DSRIP PPS Plan Application Comments

The Community Health Care Association of New York State (CHCANYS) respectfully submits these comments in response to NYS' Draft DSRIP PPS Plan Application and materials released on September 29, 2014. We appreciate the opportunity to comment on the application. CHCANYS is very supportive of the overall goals of DSRIP and its recognition of the need for a transformed health care system in New York—one that sustains and enhances our primary care foundation and shifts away from the historic emphasis on inpatient care. 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 implementation of DSRIP PPS networks, as well as lead or participate in projects that drive transformation. CHCANYS looks forward to continuing to support FQHCs in their chosen PPSs and ensure that they are able to fully contribute to the outcomes the new systems must achieve. As discussed in greater detail below, we have some concerns about the application as written and how it will affect PPS partner organizations, including FQHCs.

General Comments

Word Limitations

The word limits on application sections (often 500-1500 words) will make it difficult for lead PPSs to provide details that demonstrate meaningful inclusion of partners in the PPS design, structure, and payment.

Timing and Flexibility

It is our understanding that the State expects a level of detail on numbers (e.g., staff, beds, attributed lives, types of providers, etc.) throughout this application that may simply not be available to most PPSs at this time, and also that a PPS will be held to any numbers represented in its application. This approach is not logically consistent with the actual iterative process PPSs are undergoing to develop partnerships and projects. Much of the detailed information the State seeks likely will be become apparent during the development of the detailed implementation plans, due on April 1, 2015. We encourage the State to allow PPSs flexibility in providing information on certain specific numbers, and instead – consistent with our comment below – focus in this application on the substantive nature of the partnerships the PPS is building.

Application Does Not Appear Constructed to Capture Substantive Nature of Partnerships

The State has emphasized repeatedly that DSRIP is about collaboration and clinical integration among providers in New York's health care system. However, in multiple places throughout the application the required benchmarks focus on what appears to be nominal inclusion of partners rather than requiring demonstrated meaningful partnerships with providers. This focus on simply listing partners is evident in several sections, including, but not limited to:

- Governance: applicants are required to describe a governance model and list the types of providers included, but are not asked to comment on how a PPS's governance model ensures meaningful contributions from and voice of the PPS members;
- Project advisory committee: applicants are not asked to comment on how they will ensure meaningful contributions from all committee members;
- Financial organizational structure: again, applicants are not asked to comment on how their financial structure will ensure meaningful participation from all partners;
- Path to reimbursement reform: applicants are not required to identify how the PPS partners have been engaged in developing this plan, if at all;
- Proven Population Health Capabilities: applicants are only required to identify a lead or partner with experience, not to describe how these capabilities will be used in a meaningful way; and
- Integrated Delivery System: applicants must only identify the types and numbers of partners and issues around HIT connectivity and are not asked to identify how the integrated delivery system is likely to operate with meaningful participation from its component parts.

Comments on Specific Application Sections

1. Regulatory Relief

The process for requesting regulatory waivers must not be limited to just the PPS lead's application. Although we appreciate the opportunity to request waivers of regulations that would impede the PPS' ability to execute their reform projects, the waiver request process is an exacting one that requires PPS leads and project leads to be much further down the road with projects then they likely will be by the time the application is due. For example, in order to accomplish the goals necessary to integrate behavioral health into primary care, the PPS lead may request waivers that would impede the co-location of an Article 31 behavioral health provider into a separate Article 28 primary care provider's facility. At the time of application, the project leads may have a rough idea of the space requirements and needs at the Article 28 facility but without a thorough architectural review of the space, they may not be able to provide a complete list of necessary waivers. It is unlikely that project leads will have enough time to complete this assessment by the time the PPS lead application is due. Likewise, plans for this type of capital project often change as providers move through the process. Therefore, there should also be an avenue to make changes or additional requests for waivers once the process is underway.

2. PPS Workforce Strategy

While CHCANYS agrees that it is critical for PPSs to provide a workforce strategy related to existing staff, the application overwhelmingly emphasizes the impact on existing staff and does not include questions related to evidence-based workforce strategies that result in patient-centered, integrated care and improved patient outcomes. Because advanced staffing models such as interdisciplinary patient care teams are an essential part of a transformed delivery system, the organizational application should include specific questions about how the PPS will redesign workforce/staffing configurations and how those new configurations will transform the delivery care across the new network and achieve DSRIP outcomes. The application should include questions about how staff and providers will be trained to operate effectively and

efficiently within these new models of care. The application also should include questions about PPS recruitment and retention strategies for providers and staff, including potential new positions such as community health workers, care coordinators, and patient navigators that will support population health strategies in clinical and community settings.

The organizational application also requires PPSs to provide specific numbers and percentages of staff that will be retrained and redeployed as well as new hires. Yet the application also states that PPSs will be expected to complete a comprehensive assessment on the impact to the workforce on a project-by-project basis in the immediate future as a Domain 1 process milestone for payment. Given that many of the details of the PPS infrastructure and projects will evolve after applications are submitted on December 16, requiring exact numbers and percentages now is premature. CHCANYS proposes that PPSs be required to propose a range of numbers and percentages for the application submission and then provide precise numbers after the comprehensive assessment is completed. Optimally, the comprehensive assessment also will include an assessment of the current adoption of advanced care delivery models and staffing and provider gaps.

CHCANYS believes it is imperative that workforce training, retraining and recruitment programs under DSRIP be coordinated on a statewide basis. Relying on each PPS to identify and develop workforce initiatives for its regional programs may result in a fractured workforce strategy rather than a comprehensive, coordinated statewide plan. PPS networks' regional workforce training, retraining and recruitment programs should be coordinated statewide to ensure that curriculums are consistent and recruitment efforts support the delivery of quality care in all regions. This will be particularly important in rural areas, which tend to have fewer resources to leverage but often struggle the most with workforce capacity. These areas may need additional resources beyond what other, more resource rich areas have, to develop their workforce capacity and ensure that their programs are fully implementable and successful. Building upon the recommendations of the Medicaid Redesign Team Workforce Flexibility and Scope of Practice Work Group, New York State should identify best practice curriculums for training and retraining practitioners to work in allied professions work with educational institutions across the state to identify relevant training opportunities and develop additional training resources for PPS networks. Embedding into DSRIP a coordinated, statewide workforce strategy that meets the comprehensive health care needs across New York State will be critical to the success of the program.

Finally, in order to recruit, retain and support the additional healthcare workforce that DSRIP seeks, New York State must establish ongoing funding for the Doctors Across New York (DANY) program and the Primary Care Service Corps (PCPS). Both these programs have been successful at placing much needed primary healthcare staff in underserved areas of the state. However, they require a predictable and sustained funding source in order to achieve DSRIP's articulated workforce goals.

3. <u>Community Needs Assessment</u>

The application asks for a succinct summary of the current assets and resources that can be mobilized and employed to help achieve many of the DSRIP projects. This question should specifically ask PPSs which partners will play what roles within each project and should be asked consistently across projects. For example, project 3.a.i Integration of Primary Care and

Behavioral Health Services asks for "the total number of PCP sites, behavioral health provider sites, substance abuse provider sites, and all other sites the PPS intends to include in the project by the end of Demonstration Year 4, or sooner as applicable." However, project 2.a.iv Create a Medical Village Using Existing Hospital Infrastructure only asks for "the number of Medical Villages this project will establish by the end of Demonstration Year 4, or sooner as applicable." It should also ask for the total number of community-based providers, including PCP sites, behavioral health provider sites, substance abuse provider sites, and all other sites, the PPS intends to include in the project as part of the new medical village.

Additionally, community needs assessments tend not to identify the particular needs of special populations, including people who experience homelessness, have HIV/AIDS, live in public housing, have developmental disabilities, are migrant and seasonal farmworkers and/or are LGBT. The presence and prevalence of special populations should be an important part of PPS deliberations concerning medical service constellations and deployments of other essential services designed to facilitate access to needed care, promote good health outcomes and avoid unnecessary costs. Applicants should be required to discuss how they plan to serve special populations, identify the systems of care that are already in place for these populations and describe how PPS services will be integrated with and build on these existing systems of care.

4. Data-Sharing, Confidentiality, & Rapid Cycle Evaluation

As part of its Center for Primary Care Informatics (CPCI), CHCANYS operates a statewide data warehouse which reports on many of the DSRIP required measures and includes functions that support population management and advanced care delivery models. Currently, 34 FQHCs are connected to the CPCI, which is over half of all FQHCs in the state, and 17 more are in the pipeline. This represents over a million lives. The PPS leads should be aware of this existing resource as well as other PPS partners' current IT capabilities and leverage those systems to advance their objectives rather than ask partners to create new data reporting systems.

Additionally, any technology (e.g., health information exchange, care management software) that will be available and/or required by DSRIP outside of RHIO services should be made available at an affordable rate or at no-cost to FQHCs and other community-based providers. Ensuring unfettered access to technology will enable a system to operate as an integrated delivery system and should be considered a core operating cost.