Medicaid DSRIP PPS Public Comment Day

January 31, 2017

Testimony of

Coalition of New York State Alzheimer's Association Chapters

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Good day,

My name is Jane Ginsburg, I am the Executive Director of the Coalition of New York State Alzheimer's Association Chapters. This testimony was developed in coordination with Dr. Anafidelia Taveres, Director of Programs for the Alzheimer's Association, New York City Chapter.

I would like to begin by applauding NYS Department of Health for its commitment and support for reforming Medicaid in New York State.

The Coalition of New York State Alzheimer's Association Chapters is the leading statewide organization advocating for all New Yorkers affected by Alzheimer's disease and dementia. Our mission is to eliminate Alzheimer's disease through the advancement of research; to provide care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. We are members of Medicaid Matters and are deeply concerned that all New Yorkers facing Alzheimer's are able to receive the assistance they need to aid their care planning and best health possible to avoid crises, unnecessary hospitalization and premature skilled nursing facility placement.

Approximately 390,000 people in New York State have Alzheimer's disease and this figure is expected to grow by 20% in the next decade. Caring for these loved ones can take a severe emotional, physical and financial toll over a period of years, and yet over 1 million people in New York provide this necessary, but unpaid, care each year.

Alzheimer's has been cited as a public health crisis by the Centers for Disease Control as the rates of Alzheimer's continues to skyrocket, as does the aggravated healthcare costs of caregivers. Last year, New York spent $4.2 billion Medicaid dollars just caring for those with Alzheimer's -- Medicaid payments for people with Alzheimer's are 19 times greater than average Medicaid payments for dual enrollees.

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's advocacy, research and support. We face this public health challenge head on by providing interventions that address the continuum of care and avoiding crises. Each of the Coalition's seven statewide chapters provide comprehensive, free education, care and support to all New Yorkers affected by Alzheimer's and other dementias through the years of disease progression through our in-person and online support services and programs for caregivers, healthcare professionals, and the public.

Topics are many, and include the impact of diagnosis, early warning signs, health and advance care planning and the importance of individual health and respite. We have a diverse and multilingual staff of specialists and master's-level clinicians that can work with New Yorkers in need, in person or over the phone and through our free 24/7 Helpline.

We advocate for the needs and rights of those facing Alzheimer's disease, helping to educate policymakers on the Alzheimer's crisis and engage them in our efforts to fight the disease and its many ramifications on the person, the family, the community and the state.

Finally, as the world's largest nonprofit funder of Alzheimer's research, the Alzheimer's Association provides funding for critical advancements to bring us closer to our vision of a world without Alzheimer's.

We appreciate the opportunity to testify today on DSRIP. We recognize and support the critical work of the Department of Health in its capacity to provide health related care and reimbursement for the state's most vulnerable New Yorkers.

Alzheimer's disease is the sixth-leading cause of death in the United States and the fifth-leading cause of death for those 65 years and older. It kills more people than breast and prostate cancer combined. Those diagnosed and their caregivers consistently, and not surprisingly, rate their emotional stress as high or very high. About 40 percent of family caregivers suffer from depression.

Alzheimer's is also a leading cause of disability and morbidity and a huge driver of costs for Medicaid and Medicare. Those with Alzheimer's disease and other dementias have three times more hospital stays, skilled nursing facility stays and home health care visits than other older people. Further, a recent study found that 1 in 4 hospital stays for a person with dementia was avoidable. These hospitalizations, often for diabetes complications and hypertension, could possibly be prevented through proactive care management in the outpatient setting.

Fiscal data on people with dementia and other co-occurring chronic conditions echo the same pattern. Those with Alzheimer's face 81% higher costs when they also have diabetes, 61% with heart disease, 53% with cancer and the list goes on. As such, the available research supports that dementia would be an important target for value based payment reform strategies and as the leading statewide organization representing New Yorkers facing Alzheimer's, the Coalition of New York State Alzheimer's Association Chapters is poised to become an important partner and community provider resource.

By 2030, the segment of the population age 65 and older will increase substantially and older Americans will make up approximately 20% of the total population. The progression of Alzheimer's disease is slow and debilitating and causes the body to break down, requiring more and more costly medical services. Age remains the biggest risk factor for Alzheimer's and without a cure or robust treatments on the horizon the number of older Americans with Alzheimer's will continue to grow rapidly and so, too, will the number of New Yorkers who will rely on the critical services provided by Medicaid.

DSRIP, New York's $8+ billion Medicaid-funded program designed to reduce avoidable hospital use by 25% in five years, is supposed to be changing the way health care is paid for and delivered and advance the "Triple Aim" of better care, better health, and reduced costs. Through its Performing Provider Systems (PPSs), New York State mandated Medicaid providers and community-based organizations (CBOs) must form integrated delivery networks as a condition of receiving DSRIP funding. However, many PPSs efforts to meaningfully engage and develop partnerships with community and provider resources has been lacking.

From the start, NYS DOH prioritized the needs of health systems over the needs of consumers and while CBO's were engaged, the needs of some of New York's most frequent flyers were not considered. Further, some of the partnerships formed for DSRIP seemed motivated by

funding rather than of a sincere desire to engage in a collaborative and transformative process for the best health of all New Yorkers.

CBOs that have the best understanding of the lived realities, social service needs and medical needs of consumers have often been sidelined in the DSRIP conversation. CBOs were not empowered to conduct meaningful community health needs assessment and strategic planning early enough in the process and are several steps behind in meaningfully engaging new care models. Most notably, organizations like the Alzheimer's Association were invited to the table as an afterthought and inconsistently, though we are the experts in providing care to some of the highest utilizers of Medicaid and Medicare. Many of our statewide staff have participated in DSRIP roundtable discussions but we encourage NYSDOH to reconsider "must haves" at the regional tables to ensure all New Yorkers' needs are met and addressed.

Social determinants of health like race, income, education levels are powerful predictors of poor health outcomes for a host of chronic conditions, including dementia. African Americans are diagnosed with Alzheimer's at two times the rate of their white counterparts; Latinos are diagnosed at 1.5 times the rate. In partnership with the Department of Health, New York State Alzheimer's Association chapters are developing new programs and expanding services in underserved and under resourced neighborhoods throughout the state.

Key drivers of avoidable emergency room visits and avoidable hospitalizations are inextricably linked to social determinants of health like race/ethnicity. For safety net medical providers that take care of higher proportions of low income, uninsured, underrepresented minorities' poor health outcomes will persist despite the quality improvement gains achieved by the PPSs. As such, failure to address social determinants of health in an explicit way will result in lower reimbursements--chronically underfunding health systems already taking care of New York State's sickest and most vulnerable New Yorkers and leaving. This ripple effect results in lack of access to appropriate housing, home based care, and other health services or other drivers of avoidable hospitalizations and emergency room visits for people with dementia.

The Coalition urges NYSDOH to address the undeniable role Alzheimer's disease and dementia play in our Medicaid system and likewise recognize the role that social determinants of health plays in population health strategies moving forward. These factors must influence the guidance the Department gives to PPSs and encourages reimbursement and value based payment criteria to be modified to consider the needs of the New Yorkers with Alzheimer's and dementia - some of the state's most vulnerable citizens - and the effect their ongoing care will have on our state's fiscal and public health.

Thank you again for the opportunity to present testimony today.

Comments for PAOP on DSRIP Midpoint Assessment

January 31, 2017

The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to submit these comments on to the Project Advisory and Oversight Panel on regarding the experience of federally qualified health centers (FQHC) in DSRIP. CHCANYS is 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. All 68 of New York's FQHC are in one or more Performing Provider System (PPS) Network, and many actively participate in PPS governance, including finance and clinical boards. Health centers are extremely engaged in numerous DSRIP projects and have played a central role in the development and implementation of projects that drive transformation.

CHCANYS is dismayed that much of the information shared in both the Midpoint Assessments and the Primary Care Plans was high level and did not include information reflecting FQHCs or other community-based partners' experience in their PPS networks. We continue to urge the PAOP to seek detailed information from the PPS leads on how they have supported and enhanced primary care and implemented primary care-focused projects, including information on their meaningful engagement with community based providers, and ensuring adequate flow of funds to these providers.

Need for Definition of "Partner-Type" Categories

The success of DSRIP is reliant on meaningfully integrating PPS community partners into all aspects project planning and implementation and leveraging partners' expertise. Accordingly, PPS projects should not be focused on replicating services or advancing a PPS lead's particular business strategy, but should build off existing capabilities for providing community-based primary care. There is no way to tell from the Midpoint Assessment Reports, however, whether or not this is happening. The reports rely on broad categories of "partner-types" without defining what types of providers are included in this term. Of particular concern to CHCANYS the lack of nuance in the "clinic" category, which, based on

a chart in a DOH presentation from 2014,[1] appears to include FQHCs and all other diagnostic and treatment centers and does not distinguish between hospital-based clinics or community-based clinics. A PPS lead that is partnering primarily with its own D&TC, behavioral health, long term care, and/or substance use disorder providers would present in these reports as engaging a variety of partner types even though the DSRIP projects and funds are actually contained within one parent institution. Without a more nuanced understanding of the specific providers in each provider type – and specifically whether or not the provider-type is an affiliate of the hospital lead- it is difficult to truly assess the extent to which PPS leads are engaging with all their network partners and whether the funds are flowing beyond the four walls of the lead institutions. CHCANYS strongly recommends that the PAOP further develop definitions to reflect whether the members of each type are community-based, hospital affiliated or private and include these definitions in reports going forward.

Funds Flow

This lack of specificity about partner-types obscures information about funds flow. According to the Independent Assessor's reports, hospitals have received 30% of all DSRIP funds, PMOs have received 41% and clinics have received only 7.5%. As noted, the clinic category does not distinguish between community-based clinics such as FQHCs, and hospital-based clinics, so it is difficult to determine how the funds have flowed to non-hospital based clinic partners.

In collaboration with other community-based providers, CHCANYS developed a brief survey regarding funds flow in DSRIP which we recently distributed to our members. We continue to collect and analyze responses, but it is clear from preliminary results that participating in DSRIP has been costly and time consuming for FQHCs and that funds from PPS leads have not covered the cost of participation to date. Almost half of respondents reported that they participate in more than one PPS with overlapping and potentially conflicting requirements. Survey respondents indicated they had spent on average more than $500,000 during the planning process, and over 70% of respondents reported they had not been fully compensated for their expenditures. While specific FQHC experiences in PPS networks vary, on average, respondents reported that only 54% of their DSRIP-related expenses have been covered to date.

[1] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/a4p_pct_ss.pdf (page 7)

DSRIP costs are beginning to shift from planning-related to service-related as project implementation ramps up and providers are being asked to provide enhanced services to potentially high-cost patients in their PPS. Just 23% of FQHCs anticipate that all DSRIP related expenses will be covered by their PPS and over three-quarters anticipate losing money due to their participation in DSRIP. The PAOP should seek additional information from PPS leads regarding the funds that have been directed to FQHCs and other community-based providers and ensure that providers are adequately and timely compensated for their role in DSRIP, especially when this participation contributes to positive patient outcomes and meeting performance metrics.

Having a meaningful role in PPS governance amounts has a positive effect on the likelihood that an FQHC will receive adequate payment for their work in DSRIP. One third of FQHCs reported that they had been meaningfully involved in setting payment amounts in at least one of the PPS networks in which they participate and nearly a quarter reported meaningful involvement with all of their PPS networks. Those FQHCs who are meaningfully involved in all their PPS networks were twice as likely to report that their DSRIP expenses had been fully covered. Ensuring that FQHCs are able to participate in PPS governance is critical to ensuring that funds are made available to them.

CHCANYS supports New York's efforts to transform the healthcare delivery system through DSRIP and is pleased that the State has recognized the importance of expanding access to comprehensive, community based care- a model that FQHCs have relied on for over fifty years. We urge the PAOP to ensure that the work of FQHCs, and other community-based safety net providers, is appropriately valued throughout the DSRIP project assessment and implementation process.

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NYS Department of Health DSRIP Mid-Point Assessment Public Comment Day

Housing Works Testimony

January 31, 2017

Members of the DSRIP Project Approval and Oversight Panel and representatives of the New York State Department of Health, my name is Jillian Faison, thank you for the opportunity to testify on behalf of Housing Works as the organization's Director of New York Advocacy. Housing Works is a healing community of people living with and affected by HIV/AIDS. Our mission is to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of life saving services, and entrepreneurial businesses that sustain our efforts. Housing Works is also part of the Community Care of Brooklyn Performing Provider System (PPS) and the Mount Sinai PPS.

Housing Works strongly supports the State's Medicaid Waiver process and on May 4, 2016, submitted testimony at the hearing on the NYS Medicaid 1115 Waiver to highlight the ways in which the Delivery System Reform Incentive Payment (DSRIP) Program has already removed silos, achieved progress toward its goals, and strengthened the State's ability to meet our historic goal to end our HIV/AIDS epidemic by the year 2020.

Today, we reassert our support for the State's healthcare reform process, and we applaud the NYC PPSs for their adoption and collaboration on HIV projects to advance the State's Ending the Epidemic (ETE) goals. Housing Works remains deeply concerned, however, that PPSs outside New York City did not adopt HIV projects because the payment system did not incentivize this critical work.

We must also highlight our concerns that the mid-point assessments show a lack of attention to Substance Use Disorders (SUD), particularly outside of NYC in regions hard-hit by the State's growing opioid epidemic. DSRIP PPSs, and the assessment process, must more effectively address SUD if we are to effectively combat the State's opioid, HIV, and hepatitis C epidemics.

The DSRIP mid-point assessment process shows a lack of engagement with SUD providers. Out of the approximately 1,000 providers statewide who completed the mid-point assessment survey, only 10% of respondents were SUD providers. It is unclear whether SUD providers from across the state failed to respond to the mid-point assessment survey, or if there are major gaps in engagement with SUD providers in certain areas of the state. We must encourage PPSs from all regions of the state to engage local SUD providers. The mid-point assessments also relied too much on self-reporting and did not provide clear, independent analysis of PPS performance related to SUD, or specific recommendations to improve behavioral health projects related to SUD. Also of concern is the fact that the mid-point assessments indicate that approximately 70% of DSRIP funds have been retained by the hospitals that serve as PPS leads and their Project Management Offices (PMOs), since this means that only a small fraction of DSRIP funds have been available to additional providers in the PPSs, including SUD providers. Without clearer guidance and a call to action from the DSRIP Project Approval and Oversight Panel and representatives of the New York State Department of Health, it will be difficult to realize the potential of DSRIP to coordinate an adequate response to the State's opioid epidemic

Housing Works recommends that DSRIP Project Approval and Oversight Panel should consider additional recommendations around SUD provider engagement. On behalf of Housing Works, I thank you for the opportunity to testify at the DSRIP Mid-Point Assessment Public Comment Day.

Respectfully submitted,

Jillian Faison

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Jones, Kimberly N (HEALTH)

From: Aman Nakagawa [mailto:anakagawa@health.nyc.gov]
Sent: Wednesday, February 01, 2017 9:30 AM
To: doh.sm.mrtupdates <mrtupdates@health.ny.gov>
Subject: Comments from the NYC Department of Health & Mental Hygiene and RPC PPSs on the Midterm Assessment

Dear MRT Team:

On behalf of the NYC Department of Health and Mental Hygiene (DOHMH) and the PPSs in NYC, we thank you for the opportunity to provide feedback on the Midpoint Assessment reports.
DOHMH reviewed the January 2017 final Midpoint reports and recommend the following strengthen the document from a behavioral health perspective:

- In documentation submitted with quarterly reports, few PPSs outline a plan to achieve 80% Value-Based Purchasing (VBP) across the network by year five of DSRIP. Few PPSs indicated that partner education and training is being directly provided to their networks. One PPS shared its own training handbook to support trainers in the implementation of a corresponding online interactive VBP course. We recommend that PPSs invest this level of effort with their networks to expand applicability of VBP arrangements to CBOs and small providers.
- Additionally, the assessment found that many PPSs implementing Domain 3, subproject 3.a.1, did not include substance use into their conceptualization of integrated care. Doing so excludes persons with co-occurring disorders who can benefit from treatment. We recommend that, going forward, the PPSs include substance use in their 3.a.i implementation work.
- Finally, we would like to recommend that the State encourages PPSs implementing Domain 3, subproject 3.a.1to include and fully utilize all of the providers in their networks in implementing integrated care.

Additionally, during the January 18, 2017 Regional Planning Consortium (RPC) PPS Steering Group meeting, PPS members agreed to complete an anonymous survey on the Midpoint reports. They were informed that DOHMH will share their feedback with the NYS Department of Health during the public comment period on 1/31/2017.
The following areas were assessed:
Benefits:

- PPSs felt that the Midterm Assessment helped confirm that PPS efforts were on track based on data that was submitted. Feedback was perceived to be unbiased and helped understanding of the evaluation of the Independent Assessor. They felt that the Committee Meeting was productive and valuable and highlighted areas for improvement.

Challenges

- PPSs felt that there were minimal or no benefit to the Midterm Assessment and that it did not include information that was new or helpful to their efforts. Questions about funds flow were inconsistent. They felt that the partner survey from the State Department of Health was not well-aligned with project implementation. Additionally, they felt that the process was time consuming with too much paperwork and resources dedicated to responding.

Suggestions for improving future PPS assessments

- PPSs suggested that the review criteria for projects was not objective and that it would have helped to have knowledgeable stakeholders to focus on key areas for improvement. Finally, they suggested that additional context on the source and limitations of supporting data be provided to PPSs.

Thank you for your consideration of our comments, and we appreciate the opportunity to contribute our unique perspective in the development of New York State's transformation to value-based payment

Sincerely,

Division of Mental Hygiene
New York City Department of Health & Mental Hygiene

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HWCLI
Health & Welfare Council of Long Island

Thank you for the opportunity to comment on the DSRIP Mid–Point Assessment reports and recommendations. The Health and Welfare Council of Long Island (HWCLI) is a non-profit member organization serving the interests of the poor and vulnerable people on Long Island and is currently involved in both the Suffolk Care Collaborative (Suffolk County) and the Nassau Queens Performing Provider System. HWCLI is a member of the Steering Committee and an active participant in Medicaid Matters New York.

HWCLI would like to take this opportunity to comment on present and future CBO engagement in DSRIP.

While the Mid-Point Assessment found that all PPS's have begun contracting with and engaging partner organizations, the report also clearly reinforces the need for PPS's to create strategies to continue to engage Community Based Organizations on all projects. CBOs are an untapped resource crucial to meeting DSRIP's goals. They are well positioned to address population health issues; have long-standing, trusted community relationships; and provide critical services to New York's most vulnerable populations. Many of the project deliverables can be more successfully reached by integrating CBO partners—even from the perspective of a pilot or demonstration project. Many CBO partners could expand a current program or initiative or, quickly start-up a new project aimed at serving the population they are engaged with already. This would lead to quicker and more cost-effective regional and statewide outcomes, rather than create new, duplicative, costly programs within a hospital system.

There has been much emphasis placed on the need to work with and include CBOs in DSRIP projects but no specific requirements or guidance from the state that would encourage the PPS's to do so. The majority of PPS funds is going to or is scheduled to go to hospitals and direct health providers. Very little money is earmarked for CBO partners. The PPS's may not even understand the CBO's in their respective communities and ways in which they can contribute to DSRIP projects. New York State should provide further guidance and specific requirements related to CBO engagement and the provision of funding for CBO partners.

New York State recently announced 2 of the 3 awardees of the CBO Strategic Planning Grant. While this grant presents an excellent opportunity for Community Based Organizations to address organizational and capacity issues related to their potential involvement in DSRIP, HWCLI urges New York State to start planning now for the next steps once the grant period for this project is complete.

HWCLI recommends New York State allocate 5% of DSRIP funds in DSRIP Years 3 through 5 for the creation of a DSRIP Innovation Fund for the implementation of projects proposed and undertaken by local community groups as an integral component of each PPS's focus and strategy. The Innovation Projects can both use local assets as well as address the social determinants of health in a way that has been largely impossible so far---despite the recognized need for community-based services that are accessible, trusted and that strategically recognize community needs. The role of CBO's throughout local communities is critical to the overall success of the Statewide DSRIP program. However, infrastructure

and capacity within CBO's have to be supported for them to fully execute their roles. CBOs will need funding for infrastructure development, IT systems, data collection and measurement systems, and contracted services such as fiscal and legal expertise. Without additional support, many CBOs may lack expertise or capacity to enter into VBP arrangements. The CBO Strategic Planning Grant funding is designed to assist CBO Consortiums in planning activities to identify business requirements and formulate strategies for short-term needs as well as longer term plans that the CBO consortium may envision for sustainability in system transformation. The funding is not intended to assist CBOs in making these structural and organizational changes. HWCLI recommends the State provide funding for CBOs to facilitate their participation in DSRIP projects and implement the short and long term needs identified by each CBO Consortium as part of the CBO Strategic Planning Grant.

In closing, we are appreciative of the opportunity to provide comments and recommendations.

PRIMARY CARE DEVELOPMENT CORPORATION

Jason Helgerson
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December 21, 2016

Submitted Electronically: Comments on the DSRIP Independent Assessor Mid-Point Assessment Report

Thank you for the opportunity to comment on the Delivery System Reform Incentive Payment (DSRIP) Independent Assessor (IA) Mid-Point Assessment Report. As an organization dedicated to excellence in primary care, the Primary Care Development Corporation (PCDC) is deeply committed to the success of the NYS DSRIP demonstration program. With the ultimate goal of transforming our Medicaid delivery system, the Performing Provider Systems (PPS) will be able to deliver on the promise of high-quality care, lower costs, and better outcomes.

We appreciate the opportunity to support the strengthening of the DSRIP program, and particularly, the PPSs at this time of a midpoint assessment. In our view, primary care should be the bedrock on which delivery system and payment system reform rests. Without a strong and vibrant primary care system that is adequately resourced, technologically enabled, and integrated with other components of the health and behavioral health care systems, the triple aim will not be achievable. That is the reason PCDC advocated that each PPS should have a primary care plan that would outline goals and activities toward needed primary care access, capacity, and quality.

This mid-point assessment comes at an important time. The PPSs have had two years to develop their governance structures, do planning with their expanded networks, and begin implementation. While this is a short time frame to create fundamental change, this assessment moment offers an important opportunity to review progress to date and assess what mid-course corrections may be needed.

In order to provide the public with the ability to assess PPS performance, PCDC believes that **comparisons across PPSs** would be very useful and should be provided by the IA, including:

- Funding spent per attributed life
- Proportion of funding spent on administration/PMO costs (as was shown in the October 7, 2016 PPS progress report) and categorize the use of these funds (e.g., administrative costs, contracts for technical assistance, support for primary care, etc.)
- Percentage and amount of contracts executed by sector and project
- Percentage and amount of funds flow by sector and project

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- Number and percentage of primary care providers or practices that have received concrete support through DSRIP, including practice transformation and additional staff (nurses, care managers, care coordinators, community health workers, etc.)
- Comparisons across PPSs by project

A consistent concern raised throughout the DSRIP process, and validated through this Mid-Point Assessment Report, has been that the primary care system is not currently receiving adequate financial support through this mechanism as demonstrated by the 30 percent funds flow. PCDC supports the IA recommendations for broader contracting and engagement with primary care providers as the primary care system continues to be under-resourced. In addition, PCDC suggests that future assessments should include how each PPS provides concrete support (e.g., paying for technical assistance either through the PPS or a contractor) for a variety of needs of primary care providers, and this support should be prioritized, tracked, and reported by each PPS.

The 360 degree survey of PPS partners provided useful feedback from those who are carrying out the PPS projects, and is an important qualitative assessment. However, the significant variance in response rates (and often very small sample size) within a particular sector for a particular PPS, such as from primary care providers, renders the quantitative scoring less useful than the qualitative feedback and trends that were identified through the comments. That this section had a numeric score and was collated across PPSs makes it appear that the results are comparable; yet, it is unclear what the average score represents.

Impact on partners that would be useful to further understand includes: slow contracting, a 30 percent funds flow, communication between the PPS and their networks, and complex governance and meeting structures.

Independent Assessor's Recommendations:

- *Recommendations 1, 5, 13, 20 42, 61,109:* PCDC is concerned that a number of IA recommendations focus on educational campaigns for patients, particularly around health care utilization, which have not been shown to be effective. PCDC suggests that the IA recommend that PPSs pay for staff (including nurses, other clinical staff, or community health workers) to support patients and their families at the point of care to support decision-making on a variety of utilization issues, including palliative care/hospice and emergency department (ED) utilization. In addition, PPSs should invest in strategies such as access to urgent care, after hours/weekend access, and building primary care centers co-located with emergency rooms to help reduce ED visits by financially supporting additional hours during a period of ramp-up at primary care providers. Finally, support by the PPSs for workflow development for issues that cross providers in the integrated network (such as transitions of care) would be useful.
- *Recommendations 2, 17, 18, 55, 67, 82, 114, 125:* PCDC agrees with the IA assessment that PPSs should contract with community-based organizations (CBOs) to support patient and consumer engagement. Once there are formal contracts and payments that would enable these CBOs to invest in additional staff for services, which have no other funding stream, we anticipate that many CBOs would be glad to participate, and educational campaigns would not be necessary.

- *Recommendation 19, 26, 30, 37:* PCDC agrees with the IA that training should be provided to improve staff capacity to provide needed education and services to patients. Standard curricula should be provided by the SDOH from among the many nationally available, evidence-based curricula on asthma and other chronic disease programs for training and use by community health workers (CHW), navigators, and others, which would support each PPS to more quickly adapt and put into practice chronic disease prevention work.
- *Recommendation 35, 113:* PCDC agrees that CHW are an effective tool to support better outcomes. PPSs should hire CHW either directly, on contract, or through providing resources to primary care providers to hire them to provide home visits for asthma or other chronic diseases. There is ample evidence in the public health literature that culturally and linguistically competent and appropriately trained CHW are welcomed into the home, and are effective in teaching asthma and other chronic disease self-management.
- *Recommendation 36, 45, 46, 49, 50, 54, 60, 73, 81, 82, 87, 97, 100, 108, 115, 116, 119, 120, 123, 132:* PCDC agrees with the IA that partner -- and particularly primary care -- engagement is not yet at needed levels for success. However, engagement would likely be higher if funds were flowing. It is unclear if an educational strategy or one based on additional governance and meetings would be successful.

We appreciate the opportunity to comment on this mid-point assessment, and look forward to the continued availability of public assessment information as the DSRIP program continues. We hope that NYS DOH will consider our comments to help create a more transparent and easily comparable system.

Sincerely,

Louise Cohen, MPH
CEO, Primary Care Development Corporation

PRIMARY CARE DEVELOPMENT CORPORATION

Jason Helgerson
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December 21, 2016

Submitted Electronically: Primary Care Development Corporation Comments on the DSRIP Performing Provider System Primary Care Plans

Dear Deputy Commissioner Helgerson:

Thank you for the opportunity to comment on the Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS) Primary Care Plans. As an organization dedicated to the continued transformation and strengthening of primary care, we are thrilled to see that each PPS thoughtfully addressed the status of primary care within their networks. At the Primary Care Development Corporation (PCDC), we view access to high-quality, culturally-competent primary care as a cornerstone of healthy and thriving communities. It is why PCDC advocated for the creation of primary care plans that would help guide the DSRIP program and the PPSs in meaningful transformation and strengthen the health of our state.

As stated in the June 2016 presentation from the New York State Department of Health,[1] the purpose of the PPS Primary Care Plan is to:

- Assess current status of primary care in [the] network
- Detail plans for reaching primary care milestones
- Report on measures to assess progress toward achieving goals around access and capacity

The primary care plans submitted by each PPS addressed, in part, the stated purpose. The narrative nature of these reports made it difficult to compare how each PPS is addressing each specific primary care project and generate an overall picture of the state of the primary care system as it is now, or what it will look like as transformed through the DSRIP program. The plans, which were intended to serve as a framework for action going forward, detail previous action, rather than strategic and concrete plans for future transformation. **PCDC recommends that any future reporting or follow-up be easily comparable among the PPSs and be done in a format that is more quantitative with**

[1] NYS DOH Medicaid Redesign Team. *Performing Provider Systems (PPS) Primary Care Plan Updated from December 11th All-PPS Meeting.* June 9, 2016. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-06-09_pps_pcp_presentation.pdf.

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additional qualitative narrative where necessary. For example, the state should require that <u>all</u> PPSs provide the following key metrics including the number of practices involved, dollars spent, and percentage of overall funding allocated to the category:

Area of measurement	Factors to measure
1. Primary Care Access and Capacity	• Number and type of practices (hospital-owned, private, D&TC) • Ratio of PCPs to attributed lives
2. Governance	• Percentage of PC representation on PPS Steering Committee, Clinical Quality Committee, Funds Flow (finance) Committee, Project Committee.
3. Financial Resources	• PPS budget allocated to PC activities • PPS incentive funds available to PC (should include how the PPS plans to use upfront investment and performance-based incentive payments)
4. Workforce	• Workforce funds targeted to PC workforce
5. Role of PC in value-based payments (VBP) *including how the PPS is supporting PC in VBP (i.e., status of data-sharing arrangements within PPS critical to VBP)*	• PC practices engaged in VBP, including number and percent of lives under VBP arrangements and percent of practice revenue • Type of VBP contracts (i.e., shared savings/risk, risk-adjusted PMPM incentive) • Practices recognized as PCMH or APC

PCDC respectfully submits the following comments on the fundamentals required by the PPS in the each primary care plan:

Fundamental 1: Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs.

It appears there is a fundamental disagreement from most PPSs with the New York State Department of Health (NYS DOH) network analysis. While many plans cited figures from the SDOH analysis or the PPS's own community needs assessment, the plans appear to show conflicting results regarding the number of primary care providers in network. While networks may evolve over time, knowing which providers are participating in which PPS and in which project is critical for attribution and effective use of PPS resources to strengthen the primary care system. Many primary care providers are in more than one network, specifically downstate or in more urban areas, where an average of 51.6 percent of primary care providers are in multiple PPSs[2]. Without a full understanding of network capacity, the PPSs will be less able to make sure that their full cohort of providers are receiving adequate support and funding, thereby hindering system transformation.

[2] Ibid.

PCDC recommends that provider networks be reconciled with the NYS DOH information so that a full picture of current primary care capacity for the NYS Medicaid program can be created, and appropriate resources directed to areas of need.

Fundamental 2: How will primary care expansion and practice and workforce transformation be supported with training and technical assistance?
Fundamental 3. How primary care will play a central role in an integrated delivery system?
Fundamental 4. How the PPS will enable Primary Care to participate effectively in value-based payments?

From the plans, it is abundantly clear that primary care access and capacity are considered underprovided in all PPSs regardless of location within the state. While many PPSs noted they were working to create capacity, provider recruitment takes time. Without an adequate number of providers in the PPS and adequate resources flowing from the PPS to support the hiring or training of these providers, it will be exceedingly difficult to achieve the goals of DSRIP.

Given that primary care providers are key to system transformation and responsible for population health management, as well as the DSRIP requirement for PCMH or APC recognition, all PPSs are focused on helping their providers adopt the Patient-Centered Medical Home (PCMH) model. Most PPS plans stated that the number of PCMH-recognized practices identified in the community needs assessments were different from what was identified in the PPS's own analysis. From both the individual primary care plans and PCDC's experience with PCMH technical assistance, it is clear that there is still significant work to do in order to achieve the deadlines in DY3. With many practices working concurrently on multiple DSRIP projects within their multiple PPSs, coordination and funding from the PPS with a clear timeframe for project milestones and reporting requirements would help practices focus on the projects which are most timely while laying the groundwork for upcoming deadlines.

PCDC recommends that:

- **Affiliated practices that have identified a need for additional primary care capacity receive the necessary financial support from their PPS, including funds to recruit and retain new primary care providers, while their practices ramp up to receive associated Medicaid reimbursement for services delivered.**
- **The timeline for PCMH or APC recognition be extended, given that the majority of PPS-affiliated practices still do not have recognition and the NCQA may have insufficient capacity to handle the large number of submissions that will be filed in the coming year**
- **Primary care practices receive funding to compensate them for the significant amount of time that their leadership and clinical staff are**

spending on PPS-level work as well as the transformation work within their own organizations.

Fundamental 5: How do the PPS funds flow support primary care strategies?

The funds flow to primary care providers has widely varied by PPS, and is below the levels distributed to hospitals and the PPS Project Management Office (PMO). According to the PPS Mid-Point Analysis, 70 percent of funds had been distributed by the PPS to the PPS PMO or Hospital as of June 30, 2016. Examining the October 7, 2016 PPS progress report, which did not allow for direct comparison between PPSs, shows that only $276,631,929 of $841,971,285 awarded (33 percent) have been distributed, with $110,544,700 (40 percent) going to the PPS PMO, $80,684,762 (29 percent) going to the hospitals, $66,360,844 (24 percent) going to the rest of providers — defined as "Mental Health, Substance Abuse, Uncategorized, Case Management, Clinic, CBO, PCP, Nursing Home, Hospice, Non-PCP, Pharmacy, Non-PIT Partners" — and $19,041,623 (7 percent) going to all other providers — defined as "Home Health, OPWDD, Other."[3]

PCDC is concerned that this funding distribution is inadequate to support the transformation work in primary care settings. While it is understandable that initial funding is given to the PMO to help start and run the PPS, it is unclear how much of the funding that has gone to the PPS PMO has then been used for administration and system development relative to the amount used to contract for training and other services for providers. Although it is certainly a PPS responsibility to provide system-wide training and technical assistance to help these providers transform their practices and better coordinate with the PPS, direct investments must be made in the practices themselves to help hire staff for care coordination, upgrade technology, and pay for additional hours or providers to provide a wider suite of services. Of the 25 PPSs, roughly a third (8) distributed over 50 percent of flowed funds directly to the PMO without explanation of what these funds were ultimately used for.[4]

PCDC strongly recommends that the allocation of these funds be made public in a more detailed format and that the state require additional clarity on funds flow distribution within each provider category.

Additionally, the designation "rest of providers," which includes primary care, is expansive. While some PPSs alluded to the percentage of this funding that flowed to primary care, many did not give any indication of how much actual funding has flowed directly to their primary care providers. Some of the PPSs specified that a large percentage of distributed funds went to hospitals because much of the primary care in the PPS was delivered by providers employed by the hospital, rather than FQHCs, physician groups, or small practices.

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[3] Analysis of information included in: NYS Department of Health. *PPS Progress Report.* October 7, 2016. http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-10-07_pps_progress_report.pdf.
[4] Ibid.

PCDC recommends that the aggregated spending categories of "rest of providers" be broken out in future reports with detailed funds flow information by category of provider and that the "hospital" category be disaggregated into primary care and other activities.

PCDC recommends that the SDOH consider setting a minimum primary care funds flow requirement over the life of the program.

Fundamental 6: How the PPS is progressing toward integrating Primary Care and Behavioral Health?

All of the PPSs have stated goals for the integration of primary care and behavioral health. However, at this time it seems most have begun to plan for, but have not yet integrated, these services.

PCDC recommends that a structured analysis of the status of PC/BH integration in each PPS network be done by the PPS so that appropriate resources can be targeted for this goal. Several potential schema have been proposed, including by Henry Chung, MD and the United Hospital Fund[5], as well as by Beacon Health Options.[6]

We greatly appreciate the opportunity to comment on the PPS primary care plans, and value the time and resources dedicated to their creation by each PPS. We strongly believe that the emphasis on primary care and the transparency in information sharing fostered by these plans will strengthen primary care throughout New York State, and serve as the foundation for primary care system transformation.

PCDC looks forward to collaborating with the PPSs and the state to ensure that all New Yorkers have access to high-quality primary care in their communities through the innovative and critically important DSRIP program.

Sincerely,

Louise Cohen, MPH
CEO, Primary Care Development Corporation

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[5] Chung, H., Rostanski, N., Glassberg, H., and Pincus, H.A. "Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework." *The United Hospital Fund.* Published June 7, 2016. https://www.uhfnyc.org/publications/881131.

[6] Stanton, Emma. "Integration: A 2016 Beacon Health Options White Paper." *Beacon Health Options.* Published January 26, 2016. http://beaconlens.com/wp-content/uploads/2016/02/Beacon-Whitepaper-FINAL.pdf

Jones, Kimberly N (HEALTH)

From: Elizabeth Berka [mailto:healthinformation@stic-cil.org]
Sent: Wednesday, February 01, 2017 4:36 PM
To: doh.sm.delivery.system.reform.incentive.payment.program <dsrip@health.ny.gov>
Subject: DSRIP Mid-Point Assessment Public Comments

Thank you for the opportunity to submit the following comments on behalf of Southern Tier Independence Center:

- DSRIP does not include specific projects for people with developmental disabilities. Early on in DSRIP NYDOH staff said there will be opportunities for this population yet this is still lacking.
- If one of DSRIP?s goals is to strengthen the safety net why are PPSs contracting with so many that are not safety net providers?
- Why such limited funding to community based organizations?
- A top priority in DSRIP should be protecting Medicaid beneficiaries and the community based services upon which they depend.
- The Opt out letter to Medicaid beneficiaries regarding Medicaid sharing Medicaid beneficiaries' information with PPSs is vague and lengthy and impedes self-determination. Advocates have voiced concerns about the misleading and confusing nature of the documents and yet the documents stayed the same.
- DSRIP is a phenomenal program if it works as intended. We want the best for Medicaid beneficiaries and the community.

Best Regards,

Elizabeth Berka

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