determining health outcomes (homelessness, cultural and language barriers, housing, etc.) and tacitly acknowledges that such factors are outside of their control but may hinder the ability of providers to improve care.⁶

The VBP Roadmap does not appear to adequately take into consideration the degree to which this new paradigm may intensify the financial pressures on such providers, leaving them with increased vulnerability if they are unable to meet DSRIP quality metrics and creating a downward spiral in which their finances deteriorate further as a result of the imposition of penalties for failing to attain assigned quality improvement goals.

⁴ New York Times, May 8, 2014, “Medicaid Shift Fuels Rush for Profitable Clients,” Nina Bernstein, <http://www.nytimes.com/2014/05/09/nyregion/medicaid-shift-fuels-rush-for-profitable-clients.html>

⁵ “PAY-FOR-PERFORMANCE: TOXIC TO QUALITY? INSIGHTS FROM BEHAVIORAL ECONOMICS,” David U. Himmelstein, Dan Ariely, and Steffie Woolhandler, *International Journal of Health Services*, Volume 44, Number 2, Pages 203–214, 2014, <http://joh.sagepub.com/content/44/2/203.long>

⁶ See: VBP Roadmap, Draft 3, page 27.

Given the competition from provider systems with more economic power and better payer mixes and their inability to engage in the types of patient population manipulations discussed earlier, it likely that the VBP plan being implemented will result in increasing pressure on these core safety net institutions and a real possibility that many might eventually collapse financially.

4. The Roadmap leaves in place unnecessary overhead costs associated with Managed Care Organizations

The shift to value based purchasing is predicated upon the continued operation of managed care organizations (MCOs) and envisions an increasing role for these insurers as middlemen in directly contracting with providers at the PPS level.

The reliance upon MCOs to implement the VBP, during the DSRIP program and thereafter on a continuing basis, will reduce the availability of funds for direct patient care and will continue to drain resources away from providers in the form of overhead costs and corporate profits.

The Roadmap envisions a system in which the entire Medicaid system is administered through MCOs and in which the state DOH plays no direct role, other than as the source of payments.

The interests of the MCOs and the providers are in direct opposition, with many of the MCOs being for profit operators with a direct interest in increasing their own revenues and profits at the expense of the providers with whom they enter into service contracts. Given that the costs of treating Medicaid patients already exceed the reimbursement for such services, we can only expect that the pressures on providers will increase as the reimbursement rates shrink further, payments are increasingly tied to quality metrics and the risk of treating these patients in a VBP model shifts increasingly to the providers.

As the conflicting interests of MCOs and providers for a cut of the Medicaid funding stream intensifies over time, we can expect an increasing differentiation between providers that have the market power to impose better terms on the MCOs and those that are unable to effectively resist the imposition of disadvantageous contract terms. The effect will be most pronounced on the “core” providers, but in either case there will be a continued duplication of administrative overhead and the diversion of ACO profits away from patient care.⁷

5. VBP and Pay for Performance are not the answer

Based on the foregoing issues, NYSNA believes that the VBP Roadmap will not succeed in improving care and patient outcomes because the interests of private providers and MCOs will not align with the interests of patients and local communities. The only viable solution to the problems of waste and fraud in our healthcare system is to immediately move to a universal, single payer system of healthcare in which all patients and communities have equal access to care, regardless of their source of insurance or ability to pay, and in which more resources are available to provide proper community health care and planning.

⁷ “Currently, 37 states and the District of Columbia contract with Medicaid plans, according to Medicaid Health Plans of America, a national trade association. Revenue from Medicaid managed-care contracts totaled roughly \$78 billion in 2012, or 18% of the total insurance company revenue, according to research firm Mark Farrah Associates.” Modern Healthcare, May 27, 2014, <http://www.modernhealthcare.com/article/20140527/NEWS/305279964>

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March 30, 2015

Mr. Jason Helgerson
Medicaid Director
New York State Department of Health
Corning Tower
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Albany, NY 12237

Submitted via email to: [REDACTED]

Re: HCP Comments on Draft VBP Roadmap

Dear Mr. Helgerson,

On behalf of the members of the New York State Association of Health Care Providers, Inc. (HCP), thank you for the opportunity to review and comment on New York State's draft Value Based Purchasing (VBP) Roadmap (third draft, March 2015).

HCP is a statewide trade association representing home and community-based care providers through information, advocacy, and education. HCP represents approximately 350 offices of licensed home care services agencies (LHCSAs), certified home health agencies (CHHAs), long term home health care programs (LTHHCPs), hospices, and related health organizations.

The value of home and community-based care—both to consumers and to the State—cannot be overstated. Home and community-based care providers are central to achieving the State's triple aim of improving care, improving health, and reducing costs within the Medicaid system. Consumers overwhelmingly prefer to receive care at home, for themselves and their loved ones. The State has recognized the extraordinary value of home and community-based services, which are on average half of the cost of care provided in institutional settings.

Upon review of the State's draft VBP Roadmap, it is unclear how value-based payment methodologies will apply to home care providers, particularly LHCSAs, which make up a majority of HCP's membership. As frontline care providers across the State that play a critical and growing role in the State's health care delivery system, it

is essential that LHCSAs have a seat at the table in the development of the VBP Roadmap. Accordingly, HCP respectfully requests the opportunity to participate on the State's VBP Workgroup and key subcommittees outlined in this proposal.

HCP looks forward to working with the Department of Health (DOH) and other stakeholders to develop a workable plan to meet the State's goals while ensuring that a viable home care industry providing high-quality services across the State is sustained and adequately supported through this process.

HCP offers the following comments and recommendations on the Draft VBP Roadmap:

- 1) **The timeframe for development and implementation of the VBP Roadmap must be extended to allow time for payers and providers to adequately prepare for the transition.** The VBP process has been moving forward at a dizzying speed, simultaneous to the ongoing transition to managed care and other massive reforms in the State's health care delivery system. These rapid changes are putting a strain on the entire health care system in New York, and home and community-based care providers in particular. Home care providers are already severely challenged by inefficiencies and gaps in the managed care system that have yet to be fully addressed and resolved. More time and resources are needed to ensure that all stakeholders are able to participate fully in the development of practical, workable payment reforms.
- 2) **Home and community-based care providers need support and assistance to fully participate in the VBP.** The State has recognized the extraordinary value of home and community-based services, which support the ability of individuals to receive care in the comfort and safety of their own homes and in their communities, thereby improving their quality of life and reducing health care costs. However, despite evidence that greater investment in home and community-based care saves money, this sector of the provider community has yet to receive any significant financial or technical assistance in the transition to managed care, nor have regulatory and programmatic inefficiencies been addressed. Many home care providers in New York are experiencing severe financial distress due to a combination of inadequate levels of reimbursement, difficulties getting reimbursed by managed care plans, burdensome and conflicting regulatory requirements, and rising costs due to wage parity, minimum wage increases, workers' compensation, and other unfunded mandates. These concerns have been presented to the Department in numerous forums, such as the Home and Community Based Care Workgroup that convened in 2013-14. Until and unless these concerns are addressed, many home care providers will not have the capacity to successfully engage in VBP arrangements; indeed, their ability to continue as a viable industry in New York is in jeopardy. The Draft VBP Roadmap should identify the special needs of home and community-based care providers and include recommendations for how they will be addressed.

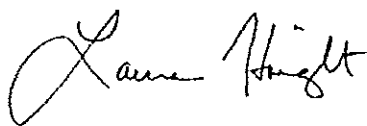
- 3) The State must develop metrics and collect data to measure outcomes for custodial/chronic care in home settings.** As the State moves to a VBP system, the collection and sharing of data necessary to measure performance outcomes is essential. Much of the emphasis in developing VBP methodologies to date has focused on episodic care, such as hospital admissions or post-acute care. However, it appears that little attention has been paid to how to effectively apply a VBP approach to long term maintenance and custodial care in the home setting. Providing home care for disabled, chronically ill, and elderly clients is already the most cost-effective option, since it saves money by avoiding or delaying more costly care in institutional settings. It is important that the Draft Roadmap identify what data the State needs to collect in order to inform outcome-based decisions for long term home care services, which are largely focused on custodial care.
- 4) Licensed home care service agencies (LHCSAs) should be fully represented in the VBP planning process.** LHCSAs are on the front lines of providing innovative, cost-effective and culturally sensitive care to people who would otherwise require far more costly institutional care. Unlike federally-certified home health agencies (CHHAs), which typically provide post-acute, skilled home health services, LHCSAs typically provide long term care services for chronically ill, disabled, or elderly clients. These services can include light housekeeping and personal care assistance such as bathing, dressing, toileting and eating, to more extensive home health services. LHCSAs' regulatory requirements vary from CHHAs, and LHCSAs have unique circumstances affecting their ability to successfully enter into a VBP system. There are currently no LHCSA representatives serving on the VBP Workgroup and it does not appear that any LHCSAs were interviewed during the Stakeholder Engagement process.
- 5) The State must provide assurances that shared savings will be passed along to home care providers in Level 1 VBP.** Value-based payment approaches should work to the benefit of home and community-based care providers. As the most cost-effective and patient-preferred method of care, in theory the VBP model would reward home care by passing along these savings to home care providers. This in turn would allow home care providers to offer better wages and benefits to their staff, improving workforce recruitment and retention, and ultimately improving the quality of care clients receive in their homes. This model represents a "virtuous cycle" that rewards home care providers, clients, and workers alike, while reducing the costs of health care delivery. However, the VBP Roadmap provides no assurances that the savings will, in reality, be passed down to providers at the lowest end of the care ladder. In the current managed care environment, home care providers are already experiencing severe challenges getting timely and adequate reimbursement to meet the rising costs of doing business. How will the State ensure that managed care organizations (MCOs) are appropriately sharing in the rewards under the proposed Level 1 VBP?

- 6) **The State must include safeguards on risk sharing in Level 2 VBP.** Value based payment approaches are based on the assumption that performing provider systems under the Delivery System Reform Incentive Payment (DSRIP) program, MCOs, and providers all have a shared stake in the outcome. However, not all of these entities have a role in directing patient care. Particularly in the managed care setting, LHCSAs typically do not control the care of the patient. Accordingly, there should be safeguards to ensure that such providers are not unfairly forced to take on risk, perhaps through the establishment of baseline requirements to ensure that they are adequately compensated for services provided. As the medical system adopts more non-traditional approaches to integrated patient care, which could include assistance with transportation, housing, and nutrition, there may be other service providers that will also fall into this category.

In conclusion, HCP supports the concept of “sharing the health and sharing the wealth” and believes that home care is a central component of an efficient and integrated patient care system. However, the rapid transformation of the health care system in New York is leading to widespread confusion and inefficiency, and home care providers are particularly at a disadvantage in negotiating this dramatically changing landscape. The Draft Roadmap must be modified to ensure that adequate time, resources, and attention are allotted to address these concerns and ensure that there continues to be a viable network of providers across the state to fulfill the State’s needs for home and community-based care.

Thank you for your consideration of HCP’s recommendations on the State’s draft VBP Roadmap, and of HCP’s request to serve on the VBP Workgroup and relevant subcommittees. HCP looks forward to working with the Department to help shape future versions of the State’s VBP Roadmap. Please direct any questions or follow up to Laura Haight at 518.463.1118 [REDACTED] or [REDACTED]

Sincerely,



Laura Haight
Vice President for Public Policy

Primary Care Development Corporation Comments on DSRIP Value Based Payment Roadmap V3

Thank you for the opportunity to comment on the DSRIP Value Based Payments (VBP) Roadmap. 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 enthusiastically support New York State's move away from unit-based reimbursement to a value-based payment approach that incentivizes providers to deliver more effective care at lower costs. The comments below are not meant to be comprehensive, but to identify key issues we believe should be prioritized as VBP moves forward.

Alignment with other VBP efforts: Alignment is critically important to ensuring the maximum adoption. Without such alignment, confusing and conflicting standards and policies that will further burden payers, providers and patients. While VBP is still very much at its early stages, others initiatives are further along in the learning curve and their knowledge and experience will prove incredibly useful to the NYS VBP "roadmap." This includes a multitude of VBP innovations taking place here in New York, in states and regions across the country and at a national level. In particular, DSRIP VBP should closely follow and engage in the work being conducted by the Center for Medicare and Medicaid Services (CMS). With a goal of linking 90% of Medicare payments to quality by 2018, aligning New York's efforts (for Medicaid and commercial insurance) is highly advisable. CMS has developed a Learning Action Network to "accelerate the transition to more advanced payment models by fostering collaboration between HHS, private payers, large employers, providers, consumers, and state and federal partners." CMS recently published its own Payment Taxonomy of Framework that is different from the terminology used in the Roadmap. We urge New York State to align with and leverage CMS efforts around VBP related to framework, timeline, requirements, language and learning.

CMS is also seeking comments on its VBP efforts. We are including a response to a CMS Request for Information on payment methodologies related to advanced primary care, which was developed by the Patient-Centered Primary Care Collaborative (PCPCC), of which PCDC is an executive member. The comments are highly instructive as they relate to the ability of primary care to participate fully in and be a key source of value to VBP.

Assure an adequate baseline of primary care spending: The Roadmap describes a fundamental shift in how health care will be delivered and paid for in New York State. Getting there will take time and be challenging, and the Roadmap recognizes that there are many factors critical to success. We are encouraged that a key pathway for VBP is through Integrated Primary Care, and that primary care is seen as such an essential part of the VBP.

However, while much is being asked of primary care, little has been given historically to support its efforts. Primary care represents only about 5% of total healthcare spending in New York State. The result is a sector that is undersized and underdeveloped.

The State must assure that primary care providers have an adequate baseline of resources necessary to build a strong, well-financed primary care infrastructure. One of the most important actions New York State can take is to require all health plans to pay an adequate baseline of spending on primary care - at least 10% of total healthcare spending. This investment would support advanced primary care/PCMH services and activities that are essential but not traditionally reimbursed. Regardless of which pathway is chosen and the timeline for implementation, upfront and sustained investment in primary care is foundational.

Technical Assistance and Financial Support During Transition: Primary care providers are critical to the success of VBP arrangements but many lack the operational, data analytical and/or financial skills required to evaluate potential arrangements and to succeed under the new models. In cases of small practices, this capability may need to be supplied externally to the practice. VBP also represents a new innovation, and as with most innovations (i.e. electronic health records), there is often a drop-off in productivity and related revenue as the practice adapts to the new methods. New York State should provide both technical assistance and working capital during the transition period to increase the likelihood of success and ensure against destabilization of the practices.

Transparency and standardization of data sharing for evaluation VBP initiatives: All practices need access to an All-Payer Database but, importantly, there must be strong requirements that all plans and providers report all cost and quality data in a standardized way on an ongoing basis. For providers to be able to make informed choices about potential benefits and risks to VBP arrangements (particularly with bundled payments and total cost of care) will require standardized and easily comparable cost data.

Standardization of process and outcome measures, administrative processes: We support the development of an industry-wide set of process and outcome measures that minimize complexity and allow practices to focus on one set of process and outcome measures. Aligning measures at the state level will simplify reporting, confusion and waste. These measures should cover all Medicaid and private payers alike.

Flexibility in contracting with MCOs: Practices should continue to have the ability to opt in or out of PPS level VBP arrangements. Not all practices within a PPS will want to contract with their PPS leads in VBP arrangements, nor would such a requirement always be the most efficient or produce the greatest value. Practices must retain the ability to contract directly with MCOs. When considering VBP arrangements that involve risk and reward, the PPS leads and downstream providers will not necessarily have the same tolerance for risk nor alignment of interests. For instance, a hospital-led PPS lead may want to retain savings to offset downsizing losses, rather than reward downstream providers responsible for generating the savings.

Coordinating multiple statewide reform initiatives: New York is undertaking several major statewide initiatives in addition to federal health initiatives that have overlapping components, including the State Health Innovation Plan, DSRIP, SHIN-NY, Health Homes, FIDAs and ICD-10. While some of these are acknowledged in the Roadmap, along with an understanding that they will be aligned, ensuring that they are effectively planned, coordinated and staggered so as to not overwhelm providers, will be critical. The State should create a Forestland scenario that illustrates the coordination of these initiatives as well as develop a practice assessment tool for the purpose of planning individualized practice roadmaps to implement all of these new initiatives that may be relevant.

Include Patient Engagement in the Value Proposition: Initiatives like DSRIP, APC, PCMH and VBP require patients to be engaged in a relationship with their primary care providers. The burden of managing that engagement falls on the PCP. Much of the VBP

discussion centers around incentivizing the provider, but incentivizing the patient is also important. VBP should consider shared savings that accrues to the patient as well. While the research of Pay for Performance for Patients (P4P4P) is still in its early stages, it should not be discounted as a strategy, particularly for high utilizers.

Conclusion

We applaud New York State’s efforts to change how we pay for care from a volume-based system to one that is value based. Implementing VBP is a challenging road, but thankfully New York State is not walking it alone. Ultimately, we believe success will be determined by two key factors: 1. how well we align with and draw from the experiences of within New York State, in other states and nationally; and 2. How substantially and effectively we invest in primary care and other parts of health system that have the ability to create the most value. We are committed to ensuring New York’s success in developing and implementing an effective value based payment system.

Contact: Dan Lowenstein, PCDC Senior Director of Public Affairs, [REDACTED] /
[REDACTED]; Julie Peskoe, PCDC Director of DSRIP Initiatives, [REDACTED] /
[REDACTED]

From: [REDACTED]
To: [US-ALB ADV MC VBP Support Mailbox](#)
Cc: [Bufalino, Mary Rose](#); [Ashe, Ryan P](#)
Subject: FW: Value Based Payments
Date: Monday, March 30, 2015 11:56:43 AM
Importance: High

-----Original Message-----

From: [REDACTED]
Sent: Monday, March 30, 2015 10:23 AM
To: doh.sm.delivery.system.reform.incentive.payment.program
Subject: Value Based Payments

Thank you for this very informative time effective presentation. I am writing from a Licensed Home Health Care agency.

1) We have implemented several programs to show "Value" and decrease hospitalizations. From what we can see these programs have yielded little to no benefit. Thus far as we do not see many patient referrals coming from the DISRPI contracts or the MLTC's. How do we change that?

2) I have two offices on long island. In terms of "keeping the lights on" and being "sustainable" NYS needs to seriously look at the fact that we are challenged with Wage Parity. It is impossible to meet the pay demands and live with the very low reimbursement. Long Island and the 5 Boroughs have challenges that other parts of the state do not have.

Sincerely,
Tina Webber
Vice President

Attentive Services

518-482-2273

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From: [Gleason, Meghan K](#)
To: [Akchurina, Zamira](#)
Subject: FW: roadmap
Date: Monday, March 30, 2015 1:34:54 PM

To add to the tracker

From: Yang, Patricia [REDACTED]
Sent: Monday, March 30, 2015 1:01 PM
To: Ashe, Ryan P; Gleason, Meghan K
Subject: roadmap

May be too late but...

Is "total care" a potential way of segregating BH issues? We want illnesses like depression considered "integrated".

On page 19 the pharmaceutical side box seems to work against prescriber prevails? Pharmacy should stay in but weighted in a way that doesn't result in dramatic treatment changes.

On page 20 the second paragraph, should the measures be made publicly? (typo later in the paragraph)

On page 25 should we include substance use disorders as potentially episodic?

On page 28 the reference to incarceration should instead read "criminal justice"...

From: [US-ALB ADV R/C DSRIP Support Mailbox](#)
To: [Bufalino, Mary Rose](#)
Subject: FW: Draft VBP Roadmap -- Third draft
Date: Thursday, March 05, 2015 4:27:20 PM

From: doh.sm.delivery.system.reform.incentive.payment.program
Sent: Thursday, March 05, 2015 4:27:07 PM (UTC-05:00) Eastern Time (US & Canada)
To: US-ALB ADV R/C DSRIP Support Mailbox
Subject: FW: Draft VBP Roadmap -- Third draft

From: Shaw, Elliott [REDACTED]
Sent: Thursday, March 05, 2015 4:26 PM
To: doh.sm.delivery.system.reform.incentive.payment.program
Subject: Draft VBP Roadmap -- Third draft

This is just an editing comment:

In the box on page 5, there is a phrase "*as outlined in the Figure on p.6*". It must be referring to the Figure on p.7

It is repeated on line 3 of p.22

Elliott A. Shaw, Jr.
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MEMORANDUM

TO: Meghan K. Gleason
FROM: John Ruge
RE: VBP Road Map/Third Draft
DATE: March 13, 2015

Meghan—

As a member of the VBP workgroup, I am writing with two purposes in mind—to help make our submission to CMS letter-perfect; and to show off that I have actually read the draft carefully.

Anyway, I am suggesting a few tiny grammatical notes as follows.

- Page 13, Line 4
“preventative” is misspelled and should read preventive.
- Page 14, Line 3 of the footnote
“involves” should be singular (i.e., involve)
- Page 30 inside the box outlining Issue 4, “currents” should also be in the singular (i.e., current).

Sorry to be so picky. Let me just add that overall I find this narrative to be a fascinating and powerful policy statement.

Thanks.

Crystal Run Healthcare LLP Comments on the VBP Roadmap

Crystal Run Healthcare LLP (Crystal Run), a physician led, physician owned multispecialty medical practice of over 350 providers across 30 different sites in Orange, Sullivan and Rockland counties and Manhattan, has been focusing on the Triple Aim and transforming healthcare delivery in our region for many years. Our efforts include:

- NCQA Level 3 PCMH at all primary care sites since 2009 and one of the first six NCQA certified ACOs in the country since 2012.. Crystal Run has its own behavioral health professionals, including adolescent and adult psychiatry, and fully integrates BH services into its primary care services
- providing primary care to 25% of the Medicaid beneficiaries in the communities we serve and specialty care services to another >20%
- single, fully implemented electronic health record since 1999 that connects all 30 Crystal Run Healthcare locations and 350 providers
- 12 full time healthcare data analytics professionals and a Health Catalyst data warehouse
- being one of the first 27 accountable care organizations (ACOs) to participate in the Medicare Shared Savings Program (MSSP) with a start date of April 1, 2012
- multi-year upside only shared savings arrangement with multiple commercial payors and Medicaid managed care organization, the results of which have in every case improved quality and lowered cost. Crystal Run is in process of moving to full risk, including percent of premium, arrangements
- sponsoring its own health plans, which will launch in 2015

Crystal Run is encouraged by and supportive of the Value Based Payment (VBP) Roadmap and respectfully submits the following comments:

Topic 1: Towards 90% of value-based payments to providers

- Crystal Run strongly agrees that the process must allow for providers to directly contract with MCOs. As Crystal Run is already in the process of working with Medicaid MCOs to take on full risk for the total cost of care of Medicaid beneficiaries to whom we serve. DSRIP should not interfere with the efforts of advanced practices like Crystal Run that are already meeting DSRIP goals, including avoidable (re)admissions, and decreased ER utilization.
- Even though one can argue that existing quality metrics are not always directly correlative with quality patient care, the state should encourage MCOs and providers to adopt a uniform set of quality measures so as to avoid unnecessary administrative and financial burdens. Outcomes

measures should include reduction in the amount of time missed from work and a patient's overall impression of his/her health and wellness.

- For Level 1 and Level 2 VBP, per member per month (PMPM) payments must be included to underwrite the significant expense in providing necessary chronic care management services, patient education, and transitional care services. These payments should be separate from the fee for service payments used to calculate annual healthcare expenditure in relation to benchmark in Level 1 and Level 2 VBPs so as to not penalize providers for providing these services.
- Alternative visit types are another tool to foster convenient, community based care. These services can be synchronous, as is the case with video visits, telephone visits, and e-visits, or asynchronous, as is the case with text or email based interactions. All of these services provide patients with increased access to their care team when it is convenient for them, thus improving compliance and potentially reducing ER utilization and readmissions. However, there is currently little or no reimbursement for providing such services despite the expensive start-up costs for such services. Payment reform should allow for MCOs to reimburse providers for such services in Level 1 and 2 VBPs.
- MCOs and providers should be allowed to provide patient incentives to encourage compliance and reward desired behaviors. CMS' recently announced Next Generation ACO model includes such incentives for patients who receive the majority of their care from the ACO with which their PCP is affiliated.
- Crystal Run supports the goal of rewarding "continued high performance." With respect to cost benchmarks for high performing providers in Level 1 and Level 2 VBP arrangements, such providers should be compared against and rewarded for performing better than the market. If only benchmarked against themselves, highly efficient practices will be penalized rather than rewarded for their success.

Topic 2: Ensuring alignment between DSRIP goals and value based payment deployment

- The list of diseases on page 25 of the VBP Roadmap should be revised to include oncology care, as such care is typically high cost and highly variable despite the existence of clear treatment pathways. We note that CMS' recently announced Oncology Care Model is an attempt to improve quality, reduce variation, and reduce cost in this field.
- MCOs and providers should be allowed to incent beneficiaries for obtaining the majority of care from providers within the PPS and when beneficiaries achieve wellness goals, such as tobacco cessation and weight loss. Some commercial plans provide free Fit Bits or similar devices to patients, and reduce health insurance premiums if a pre-determined number of daily steps are reached most days of the week. All of these efforts will engage patients in their care, promote wellness, and prevent future complications from chronic diseases.

Topic 3: Amending contracts with the MCOs to realize payment reform

- Although we agree that MCOs should not be held accountable when providers, to no fault of the MCO, run into financial difficulty because of underperformance, MCOs should face financial and other penalties when they fail to timely supply available data necessary for providers to succeed in improving quality and lowering cost. Without timely, accurate data that identifies the population of patients under care, patients with high ER or inpatient utilization, and the largest areas of opportunity to lower cost, providers will find it more challenging to achieve DSRIP's goals.

Topic 4: Amending contracts with the MCOs: collection and reporting of objectives and measures

- No comment

Topic 5: Creating synergy between DSRIP objectives and measures and MCOs efforts

- No comment

Topic 6: Assuring that providers successful in DSRIP are contracted

- Crystal Run supports efforts to assist smaller, less prepared providers to access or develop needed infrastructure and skillsets. Providers farther along the value path should, however, also be supported for their continued investments in personnel, analytics and infrastructure to manage populations. Accordingly, similar incentive payments should be made available to providers further along the path to full risk. One mechanism to do so is to provide PMPM payments separate from any shared savings in Level 1 or Level 2 VBP arrangements.
- Crystal Run supports assigning/having patients select a PPS at the time of enrollment as they do a PCP. It is very difficult for a medical group, health system, or PPS to coordinate care, improve quality, and contain cost when patients have the ability to choose any provider they want, including those that are not participating in value based efforts and are therefore less efficient and more costly. Therefore, mechanisms should be in place to incentivize patients to receive the majority of their care within the PPS. These incentives can include direct payments to patients similar to those proposed in CMS' Next Generation ACO, housing subsidies, or other financial incentives.

Topic 7: Amending contracts with the MCOs: adjusting Managed Care rates to improve population health and care utilization patterns

- No comments

Topic 8: Amending contracts with the MCOs: ensuring alignment between DSRIP objectives and measures and MCO rate setting

- No Comments

March 31, 2015

Dear Value Based Payment Workgroup Committee,

EmblemHealth has reviewed the 3rd draft of the Value Based Payment Roadmap released on March 4, 2015. As a result of our review, the company has four primary comments that have been identified in the enclosure. EmblemHealth is both experienced with and committed to Value Based Payment (VBP) and payment reform initiatives, as almost 60 percent of today's HMO payments already fall under the VBP definition. Below please find EmblemHealth's VBP Roadmap comments:

- 1) The goal of 80-90% of all statewide Managed Care Organization (MCO) provider payments be made through Level 1 VBP by DSRIP Year (DY) 5 is insufficient to enact true payment reform. An abundance of payment reform research suggests that a two-sided risk model – in which providers can share in savings, but also repay deficits – is necessary to evoke provider attention and to motivate behavior change, particularly provider referral and practice patterns. The current established standard of achieving Level 1 VBP by DY 5 does not recognize the current market trends. Please consider moving benchmarks on an expedited path, to at least Level 2 VBP methodology well before DY 5. To motivate providers who are resistant toward shared-risk models, budgets should be established with historical spending trends in mind and providers should be allowed to earn substantial payments based on quality.
- 2) There appears to be a lack of clarity around how the VBP levels would apply to contracting arrangements. Health plans should be able to retain flexibility in contracting with subsets of Performing Provider Systems (PPSs). Insurers need to have the ability to contract with high performing providers, while still maintaining competition. Please provide further guidance detailing the contracting arrangements. In addition, in the case that health plans already have an existing VBP arrangement with a PPS, we are concerned about the possibility of duplicative payments.
- 3) In view of the limited empirical evidence supporting the on-going use of Health Homes and Advanced Primary Care Practices in terms of substantially improved quality outcomes or cost-effectiveness. It is our hope that there are possible other care models when further developing the VBP Roadmap.
- 4) Aside from the “VBP Innovator Program,” there appears to be limited flexibility in choice of VBP methodologies. Insurers should be able to enter into as alternative risk models as the plan and provider are mutually comfortable with. If plans, like EmblemHealth, have existing global capitation arrangements, it should be permissible to expand upon them. We are concerned that the “VBP Innovator Program” has stated that providers will receive approximately 95% of the dollars paid to the MCO – a reasonably lower reimbursement would be better suited to fall in line with existing arrangements. Furthermore, this proposed capitation rate does not account for the on-going support health plans typically already offer PPS providers, like coaching, research findings and data sharing. Our lengthy experience with global cap arrangements suggests that a somewhat more modest rate

benefits both the provider and the health plan. We look forward to hearing more detail on both the “VBP Innovator Program” and possible “off-menu” agreements. Thank you for the opportunity to comment.

Sincerely,

Paul Zurlo, Vice President
Small Group & Individual Business
Health Care Reform



555 WEST 57TH STREET NEW YORK, NY 10019
[REDACTED]

March 30, 2015

VIA E-MAIL
[REDACTED]

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

Subject: Comments on Third Draft of New York State's Value-Based Payment Roadmap

Dear Mr. Helgerson:

The Continuing Care Leadership Coalition (CCLC) represents not-for-profit and public long term care providers in the New York metropolitan area and beyond. The members of CCLC provide services across the continuum of long term care (LTC) to older and disabled individuals. CCLC's members are leaders in the delivery of home care, skilled nursing care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. CCLC's members have also shaped innovative solutions to long term care financing and service delivery in the United States, with several of its members having pioneered managed long term care programs in New York and managed care programs for dual eligibles at the national level.

On behalf of the LTC providers in the CCLC membership, I appreciate this opportunity to comment on the Third Draft of the Value-Based Payment (VBP) Roadmap for the Delivery System Reform Incentive Payment (DSRIP) program.

CCLC Supports Ongoing Refinement to Value-Based Payment Pillars

CCLC agrees with the State's approach - articulated in page 5 of the Roadmap's third draft - to treat the Roadmap as a living document with flexibility to be updated over time. This will allow the Roadmap more precisely to meet the needs of the full range of provider, beneficiary and plan stakeholders in our State. We also support a number of specific framing elements articulated within in the Third Draft and attendant discussions. These include the reduction of the 90% VPB target for DSRIP Year (DY) 5 to a target of a range of 80% to 90%; the measuring of attainment of the VBP targets at the Statewide versus the PPS level; and the eschewing of a "one size fits all" approach in favor of an approach that provides more latitude for alternative VBP arrangements and options to be worked out among stakeholders.

Long Term Post-Acute Care Populations, in the Context of Value-Based Payment

CCLC makes the above observations in the context of the sizable role that the Long Term Post-Acute Care (LTPAC) community plays in New York State - a continuum of care that must be considered in the development of the VBP paradigm. Indeed, as the State pursues a VBP methodology and related implementation, it is critical to recognize that more than 40% of total annual Medicaid spending in NYS involves services for individuals accessing LTPAC. As such, ensuring a strong LTPAC sector is vital to meeting population health needs as the State's population ages.

Already, LTPAC providers deliver value in multiple ways. Some of these - such as investing in interventions that can reduce rates of avoidable acute care transfers - tie neatly to triple aim objectives of providing better care at lower costs. Others, such as the implementation of person-centered care models for long stay residents that maximize resident autonomy or the adoption of "consistent assignment" staffing models that foster family-like bonds between caregivers and care recipients, generate value that is harder to quantify when cost savings is the primary measure. Nonetheless, these elements are undeniably essential as a matter of policy and good care.

In the context, above, CCLC respectfully asserts that the Roadmap should engage the LTPAC community more thoroughly. Indeed, there should be more explicit acknowledgement and integration of the various dimensions of value that such providers deliver. Consequently, we urge that DOH, at minimum, ensure that:

- a. nothing in the roadmap would harm, destabilize, or otherwise disadvantage LTPAC providers in New York State;

- b. the roadmap be amended - consistent with recommendations provided below - to ensure there are meaningful ways for LTPAC providers to participate in VBP; and
- c. the workgroup process is leveraged as a forum to work through ways to engage LTPAC providers as full VBP participants and to develop and encourage shared savings models that reward the multiple forms of quality and value that the LTPAC sector delivers.

Recommendations

Refining VBP Approaches to Reward Value in the LTC Context

As noted above in the context-setting for our comments, care needs to be taken to ensure a fit between VBP incentives and the unique ways in which LTPAC providers deliver value in the Medicaid context. Many value-driven activities of LTPAC providers - such as the investments in interventions to reduce avoidable acute care transfers, mentioned above - create savings, but those savings accrue to Medicare, not Medicaid. On the other hand, LTPAC providers are engaged in many other activities to improve clinical outcomes, and maximize autonomy and quality of life, which are essential to achieving Medicaid program objectives, but which often entail added costs to providers, and do not per se lead to “savings” to the Medicaid program. To ensure meaningful participation of the LTPAC community in the State’s VBP environment, we offer the following recommendations:

- The State should seek to facilitate full participation of residential and community-based LTPAC providers in value-based measurement, and should accommodate that participation by modifying its VBP roadmap with options for such providers, to include potentially the deeming of Level 0 VBP arrangements as counting towards attainment of Statewide VBP goals.
- Where it is determined that a service is not amenable to VBP, it may be considered for exclusion in the calculation of VBP numerators and denominators, for purposes of evaluating broad VBP goal attainment; however, should any LTPAC services be subject to such an exclusion, providers of LTPAC services should not be precluded from otherwise engaging in shared savings arrangements. Rather, standards should be established explicitly to define how such providers should benefit from shared savings based on attainment of relevant outcomes, including quality and quality-of-life outcomes, and financial measures such as the achievement of Medicare savings.

Inclusion of Risk-Based Arrangements with Managed Long Term Care Entities

- CCLC recommends that VBP should potentially include risk based arrangements that LTC providers forge with managed care entities, including through the Managed Long Term Care (MLTC) and Fully Integrated Duals Advantage (FIDA) program. Such arrangements should be recognized in the measurement of attaining Statewide VBP goals, and further, consideration should be given to inclusion of the participants in such arrangements as eligible to participate in the VBP innovator program.

Meeting Readiness/Resource Needs of the LTPAC Community

- To ensure that LTPAC providers are positioned to meaningfully support continuum-wide VBP activities, NYS should proactively look to identify resources to support investments needed in the LTPAC sector, including in Health Information Technology and Health Information Exchange domains. Such investments would help greatly to offset the impact of LTPAC providers having been deemed ineligible for Federal meaningful use incentives.

Concluding Remarks

CCLC is grateful for the opportunity to comment on the VBP framework, and asks for due consideration of the above recommendations. Should you need further information, or if you have any questions about these comments, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink that reads "Scott Amrhein". The signature is written in a cursive style with a horizontal line extending to the right.

Scott C. Amrhein
President

COALITION OF MEDICATION-ASSISTED TREATMENT PROVIDERS AND ADVOCATES

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March 30, 2015

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

Re: *Value Based Payments Roadmap*

Dear Mr. Helgerson:

COMPA, the Coalition of Medication-Assisted Treatment Providers and Advocates, represents the Opioid Treatment Programs of New York State, which are currently providing medically needed opioid addiction treatment services to approximately 40,000 New Yorkers. We are aware of the importance in redesigning the Medicaid system so that it is sustainable and we are particularly cognizant of the strains that combating the deadly upsurge in heroin and opioid epidemic has and will put on our healthcare system.

Many Paths to Payment:

COMPA supports the Menu of Options approach to creating innovative value-based payments.

The Roadmap provides for 3 contracting options with the MCOs (at the PPS level, PPS contract allows for direct provider/MCO contract, MCO direct to provider contracts).

COMPA is concerned that the third option may become unavailable over time, as relationships between MCOs and PPS networks become more solidified. It is foreseeable that providers and/or provider groups will lose their ability to freely negotiate with MCOs in this structure.

COMPA believes that clear and unambiguous regulation is essential to prevent a monopoly and unfair practice from developing.

Integrated primary care, shared savings and assuming risk:

The ability of integrated primary care providers to transition into VBPs and benefit from shared savings and assumed risks by counting avoidable episodes when part of a PPS, it is unclear how this plan will work for the third contracting option, between MCO and provider groups. Is this option available to all providers?

Setting rates and rebasing:

“The state does not intend to set target budgets, not does it intend to set the PMPM or bundle rates once level 3 arrangements come into view”

This statement must be reconsidered in light of the essential treatment services provided by OTPs. OTPs are restrained by NYS OASAS census capacity restrictions from increasing the number of patients that can be treated in an OTP. In this arrangement an MCO may negotiate a separate rate with one OTP provider which undermines the fiscal viability of another essential OTP provider. The state will lose essential services which it cannot afford in the midst of an epidemic. This has happened in other states, to the detriment of their healthcare systems. COMPA urges a uniform approach in negotiating payments for the OTPs, which can and should be innovative in design.

Housing:

COMPA appreciates and supports the commitment to stable housing maintained in the VBP Roadmap. We agree that housing is a major factor in health, one that too many of our patients cope with daily. Unfortunately, even our best community based housing providers cannot solve the problem of housing shortages. Nor should we expect them to.

DSRIP/VBP and Community Based Organizations:

COMPA supports the idea of creating synergy between DSRIP objectives and measures. However, many behavioral health providers, certainly substance-use disorder providers and definitely OTPs have not been well-integrated into DSRIP, nor the PPS projects. The state has been persistent in encouraging stakeholder input and involvement in the PPS networks and projects but COMPA has seen inconsistent response.

COMPA believes that the transition to value-based payments is too critical an issue to base entirely on DSRIP outcomes and measures unless and until PPS networks are regulated to ensure stakeholders are adequately represented and involved.

COMPA would like to see additional standardized measures used to ensure that downstream providers whose outcomes are not truly reflected in the PPS are captured. We would also like a fuller discussion of proposed outcome measures that will ensure that patients who are the most vulnerable, with chronic, co-morbid conditions continue to receive care although they are likely to “hurt” outcomes.

COMPA believes that the OTPs can lead the way down the road to value based payments. Our programs have the infrastructure, staffing and experience to make an impact early in this multi-year process. Please consider the areas that we have outlined in order to clear the path.

Thank you for your consideration.

Very truly yours,

Allegra Schorr
President
COMPA

*Fred Hyde, MD
57 Main Street
Ridgefield, CT 06877*

March 30, 2015

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

Dear Mr. Helgerson,

These comments are sent in response to your invitation to review the Value-Based Payment proposal (“VBP Roadmap—Third Draft”), dated March 2015. My comments are submitted as an individual, and pertain to any recommendations to introduce a value-based payment methodology to the New York State Medicaid program or to introduce legislation which would persuade or compel private third parties to do likewise.

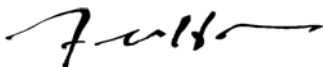
These comments are “negative,” in the sense that they do not favor value-based payment proposals, in the absence of a rationale, evidence, pilot projects which would demonstrate efficacy, or protections against untoward result. The import of questions and comments at this time is simple: this is an opportunity to examine one - - of many - - controversial areas, to ask whether it is in fact at all appropriate to consider variable (and governmentally set) standards of “quality” in the payment for professional and institutional services.

We risk embarking on (another) merry circus, chasing dollars - - intended for services to Medicaid beneficiaries - - and likely shortchanging those institutions which struggle under the rules of Medicaid reimbursement and the increasingly penurious reimbursement from “Managed Medicaid” companies. It is well known that genuine safety net hospitals don’t do well on these measures, and there is ample evidence that their shortcomings are due in large part to circumstances beyond their immediate control. The predictable result of financial penalties for safety net hospitals is that we will be treated to more buffoonery (“Too many hospitals,” “Bad management”) before diagnosing the problem.

Coincidentally, it appears that the authority for expanded value-based payment proposals may have been circumscribed in the Governor’s budget, released today. Still, the temptation will remain, and should be examined closely and vigorously at the very outset.

Best regards.

Very truly yours,



Fred Hyde, MD

Introduction

American health care has suffered from “policy by slogan” for much of its modern (post-Medicare) era. Successive waves of regulation (health planning and certificate of need; rate and budget regulation; now incentives and disincentives associated with provider behavior) have been introduced and, for the most part, failed, at least in their stated efforts to constrain concentration of provider power, the resulting increase in health care prices, and the impact of those prices on state (through Medicaid) and federal (through Medicare) budgets.

Also, health policy has, as a result of programs associated with these slogans or initiatives, become increasingly complex. A reasonable hypothesis is that these trends have gone hand in hand: that complexity (at the institutional, third party, state and federal levels) has increased the price of health care, that the larger, more powerful and more expensive institutions have been most adept at managing that complexity, and that, as a result, we have available fewer community-based providers and, in some parts of New York State, almost no private practice physicians.

Finally, something should be said about the potential confusion associated with what may appear to many to be “content-free” slogans. The slogans attract the expectations, desires and perhaps the business plans of onlookers. Since the impact of the slogan will be on the expenditure of nearly \$60 billion per year in public funds, precision is warranted. Even informed commentators may have their work confused with headlines¹ having nothing to do with “pay for performance” *per se*, but rather conflated and mixed in with other (also largely evidence-free) slogans, including the impact of “accountable care” organizations, “delivery system reform,” and the predecessors of value-based payment, pay for performance and value-based purchasing. (See for clarity Uwe Reinhardt on metrics set centrally, vs. the professionalism of educators and health professionals, “The idea that everyone’s professionalism and everyone’s good will has to be bought with tips is bizarre.”)

Behavioral Economics

It is beyond the scope of these comments - - but should, at the same time, be considered - - that the latest iteration of “health policy by slogan” stems from the enormous influence of behavioral economics on modern American society, and especially on social policy.

When we encounter the misadventures of, for example, Chinese bureaucrats², we may make the mistake of thinking that our use of behavioral economics will render us immune to such results. (In Mr. Porter’s recent article, attention was paid to Goodhart’s Law, summarized simply as you get more or less what you pay for, and if you pay for what you measure, you will get quite a bit of it.)

However, we don’t need to look far to see that our national attempt at incentives and disincentives has had a decidedly mixed and generally negative history. For example, when the “metric” given to the Veterans Administration hospital in Phoenix, Arizona was to cut down the wait time for individual Veterans to see physicians, employees who were pressured to achieve this metric found “work-arounds” that, inadvertently, made the situation facing the Veterans worse. General Shinseki, notwithstanding his distinguished career, was the sacrifice at the time, but blame should have been shared by the late Gary Becker and other behavioral economists whose theories lay behind the appointment delay “metric.”

A local (New York State) equivalent controversy may be seen in the current debate over educational testing. In fact, the very idea of value-based payment (pay for the patient experience or outcome, not for

¹ Hartocollis, A., “Pay for Performance Extends to Health Care in Experiment in New York,” *The New York Times*, March 30, 2015

² Porter, Eduardo, “Grading Teachers by the Test,” *The New York Times*, March 24, 2015

the professional service) is remarkably similar to proposals that would link payment of teachers to the results of tests given to children (pay for the outcome for the child, not the service delivered by the professional).

At least two major issues link these proposals (value-based payment and teacher compensation based on testing). The first is the frustration of policy-makers with relatively poor performance of some students in some schools. This frustration does not take into account the impact of economics, the role of parents, the activities of peers, other (non-school) educational and recreational opportunities, etc., and, instead, judges the teacher to have failed if the child does not progress. Likewise, the literature of value-based payment in health services vilifies payment for “quantity” of service rather than (in the mind of the payer) “quality,” notwithstanding that all other parts of American society reward increased productivity. A second theme may, more darkly, lay behind value-based payment in education and in health services, and that is the indisposition of some public officials to fulfill the promises (to professionals in education and in health care) made by their predecessors. The cost of paying for professionals, in other words, grows, in contrast to static or declining enthusiasm for payment.

In any event, the (1) background of behavioral economics and (2) analogies to education may both seem beyond the scope of reasonable comments on this proposed plan. However, to the extent there are leading policy-makers involved (a newly constituted work group, the chairman of the respective Assembly and Senate committees on health and insurance, commercial conferences) who are not ideologues on this subject, these arguments may be worth making.

The time, in other words, to stop an unfortunate new (and predictably expensive and complex) thrust (at a time when providers are reeling from the absorption of other change at the state and federal level) may be now.

The Measurement of Quality

Proposals to link reimbursement to “value” presume a consensus on these questions:

- (1) How do we measure quality?
- (2) Who does the measurement?
- (3) What do we do when we discover that our measurements are flawed?

There is, to the contrary, no apparent consensus on these questions. Rather, the measurement of “quality” and of “value” is an evolving area.

For example, we have proceeded for some years under the assumption that the readmission of a patient to a hospital is “bad,” that is, to be avoided. Penalties have been in place since 2012 for hospitals seen as readmitting an excessive number of Medicare patients in defined diagnostic categories within a 30-day period. Moreover, there has been an assumption that hospitals with higher volume will have “higher quality” and will therefore have lower readmission rates. There is no support for any of this in the literature. To the contrary, hospitals with a highest volume of patient admissions had the highest readmission rates in one recent comprehensive study, whereas those with the lowest volumes had the lowest readmission rates.³

What would the explanation be for that? The authors indicate that “This finding suggests that smaller medical centers may provide higher quality transitional care than larger centers.” There is no evidence for that, either. Alternative hypotheses abound: that smaller hospitals and smaller medical centers have

³ Horwitz, L. et al, “Association of hospital volume with readmission rates: a retrospective cross-sectional study,” *The BMJ*, February 14, 2015

more short stay admissions, fewer complex cases. Or, in the alternative, that smaller hospitals may be found in suburban and rural areas (the academic medical centers having consolidated in the larger urban areas), with tighter social structure, family and community support, etc.

The problem is obvious: if we penalize hospitals for failing to provide “value” we risk disrupting necessary services, in the service of highly contested and controversial evidence.

History of Value-Based Payment

The first brand of value-based payment in health services was “pay for performance,” begun in the U.S. in 2003. As frequently observed⁴, it was “one of those slogans that seemed to upset no one. To most people it’s a no-brainer that we should pay for quality and not quantity.” This author went on to note that the disappointing results from pay for performance were “Sometimes it’s because providers don’t change the way they practice medicine; sometimes it’s because even when they do, outcomes don’t really improve.”

And, of course, it is also possible that the changes that are made (albeit for short-terms, with small impact) have nothing to do with the interests of individual patients.

Another study indicated the short-term nature of any results⁵. The Hospital Quality Incentive Demonstration in England in 2008 found that short-term relative reductions in mortality for conditions linked to financial incentives in hospitals participating in pay for performance programs were not maintained.

Another English program, begun in 2004, the Quality and Outcomes Framework (the world’s largest pay for performance experiment), had fully a quarter of the income of family practitioners linked to performance.⁶ Early into the program⁷, researchers focused on chronic disease management (in this case hypertension) noted that “Pay for performance had no discernible effects on processes of care or on hypertension related clinical outcomes. Generous financial incentives, as designed in the UK pay for performance policy, may not be sufficient to improve quality of care and outcomes for hypertension and other common chronic conditions.”

The largest hospital-based pay for performance program in the U.S.⁸ showed no evidence of decreasing 30-day mortality; the authors concluded that “Expectations of improved outcomes for programs modeled after [the] Premier HQID [Hospital Quality Incentive Demonstration] should therefore remain modest.”

So while it is clear that financial incentives change some physician behavior, whatever change takes place is only arguably related to any outcome for the patient, and doesn’t last. The cost, aside from the cost of the program and its appurtenances, included a “loss of autonomy and of professionalism and becoming less skilled in dealing with certain conditions.” and of course the offsets, where family practitioners who “welcomed the initial pay increase...[then] began to resent the program as successive governments clawed back the initial large increases with a succession of below inflation-raises.”

⁴ Carroll, Aaron, “The Problem With ‘Pay for Performance’ in Medicine,” *The New York Times*, July 28, 2014

⁵ Kristensen, S. et al, “Long-Term Effect on Hospital Pay for Performance on Mortality in England,” *The New England Journal of Medicine*, 371;6, August 7, 2014

⁶ Roland, M. and S. Campbell, “Successes and Failures of Pay for Performance in the United Kingdom,” *The New England Journal of Medicine*, 370;20, May 15, 2014

⁷ Serumaga, B. et al, “Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom: interrupted time series study,” *British Medical Journal*, 342:d108, 2011

⁸ Jha, A. et al, “The Long-Term Effect of Premier Pay for Performance on Patient Outcomes,” *The New England Journal of Medicine*, 366;17, April 26, 2012.

Value Based Purchasing

Value based purchasing, the second generation of pay for performance, has also proven to be problematic.

First, the “values” which were “purchased” changed over time. From its beginning in 2005, to its current incentive and penalty phases, the value based purchasing program has had a changing constellation of variables measured, and now rewarded or penalized.

Second, the “values” proved highly susceptible to influence that would not necessarily have been related to “quality” metrics. For example, hospitality and “guest relations” programs to raise the scores on surveys given to Medicare beneficiaries no doubt improved the patient experience, but may have only arguably been related to any aspect of the “quality” of the medical care.

Third, as noted above, safety net hospitals fared poorly.⁹ Once again, safety net hospitals were held accountable for outcomes which may have been (but probably were not) within the influence of those hospitals.

Just as the pay for performance experiment showed little impact, of no lasting value, non-payment has also been a “non-starter.” In October of 2008 the Centers for Medicare and Medicaid Services stopped paying for hospital-acquired conditions that were deemed (by them) “preventable.” Four years later, a research effort reported¹⁰ that

“We found no evidence that the 2008 CMS policy to reduce payments for central catheter-associated bloodstream infections and catheter-associated urinary tract infections had any measurable effect on infection rates in U.S. hospitals.”

This isn’t (by any means) to indicate that we shouldn’t strive to eliminate unnecessary infections, or other shortcomings that have (quite independently of the payment and reimbursement fields) brought alarm and concern to the question of patient safety in U.S. hospitals.

To the contrary, it illustrates that focus on financial punishment (non-payment) has, at least so far, had little impact. Nor is this to pretend that the question is “settled” for the long run. Rather, the purpose of these comments at this time is to raise doubts that any wholesale press toward “value-based payment” - - with its inevitable incentives and disincentives - - would be based on evidence, or indeed, anything other than a capacity to influence the rules.

⁹ Gilman, M. et al, “Safety-Net Hospitals More Likely Than Other Hospitals To Fare Poorly Under Medicare’s Value-Based Purchasing,” *Health Affairs*, No. 3 (2015): 398-405

¹⁰Lee, G. et al, “Effect of Nonpayment for Preventable Infections in U.S. Hospitals,” *The New England Journal of Medicine*, October 11, 2012

Recommendations

- (1) The State of New York should, for the moment, eschew and avoid any embrace of value-based payment methodologies. While this proposal indicates that it is not a new rate-setting methodology, the idea that the State can propose, oversee and reimburse, and not create a *de facto* new rate-setting methodology is incorrect;
- (2) The State should avoid recommending additional rate-setting methodologies (whether “off menu” as noted in the proposal or not) which will involve Medicaid reimbursement, thereby taking funds away from services for the Medicaid beneficiary;
- (3) The State should retain independent academic researchers, preferably from out-of-state, not otherwise related to the Department of Health. The statements in the proposal that the State is not backing away from adequate reimbursement, or attempting to “make providers do more for less,” can only be verified through independence, which is otherwise not provided for in this proposal;
- (4) The State should make transparent communications to the PPS on this and all related subjects. The aggregation of all or nearly all providers involved in Medicaid work in New York State into 25 PPSs is persuasive in this argument: The State is preparing to capitate PPSs who will, in the end, bear the brunt of yet further reimbursement decline for doctors and hospitals;
- (5) The State should clarify and define its terms, and demonstrate the evidence behind its use of and argument for those terms. Nearly the entirety of the 42 page proposal is replete with vaguely defined and possibly overlapping terms, subject to highly variable interpretation. Until it has an opportunity to retain independent examination of any of these terms, and develop a coherent means of demonstrating the capacity of hospitals and doctors to serve the Medicaid beneficiary under current and *any projected future* reimbursement scheme, it should refrain from pursuit of a roadmap which is leading only to greater complexity, higher cost and lower responsiveness; and
- (6) The State should refrain from conflating fraudulent services with those that are not “valuable.” If in fact the State’s desire is to ensure that it is not paying for “quantity” of services that are inappropriate, the answer is not to penalize all providers of those services, but rather to bolster its defenses against fraud, that is, the provision of services which are not medically necessary. Evidence of services not medically necessary should be pursued with fully as much vigor as any of these “reform” proposals. If the services are medically necessary, on the other hand, why should the State be attempting to pay less to the professionals and institutions that provide those services?



HOSPICE AND PALLIATIVE CARE ASSOCIATION OF NEW YORK STATE

Comments on 3rd Version of Value Based Payment Roadmap

March 30, 2015

Thank you for the opportunity to offer comments on the 3rd version of the Value Based Payment (VBP) Roadmap (March 2015). The Hospice and Palliative Care Association of New York State 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).

Therefore, it is deeply troubling that the latest draft Value Based Payment Roadmap continues to ignore the critical role of hospice and palliative care. New York ranks at the bottom of the country – only above Alaska, North Dakota, and Wyoming – for 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. Increased 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 over the next months. Hospice and palliative care services can 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 integrate palliative care and hospice into the Value Based Payment (VBP) Roadmap.

I would 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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March 27, 2015

***Comments regarding Value Based Payments (VBP) and
the Third Draft of the VBP ‘Roadmap’ document***

The New York State Council for Community Behavioral Healthcare is a statewide non-profit membership association representing the interests of nearly 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. We welcome the opportunity to provide comments related to Value Based Payments (VBP) and the third draft of the VBP ‘Roadmap’ document.

1. Please include community based providers and consumers in the planning and decision-making process regarding how to transition the behavioral health delivery system to VBP. The scale and speed of VBP implementation should be modified to meet the capacity of small providers who do not necessarily have the infrastructure to make the transition. Their guidance and inclusion in decisions about how to shift them to a value-based payment system will prove invaluable.
2. Many non-Medicaid providers in the behavioral health system have been using bundled payments for decades to achieve measurable outcomes outside of Medicaid. The transition away from Fee-for-Service may create certain unintended consequences in terms of downtime.
3. We appreciate the various options depicted in the VBP ‘Roadmap’ document to include low and no-risk models. Nevertheless, there may be a need to convene a meeting specifically designed to address the learning and infrastructure needs of currently non-Medicaid billing community based providers. This meeting should be designed to assist these providers in understanding what the state is and is not willing to do to help “skill them up” for the transition to VBP.
4. Employment should be included as a valued outcome (metric). There are three essential priorities for employment within VBP for the behavioral health community:
 - Workforce determinations and initiatives, undertaken in DSRIP and VBP planning and projects, must include standards for excellence in training and recruitment, and create a benchmark that offers strategies for non-licensed professionals to enter and be equally valued in the workforce. Workforce development must be aligned with the highest performance standards in current best practice in all domains.

- Employment standards for recipients should be evaluated within discreet sub-populations, with a standard benchmark offered by region.
 - Incentives should be offered to providers to help consumers access and succeed in employment as well as be offered for providers that offer valuable jobs to people attributed to their PPS, managed care network, or individual provider population of care.
5. Criminal justice as a prevalent aspect of the social determinants of health should be valued not just in form, but in practice, by including people within the criminal justice policy system into conversations about how to measure achievements and value payments based on these achievements.
 6. As we make the transition to Value Based Payments, we cannot overstate the importance of a thorough assessment and planning process to address the very real deficits that exist currently in the community-based system both in terms of infrastructure and personnel necessary to make this transition successful. Perhaps the state could be clear with DSRIP PPS's that they must have a certain percentage of their 'in network' community based providers prepared for this transition at its' inception.
 7. Administrative burden is a huge issue for providers with all of the various transitions taking place at present. What would be helpful would be continued opportunities to dialogue with the state regarding ways we can waive/omit regulations that are burdensome / unnecessary and prevent greater focus on improving care, increasing efficiency, and focusing on participation in new models of care.

Thank you for the opportunity to provide comments on Value Based Payments and the third draft of the VBP 'Roadmap' document. If you have any questions, please feel free to contact Lauri Cole, Executive Director, at [REDACTED] or [REDACTED]

TO: Jason Helgerson, State Medicaid Director
Marc Berg, KPMG
FROM: John Navarra RPh
DATE: March 24, 2015
RE: **Value-Based Payment Roadmap**

The State's community pharmacies currently play an essential role in improving patient care and helping to control healthcare costs through extensive counseling, follow-up and additional care management services to ensure that patients are adherent. As the State embarks on new payment models and value-based payments (VBP) in particular, pharmacies must be integrated into the evolving systems and innovative models in order to truly affect patient care, improve quality and outcomes and reduce costs on a system-wide basis.

Building on the prior comments and recommendations that the pharmacy sector has submitted related to the Value-Based Payment Roadmap, below please find specific recommendations for where outcome-focused pharmacy services should be weaved into the Roadmap to maximize the role of pharmacists and pharmacy services in achieving our shared goals across the healthcare continuum.

Pg4. Introduction. The DSRIP system transformation and move to VBPs are predicated on investing \$8 billion to reduce hospital admissions by 25% and implementing 80-90% of payments under Medicaid being value-based within five years.

Evidence

The National Action Plan for Drug Event Prevention¹ indicates that in inpatient settings, research indicates that ADEs are the single largest contributor to hospital-related complications. ADEs comprise an estimated one-third of all hospital adverse events, affect approximately two million hospital stays annually, and prolong hospital length of stay by approximately 1.7 to 4.6 days. ADEs have also been identified as the most common causes of post-discharge complications (those occurring within three weeks of hospital discharge), accounting for two-thirds of all post discharge complications – more than half of which are likely preventable. In outpatient settings, nationally representative surveillance data indicate that ADEs account for over 3.5 million physician office visits, an estimated one million emergency department (ED) visits, and approximately 125,000 hospital admissions each year. Consequently, the Action Plan identifies three target areas: (1) Anticoagulants (primary ADE of concern: bleeding), (2) Diabetes agents (primary ADE of concern: hypoglycemia), and (3) Opioids (primary ADE of concern: accidental overdoses/oversedation /respiratory depression)

A reasonable and growing body of evidence demonstrates that pharmacist-provided medication management consultations at transitions of care is effective in reducing avoidable hospital admissions.^{2,3}

Recommendation

The Roadmap might include a reference to adverse drug events as a primary driver of avoidable health care utilization (especially hospital utilization) and the impact of medication management

/ reconciliation services provided by a pharmacist at every transition of care as an effective strategy for PPSs to consider.

Pg10. Specialized Continuous Care Services. There are several chronic illnesses that are cited (• Diabetes • Asthma • Hypertension • Depression • Chronic Heart Failure • Coronary Artery Disease • COPD) for which medication therapy management is the primary therapeutic intervention.

Evidence

The literature provides numerous examples that Medication Management improves clinical outcomes when it is provided in one-to-one consultations between a pharmacist and a patient. Medication Management is a component of primary care in populations with these chronic conditions.^{4,5,6,7} Moreover, this benefit extends to under-served patients.^{8,9} Finally, a CMS commissioned study to evaluate the effect of Medication Therapy Management in the Part D program illustrated that MTM appropriately applied can improve the quality and decrease the cost associated with chronic disease¹⁰ and confirmed the findings of a previous Congressional Budget Office report on offsetting Part D costs with MTM.¹¹

Recommendation

The Roadmap might include a reference to Medication Management as a key component of coordinating care for many of these focus populations

Pg11. Integrated Primary Care. The Roadmap states that Integrated Primary Care will be a core feature of each PPS.

Evidence

As the prevalence of PCMHs and ACOs grows, the evidence demonstrating the benefit of embedding pharmacy medication management services in medical practices grows. In the majority of practices, the pharmacist acts as a medication consultant (i.e. operating without prescriptive authority) and produces a positive impact on cost and quality of care.^{12,13} The acceptance of integrating pharmacist based medication management is illustrated by the American Academy of Family Physicians in a 2013 position paper.¹⁴ The pharmacist impact in an integrated environment can be further amplified when the pharmacist is provided with prescriptive authority under a Collaborative Drug Therapy Management (CDTM) agreement. While CDTM arrangements are well documented nationally¹⁵, in New York they are still in a demonstration phase, however pending legislation would expand pharmacist prescriptive authority.¹⁶

Recommendations

The Roadmap might include a statement that medication management efforts be a core component of any Integrated Primary Care initiatives.

Pg26. Patient Incentives. The Roadmap opens the possibility that PPS/MCO's should encourage patient engagement through payment incentives.

Evidence

The Asheville Project is one of the seminal works upon which the Part D Medication Management requirement was based. In the Asheville Project, patients who participated in chronic disease medication management activities were provided with copay reduction incentives. Further, the Asheville project was able to demonstrate that patients who engaged in medication management were able to improve the quality of care and decrease costs. In general, the medical literature demonstrates that patients who are provided with incentives to participate in medication management consultations with a pharmacist are more engaged and show clinical improvements that reduce overall care costs.

Recommendation

The Roadmap might specifically cite incentives such as copay reductions for participating in care management activities such as medication management

We thank you for your consideration of our comments related to the latest version of the VBP Roadmap. Please let us know if we can provide any further information in this regard.

¹ National Action Plan for Drug Adverse Event Prevention, US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2013

² Westberg, S.M, et. al., Evaluation of the Impact of Comprehensive Medication Management Services Delivered Post-hospitalization on Readmissions and Emergency Department Visits, *J Manag Care Pharm.* 2014;20(9):886-93

³ Walker, et. al., Impact of a Pharmacist-Facilitated Hospital Discharge Program, *Arch Intern Med.* 2009;169(21):2003-2010

⁴ Farland, M.Z, et. al., Pharmacist-Physician Collaboration for Diabetes Care: The Diabetes Initiative Program, *Ann Pharmacother* 2013;47:781-9.

⁵ Koshman, S.L., et.al., Pharmacist Care of Patients With Heart Failure, *Arch Intern Med.* 2008;168(7):687-694

⁶ M. Christopher Roebuck, Joshua N. Liberman, Marin Gemmill-Toyama and Troyen A. Brennan. Medication Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending. *Health Affairs*, Vol. 30, no.1. (2011): 91-99

⁷ Janice L. Pringle. Annette Boyer, Mark H. Conklin, Jesse W. McCullough, Arnie Aldridge. "The Pennsylvania Project: Pharmacist Intervention Improved Medication Adherence and Reduced Health Care Costs". *Health Affairs*. August, 2014. 1444-1452

⁸ Congdon, H.B., et.al., Impact of Medication Therapy Management on Underserved, Primarily Hispanic Patients with Diabetes, *Ann Pharmacother* 2013;47:665-70.

⁹ Hogue, V.W., et.al., Pooled Results of Community Pharmacy Based Diabetic Education Programs in Underserved Communities, *Diabetes Spectrum*, 2003

¹⁰ Marrufo, G., et. al., Medication Therapy Management in a Chronically Ill Population: Interim Report, Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation, 2013

¹¹ Congressional Budget Office, Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services, November, 2012

¹² Marie Smith, David w. Bates, Thomas Bodenheimer, Paul D. Cleary. “Why Pharmacists Belong in the Medical Home”. Health Affairs. May, 2010. 906-913.

¹³ Carter, B.L., et. al., Physician and Pharmacist Collaboration to Improve Blood Pressure Control, Arch Intern Med. 2009;169(21):1996-2002

¹⁴ <http://www.aafp.org/about/policies/all/pharmacists.html>

¹⁵ www.cdc.gov/dhdsp/pubs/policy_resources.htm

¹⁶ Report to the New York State Legislature. The Impact of Pharmacist-Physician Collaboration on Medication-Related Outcomes: Results of the New York State Collaborative Drug Therapy Management Pilot Project as required by Chapter 21 of the Laws of 2011. May 6, 2014. (See A7521-A McDonald)

From: [Akchurina, Zamira](#)
To: [McGhee, Patrick A](#)
Subject: Fwd: DSRIP Value-Based Roadmap
Date: Thursday, April 23, 2015 12:27:26 PM

Zamira Akchurina
KPMG | Senior Associate | Advisory
917 803 0800

Begin forwarded message:

From: US-ALB ADV MC VBP Support Mailbox [REDACTED]
[REDACTED] EDT
To: [REDACTED]
Subject: FW: DSRIP Value-Based Roadmap

From: doh.sm.delivery.system.reform.incentive.payment.program
[REDACTED]
Sent: Wednesday, April 01, 2015 8:19 AM
To: US-ALB ADV MC VBP Support Mailbox
Cc: Ashe, Ryan P
Subject: FW: DSRIP Value-Based Roadmap

Good Morning Ryan,

Would you like me to continue to send these comments to you or reply stating that the comment period has closed?

Thanks,
Kathy

From: Moe Auster [REDACTED]
Sent: Tuesday, March 31, 2015 5:14 PM
To: doh.sm.delivery.system.reform.incentive.payment.program
Subject: DSRIP Value-Based Roadmap

March 31, 2015

Jason Helgerson
Deputy Commissioner, Office of Health Insurance Programs
Corning Tower, Empire State Plaza

Dear Mr. Helgerson:

We thank you for the opportunity to provide comments regarding the proposed Value-Based Payment Roadmap for the DSRIP program. Below please find comments from MSSNY on this draft Roadmap, with assistance from counsel at the American Medical Association:

A. **Overlap with the requirements of the Medicare Shared Savings Program (MSSP) and the commercial sector.** It is imperative that, to the greatest extent possible, with respect to Level 1 and above, there should be as much overlap as possible between the measures and methodologies, e.g., attribution, risk adjustment, etc., used in the NY VBP as used in the Medicare Shared Savings Program and in the commercial sector. We are aware that there will be big differences with respect to the patient populations in the NY VBP and the MSSP, and this in itself might make a lot of overlap impossible (but this may not be nearly the case when comparing the NY VBP population to commercially insured population. Many potential PPS members may already be operating as an accountable care organization (ACO) in the MSSP or in commercial ACOs, and it might save those, and future, participants with a lot of hassle if the requirements of the NY VBP could be maximally coordinated with those of the MSSP and commercial programs. And MSSP requirements may be more transferable than others, e.g., perhaps both programs could use the same or very similar patient attribution rules even if the patient populations differ substantially? The need to coordinate with Medicare is briefly discussed on page 36, but this is a huge issue and physicians representatives need to be at the table when discussions are taking place with CMS.

B. **The aggressiveness of the VBP.** Under “Timeline” (page 34), by the end of 2019, 80-90% of the state’s total MCO-PPS payments (in terms of total dollars) will have to be captured in at least Level 1 VBPs. Also, NY aims to have = 70% of these costs contracted through Level 2 VBPs or higher by the end of 2019, although this goal may be moved up- or downwards. We are very concerned that this goal may be too optimistic, and it will be important that physicians and even large organizations or health systems not to be pressured into payment arrangements that are not truly operational. This is a legitimate concern. MSSP ACOs have struggled to hit quality goals, and of the 32 original Pioneer ACOs, only 19 remain, suggesting that “even the most sophisticated health systems may be unwilling to take losses of policy makers test new payment and delivery models.”

C. **Page 5, “a new rate setting methodology.”** The Roadmap indicates that “the state will show benchmarks and give guidance, but it will not set rates for value-based payment arrangements.” It is imperative that, if it is up to the market to set the rates, it is imperative that those rates are not only sufficient to incentivize physicians to make changes, they need to make it possible for physicians to fund the infrastructure that they will need to make changes, such as hiring additional staff to perform case management and technology improvements. Therefore, it

may necessary to give some guidance concerning at least a floor that payers need to satisfy with respect to payments. Otherwise, we are concerned that insurance companies might be able to use superior bargaining power over PPS or certain PPS members or “hubs,” and extract reimbursement terms that might be sufficient to sustain the delivery side of the VBP over the long term.

<!--[if !supportLists]-->**D.** <!--[endif]-->**Page 6, second paragraph--metrics.**

In terms of metrics, it is important that physicians are involved in their selection, development, and implementation. Although there are so-called “off the shelf” measures available, these may or may not be optimal measures for a specific physician practice, e.g., specialty, or for the practice’s patient population. In many cases, only the practice will know what measures are most applicable, and thus where the most cost-reduction and quality improvement activities are (although that knowledge could be augmented by claims data from MCOs—assuming that MCOs actually provide the data in a readily-understandable and actionable form). Also, consideration ought also to be given to measures developed by physician organizations—this would be especially true for measures developed by national specialty societies, given that there are not many quality measures for many specialties at this time. Consideration also ought to be given to resource utilization measures developed by national specialty societies, e.g., Choosing Wisely. The last thing that NY physicians want, and that NY State needs if it wants its VBP program to succeed (during and especially subsequent to the end of DSRIP funding), is measure selection and implementation that is driven by consultants or anyone else other than those persons who are providing direct patient care.

<!--[if !supportLists]-->**E.** <!--[endif]-->**Last paragraph on page 7, VBP v.**

fee for service. The last sentence of this paragraph states “In fact, many PPSs are already actively discussing the importance of payment reform as a means to alleviate predicted losses in FFS revenue due to improved performance on DSRIP outcomes (reduced admissions, reduced ED visits).” You should be aware of the recent AMA-commissioned RAND study entitled “Effects of Health Care Payment Models on Physician Practice in the United States,” (<http://www.ama-assn.org/ama/pub/news/news/2015/2015-03-19-rand-study-payment-models.page>) that concluded that the transition from FFS to VBP created serious conflicting incentives for physicians, particularly for physicians who are employed by hospitals.

<!--[if !supportLists]-->**F.** <!--[endif]-->**Page 9—the description of “1. Initial investment...2. Interim support...3. Ongoing support.”**

One key question will be *how much* the DSRIP will actually fund an APC model, e.g., what will be the PMPM support, and to what extent do those payments correspond to the health, socio-economic, and other factors that need to be risk adjusted with respect to the primary care practice’s attributed patient population. It is not clear how long the support from the DSRIP will last - is it all the way up to the end of the DSRIP waiver period? In terms “Ongoing support,” it looks like funding for practice efforts will come from Level 1 VBP, which is more fully described in the chart on page 17. In that chart, in the row describing “Integrated Primary Care,” funding under the column “Level 1 VBP,” it is incredibly important, as stated previously, that the PMPM subsidy is adequate and accurate given the practice’s attributed patient population. It is important that more specifics ultimately be provided concerning how shared savings will be distributed, e.g., how much will go to the practice, the MCO, the Medicaid

program. Since most of the savings will directly result from physician efforts, the percentage of savings must reflect those efforts.

We are also concerned regarding lack of assurance for receiving savings generated by the practice. For example, in the MSSP, there are specified shared savings percentages to which the ACO is entitled, e.g., in some cases 50% in Track I. However, under the VBP, there is no assurance that PPS participants will receive a minimum percentage of savings. In other words, there is a concern that MCOs might be able to use superior bargaining power to take a disproportionate share of savings, and underfund PPS participants in a way that might make their quality improvement and cost reduction goals unsustainable. This result would be inconsistent with the Roadmap’s statement on page 7 to the effect that:

“Payment reform, then, is required to ensure that the changes in the care delivery system funded by DSRIP are sustained well beyond the waiver period, such that patient engagement and care coordination activities...can be reimbursed, that value destroying care patterns... do not simply return when the DSRIP dollars stop flowing.... “

If physicians are not convinced that the system will treat them fairly financially, they will be disinclined to participate at all, and even if forced, are not likely to have the kind of buy in that DOH wants to bring about the desired, but dramatic, changes in its Medicaid program.

<!--[if !supportLists]-->**G.** <!--[endif]-->**Page 9 and 10, “Episodic care services” and “Specialized continuous care services.”** Although there has been much discussion concerning bundled payment arrangements, there are not many that have been successfully implemented. (The RAND study previously referenced entitled “Effects of Health Care Payment Models on Physician Practice in the United States” highlights this fact). So it is important that any implementation of payment arrangements based on episodes of care, e.g., maternity care, hip replacement, etc., or certain chronic conditions like diabetes, be done cautiously. It is essential for physicians to be involved from the beginning in the development of those arrangements, particularly with respect to the kinds of items and services that are to be included in the episodes and any evidence-based guidelines that will be used to determine performance—both concerns identified by physicians in the RAND study.

<!--[if !supportLists]-->**H.** <!--[endif]-->**Integrated Primary Care, page 11-12.** This paragraph references “quality outcomes,” a phrase that is repeated in other sections of the Roadmap. If payment to physicians and providers is to be based actually on *outcomes*, then given the current state of outcome measures, the Roadmap may be problematic in so far as it has not grasped the current state of the science. Although there are many quality process measures, outcome measures are relatively few because they are much more difficult to develop. So, if the term “quality outcomes” refers to performance determined with respect to outcome measures (as opposed to, say, performance results under quality metrics, process or outcome), then it is unclear how the integrated primary care model can accurately reimburse PCMHs/APCs in the near or perhaps even distant future. (There is only one quality measure

specified in the Roadmap, i.e., “% of eligible patients having received breast cancer screening,” in the first full paragraph on page 13, and that measure is obviously a process measure).

I. “**Downstream savings**” (Page 11) should be carefully defined so that PCMHs’/APCs’ understand the categories of items and services in which they may be eligible to receive a share of savings and perhaps be financially responsible in addition to avoidable ER visits, and hospital admissions for diabetes and asthma, for example, reduction of hospital readmissions, prescription of generic drugs, percentage referrals to providers who are members of the PPS, etc.?

J. “**Contracting combinations, P. 13 through the second paragraph on page 15.** There are several issues here that may require some clarification. One issue concerns attribution. There is no discussion concerning how cost and quality results are to be attributed to a PPS and PPS members. (There is a brief discussion concerning how patients are to be attributed to a PPS on page 22). Perhaps that level of detail is not appropriate for the Roadmap at this stage, but practicing physicians must be involved in discussions regarding attribution. Otherwise, we are concerned that rules could be developed that penalize physicians for costs for which physicians are not responsible or fail to reward physicians for cost savings and quality improvement that are the direct results of their efforts.

Another concept not discussed in much detail is risk adjustment. All cost and outcome results need to be risk-adjusted under the most accurate risk-adjustment methodology that is commercially available to take into account sensitivities such as health status, gender, socio-economic status, etc. Otherwise, physicians may be penalized due to factors beyond their control.

There is also a discussion in this section regarding “combinations of integrated care services.” Although the Roadmap does not discuss groupers, when the time comes, some consideration ought to be given to the kinds of methodologies that may be used to group items and services into specific episodes, although page 21 states that for “care bundles,” the Health Care Incentives Improvement Institute will be used. At any rate, it is essential that, when episodes of care are created, whether those packages are built around specific procedures, e.g., hip replacements, or chronic care, e.g., diabetes treatment per annum, the construction of those packages must be transparent and with physician input.

K. “**Standardization, the second and third paragraphs on page 15.** Physicians have to be integrally involved in helping define and standardize quality measures (both process and outcome), care bundles, care for specific populations, utilization and total cost of care measures. Physicians in the commercial sector are often responsible for complying with different measure sets from each health insurer. And even though there will likely be some overlap among measures, scoring methodologies may be different. For example, the size of the denominator that is employed as an acceptable threshold may differ across payers. We are also concerned that the reference to “similar set of measures” in the second

paragraph may not be sufficient to address issues concerning the lack of uniform application or standardization.

Although the Roadmap does not address the issue, it is essential too, that data reporting requirements on PPS members be as standardized and as minimal as possible. The AMA RAND study referenced earlier indicated that data reporting requirements can significantly burden practices without improving quality or reducing costs. Physicians need to be at the table to ensure that any reporting obligations will directly contribute to patient care or more efficient resource utilization and not impose unnecessary administrative burdens on practices.

L. **Last full paragraph on page 15 “The state will provide MCOs and providers with extensive information detailing their data and performance.”** It is vital that physicians participating in VBP arrangements receive timely, readily understandable, and actionable performance data. The receipt of time, understandable, and actionable data has been an issue for physicians in some MSSP ACOs. The best practice is to receive information at least on a two –week basis, though quarterly reporting should be considered the absolutely floor in terms of timeliness. If data cannot be deliver timely (if not contemporaneous), and in an understandable format, it could seriously undermine the ability of this VBP to be successful.

M. **Text box on page 18.** The second paragraph in the text box on page 18 is unclear, and needs further clarification, such as examples to illustrate the concepts that they are attempting to articulate in that paragraph.

N. **Pages 31-32 “Assuring that providers successful in DSRIP are contracted.** If physicians or other providers believe that they have received inaccurate performance scores that may affect their selection, these physicians and other providers must have the ability to challenge those scores and reverse any adverse selection decisions based upon those scores, should a challenge be successful.

We thank you for the opportunity to provide comments, and are anxious to meet with you at your earliest convenience to further discuss these comments and concerns. We will be contacting your office to set up a time.

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MSSNY thanks its members, whose support helped us save physicians \$1,000s per

year by defeating regressive medical liability proposals this session. Internists saved as much as \$9,500. How much did MSSNY save you or your doctor? [Click here](#) to find out.

From: [Akchurina, Zamira](#)
To: [McGhee, Patrick A](#)
Subject: Fwd: Comments on the value base path to improve health care in the context of D.S.R.I.P.
Date: Thursday, April 23, 2015 12:28:08 PM

Zamira Akchurina
KPMG | Senior Associate | Advisory
917 803 0800

Begin forwarded message:

From: US-ALB ADV MC VBP Support Mailbox [REDACTED]
Date: March 31, 2015 at 3:19:39 PM EDT
To: [REDACTED]
Subject: FW: Comments on the value base path to improve health care in the context of D.S.R.I.P.

[Here are his questions.](#)

From: doh.sm.delivery.system.reform.incentive.payment.program [REDACTED]
Sent: Tuesday, March 31, 2015 8:25 AM
To: US-ALB ADV MC VBP Support Mailbox
Subject: FW: Comments on the value base path to improve health care in the context of D.S.R.I.P.

From: Trevor Litchmore [REDACTED]
Sent: Monday, March 30, 2015 6:44 PM
To: doh.sm.delivery.system.reform.incentive.payment.program
Subject: Comments on the value base path to improve health care in the context of D.S.R.I.P.

The questions are this : How will you improve access to mental health for those who are unstable (mentally) and whose instability makes it impossible to achieve any medical care bench marks or healthy goals that would factor into the value to the community in which these patient lives due to the lack of timely access to psychiatrist and Mid level providers for example Nurse Practitioners and Physician Assistants : specializing in psychiatry ?2) How will you make these medicaid patients who require subspecialist care in conjunction with primary care to achieve Value base care : more attractive to these subspecialist to

the extent that they will make their practices more accessible to these patients? 3) How do you plan to address the issue of medicaid patients with Asthma and C.O.PD who continues to smoke tobacco that have lead to worsening of their illness and multiple avoidable hospitalizations?

Sincerely

T.Litchmore M.D. (General Internal Medicine)