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

**May 14, 2014**

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

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

## I. Recommendations for Attachment I

### A. Comments on Attribution:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

are reasonable and in the best interest of Medicaid patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> *…the state must ensure… that each Performing Provider System receiving payments under DSRIP maintains (or participates in) a health information system that collects, analyzes, integrates and reports data and can achieve the objectives of this DSRIP. The state must require that each Performing Provider System ensure that data received from providers within the system is accurate and complete….To the degree that the data and metrics are generated and obtained via managed care systems already subject to 438.242, no additional validation of the data is required.*
>
> *For data and metrics reported in systems not subject to 438.42, these agreements between the state and Performing Provider Systems should also be accompanied by validation process performed by the independent assessor to ensure that the processes are generally valid and accurate.*

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

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

## II. Conclusion

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

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

**About CHCANYS**

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

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

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

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