Comments on the NYS Draft DSRIP Waiver Amendment Request

November 4, 2019

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Amendment Request concept paper published on September 17th. CHCANYS represents New York's federally-qualified health centers (FQHCs), also referred to as community health centers (CHCs), which operate over 800 sites and serve 1 in 8 New Yorkers. CHCANYS commends the State's work in the first round of DSRIP to reduce costs, improve patient outcomes, and decrease unnecessary inpatient and emergency room utilization. For New York to experience a real transformation of the health care delivery system and sustain the gains thus far achieved through DSRIP, there must be a significant investment in community-based primary care. Only through this investment can the State achieve a true value-based system that improves health outcomes and reduces costs. CHCANYS supports the renewal of the DSRIP program through March 31, 2024 but offers the following comments on the proposed amendment request.

I. Driving Promising Practices to Improve Health Outcomes and Advance VBP

By mission and in statute, health centers serve the State's most vulnerable and hard to reach populations. FQHCs are non-profit, community run centers located in medically underserved areas that provide high-quality, cost effective primary care, including behavioral and oral health services, to anyone seeking care. Each FQHC is governed by a consumer-majority board of directors who are tasked with identifying and prioritizing the services most needed by their communities. 59% of New York State health centers' 2.4 million patients are enrolled in Medicaid or CHIP.

The more than 800 CHCs located across the State provide access to comprehensive primary care services, especially among populations that are most likely to present at the ED with a non-urgent or avoidable condition. In the first round of DSRIP, every health center participated in at least one Performing Provider System (PPS) and many health centers were members of multiple PPS. Multiple health centers expanded their capabilities to address the opioid crisis by expanding the number of physicians that are waivered to provide Medication Assisted Treatment (MAT). One PPS provided a health center with funds to create a residency program to address nursing workforce shortages. One health center used DSRIP funds to enhance their Electronic Health Record (EHR) to include Aunt Bertha, a software to identify local social services organizations. The health center also tracks referral volume and receives feedback from community partners regarding attendance and utilization. DSRIP provided health centers the flexibility to waive regulations to more effectively integrate primary care and behavioral health services – many health centers have taken up that flexibility and also have begun hot spotting high risk patients in an effort to reduce their use of emergency departments and improve their overall quality of life. These are just a handful of examples of health centers leveraging DSRIP funds to drive promising practices.

The first round of DSRIP complemented the health center model's unique and innate ability to provide comprehensive and innovative care to New York's Medicaid beneficiaries. Health centers played and

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continue to play a key role in advancing the promising practices within their regions and driving improved health outcomes. In the second round of DSRIP, health centers are well-prepared to take a leadership role to advance the State's vision of an expanded value-based payment (VBP) landscape driving DSRIP promising practices.

II. Embracing the Role of VDEs

CHCANYS is pleased to see that the State has acknowledged the need for additional flexibility in the next round of DSRIP and is interested in ensuring the success of Value-Driving Entities (VDEs). However, we encourage the State to provide direct investment in community-based providers. Currently, 23 of 25 of the PPS leads are hospital-based, with no specific requirements about how funds flow to partners in the PPS networks. Meaningful governance participation by community-based providers, such as community health centers and community behavioral health organizations, and downstream investments to health centers and other community-based providers varied greatly from PPS to PPS. Using publicly available data reported by the State, it is extremely difficult to determine the amount of money received by health centers in the first round of DSRIP – they are included as "clinics" with hospital ambulatory providers. However, the most up to date data reported by the State in November 2018 demonstrates that hospitals received more than 28% of total funds flow while representing only 0.2% of total engaged PPS partners.[i] It is exceedingly difficult to transform the healthcare delivery system by continuing to invest most transformation dollars into inpatient-based care models, when it is the long-standing established CHC providers and workforce that can make the biggest impact on patients' health outcomes. CHCs are especially well-posed to integrate care, make connections to address social needs, and become the more adept and agile VDEs envisioned in the State's concept paper.

We support the State's charge that VDEs include providers, community-based organizations (CBOs), and managed care organizations (MCOs) to leverage VBP and advance promising practices. A collaborative partnership between community-based providers, CBOs, and MCOs is critical to implementing and supporting transformative initiatives that move away from a volume-driven care model. However, to support improved access to care in the community and reduce reliance on emergency departments and inpatient care, the State must direct additional resources to a broad range of community-based providers. **CHCANYS requests that the State dedicate, at a minimum, 25% of DSRIP funds to the development of community-based VDEs where CHCs, in collaboration with other community-based providers, are leads.**

a. VDE Lead Entities

The State should capitalize on existing health center Independent Practice Associations (IPAs) as a launching point for the creation of community-based VDEs. There four CHC-led IPAs currently organized across the state, Community Health IPA (CHIPA), Safety-Net IPA (SIPA), Finger Lakes IPA (FLIPA), and Upstate Community Health Collaborative IPA (UCHC), are engaged with MCOs in at least one VBP contract while working on additional agreements. Also, several CHCs are engaged in regional, integrated IPAs with behavioral health providers and CBOs. These IPAs leverage the experience and expertise of

primary care and behavioral health providers to improve care coordination and care delivery for many of the most at-risk and highest cost patients. Another key feature of these IPAs is their ability to take on risk and become financially accountable for both the quality of care and the most efficient delivery of care services. CHCANYS believes that these integrated IPAs are well positioned to work with other entities as a VDE in the second round of DSRIP. Below are some examples.

Finger Lakes PPS (FLPPS) invested $275,000 into the creation of an integrated IPA, FLIPA, which includes 5 community health centers and 6 community behavioral health organizations and covers about 60,000 lives. The initial investment supported clinical and information technology population health management activities. To date, FLIPA has is engaged in two VBP contracts with regional MCOs and their work has saved FLPPS $11.5 million.

EngageWell IPA, which is supported by a grant from the State's Behavioral Health Care Collaborative (BHCC) program, is an integrated IPA serving Medicaid Managed Care enrollees. Over 20 member agencies, including health centers, provide health care, mental health and substance use treatment, harm reduction, care coordination, supportive housing and housing assistance, education, employment support, food and nutrition and benefits assistance address enrollees social needs to improve their health outcomes. EngageWell is in the process of using investments to launch quality data dashboards and a corresponding internal quality improvement program for all participating providers.

These two successful models of promising practices can be scaled and modified for replication in other areas of the State. CHCANYS is currently working with the New York State Council for Community Behavioral Healthcare to identify opportunities for collaboration among BHCCs and health center IPAs. Our members are committed to this integration of care approach piloted by FLIPA and EngageWell. Acceleration and support of this work by the State can only result in the State achieving its stated DSRIP goals of sustainability and improved integrated care models.

While health centers are already developing relationships needed to advance in VBP contracts, a second round of DSRIP is an opportunity to invest in building capacity to ensure health center and CBO IPAs have the foundation to serve as VDEs. Currently, health center-led IPAs are self-funded and have little financial capacity to support many of crucial functions that would accelerate their successful participation in VBP arrangements. **Health center-led IPAs require DSRIP investment to support the data analytic capabilities needed to effectively manage population health and drive improved outcomes.**

b. Considerations for Engaging MCOs

CHCANYS is pleased that the State is taking steps to ensure engagement of MCOs early in the planning process for a second round of DSRIP. However, there are significant challenges that must be addressed ahead of the creation of VDEs. One of the current difficulties faced by providers as they seek to participate in VBP arrangements is a lack of comprehensive data about their attributed patients. **The State should update the MCO Model Contract to create and enforce a uniform data sharing policy for**

the managed care plans to further support the transition to VBP, for example, by enforcing transparency in expenditures and utilization.

In the first round of DSRIP, the discrepancies between MCO attribution and PPS attribution made it difficult for health centers to effectively manage patient health outcomes. PPS networks do not necessarily encompass the same providers that are contracted with a given MCO. If there are discrepancies between MCO attribution, consumer utilization, and PPS network, it becomes incredibly difficult, if not impossible, for the PPS to effectively manage health outcomes for these populations. PPS and VDEs should not be expected to manage the health care improvements of individuals who are enrolled in managed care plans that contract outside of the VDE. **CHCANYS recommends that in the next round of DSRIP, VDE attribution should be aligned with MCO attribution to ensure seamless VBP contracting.**

Finally, we understand the State's desire to drive regional innovation – local health care needs vary based on geography, CBO and health care provider landscape, and other factors. However, we would like to raise the concern that in densely populated areas served by many MCOs with overlapping service areas (notably, New York City), defining distinct regions may prove difficult. **In New York City, CHCANYS recommends that VDE networks should align with patient utilization patterns as much as possible.**

III. Relationships of PPS and VDEs

Based on the language included in the concept paper, *"The Second Generation "Value-Driving Entities" (VDEs) will consist of a Performing Provider System (or a subset of the Performing Provider System), provider, CBO and MCO teams specifically approved by the state to implement the high-priority DSRIP promising practices."* it is our understanding that the PPS will be active agents in the creation of VDEs. In addition to our recommendation that the State dedicate at least 25% of DSRIP funds to the development of community-based VDEs, two other attributes of the PPS and VDE structures must be addressed.

a. Re-Open PPS Provider Networks

The PPS provider networks were established in 2015 when most providers were not familiar with the mechanics and relationships required for successful participation in DSRIP. Primary care providers and community behavioral health organizations made their PPS selections based on the information available at the time. The PPS selection was locked-in over the 5-year DSRIP program. Since that time, health centers have fostered new relationships with hospitals, behavioral health providers, and CBOs as new payment models have evolved - many outside of the PPS structure. To continue to foster the provider networks that have evolved over the past 4-5 years, **DSRIP 2.0 must allow for providers to re-assess and revise their PPS selection.**

b. Approval of a Single VDE Across Multiple PPS

Many primary care providers, including FQHCs and community behavioral health organizations, work with multiple hospital systems within the communities they serve. As most PPS are hospital-led and

providers were initially able to select one PPS, this has created an operational nightmare for the primary care and behavioral health provider communities. Health centers have been required to participate in certain projects for their patients within their selected PPS, meanwhile a subset of their patients are served through hospital relationships that exist in a different PPS. Over these past 4-5 years, providers have formed relationships in preparation for VBP, both within and outside of the PPS structure. To allow for a more cohesive and seamless primary care delivery system, **the extension of the DSRIP waiver must provide for VDEs that cross PPS and are eligible to receive investments for provider networks that cut across multiple PPS.**

IV. Supporting Non-Clinical Workforce to Address Social Needs

CHCANYS echoes the State's observation that many of the successful DSRIP initiatives rely on non-traditional, non-clinical workforce that help patients navigate clinical and social services systems to address their multi-dimensional needs. In the first round of DSRIP, health centers embraced the flexibility to address patients' social needs. Many health centers have leveraged DSRIP investments to gain contracts for WIC programs onsite, collaborate with food kitchens, local jails, transportation and employment agencies, and have hired additional non-clinical, non-reimbursable support staff, such as Community Health Workers (CHWs) and peer navigators.

In the first round of DSRIP, the State encouraged primary care practices to become patient-centered medical home (PCMH) recognized. Today, 97% of New York's health centers are PCMH certified. PCMH certified practices provide mental health, oral health, and health promotion/disease prevention services through comprehensive primary care. This model of patient-centered care is associated with improved health outcomes and reduced costs and should be robustly supported in the second round of DSRIP. There are numerous studies that have analyzed the success of PCMH, including citing fewer specialty visits needed, lower per member costs, and better health outcomes amongst individuals seeing PCMH-certified providers.[ii]

One NYS PCMH accredited FQHC reported that the PCMH program served as the impetus for their engagement in VBP contracts. Incentive payments aided in the development of comprehensive risk stratification algorithms that ultimately identified patients for intense care management. After reviewing the risk score, patient advocates, behavioral health providers, and other non-clinical staff were engaged to comprehensively address patients' needs and address gaps in care. In addition to the specific NYS PCMH qualifications, PCMH payments allow the health center to focus on quality improvement processes within the health center and improve timely, data-driven, team-based communication. **The State should use a second round of DSRIP to continue investments in care management programs like PCMH and Health Homes to address patients' social and medical needs.**

V. Aligning Performance Measures

CHCANYS strongly supports the State's desire to work with CMS to align performance measures across initiatives. Health centers' participation in Medicare, Medicaid, NYS PCMH, and contracts with managed care plans (among various other programs) requires a significant amount of resources invested in

measure/data collection and reporting. **The State should target measures most likely to be of value for all participants in DSRIP 2.0.**

VI. Health Center Alternative Payment Methodology

FQHCs embrace the State's transition of Medicaid payment from volume to value. CHCANYS supports this direction and is also engaged in permissible activities to move away from a visit based FQHC payment to a capitated FQHC Alternative Payment Methodology (APM). Federal statute permits states to implement an APM in lieu of the legally required prospective payment system reimbursement methodology. States must ensure that reimbursement under the APM is not less than it would be under the prospective payment system rate; however, adoption of an APM is essential to move FQHCs from a visit-based payment that incentivizes volume to a payment methodology that rewards efficiency and outcomes. A capitated FQHC APM aligns with the State's DSRIP goals of advancing VBP and provision of enhanced care coordination.

An FQHC APM supports team-based, integrated care and enables CHCs the flexibility needed to create innovative approaches to care which can include non-clinical support staff who are not billable providers under the prospective payment system rate. The creation of innovative care coordination workflows will improve care provided directly by FQHCs, therefore reducing costs across the health care system.

CHCANYS looks forward to working closely with the Office of Health Insurance Programs to establish a mutually agreeable approach that supports health centers' ability to transform their entire practice to a value-based care delivery model. Once the APM receives a federal approval, CHCANYS envisions that a small subset of health centers will transition from the prospective payment methodology to the APM. **To ensure the success of an APM, State investment is needed to enhance data collection capabilities and catalyze the development of new staffing roles, models for care teams, and innovative work flows.** These investments may include: enough funding to support interventions addressing patients' non-clinical social needs, support for an alternative payment learning community, clinical and cost data analyses, quality metric identification, and reporting mechanisms.

CHCANYS and our member community health centers have actively engaged in DSRIP implementation and contributed to many of the successes achieved. We look forward to continuing to partner with the State to achieve our shared goals of system transformation and improved patient care, better patient outcomes, and reduced care costs.

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[i] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/paop/meetings/2018/docs/2018-11-29_updates.pdf

[ii] Kaushal R, Edwards A, Kern L. May 2015. Association Between the Patient-Centered Medical Home and Healthcare Utilization. American Journal of Managed Care. Am J Manag Care. 2015;21(5):378-386.
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