January 30, 2015

Jason Helgerson
New York State Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Comments on Draft VBP Roadmap

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our preliminary comments on the draft Value-Based Purchasing (VBP) Roadmap for the Delivery System Reform Incentive Payment (DSRIP) program. We appreciate the opportunity to provide input on this document. Below are some overarching themes we have identified from the perspective of long term and post-acute care (LTPAC) services:

1. ***The term "Value-Based Purchasing" is not defined.*** The Roadmap gives examples of "value of care" and "value-destroying care patterns," but nowhere is an objective definition of VBP offered. Relatedly, the blanket characterization of pay for performance approaches as "level zero" incentives seems particularly arbitrary since such arrangements often do entail coordination and integration of care and can produce results that are of value to patients and the system.
2. ***The Roadmap seems to focus primarily on medical care, and not custodial/chronic care.*** We do not see evidence of a well thought-out strategy on how to promote value-based care for the LTPAC population receiving Medicaid-covered services. Admittedly, there are formidable challenges associated with defining the episodes of such care and predicting – with sufficient reliability – the costs of total care of a LTPAC subpopulation, across settings and levels of comorbidity. Furthermore, a successful outcome of chronic care may not be actual patient improvement, but rather delaying disease onset or progression, and delaying functional decline. In spite of these realities, there are tremendous opportunities and reasons to promote value in LTPAC services that should be further considered in the context of the Roadmap.
3. ***The Payment Reform Guiding Principles upon which the approach is based need to be carefully considered.*** First, while the second principle refers to preserving "an efficient essential community provider network," it fails to address the need to guard against destabilizing essential providers and jeopardizing access to services. In addition, the second principle contemplates that all providers and communities can participate, but the reality is that not all providers will be able to meaningfully participate in DSRIP. Principle three refers to the infrastructure needed to support implementation such as health information technology (HIT). However, LTPAC providers have been left behind in meaningful use incentives and capital financing programs aimed at promoting deployment of interoperable HIT. Without this basic

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infrastructure in place, many LTPAC providers will be unable to meaningfully participate in DSRIP Performing Provider Systems (PPSs) and VBP programs.

4. ***The timeframes for development and implementation of VBP are inordinately aggressive.*** The third Payment Reform Guiding Principle also refers to a flexible multi-year phase in to recognize administrative complexities. We believe that implementing VBP arrangements will require significant time for managed care plans and providers to develop and operationalize the required contracting, quality reporting/measurement, training, billing systems, clearinghouse arrangements and software. Furthermore, some major benefits/populations have not yet even been transitioned into mandatory managed care. As a result, plans and providers do not as of yet have sufficient experience with fee-for-service (FFS) type payments and the associated risks for these benefits, and yet the unrealistic expectation is that they can be prepared for VBP (including risk sharing and global capitation/sub-capitation) based on the noted timeframes. For example, plans are required to pay nursing homes at benchmark (i.e., FFS) rates for the first three years following the transition of the nursing home benefit, which has not yet even begun.
5. ***Implementation of VBP as proposed would appear to add, rather than subtract from, the overall level of administrative complexity.*** Under the State's "care management for all" initiative, LTPAC providers are contracting individually with managed care plans. With the inception of DSRIP, PPSs will engage in aggregate contracting based on a range of VBP approaches for different population groups using various VBP approaches. It is not entirely clear whether, and how, PPS networks will come into alignment with existing managed care networks, and what impact would this have on existing contracts and network requirements. Furthermore, establishing VBP and all of the associated data gathering/quality monitoring/risk measurement activities for DSRIP-related Medicaid payments will add to administrative burden if these activities do not support Medicaid payments outside of DSRIP and other payers the State does not control.
6. ***VBP approaches will necessitate a new regulatory approach to integrated service delivery.*** There are significant federal/state provider regulatory impediments at the program level that interfere with service integration and flexible/orderly service delivery, which have yet to be addressed in the context of managed care arrangements. Medicaid beneficiaries should be able to access the services they need, when they need them, and providers should be reimbursed for the needed services that are provided. How will significant regulatory conflicts and redundancies be overcome, particularly in a VBP context that makes the need for regulatory alignment even more compelling?
7. ***Validated data tools and outcome measurements are an essential building block of measuring and recognizing value.*** In this regard, we question whether: (1) the DSRIP Domain 2 and 3 measures were selected based on empirical research for their potential for objective measurement and use in VBP; (2) the data sources underlying the measures (e.g., CAHPS, UAS-NY, etc.) are appropriate to the purpose of measuring outcomes and have been in use for a sufficient amount of time to provide credible data; and (3) sufficient data exist to develop robust and reliable risk-adjustment methodologies for the cost of care, particularly for subpopulations which may have multiple chronic conditions.
8. ***The Roadmap needs to carefully balance flexibility with standardization when it comes to deployment of VBP approaches.*** The Roadmap is overly prescriptive in terms of the timeframes, populations, participation levels, methodologies and approaches it espouses. Standardization holds the potential for ensuring critical mass and containing administrative

costs, but could stifle innovative approaches and ignore the formidable challenges of creating uniform approaches to VBP design, outcomes measurement and contracting arrangements. Flexibility recognizes that one size does not fit all and addresses the reality that timelines, performance and payment mechanisms will need to be modified over time based on experience, provider/plan capacity for change and other developments in the environment.

9. ***Medicaid VBP should not be imposed on other payers.*** Medicare is the predominant payer for episodic care services in LTPAC, and has subsidized inadequate Medicaid payments for LTPAC services for many years. Expecting providers to put this revenue stream at risk or to participate in State programs that are at odds with Medicare policies and programs would jeopardize the stability of the LTPAC delivery system.
10. ***The development and implementation of the VBP Roadmap should be transparent and meaningfully engage stakeholders.*** It does not appear that the LTPAC sector was consulted with in the preliminary interview process that preceded the development of the draft Roadmap. LeadingAge New York and other members of the Value Based Payment Work Group were given only one week to comment on this complex and far-reaching document, a timeframe which did not allow sufficient time for a thorough analysis or meaningful engagement of our membership. We hope that future Work Group meetings will offer opportunities for robust dialogue; that more information will be provided on the research and discussions that led to the proposed approaches in the paper; and that the final product to CMS will reflect the timeframes, participation levels and options that the Work Group agrees upon.

LeadingAge New York is convening a Task Force on Alternative Payment Arrangements, and we look forward to providing substantive feedback on VBP approaches for the LTPAC population in the coming weeks. Thank you for your consideration of our concerns and recommendations. If you have any questions, please do not hesitate to contact us at (518) 867-8383.

Sincerely,

Daniel J. Heim
Executive Vice President