NYSDOH *VBP Roadmap* Update: Public Comment Report

April 2022

Executive Summary

On January 19, 2022, New York State Department of Health (NYSDOH) released an updated draft of *A Path toward Value Based Payment (VBP), New York State Roadmap for Medicaid Payment Reform (VBP Roadmap*) for a 30-day public comment period. The *VBP Roadmap* was updated to streamline the original document, provide clarity for VBP contractors, and reflect NYSDOH's ongoing expectations and current processes related to the implementation of the State's VBP goals.

The purpose of the public comment period was to seek broad stakeholder input on the updated *VBP Roadmap* and gather ideas for future *VBP Roadmap* iterations and the State's forthcoming 1115 waiver amendment.

General Analysis of Comments

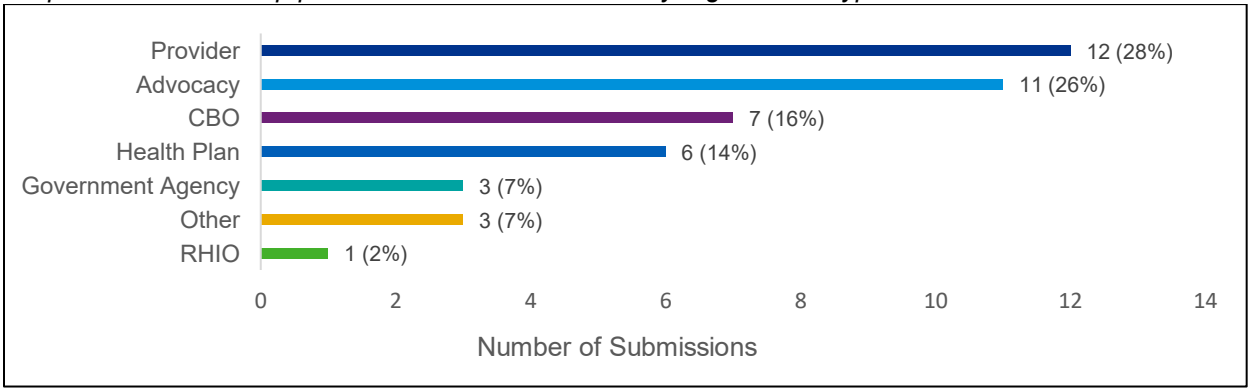
During the public comment period, NYSDOH received a total of 284 comments that were subsequently broken down into five major topic areas (see Table 1). About a quarter of the comments focused on additional suggested changes to the updated *VBP Roadmap* and close to half of the comments received pertained to concepts that may be introduced into future iterations of the *VBP Roadmap.*

Table 1: VBP Roadmap public comments by topic area

Topic area →	Updated *VBP Roadmap*	Operations	Future Iterations of the *VBP Roadmap*	Upcoming 1115 Waiver Amendment	Other	**TOTAL**
Number of Comments	69	38	107	52	18	**284**

Submissions were received from 43 organizations, mostly from providers and advocacy groups. Graph 1 depicts the number of submissions based on organization type. *Note: A submission may contain multiple comments.*

Graph 1: VBP Roadmap public comment submissions by organization type



Summary of Public Comments

Overall, feedback was positive for updating, streamlining, and clarifying content from the previous VBP Roadmap. There were requests for further clarification on several updates, such as the removal of community-based organization (CBO) tiers and updated guidelines for Managed Long-Term Care (MLTC)

partially capitated plans. Comments related to operational considerations included a focus on expanding data access and improving the utilization of data through the Medicaid Analytics Performance Portal (MAPP) and the Statewide Health Information Network for New York (SHIN-NY). Comments related to future iterations of the *VBP Roadmap* included requests for standardized reporting and a member-centric attribution methodology. Comments related to attribution were largely submitted by providers or CBOs. Comments related to ideas for the upcoming 1115 waiver focused primarily on expanding behavioral health in VBP, improving the implementation of VBP interventions that address social care needs, and increasing emphasis on health equity through quality measures.

Outcomes of the Public Comment Period

Responses from the public comment period provided insight into stakeholder experience and interests in the transition to VBP. While some requests would require material changes to *the Roadmap* or a formal approval through vehicles such as the 1115 waiver, requests to provide further clarity on current VBP requirements and guidelines were considered for the final version of this Roadmap. Based on these comments, NYSDOH made the following additional changes prior to finalizing the 2022 update. These included:

1. Adding language to the requirements for social care needs interventions to intervention utilization, disbursed funds, and outcomes.
2. Removing conflicting language to clarify that minimum shared savings must be paid out when at least 50 percent of quality targets are met.
3. Adding clarification in the target budget calculation guideline that provider historical cost and other factors such as regional benchmarks may be considered rather than only provider historical cost.
4. Adding clarification that CBO networks composed of not-for-profit organizations are eligible CBOs for the purposes of VBP contracting.
5. Adding guidance on the method by which startup funds/seed money is represented in contracts.
6. Adding language regarding managed care organization (MCO) collaboration with third-party partners for SDH interventions.
7. Adding clarification that with the removal of CBO tiers, selected services related to SDH interventions cannot be Medicaid billable services.
8. Adding additional clarification regarding the requirements of SDH reporting and that MCOs are responsible for reporting on fund utilization via the SDH Intervention Status Report.

1. Introduction

In January 2022, NYSDOH released an updated *VBP Roadmap* for public comment. Through this process, NYSDOH received 43 submissions, resulting in a total of 284 comments. These comments were subsequently classified into five topic areas: Current *VBP Roadmap* Update Content, Operational Considerations, Future Iterations of the *VBP Roadmap*, Upcoming 1115 Waiver Considerations, and Other. The major findings within each topic area for NYSDOH to consider as they continue on the transition to VBP are highlighted in more detail below.

2. Overview of Comments Received by Topic Area

The majority of the total comments received during the public comment period were from providers and advocacy groups (see Table 2).All organization types included comments related to operational considerations and recommendations for future iterations of the *VBP Roadmap.*

Table 2: Comments submitted by topic area and organization type

Topic Area / Organization Type	Current *VBP Roadmap* Update Content	Operational Considerations	Future Iterations of the *VBP Roadmap*	Upcoming 1115 Waiver Considerations	Other	**TOTAL**
Provider[1]	16	10	43	20	8	**97**
Advocacy	20	13	30	17	6	**86**
CBO	12	7	10	9	1	**39**
Health Plan	15	1	14	4	3	**37**
Government Agency	6	1	5	2	0	**14**
Other	0	3	4	0	0	**7**
Regional Health Information Organization (RHIO)	0	3	1	0	0	**4**
TOTAL	**69**	**38**	**107**	**52**	**18**	**284**

[1] The provider organization type represents comments from physicians, hospitals, independent practice associations (IPAs), behavioral health clinics, adult daycares, and other clinical service providers.

2.1. Current *VBP Roadmap* Update Content: 69 Comments

The current *VBP Roadmap* topic area included any comments that could be incorporated into the *VBP Roadmap* without a material change or addressed through direct response to the commenter, such as further clarification of requirements and compliance-related concerns.

2.1.1. Updates Based on Public Comments

Comments collected during the public comment period resulted in nine revisions to the updated *VBP Roadmap* to further clarify requirements and address areas of concern.

Summary of Comment	**Change to *VBP Roadmap***
Commenters expressed concerns for the referral to SDH services and tracking SDH utilization, as well as the lack of repercussions if an MCO is not using their SDH intervention contract.	*Page 8:* "Using the Social Determinants of Health Intervention Status Report Template, MCOs contracting in Level 2 and 3 arrangements must report the following information to the State on an annual basis: **intervention utilization, evaluation, disbursed funds, evaluation**, quality measurement outcomes, and success of the programs implemented … **MCOs must also demonstrate use of the SDH intervention(s) and CBO contract through the report by reporting on the utilization to the State."**
Commenters requested clarification whether 40% is the minimum to be allocated once ALL ASSOCIATED quality goals are met because they believed it was required to share the minimum 40% once HALF of the quality metrics were achieved (and 50% for ALL metrics).	*Page 6 and 18:* "To be counted as a Level 1 VBP agreement, the minimum percentage of potential savings to be allocated to the VBP contractor, if ~~all~~ associated quality goals are met, is 40%." *Note:* *"All" is being removed to remain consistent with original VBP Roadmap language and to clarify the requirement.*
Commenters expressed concerns that comparing providers against	*Page 7:*

their own historical cost for target budget setting would penalize highly efficient providers, especially those whose historical performance are significantly lower than the statewide/MCO average.	"When calculating target budgets, providers and plans could consider both the provider's historical cost **and the regional benchmark/MCO average during their negotiation process**."
Commenters requested clarification whether a social care network, which are predominantly organized around an LLC IPA structure, would meet the minimum CBO criteria for Level 2 and 3 contracts.	*Page 8:* "All Level 2 and 3 VBP arrangements shall include a minimum of one not-for-profit Community Based Organization (CBO). This requirement does not preclude VBP contractors from including more than one CBO in an arrangement **or a CBO network composed of not-for profit organizations** to address one or more social care needs. **MCOs must provide a copy of the CBO or CBO network contract to the State that demonstrates funding to not-for-profit organization(s) for services."**
Commenters requested additional guidance and clarification on startup funds/seed money.	*Page 8:* "In the instance where a CBO is implementing these interventions, the CBO entity must receive start-up funds or seed money in addition to payment for services rendered. **The details for distribution of start-up funds/seed money should be part of the CBO contract, and the start-up funds/seed money should be used for the initial costs of the intervention outside of the service cost. Start-up funds/seed money must be reported to NYSDOH through the SDH Intervention Status Report.** ~~To ensure that funding investments are put toward addressing SDH, all recipients of this funding will need to report on fund utilization to NYSDOH."~~
Commenters asked that previous *VBP Roadmap* language encouraging MCO collaboration with third-party partners for support for SDH interventions be added back into the updated *VBP Roadmap.*	*Page 8:* **"MCOs and providers that engage in VBP arrangements may collaborate with third party partners to identify and secure investment and support for these interventions, consistent with applicable law."**
Commenters wanted confirmation whether the updated *VBP Roadmap* differentiates CBOs on their Medicaid-billing status.	*Page 7:* "VBP contractors shall select an intervention that aligns with at least one of the five (5) key domains of social care needs, as outlined in the Social Determinants of Health (SDH) Intervention Menu and VBP Subcommittee Recommendation Report …**The intervention cannot be a Medicaid billable service."**
Commenters requested additional clarification on what is required for SDH reporting and who is responsible for reporting.	Page 8: "Using the Social Determinants of Health Intervention Status Report Template, MCOs~~ and VBP Contractors~~ **contracting** in Level 2 and 3 arrangements must report **the following** information to the State on an annual basis: **intervention utilization, disbursed funds,** evaluation, quality measurement outcomes, ~~spending~~ and success of the programs implemented. **If agreed upon by the contracting parties, the VBP contractor and CBO may complete the report and provide it to the MCO for their reporting submission.**" Page 14: "Requirement 2: Social Care Needs Investments Shall be Reported Through the Appropriate Template All ~~recipients of~~ social care need-targeted funding shall be reported **by the MCO** ~~on fund utilization~~ to NYS using the Social

	Determinants of Health Intervention Status Report template. Information requested in the template includes **intervention utilization, disbursed funds**, evaluation, quality measurement outcomes, ~~spending~~ and success of the programs implemented. The expenses for interventions being implemented within the VBP contract for which the MCO is making the investment shall be included in "Other Medical" on the Medicaid Managed Care Operating Report (MMCOR) and MLTC Reporting Requirements (MLTCRR)."

2.1.2. Direct Responses to Commenters

Comments requested clarification in areas such as quality reporting for MLTC partially capitated arrangements, removing CBO tiers, Program of All-Inclusive Care for the Elderly (PACE) requirements, fund utilization reporting, VBP contracting levels, and off-menu arrangements. These comments did not necessitate a change or added language to the *VBP Roadmap* and could be addressed by directly responding to the commenter.

2.1.3. Positive Feedback

Comments expressed positive feedback on streamlining the *VBP Roadmap*, as well as support of the specific items below:

- Removing the CBO tiers from the requirement to include one not-for-profit organization
- Clarifying target budget setting requirement language
- Moving MLTC partially capitated arrangements from requirements to guidelines
- Reinforcing emphasis on the importance of SDH interventions in VBP contracts
- Highlighting interest in the upcoming public facing VBP Performance File dashboard

2.2. Operational Considerations: 38 Comments

This topic area included all comments that do not apply to the *VBP Roadmap* directly, but to internal policies or procedures, such as how VBP contracts are reviewed and approved by NYSDOH.

2.2.1. Quality Measure Sets

Comments indicated a desire to make additions to the quality measure sets. One comment proposed that the State host a public comment period or listening session to collect ideas and suggestions for updating the quality measure sets.

A selection of the suggested measures included:

- Adding health equity measures or adding equity stratification to existing approved quality measure
- Including standardized measures that are recognized across payor types (e.g., 3M Potentially Preventable Admissions (PPA), 3M Potentially Preventable ED Visits (PPV), etc.)
- Adding home care measures (e.g., sufficient workforce numbers, adequate compensation, and benefits, etc.)
- Adding age-related measures, such as developmental disability diagnosis measures for the Children's Domain within the Total Care for the General Population (TCGP) Quality Measure Set
- Adding Harm Reduction Services (HRS) as a third Quality Assurance Reporting Requirement (QARR) measure for behavioral health

2.2.2. Clinical Advisory Groups (CAGs)

Commenters also provided recommendations for the CAGs to consider, including, forming an advisory group focused on innovation within VBP, incorporating more community voices into existing CAG processes, increasing attention towards racial, ethnic, and cultural issues, and reconvening a newly

designed group of key stakeholders for Individuals with Development Disabilities (I/DD) measure development and implementation as those groups become VBP eligible.

2.2.3. Contracting Process

Commenters advocated for an organized, transparent, and timely process for contracting review that clearly defines both State and contractor expectations to avoid miscommunication, confusion, and delays. One comment suggested that the State use a standard contracting portal that enables all contract documents to be uploaded, and tracks where the contract stands in the review process. Commenters also requested the State review and approve contracts within 60 days and make the off-menu review process more streamlined, similar to that of on-menu arrangements.

2.2.4. Expanding Access to Available Data and Datasets

Comments expressed interest in expanding access to MAPP and SHIN-NY for all VBP contractors. Additionally, commenters requested that NYSDOH consider producing a comprehensive guide of best practices and specific use cases for how to work with health information exchanges (HIEs), as well as a list of each HIE and its specific capacities for each region. Commenters had concerns with the interoperability of the data as well as the timeliness of it (e.g., with the potentially avoidable hospitalization (PAH) measure).

2.2.5. Education, Training, and Technical Assistance

Commenters requested that NYSDOH commit to providing sufficient and effective technical assistance and infrastructural tools to better support provider success with meeting VBP goals. Similar to the Delivery System Reform Incentive Payment (DSRIP) program, one commenter also proposed that NYSDOH host updated versions of the periodic VBP Bootcamps, educational sessions, and learning collaboratives to help providers with the ground-level implementation of VBP, particularly as the State prepares for the upcoming 1115 waiver amendment application. Several commenters asked the State for additional guidance or direction to assist providers and plans that struggle to set up programs, refer individuals in need of services from CBOs, identify the population to target, and perform other administrative tasks, such as referral processes and billing.

2.3. Future Iterations of the *VBP Roadmap:* 107 Comments

The future iterations of the *VBP Roadmap* topic areas included recommendations that would require material changes to the *VBP Roadmap.* While recommendations requiring substantial changes to the implementation of the VBP Roadmap were not included in this version, these insights may inform future updates to the VBP Roadmap.

2.3.1. VBP Arrangements

Commenters suggested changes that may be considered for VBP arrangements including:

- Updating the Maternity Care VBP arrangement definition to extend postpartum care through the newborn phase and to a full year
- Creating an on-menu arrangement focused on prevention in the pediatric population that is not dependent on shared savings in a 1-year period
- Providing value based options for I/DD services
- Revising Integrated Primary Care (IPC) bundles in the future
- Broadening adoption of VBP by allowing plans to combine VBP contracts with providers serving members in multiple lines of business, adding other bundling models, and providing more flexibility to create VBP arrangements
- Loosening the extensive rules in off-menu arrangements to make them more appealing to providers
- Allowing federally qualified health centers (FQHCs) to assume downside risk by being the lead contractor in Level 2 and 3 arrangements
- Including consumer directed personal assistance services in VBP

2.3.2. Concerns for Smaller Providers

Commenters expressed concerns about how smaller providers struggle to fit in the standard mechanism for VBP, mainly regarding their low attribution for the 80% threshold requirement and with FQHCs. Additionally, through the public comment period, providers stated that MCOs were not following the target budget setting guidelines, such as the Next Generation Accountable Care Organization (ACO) approach, in practice. Small and independent practices also reported not having the tools necessary to identify patients that would accurately fall into a single subpopulation category as currently defined by on-menu arrangements.

2.3.3. Quality Measures

Commenters suggested further enhancing the quality measure requirements by requiring one Pay for Reporting (P4R) measure alongside the Pay for Performance (P4P) measure and making the TCGP Category 1 P4P measure requirement more stringent for the Mental Health and Substance Use Disorder (SUD) domains. However, commenters also reported difficulty in sharing actionable data on quality measures within the HIV/AIDS, Mental Health, and SUD domains due to data protection laws.

Comments recommended requiring, rather than encouraging, standardized quality measure reporting and asked NYSDOH to consider including Category 2 measures in the quality measure reporting requirement. Commenters requested a finite and manageable number of quality measures to reduce reporting burdens. Furthermore, commenters shared that without tying quality measures to specific patient-based actions, it is difficult to link the actual process of care to the VBP reimbursement model.

2.3.4. Social Determinants of Health

Commenters believed SDH interventions should also be incorporated in Level 1 arrangements, more than one CBO should be required, and clear guidance/policies should be provided (e.g., creating fee schedules for SDH interventions). Commenters also requested that entities that create a network of CBOs and not-for-profits offering SDH related services should meet the SDH requirement and be able to pass the funds downstream to their subcontractors who deliver SDH services.

Commenters requested the *VBP Roadmap* consider requiring MCO networks to comprehensively screen for SDH using an approved screening tool (e.g., AHC HRSN, PRAPARE) and Z codes or other standard codes and share the data with HIEs. Comments also urged NYSDOH to support integrated and coordinated care management by incorporating performance metrics that track referrals to social services, integrating social or community health workers in care coordination teams, and including requirements to ensure adequate data sharing across providers. One commenter voiced a concern that selecting one SDH intervention from one of the five key domains would create siloed SDH interventions in communities where there are multiple VBP contracts in place, thus creating disconnected SDH investments.

2.3.5. Attribution

Commenters requested NYSDOH adopt a consistent state-defined attribution methodology that is based on the majority of care received by Medicaid enrollees (e.g., behavioral health (BH) providers for HARP arrangements) and consistent across partners and agreements to support administrative ease for all parties.

2.3.6. Behavioral Health

Commenters suggested that additional requirements targeted towards BH include requiring VBP Level 2 or 3 arrangements to include BH IPAs and requiring non-BH VBP contractors in a TCGP arrangement to include meaningful participation from community based BH providers. One commenter recommended including an additional goal “ensuring full access to and integration of behavioral health services" to focus on integrating behavioral health services within the overall system and between different behavioral health services.

2.3.7. Data Sharing

Commenters described struggles with MCOs not sharing meaningful, actionable data with providers. Thus, they requested that the State require timely reporting and data sharing from MCOs to VBP Contractors (e.g., cost and claims data, care gap reports, utilization, and regularly updated patient attribution lists).

2.3.8. Minimum VBP Goals

Several commenters expressed concerns that the 80% expenditure requirement is difficult to meet due to small attribution sizes for larger plans, HIV Special Needs Plans (SNPs), and Health and Recovery Plans (HARPs). One suggested solution included a threshold to exclude providers below a minimum attribution level, tying minimum VBP goals to performance rather than a percent of total cost. Another suggestion included creating regional provider pools as a mechanism to contract with smaller providers that are not associated with an IPA, ACO, or group practice.

2.3.9. Areas of Improvement for Providers

Commenters raised concerns related to the unwillingness of many hospital providers to be accountable for quality improvement and cost savings. Many of these comments were submitted by health plans. To improve quality and accountability, commenters recommended that the State enforce rewards and penalties that apply equally to health plans and providers. Additionally, comments expressed concerns with capping downside risk for providers but not upside risk for health plans in Level 2 arrangements. Comments requested that larger entities, including hospital systems, be encouraged to accept more downside risk. To drive meaningful and lasting change, commenters asked that the next iteration of the *VBP Roadmap* shift to deepening provider-payor relationships in shared and full risk models, along with a reasonable goal of penetration in these programs.

2.3.10. Target Budget

Commenters suggested that the *VBP Roadmap* clarify what, if any, non-medical expenses (e.g., care management and administrative cost) can be included in the target budget and require a risk adjustment component.

2.4. Upcoming 1115 Waiver Amendment Considerations: 52 Comments

This section included all comments that provided feedback on items mentioned in the State's Concept Paper and additional ideas to broaden the VBP program that would require additional approval, such as through the 1115 waiver authority. Many comments aligned with the goals of driving innovation and emphasizing health equity.

2.4.1. Data and Databases

Commenters provided feedback on data collection approaches and suggested improving the quality and granularity of race/ethnicity data collected, standardizing the collection of granular data, and prioritizing sexual orientation and gender identity (SOGI) data. Home care agencies requested additional funding and technical assistance to help develop their data infrastructure and improve their ability to collect, monitor, and share data. Comments indicated concerns with accessibility to data and data sharing and requested clear guidance surrounding the use of SUD claims. Additionally, commenters requested that NYSDOH make the same data and analytics tools available to all VBP contractors, including CBOs and Social Determinants of Health Networks (SDHNs). Commenters also voiced concerns about the opt-in only option because it can be an impediment to true coordination for patients and add cost to the system. Commenters acknowledged an opportunity associated with the use of RHIOs to support the timely exchange of information in connection with VBP arrangements.

2.4.2. Assisting Smaller Providers

To accommodate smaller providers, comments encouraged NYSDOH to create incentive structures that fund practice management redesign and tie those funds to VBP Level 1 contracting. Commenters also proposed that the State create a risk pool to assist smaller providers in funding reserve requirements if an MCO fails to help fund the statutory risk requirements. Comments suggested that NYSDOH consider

setting reserve levels for specific arrangement types so that plans and providers have known financial parameters to consider when negotiating. To account for patient mix, eliminate adverse selection, and set prices that are fair to all providers, commenters recommended robust risk adjustment.

2.4.3. Social Determinants of Health and CBOs

Commenters suggested adopting a standardized health related social need screening tool, adding a billable service to incorporate SDH screening into a visit, incentivizing coding for SDH, and systematically recording outcome results as Z code diagnoses to further improve SDH within VBP arrangements. Commenters urged NYSDOH to move away from process-related requirements and focus on describing the outcomes it expects plans to achieve, and then evaluate their success in achieving them. To advance investment in SDH strategies, comments recommended actuarial tools, such as profit margins and efficiency adjustments.

Commenters expressed that SDHNs could support with the implementation of the SDH intervention by managing the administrative and implementation costs while expanding multiple CBO offerings within a region. Commenters suggested that SDHNs having oversight responsibility and disbursing funds in accordance with pre-determined milestones would allow CBOs to focus on the service rather than on contract negotiations. Comments also voiced that SDHNs could provide a network of CBOs to support implementation of an intervention and ancillary services to CBOs, such as closed loop referrals and data collection. Commenters expressed that having SDHNs in a given region with shared technological infrastructure would prevent further health data silos and allow for better transparency.

Plans also requested that the State provide additional funding to support the CBOs. Commenters encouraged NYSDOH to directly incentivize health plans to invest in efforts to meet non-medical needs through quality withholds or quality incentive arrangements, that hold health plans accountable for state-specified performance metrics (e.g., reduction in obesity or maternal mortality). Commenters also believed that MCOs should be encouraged to cover in lieu of services (ILS).

2.4.4. Applicable Programs

Commenters highlighted their own programs that aligned with the ideas proposed for the 1115 waiver. For example, one commenter discussed their advanced special populations model that will focus significant new resources on the health and social needs of three special populations: single adults experiencing homelessness, individuals leaving the correctional system, and children in the foster care system and families receiving the certain prevention services. Another commenter described their Social Impact Pilot Program (SIPP), which convenes and administers a network of CBOs to deploy social care interventions to targeted Medicaid members and very closely aligns with the State's envisioned SDHN structure. Another comment recommended the National Committee for Quality Assurance (NCQA) new program, Health Equity Accreditation Plus, that guides organizations to establish the processes and cross-sector partnerships necessary to continuously identify and address the social risk factors of the community where they operate and the social needs of the individuals they serve.

2.4.5. Behavioral Health

Commenters expressed the importance of including population-based payment methods or case rates for behavioral health including actions intended to reduce administrative requirements, such as reduced claims submission requirements, and removing preauthorization requirements for high-performing providers. Comments hoped that the historical underfunding of the BH delivery system be addressed by holding MCOs accountable for ensuring their members have access to services. Commenters suggested achieving this by establishing minimum medical loss ratio (MLR) spending levels for community BH providers in TCGP arrangements.

2.4.6. MLTC

MLTC contracting commenters felt as though they were duplicating efforts since the SDH interventions and social care assessment promoted by the *VBP Roadmap* and the 1115 Waiver Concept Paper are already incorporated into the MLTC program and benefit package. Comments also expressed an urge for

NYSDOH to develop more meaningful, performance based VBP arrangements designed for MLTC. Additionally, several comments emphasized the importance of including provisions to generate funding to support the long-term care delivery system.

2.4.7. Workforce

Commenters urged NYSDOH to acknowledge that adequate compensation for direct service BH staff is a core essential cost. Comments also requested NYSDOH to consider investing in home care workers' training through renewed funding of the Workforce Investment Organizations (WIOs) and require that contracts between MLTC plans and home care contractors include provisions for the distribution of shared rewards directly to home care workers.

3. Next Steps

NYSDOH reviewed all public comments for consideration in the updated VBP Roadmap. Recommendations that have been incorporated into the updated Roadmap either provide further clarity for VBP contractors or support the successful implementation of the Roadmap without making materials changes. The VBP contracting checklists and model contract language will be updated accordingly to reflect the final Roadmap requirements. Additionally, the updated *VBP Roadmap* Executive Summary will reflect the changes made after the public comment period.

NYSDOH will continue to evaluate the additional public comments for further enhancements to future iterations of the *VBP Roadmap*, as well as considerations for broader programmatic changes to be included in the next 1115 waiver amendment.