**Comments on A Path toward Value Based Payment: Annual Update; June 2019: Year 5**

**May 23, 2019**

The Community Health Care Association of New York State (CHCANYS) is pleased to submit comments in response to recent proposed changes to the "A Path toward Value Based Payment: Annual Update; June 2019: Year 5" (2019 Roadmap). As the statewide association for federally qualified health centers (FQHC), we advocate on behalf of the 65 FQHCs that operate 800 sites and serve 2.3 million patients across the State. Medicaid is the most prevalent source of coverage for health center patients, and Medicaid reimbursements provides the majority of health center income. 59% of patients at New York State FQHCs—1.4 million—are covered by Medicaid. Approximately 20% of all Medicaid patients in New York State are served by an FQHC. Medicaid reimbursements account for over half of health center revenue. In light of this, we are extremely concerned about the recent proposed changes the 2019 Roadmap that would exclude health centers from participation in value based payment (VBP) arrangements in Medicaid that include downside risk.

Specifically, page 37 of the 2019 Roadmap proposes that FQHC cannot enter into Level 2 or Level 3 arrangements as lead VBP contractors and that "Spend attributed to members who have an FQHC designated as their primary care provider from total medical expense when calculating MCO progress to level 2 & 3 will be excluded." However, FQHCs who have formed an IPA would remain eligible to participate in level 2 or 3 arrangements "with the understanding that the risk would be held by the IPA."[1]We believe that these proposed changes are based on a misunderstanding of the FQHC payment methodology and health centers ability to enter into risk arrangements with managed care

[1] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2019/docs/2019-06_redline_version.pdf, page 37



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plans and ask that the Department of Health strike changes to the Roadmap prohibiting FQHC participation in certain VBP arrangements.

In recognition of the importance of FQHCs to the healthcare safety net, Congress created a unique bundled payment methodology for health centers in Medicaid—the prospective payment system (PPS). Federal law requires that all health centers be paid a PPS rate, or be paid via an alternative payment methodology (APM) which results in the health center receiving as least as much as they would under their PPS rate. In states with Medicaid Managed Care plans, such as New York, health centers contract directly with managed care plans and the state pays the difference between the contract MCO rate and the PPS rate. This difference is referred to as a wrap around payment. In New York, the wrap amount is calculated based on what a health center reports on the Managed Care Visit and Revenue (MCVR) Report. DOH guidance makes clear that positive surplus-sharing payments or negative deficit payments are not reported on the MCVR, and are explicitly excluded from the determination of a wrap around payment:

> Financial incentive payments received by the FQHC from the contracting MCO/IPA are not included in the calculation of managed care supplemental payments. The MCO/IPA payments must represent the baseline payment wider the contract for services being provided, *without regard to the effects of either positive or negative financial incentives that are linked to utilization outcomes or other reductions in patient costs.* [2]

The State's approach to calculating the wrap payment is consistent with long-standing CMS guidance, as outlined in a 2000 State Medicaid Directors Letter:

> Inclusion of incentive amounts (whether positive or negative) in calculating supplemental payments would negate the financial impact the incentive is designed to provide, since the FQHC/RHC would get the same total amount of money, regardless of whether it met the utilization or other goals set by the MCO. For this reason, we have determined that the State's quarterly supplemental

[2] https://www.health.ny.gov/health_care/medicaid/rates/fqhc/docs/fqhc_policy_document.pdf, page 7



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> payment obligation should be determined using the baseline payment under the contract for services being provided, without regard to the effects of financial incentives that are linked to utilization outcomes or other reductions in patient costs. [3]

Because upside and downside risk arrangements offered to FQHCs under Level 2 arrangements would constitute financial incentives under existing CMS policy, the State would not be permitted to consider them in the calculation of wrap around payments, and any financial gain or losses a health center incurred would be outside of the PPS rate.

Furthermore, there are numerous ways a VBP arrangement could be constructed to further ensure that wrap payment, and a health center's financial viability, is not impacted by downside risk. For example, under a "deficit carryover" arrangement, deficits are applied to future surplus and there is no obligation on the part of the FQHC to repay the deficit if there is no surplus. FQHCs arrangements could also use a risk corridor that limits the downside risk to any amount that is greater than the PPS rate. If an FQHC experiences a financial loss, but one that was limited by the risk corridor, the health center could use financial reserves—outside of their federal grant dollars or PPS revenue-- to cover such a loss. Finally, CMS or DOH could design additional assurances that an arrangement would not result in increased wrap around payments. FQHCs are already required to certify that no payment amounts -- surplus sharing or deficits -- are reported on the MCVR. This ensures that no risk arrangement affects the revenue received by an FQHC from DOH or CMS.

In light of the above guidance, CHCANYS requests that DOH confirm that FQHCs may enter into VBP Level 2 or higher agreements directly with health plans and strike the proposed changes to

[3] https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd092700.pdf, page 2



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the 2019 Roadmap limiting FQHC participation in VBP arrangements.

While we are pleased that the State agrees that FQHCs can participate in all levels of VBP arrangements as part of an IPA, CHCANYS is very concerned that the proposal to exclude FQHC spend from Statewide level 2 & 3 targets will negatively impact all FQHC's ability to enter into VBP arrangements with plans, even those that are part of an IPA. The State has committed to CMS that 80-90% of all managed care spend will be in VBP arrangements by 2020, and 35% of that spend will be in level 2 or level 3 arrangements. To incentivize managed care plans to enter to these arrangements, last year the State began penalizing plans who did not meet set targets, with the expectation that penalties will increase annually. Beginning on April 1, 2019, State payments to plans will be reduced by 1% if they do not have 50% of their premiums in Level 1 or 15% or premiums in Level 2 arrangements. In 2020, penalties will accrue if plans do not meet 80% in Level 1 or 35% in Level 2. Thus, in order to avoid penalties plans are seeking to enter into VBP arrangements that help them meet their targets. By removing FQHC level 2 and 3 spend from these targets, managed care plans have virtually no incentive to contract with any FQHCs. As a result, FQHCs will be left out of the movement to VBP, even though nearly 20% of Medicaid patients are seen at health centers. The State received $8B from CMS to transition Medicaid payments from volume to value, with the goal of improving health outcomes and reducing costs to the system. However, by excluding FQHCs from VBP arrangements, the State is allowing a large portion of Medicaid to remain in volume driven payment arrangements, undercutting their own policy statements and potentially creating a two-tiered system of care in Medicaid.

FQHCs have been excellent partners in DSRIP over the past 4 years, with every single health center participating in at least one providing performing system network. In many PPS networks,



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health centers have been key drivers of improved health outcomes, ensuring that the PPS received full payments from the State. Like other large Medicaid providers throughout the state, health centers have been preparing to transition to VBP by establishing and joining IPAs and adopting team-based care models. To now exclude FQHCs from participation in VBP arrangements limits their ability to take advantage of shared savings investments and will hamper their ongoing advancement toward value based care models. Health centers are ready and willing to partner with New York State to transform the healthcare delivery and payment system. CHCANYS emphatically requests that the State clarify their position on FQHC participation in VBP arrangements in the 2019 Roadmap and ensure that health centers can continue to provide high quality, comprehensive care to 2.3 million New Yorkers annually.

Thank you for the opportunity to comment on these proposed changes. We look forward to continuing to work with the Department of Health to transform New York's health care delivery and payment system.



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