Comments on Value Based Payment Roadmap Annual Update

April 8, 2016

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

1. Shared Savings Requirement for Professional-Led VBP Contractors

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

Scope of Shared Savings Requirement

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

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

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

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

Notification of VBP Intent

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

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

Calculating Savings for Purposes of Sharing

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

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

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

Definition and Criteria for Cooperating Hospitals

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

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

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

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

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

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

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

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

Duration of Shared Savings Program

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

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

Equitable Distribution of Resources

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

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

2. **General Guiding Principles for Distribution of Shared Savings**

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

3. Future Budget Adjustments in VBP Arrangements

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

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

4. **Ongoing Role of PPS**

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

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

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

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

5. **Quality Measures and Model Contract**

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

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

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

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

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

6. **VBP and Consumers**

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

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

7. **VBP Bootcamps**

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

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

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8. Additional Comments

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

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

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

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

- The State's interest in measuring and encouraging creativity in incentive programs, specifically its plan to "analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publically available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of

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

- The requirement that Level 2 and 3 VBP contractors implement at least one intervention designed to address a social determinant of health. We strongly support the proposal that that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)

- The proposal that a social determinant intervention "should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (p. 42). It is critical that any intervention addressing social determinants of health be guided by individual members' own health goals and desires and community needs and resources.

- The mandate that all level 2 and 3 VBP arrangement include a minimum of one Tier 1 CBO, with the understanding that this may be difficult in some more rural regions of the state, as noted on page 42. It is critical that community-based organizations are included in VBP arrangements, and CHCANYS appreciates the State's recognition that contractors may engage with CBOs in a variety of ways to address social determinates of health and further their VBP goals.

- The creation of a taskforce focused on children and adolescents in the context of VBP. (page 59) CHCANYS strongly supports a separate process to consider how to measure value for children, in the context of value-based payment. Though there has not been discussion of the unique needs of children in VBP, the approaches being considered would be applicable to payment for services for children. To the extent that system transformation efforts currently underway aim to fundamentally change New York's health care delivery

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

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

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