



4401 Vestal Parkway East
Vestal, NY 13850

To: DSRIP@health.ny.gov Value Based Payment (VBP) Workgroup
From: Southern Tier Rural integrated PPS dba Care Compass Network
Subject: Public Comment on Value Based Project Alignment Proposal
Date: August 31, 2015

Purpose

This letter is being submitted as a public comment on the NYS DOH VBP Workgroup announcement on 8/3/15 (version 5) of a proposal to align Medicare's and NYS Medicaid Reforms (copy attached).

Background

Care Compass Network (CCN) is an entity formed in the Greater Southern Tier region of Central New York to serve as the Performing Provider System (PPS) under the NYS Delivery System Reform Initiative Program (DSRIP). CCN is comprised of over 1,500 providers and partner community based organizations. The legal name for CCN is the Southern Tier Rural Integrated Performing Provider System, Inc. (STRIPPS).

Comments

CCN respectfully submits the following comments for consideration as NYS DOH contemplates expanding efforts toward Value Based Payments. CCN suggests that NYS should not seek alignment between NYS Medicaid payment reform and that of Medicare or Medicare Advantage programs for the following reasons.

1. **Readiness** – NYS DOH is in the nascent planning stage of VBP reform for providers providing care to Medicaid enrollees. In July 2015 NYS DOH distributed a VBP questionnaire requiring each PPS to describe its position on value based payments with particular focus on encouraging and enabling PPS's to achieve Mode 3 capitation. Responses were due on 7/31/15 and CCN submitted its questionnaire timely. Prior to receiving the questionnaires from each PPS across the state, NYS DOH prepared the CMS VBP alignment announcement. The timing of these distributions seems out of sequence and suggests that NYS DOH may not be considering input from impacted parties. CCN believes that NYS DOH should first obtain the distributed questionnaires, analyze and summarize the feedback, and develop action plans or alternatives for consideration. It is likely there will be great diversity of viewpoint gleaned from those questionnaires. We believe that NYS would benefit from the input from the PPS and providers and should take some time to incorporate that input into its planning before advancing an expansion into Medicare.
2. **One Size Does Not Fit All** – In CCN's response to the VBP questionnaire mentioned above, CCN described its planned approach toward VBP, as more fully described in the DSRIP Application filed in December 2014 and subsequent Implementation Plan filed in June 2015. Those

documents clearly show that CCN is pursuing Model 1 type approach as defined by NYS DOH. CCN does not anticipate directly contracting with payers at this time. The PPS can effectively, coordinate and communicate with payers but would defer contracting decisions to individual providers. This approach was well within the parameters offered by NYS DOH in its previously published VBP Roadmap documents. CCN believes that NYS DOH will see wide variation in responses to its VBP questionnaire based on many factors that vary from PPS to PPS across the state.

In the introductory announcement NYS mentions Montefiore Health System and its ACO. The broader healthcare community has an appreciation for Montefiore. As a PPS in the downstate region it operates in a highly concentrated community from both population density and provider integration perspectives. Those attributes may make Montefiore a good area for a pilot project on development of value based payment advanced models, however those attributes are not ubiquitous across all areas of the state. CCN serves a nine county region and is comprised of over one hundred separate and independent providers, each with different abilities, legal ownership, governance structures, and risk appetites. In regions which are not dominated by a single provider system and span large geographies, formation of an ACO and risk capitation is difficult if not impossible. As a PPS, CCN cannot force any providers to take capitation risk.

3. Voluntary v. Compulsory – In the NYS DOH 8/3/15 alignment announcement NYS states in its introductory paragraph on page1 the following...*“In parallel, NYS requests CMS to allow NYS providers to include Medicare FFS patients in the VBP arrangements outlined in the NY Payment Reform Roadmap”*. CCN understands and supports the NYS request. However, if such a request is permitted by CMS, CCN believes NYS providers should have the election of whether to include Medicare FFS patents in the VBP arrangement and not be forced to do so. CCN believes such inclusion should be voluntary and not compulsory and such election should be at the provider level, not the PPS level or otherwise mandated by NYS or CMS.
4. Where are the MCO Requirements? – CCN remains unclear regarding the position of NYS DOH with respect on forcing Medicaid Managed Care Companies (MCO) to enter into contracts with either PPSs or individual providers on terms that align with the DSRIP goals. Without this clarity, it seems premature and dangerous to expand the VBP reach to include Medicare FFS or Medicare Advantage patients where NYS DOH has no regulatory authority to oversee. Under the VBP roadmap that has been published by NYS DOH, there do not seem to be requirements or mandates for the MCOs to enter into reasonable contracts. So each PPS or the thousands of providers across the state must do that themselves. While that approach enables flexibility, there does not seem to be any meaningful dispute resolution or grievance process. And if there is one, is it overseen by NYS DOH, or the NYS Department of Insurance? These highlight a few of the many simple examples of the details that should be clarified over time and a further indication that expansion of VBP planning to include Medicare patients is premature.

5. Anti-Trust Concerns – Like many of the PPS entities, CCN is concerned about the lack of clarity and cohesion of position between what NYS DOH is seeking in relation to Value Based Payments in relation to federal anti-trust issues. Only three of the 25 (12%) NY PPSs filed COPA application in early 2015, after which they have been subject to strong criticism by the Federal Trade Commission (FTC). FTC comments to the COPA applications submitted dated 4/22/15 indicated “FTC staff fully recognizes that collaborations among health care providers often are precompetitive. We write to express strong concerns that the COPA regulations, as well as the underlying authorizing legislation, are based on inaccurate premises about the antitrust laws and the value of competition among health care providers. A COPA is unnecessary for these three DSRIP PPSs to engage in precompetitive collaborative activities. The antitrust laws are not a barrier to the formation of efficient health care collaborations that benefit health care consumers, as explained in extensive guidance issued by the federal antitrust agencies.”

Following the initial filing and FTC comment, one of the three PPS applicants withdrew their application and no additional PPS COPA applications have since been filed. Until these issues are clarified and uniformity of anti-trust protection at both the state and federal levels, CCN is unwilling to bear the anti-trust risk that comes with joint contracting amongst providers. We respectfully request that the NYS DOH secure that anti-trust action from the federal level for all PPSs and all providers acting on DSRIP Value Based Payment initiatives. If NYS is unable to use its power and ability to secure anti-trust protection, then it is unlikely singular PPSs or individual providers will be able to do so with the same efficacy and efficiency.

August 31, 2015

Howard Zucker, M.D., J.D.
Commissioner of Health
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

RE: Proposed alignment of Medicare and Medicaid Value-Based Purchasing Programs

On behalf of the American Society of Plastic Surgeons (ASPS) and the New York State Society of Plastic Surgeons (NYSSPS), representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States and 500 plastic surgeons in New York State (NYS), we commend New York State for its commitment in improving the quality of care for its patients and populations; rewarding high-quality delivery of care and seeking opportunities to reduce administrative burden for providers in New York.

We write today to express serious reservations about the New York State Department of Health's proposal to allow the pooling of Medicare Fee For Service (FFS), Medicaid, and dual eligible patient populations into the same value-based payment (VBP) programs. These comments refer to Version 5 of "Value Based Payment Reform in New York State: A Proposal to align Medicare's and NYS Medicaid's Reforms" (the proposal).

The following details two overarching problems our organizations have identified with the proposal:

- (1) A change of the magnitude it proposes should only be considered in light of a thoroughly detailed plan – replete with actual structures, methodologies and metrics – that has been subject to rigorous modeling. The proposal contains almost no such detail.
- (2) The proposal relies on a strategy for healthcare payment – value-based purchasing – that is still trying to perfect its own basic building blocks, that has yet to develop a structure that allows for the participation of all medical specialties, and that has yet to be widely proven effective in practice.

THE PROPSAL NEEDS MORE DETAIL AND A QUANTITATIVE FOUNDATION

THERE ARE OUTSTANDING KEY STRUCTURAL QUESTIONS

ASPS and NYSSPS believe a proposal for aligning Medicare and Medicaid VBP arrangements should at a minimum offer a framework for a structural design. That framework should describe specific program

components and detail how they will achieve synergy across programs, locales and populations; it should be subjected to rigorous application of projections, modeling, analysis, and review; and a decision to offer such a proposal should only be done after modeling and projection suggest a likelihood of achieving predefined measures of success.

Before submitting the proposal to CMS, we ask that NYS sufficiently account for these essential elements by asking, answering and sharing for public response the following structural design questions:

- **How will existing Medicare and Medicaid VBPs be recalibrated to accommodate the influx of patient populations for whom those VBPs were not originally designed?**
- **What specific attribution methodology will be used for the respective patient populations in each potential VBP arrangement?**
- **What specific risk adjustment methodology will be applied to the respective patient populations in each potential VBP arrangement?**
- **What specialty-specific adjustment methodologies will be applied to all potential specialty participants for each potential VBP arrangement?**
- **How will initial value baselines will be determined?**
- **How will subsequent baselines will be calculated?**
 - If performance goals are benchmarked to a provider's recent history, how does NYS propose to ensure fair treatment for those providers who struggle to show improvement because they are already achieving high performance rates?
- **How will the program impact providers that are not able to achieve sufficiently-sized patient populations?**
- **What is the planned payment structure for these programs?**
 - Will care for Medicare FFS beneficiaries in a Medicaid VBP be reimbursed at Medicaid rates?
 - Do the requirements also apply to dual eligibles participating in a Medicare VBP?
 - Will there be different tiers for each patient population within each respective VBP?

Without answering these questions, the proposal risks unintended consequences that have undermined previous efforts to establish value-based purchasing: the emergence of counterproductive incentives, under which health systems are driven to focus on selecting healthier (and, thus, less expensive) patients at the

expense of those patients for whom individual physicians can do the most good; the misallocation of costs to – and resulting unfair financial punishment of – individual providers whose resource use may be impacted by the care their patients receive upstream; or a singular focus on cost reduction at the expense of improving the quality of care.

THE JUSTIFICATIONS FOR THE PROPOSAL ARE CURRENTLY IMBALANCED TOWARD THE QUALITATIVE INSTEAD OF THE QUANTITATIVE

In addition to the key structural questions mentioned in the preceding section, the proposal leaves unanswered questions about the broader benefits it seeks to bring about. These benefits are treated as near certainties and not supported by quantitative evidence or analysis, which is problematic given that they are the bedrock purpose of this effort.

For example, the proposal repeatedly asserts that aligning Medicare and Medicaid payment reforms will produce sizeable savings, but never clarifies how sizeable the savings will be, where they will be realized, the degree to which they will be offset by the cost of addressing the enormously complex challenge of putting the proposal's ambitions into practice, or, fundamentally, how the proposal came to the assumption of savings. All of these outstanding questions can be examined quantitatively, and we believe they should be.

As another example, the proposal claims that it will “strengthen financially weak Safety Net providers,” but offers nothing substantial to support this claim. Given that these institutions' struggles are driven by the unique, significant challenges presented by the patient population they serve, we believe that a claim like this needs to quantitatively demonstrate how the proposed alignment will result in an inflow of new patient populations into Safety Net systems, or how it will result in improved margins for treating existing populations.

These examples do not represent a complete list of instances in which important benefits of the proposal are simply assumed, rather than proven. **ASPS and NYSSPS ask that NYS comprehensively examine the reasons given for affecting the proposed changes and seek wherever possible to employ a quantitative, evidence-based approach to supporting those reasons.**

THE PROPOSAL OVER-COMMITS TO DELIVERY REFORMS THAT ARE STILL A WORK-IN-PROGRESS

WE CANNOT YET CONSISTENTLY AND ACCURATELY DETERMINE “VALUE”; THIS IS PARTICULARLY PROBLEMATIC FOR MEDICAL SPECIALTIES

Above all else, value-based purchasing requires the capacity to accurately determine “value.” Value is a measure of cost and quality, but the determinants of those two concepts within VBP arrangements are still largely elusive.

As mentioned above, equitable VBP arrangements must go beyond simply determining the cost of a particular patient, disease category or episode of care. They have to accurately parse and assign the

responsibility each provider has in driving an aggregate cost, and the early returns on VBP programs have shown that distortions in this allocation process exist. Moreover, for some medical specialties, the very nature of their discipline demands that they treat patient populations with highly-heterogeneous diseases that defy benchmarking. In many of these cases, the standard of care for particularly severe or complex disease presentation is an expensive, high-volume proposition. Forcing specialists to treat these patients in a system that evaluates cost relative to a bluntly-derived average puts those specialists in the difficult position of either (1) inappropriately deviating from the standard of care in order to focus on costs, or (2) being punished for doing their jobs well.

ASPS and NYSSPS do not necessarily believe it is impossible to accurately assign responsibility for aggregate costs down to the individual provider level, nor do we necessarily believe it is impossible to account for the intricacies of various medical specialties. However, **we *do* believe that this proposal needs to indicate how NYS intends to address these problems.**

In addition to these cost-allocation challenges, existing VBPs have not yet mastered the assessment of care quality, which is in no small part driven by a lack of relevant, high-caliber quality measures for specialty providers. Most measures currently used in value-based purchasing are heavily geared toward primary and preventive care, and focus on the treatment and management of chronic conditions. In order for a VBP arrangement to accurately assess quality for all participants, they must look beyond existing measures and find the best new measures, developed by specialty societies. Doing so will allow a VBP to assess performance on those specialties' most critical processes of care, patient safety concerns, complications, procedural efficacy and outcomes.

There are a number of physician-led specialty organizations, including ASPS, that are aggressively working to develop evidence-based, clinically-relevant quality measures. For small specialties, though, this process requires a significant allocation of resources. Consequently, the existing portfolio of highly-relevant, high-caliber specialty-specific measures is still too narrow to allow the sort of quality assessment that your proposal will require if it is to succeed. The recent provision in H.R. 2, the *Medicare Access and CHIP Reauthorization Act*, providing \$75 million for the development of quality measures for use in the Merit-based Incentive Payment System underscores the work that is yet to be done to enhance the existing measure set.

Your proposal does not currently address quality measurement. In line with our previous request for more structural detail, we ask that NYS share with stakeholders **(1) the existing or developing measures that will be reportable for each patient population in each potential continuum of care in every potential VBP arrangement; and (2) the plan NYS has in place to ensure that selected measures are appropriate and scientifically acceptable for measuring the process or outcome in question.**

CURRENT VBP ARRANGEMENTS ARE NOT WELL-SUITED TO ALL MEDICAL SPECIALTIES

For the reasons articulated in the previous section, and because alternative payment models are generally geared toward either comprehensive primary care or disease-specific management, many medical specialties are not well-suited to the existing suite of VBP arrangements. Additionally, some specialists do not see a large volume of public-payer beneficiaries. Consequently, because your proposal seeks to eliminate opportunities for physicians to care for Medicare and Medicaid beneficiaries outside of VBP, it holds the potential to eliminate those beneficiaries' access to those specialists altogether. Unfortunately, the proposal does not address this potential problem.

We believe there needs to be **explicit safeguards against reduced patient access to specialty providers, chief among them being an enduring fee-for-service option** that works well for providers with low Medicare and Medicaid patient volume. Any system that proposes penalties, shared risk, or provider-only risk needs to have appropriate low-volume thresholds that allow exceptions for those specialists, like plastic surgeons, who may see a small number of Medicare or Medicaid beneficiaries. The absence of these thresholds will drive low-volume providers out of the public payer programs entirely.

VBPs DO NOT HAVE A TRACK-RECORD OF SUCCESS

Finally, we question the wisdom of moving all NYS Medicare and Medicaid beneficiaries into models that have not achieved widespread success. At best, the results of recent forays into VBP programs have varied. According to CMS's 2014 performance data on the Pioneer and Medicare Shared Saving Program ACOs, the total savings only came to about \$1B and only one-quarter of Medicare ACOs performed well enough to earn shared savings. Considering the fact that total Medicare spending is around \$600B and about 15 percent of Medicare beneficiaries are enrolled in these programs, the savings are marginal. Beyond these minimal cost savings, physicians have testified that these models do not have a positive impact on the quality of care provided to patients. According to a recent study by The Commonwealth Fund and The Henry J Kaiser Family Foundation, one-quarter of physicians who participate in an ACO stated that the model has a negative impact on care provided, and half of all participating physicians believe that the increased use of quality metrics to assess provider performance is negatively impacting quality of care.

There is very little evidence that any model deployed has consistently achieved cost reductions and quality improvements throughout a sufficiently diverse set of practice areas. Therefore, in spite of the proposal's numerous unsubstantiated claims to the contrary, there is very little evidence to support the implication that the NYS plan will have a positive impact on value in care delivered to Medicare and Medicaid beneficiaries.

In closing, ASPS and NYSSPS would like to commend NYS for its commitment to improving the quality of care for Medicare, Medicaid and dual eligible patients in New York, and we would like to commend NYS for its desire to improve the financial health and reduce the administrative burden of providers in New York.

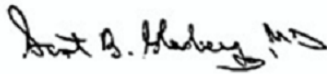
These are both tremendously important pursuits.

It is for that very reason that we are so concerned about the quality of the proposal. An undertaking of this scale requires significant planning, significant testing, significant review and significant adjustment *before* it is put forth for approval. The proposal as currently constituted is really more of a concept, and while it is an appealing concept, we believe proof-of-concept is required before advancing.

Thank you for considering our comments. Should you have any questions, please contact Patrick Hermes, ASPS Senior Manager of Advocacy and Government Affairs, at [REDACTED], or Babette Grey, NYSSPS Executive Director, at [REDACTED].

Sincerely,

Scot B. Glasberg, MD



President, American Society of Plastic Surgeons

Paul Weiss, MD



President, New York State Society of Plastic Surgeons



**COMMENTS REGARDING THE DRAFT MEDICARE ALIGNMENT
PAPER**

*Submitted to New York State Department of Health
August 2015*

*Submitted by Cerebral Palsy Associations of New York State
3 Cedar Street Ext, Suite 2, Cohoes, NY 12047*



Thank you for the opportunity to provide feedback on the Draft Medicare Alignment Paper. While we agree in the concept of aligning payment reform between NYS Medicaid and Medicare, we have some concerns specific to the information provided in the Draft Paper.

A one payer system has the potential to produce administrative efficiencies for providers while incentivizing better health for patients – both worthy goals. However, the Draft Medicare Alignment Paper provides very little in the way of specifics or details that can be measured against, and therefore makes it nearly impossible to provide real, substantive comments, either positive or negative. The document provides broad, general ideas, but nothing substantive regarding how individuals with varying needs will be addressed or how reimbursement will account for the individual that is not “average” or “standard” in the level of care or type of facilities and equipment they need to receive proper care. Without specifics on how this would occur, we are unable to provide substantive comments, and would encourage a more complete document be issued to allow us the opportunity to comment on a more refined process.

We do, however, have a specific focus of our general concern which has time and again been problematic for people with disabilities when included in Department of Health initiatives: the high needs of patients often are marginalized and not afforded proper consideration. The high cost/high needs patients may have different outcomes and the assumption that any high cost patient/outcome can be balanced by less costly patients in a mix of patients is flawed. High cost patients’ needs are marginalized under a system using averages or payments that are driven by outcomes generated on typical population needs. The actual provider network that specializes in the care of these people must be compensated in a manner that will ensure access to, and quality of, appropriate services for the high needs patients, and aren’t lost or otherwise mitigated in an attempt to maintain operations under a reimbursement system developed with typical patients in mind. It cannot be assumed that such specialty providers will, through partnerships and collaborations with other providers, become more efficient (i.e., able to reduce costs) because the payment system now is based on outcomes. The real costs for providing needed services for high

needs/high cost patients, such as the time it takes to prepare them, including undressing and dressing them, positioning them, dealing with communication barriers and behavioral episodes, etc., as well as the specialized equipment often necessary, such as tables that rise and lower to help access, must be factored into any value-based payment approach.

A specific concern we have is the lack of an apparent acuity measure in this discussion.

Acuity Measure

Our one specific concern is that Medicare payments do not utilize any type of acuity measure. Although people with developmental disabilities are currently not included in the discussion, since they are not yet transitioned to Medicaid Managed Care, the use of an acuity measure will be paramount to ensuring that individuals with DD and not discriminated against or have limited access to care, are able to receive the appropriate care and services they require. With value-based payments, desired outcomes generated for a typical population may not anticipate the special needs of higher needs/cost patients that are served by providers specializing in complex care supports and services.

Again, we thank you for this opportunity to comment and for your consideration of our input. We await more detail on how the specialty services we provide will be adequately brought into the value-based payment discussion. We are available for additional information, at your request and convenience.



cc: M Berg
M. O'Leason
(via email)

RECEIVED

SEP 03 2015

NYS DOH-OFFICE OF
HEALTH INSURANCE PROGRAMS

M-359

August 26, 2015

Jason A. Helgerson, NYS Medicaid Director & Deputy Commissioner
New York State Department of Health
Empire State Plaza, Corning Tower
Albany, New York 12237

Dear Mr. Helgerson:

Finger Lakes Health Systems Agency (FLHSA) is pleased to express support for New York's draft proposal to align Medicare's and New York State's Medicaid value based payment reforms. As an active member of the Value Based Payment Workgroup and co-chair of the Engagement and Advocacy Subcommittee, FLHSA offers the following comments and suggestions for subsequent drafts of the proposal.

We are enthusiastic about the state's efforts to ensure a payment reform structure capable of sustaining the investments in Medicaid's Delivery System Reform Incentive Payment (DSRIP) program. Value based payment reform in Medicaid, as conceptualized in the *NYS Payment Reform Roadmap* approved by the Centers for Medicare and Medicaid Services (CMS), provides a menu of alternative payment mechanisms capable of incentivizing varied utilization across different specialties as appropriate for maximizing health outcomes.

The state's proposal to extend value based payment reforms to Medicare should make it easier for providers to participate in alternative payment mechanisms by reducing administrative costs and aligning approaches to clinical practice and quality measurement. These gains should propel both NYS and CMS toward their goals of achieving a high percentage of provider participation in value based payment. However, these gains are dependent upon close attention to consistency across Medicaid and Medicare in approaching both payment *and quality measurement* in value based payment reforms.

The draft proposal provides a chart (p.5) mapping the alternative payment mechanisms laid out in the *NYS Payment Reform Roadmap* with those being tested by the Center for Medicare and Medicaid Innovation (CMMI). A second chart (p.6) continues the mapping within levels and categories of payment. However, the proposal does not provide any mapping of quality measures across Medicaid and Medicare. The brief section of the proposal that references quality of care for patients calls out fragmentation for those dually eligible for both Medicaid and Medicare, and inappropriate financial incentives within Medicaid for community long term care; but there is no discussion of quality reporting in either system, no mapping of quality measures across both payers, and no proposal for improving quality measures and alignment in order to enhance participation.

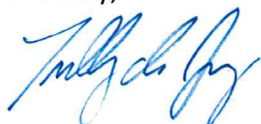
Value based payment reform needs to provide a vision for improved quality reporting that can be aligned across payers and includes a patient experience component. If a vision of quality measurement can be developed that calls for meaningful reporting of the experience of care from a patient's perspective, consistent across Medicaid and Medicare, New York will not only enhance participation by providers, but engagement by patients. Given that clinical outcomes are largely dependent on behavior outside the clinician's office, patient engagement remains fundamental to achieving broad based health improvement.

FLHSA strongly urges the state to further develop the quality measurement component of the draft proposal – beyond reference to DSRIP metrics -- to include Patient Reported Outcomes that are tailored to different conditions and services as reflected in proposed alternative payment mechanisms. Patient Reported Outcomes (PROs) are a systematic and validated way to hear from patients as to the changes in an individual's physical and/or mental health status, including the ability to perform normal household functions and job duties unhampered by disability, following medical treatments and procedures. If we do not start asking patients how care affected their functioning, we will not have the information we need to assess the effect of treatments on quality of life, nor will we be able to fully engage patients about their health.

FLHSA stands ready to participate in further discussions and help shape proposals for integrating PROs into patient care and quality measurement in New York. Successful efforts to incorporate PROs into performance measures for specific conditions are often launched locally, and include asthma, (Minnesota Community Measurement), CABG (Partners Health Care, Boston), and hip and knee replacements (California Joint Replacement Registry, Minnesota Community Measurement). We recommend that the state engage local communities in robust discussions of value that can line up support for improved measures, including PROs.

While our nation's health challenges affect the entire nation and require a national response; finding the right solutions is, in large part, dependent on the responses of our nation's various states and their sub-regions. For this reason, we believe it is appropriate for New York to see federal approval of a state specific approach to value based payment, across payers. The State Health Department has done an excellent job of engaging stakeholders. Ultimately, well-constructed, community engaged proposals – like New York's – are powerful vehicles by which the national government can ensure that its policy approaches are rooted in solutions that keep the local community central to the pursuit of the Triple Aim. The road to cost effective, quality health care is incumbent on local communities being active participants in developing and implementing approaches to health improvement.

Sincerely,



Trilby de Jung, CEO
Finger Lakes Health Systems Agency

55 Water Street, New York, NY 10041

September 4, 2015

Jason Helgerson
Medicaid Director
New York State Department of Health
One Commerce Plaza
Albany, NY 12210

Dear Mr. Helgerson:

We appreciate the opportunity to comment on the draft VBP Medicare alignment proposal, released for comment on August 3, 2015. EmblemHealth seeks to be a full partner with the State in creating a new vision that would bring together the Medicare and Medicaid programs. We strongly support the goal of shifting public programs from uncoordinated and retrospective fee-for-service payments to quality-producing and cost-reducing prospective payments, and we have been leaders in this transition.

We are concerned, however, that the current proposal promotes a single solution based on one company, potentially establishing program requirements that are not as robust or consistent with the requirements under other State and dual eligible programs. Specifically, we are concerned that this proposal misses an opportunity to set a benchmark that could both meet and exceed the best practices for value based reimbursement currently employed by EmblemHealth and others in the market today. We urge the State also to consider other entities, such as health plans, capable of assuming full financial risk and population health responsibility for the Medicaid and Medicare populations, and to harmonize the design of this new initiative with the requirements of existing programs.

EmblemHealth's Commitment to Value Based Programs

At present, a full two-thirds of EmblemHealth's payments are value based. Over half (55 percent) of all of our payments involve full capitation with clinicians, and by next year another 12 percent will involve two-sided risk. We have the infrastructure to help clinicians manage risk and support their efforts to coordinate care through direct engagement and data sharing. Our health plan is interested in using this expertise to partner with the State. We have strong neighborhood roots and experience coordinating care for special populations. In the Medicare arena, 78 percent of our payments are value based and 65 percent of our Medicaid contracts are value-based. The majority of our payment arrangements currently meet the State's level three requirements, and we rapidly are moving level one arrangements to levels two and three based on individual providers' capabilities to bear risk. We have tangible experience demonstrating that these risk-based and quality payments are driving the change that consumers and purchasers want and recommend that the requirements of future programs be set at level three.

Comments on the Current Proposal

We believe that there is an opportunity for NY State to build on the pioneering work that it has done in Medicaid Managed Care and build on that leadership position to better coordinate between Medicare FFS and Medicaid. Powered by the health plan community, NY State successfully reduced its Medicaid costs and improved quality, leading the shift to value based purchasing. It makes sense for the State to create a new program that meets the same standards which enabled this achievement.

Any efforts that might dilute previously established standards, or lower expectations, consumer protections and program integrity, will have the unintended consequence of shifting costs onto the same programs that have given the State its important leadership position. The State can best achieve its goals by setting consistent performance expectations, without prescribing contract terms between hospitals and health plans. Additionally, with hospital consolidation already dangerously impacting costs in NY State, the current proposal would inhibit innovation and discourage competition within key geographic areas.

EmblemHealth's Commitment to the State

We are fully committed to working in partnership with the State to achieve synergy and coordination between Medicaid and Medicare FFS. Together with our affiliated Advantage Care Physician practices, we are excited to bring our experience serving hundreds of thousands of Medicaid and Medicare beneficiaries to this new program and be considered a partner with the State in bringing a proven track record to this initiative.

We urge you to align this initiative with the program requirements upon which vulnerable populations now rely, and set standards that involve the two-sided risk sharing that has allowed the State to take an important thought leadership position on the national stage. At this time, it appears the current proposal may reduce standards and restrict potential participants, which would be a missed opportunity and a significant step back.

You have our commitment to work with you in crafting a design that continues the pathbreaking programs now operating in New York State.

Sincerely,



Karen Ignagni
President and CEO