Comments on
DSRIP Primary Care Plans
December 21, 2016

The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to submit these comments on the DSRIP Primary Care Plans. 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 65 of New York's federally qualified health centers (FQHC) are in one or more Performing Provider System (PPS) Network, and a majority are active participants on 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 DSRIP projects that drive transformation. CHCANYS solicited input from our members on their PPS leads' Primary Care Plan(s) which informed the comments below.

Support for Community-Based Providers

CHCANYS thanks the Department for including the Primary Care Plans as a component of the Midpoint Review Assessment. The success of DSRIP is reliant on meaningfully integrating PPS community partners into all aspects project planning and implementation and leveraging partners' expertise and existing capabilities. 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. CHCANYS provided feedback to the Department during the development of the Primary Care Plan process and urged the Department to require the PPS specify how they are working with *community-based* primary care providers, as opposed to solely hospital or institution based primary care providers.

Unfortunately, the Primary Care Plans do not uniformly include this level of specificity and instead tend to just refer to PCPs generally, without indication of whether they are hospital

affiliated or community-based. In fact, CHCANYS heard from many of our members that they were unaware that their PPS had drafted a Primary Care Plan and were not involved in its development. This sentiment was echoed in comments we received from FQHCs on the content of their PPS lead's Primary Care Plan. One FQHC noted that their PPS did not contact them to determine their capacity for expansion or seek additional information on their model of care, despite the fact they are one of the largest health centers in their PPS network, and would be willing and able to collaborate. This same health center commented that although the PPS lead states that they are looking to leverage the existing FQHC infrastructure and experience to further develop a sustainable primary care system, the resources they have received from the PPS to date are "miniscule compared to our contribution" and the total amount of funding distributed to PCPs and clinics – which includes both community-based and hospital affiliated providers – thus far totals less than 5% of the funds the PPS has received from the State. The FQHC writes that providing community-based primary care providers with "some real financial resources" would help the PPS "improve preventative quality measures" and meet several key performance targets they are currently missing. While CHCANYS appreciates that the Primary Care Plans are intended to highlight the fact that primary care is integral to the success of DSRIP, we continue to be concerned that FQHCs and other community-based providers have not been given adequate voice and support in DSRIP for their critical work. As one health center, who is on the governance board of their PPS, notes, "In general [our PPS] is a transparent organization with a democratic decision making process; however, because of their size, [two large hospitals in the PPS] dominate decision making and have more resources to chair committees and take on leadership roles."

Greater Transparency on Funds Flow

The need for transparency of funds flow was raised repeatedly in health centers' comments. One health center noted that although they were pleased that the Primary Care Plans included training and resource opportunities for primary care networks, there remained no clear accounting of what percentage of these dollars and resources were being devoted to the development of entities that are directly affiliated with the PPS lead. Another FQHC stated one of their biggest overall

complaints was the amount of money going to consultants and PPS management, and the comparable lack of funding going to the network partners. Health centers across the state remain very concerned that the hospital-based PPS leads are seeking to expand and/or build their own primary care networks, even when there are well developed community-based primary care systems with the capacity, ability, and desire to grow. In one region, a health center notes, a hospital is seeking to develop at least two new ambulatory care facilities in very close proximity to the existing FQHC site, claiming a lack of capacity. CHCANYS strongly urges the Department to require PPS to provide more detailed reports on funds flow to their network partners, in addition to public reporting of the same.

PPS Collaboration with Other Statewide Initiatives

CHCANYS previously recommended to the Department that PPS should report in their Primary Care Plans how they plan to collaborate with statewide programs that provide TA, including the Regional Extension Center, the Transforming Clinical Practice CMS grant and the SIM grant. We are pleased to see that PPS leads did report of on how they were leveraging existing TA programs to support their primary care providers. However, it appears as though in some PPS those opportunities have not been made available to all the network partners. One health center noted that the at least two of the contractors chosen by their PPS to assist PCPs on meeting DSRIP outcomes, including achieving PCMH level III and integrating primary care and behavioral health, had limited experience working with community-based providers and had not sought to engage with the health center at all. They are very concerned that the PPS contractor leading TA on integration of behavioral health, "has no experience implementing integrated care in… FQHC settings, which are markedly different, including workflows, billing, and reimbursement." Furthermore, the health center reported that they were unaware of any efforts by the PPS or the contractors to address or incorporate Advanced Primary Care (APC) into their TA and practice transformation strategy. One health center expressed deep concern that their PPS lead's efforts to increase access to specialty services was overly reliant on using telemedicine services and seemed to be reducing on-site specialty staffing, leading to a marked decrease in access for patients.

Transition to Value Based Payment

As major Medicaid safety net providers and comprehensive care providers, FQHCs have vast experience in caring for and designing effective interventions for at-risk populations, those who face health disparities and have inadequate access to quality health care. Accordingly, health centers are essential partners in the State's healthcare transformation efforts, including the transition from visit driven payment to value based payment (VBP). CHCANYS appreciates that the PPSs were required to report on how they are supporting primary care providers' ability to effectively participate in VBP arrangements.

State law generally prevents PPSs from being contracting entities in VBP arrangements. Thus, many PPSs are seeking to become independent practice associations (IPA) for purposes of VBP. It is understandable that many PCPs will seek to join these hospital-led IPAs, to increase their negotiating power with managed care companies. However, we have a strong concern that at least two PPS leads may be inappropriately seeking to influence primary care providers' decision to join the PPS-lead IPA by indicating that they may withhold DSRIP payments, or prevent them from earning shared savings, if they do not join their IPA or join another IPA. A health center commented that although their PPS has spent a considerable amount of time discussing the transition to VBP and the potential structure of an IPA, very little time has been spent addressing if and how FQHC patients who are not affiliated with the lead hospital entities would access needed specialty care. CHCANYS requests that the Department affirmatively ensures that PPS leads and network partners are aware that participating in a PPS-led IPA is not a condition of DSRIP, that patients will still have timely access to specialty care, and that the Department seeks to prevent such undue influence from occurring.

Additionally, the State should ensure that those PCPs who do choose to participate in hospital-led IPAs have access to adequate resources, in the form of pre-payment or shared savings, to support their role in increasing quality outcomes and reducing avoidable hospitalizations and associated costs. The VBP Roadmap recommends that professional-led IPAs share a portion of their savings with the affiliated hospitals, yet the State does not recommend a reciprocal

requirement in which hospitals share their savings with professional-led VBP contractors in any type of hospital-led VBP contract. A VBP arrangement in which a PCP-led IPA is required to share savings with an affiliated hospital limits the primary care providers' return on investment and creates yet another disincentive to their participation in VBP contracts. CHCANYS is very concerned that this paradigm not only disincentivizes primary care providers from participating in VBP arrangements, but creates an unequal playing field that continues to perpetuate a hospital centric delivery model. CHCANYS strongly opposes any such shared savings requirement for professional-led IPAs without a comparable requirement for hospital-led IPAs.

CHCANYS thanks the Department for the opportunity to comment and looks forward to continuing to work together to ensure that community-based primary care providers are provided with the resources necessary to support their critical role in State's healthcare transformation goals.

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December 9, 2016

Via Electronic Submission
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To Whom It May Concern:

The New York City Department of Health and Mental Hygiene (DOHMH) applauds the focus of the Performing Provider Systems (PPSs) on strengthening primary care, which is proven to improve the public's health and reduce disparities. We support expanding comprehensive, high-quality, affordable primary care to all New Yorkers, while providing additional resources to communities that have historically faced disinvestment.

DOHMH appreciates the opportunity to comment on the PPS Primary Care Plans and Midpoint Assessment Results. We have reviewed and have the following comments.

Tobacco

Tobacco cessation is one of the most important modifiable risk factors for chronic diseases. We recommend that PPSs provide details of their tobacco screening and treatment work as examples of their ongoing strategies and opportunities for primary care transformation, especially for those PPSs working on Domain 4.b.i. For example, tobacco screening and cessation quality measures might be part of a larger Patient-Centered Medical Home (PCMH) strategy related to Fundamental Question 2. Additionally, given the high burden of tobacco smoking among behavioral health populations, specific attention to tobacco cessation metrics and strategies related to Fundamental Question 6 would highlight the importance of addressing tobacco use in these populations. Tobacco remains the leading cause of preventable death in New York State and primary care providers are on the front lines of addressing smoking. We encourage the PPSs to use the platform of the Primary Care Plan to highlight their efforts and inspire others to action.

Healthy Eating

Diet is a key modifiable risk factor for many chronic conditions, and improving population nutrition can support the DSRIP goal of improving population health. The food environment in health care settings impacts patients, visitors, and staff, and providing healthier food options can help model and support improved nutrition and diets. In NYC, one quarter of adults are obese (24.1%), more than one in nine adults (11.6%) currently have diabetes, and nearly 30% of adults report having high blood pressure (28.8%). The NYC Food Standards were created by mayoral executive order in 2008 with the goal of improving the health of all New Yorkers served by City agencies by decreasing risk of chronic disease related to poor nutritional intake. Food Standards exist for meals and snacks served, for food and beverage vending, and for meetings and events. NYC's H+H hospitals are already required to follow the NYC Food Standards, demonstrating the feasibility of implementing these standards in a healthcare setting. Voluntary food standards for cafes and cafeterias are also available as part of the Healthy Hospital Food Initiative. We recommend that other PPSs adopt the NYC Food Standards to support population health by offering healthy food in their facilities and incorporate this adoption into their primary care plans for the coming year. We also recommend that implementation of these food standards in primary care practices become a part of all primary care plans, creating models of healthy eating in the clinical environment that can serve as a model of patients and providers.

Hypertension
One out of four New Yorkers have hypertension, a leading cause of cardiovascular disease. To prevent and control hypertension, we recommend PPSs work with their primary care practices and systems to adopt a standardized workflow that encourages team-based care and integrates evidence based treatment guidelines. While some PPSs reference addressing hypertension in their primary care plans, few identify how critical the role of primary care is in preventing, diagnosing, treating, and controlling hypertension. The model used for HTN applies to many other chronic diseases and thus testing this model using DSRIP will have broad applicability.

There are several elements that are critical to a successful workflow: accurate blood pressure measurement; utilization of evidence based treatment guidelines including simplified medication regimens; reinforcing on-going self-management by providing at-home tools like self-monitoring blood pressure cuffs and partnering with patients, families, caregivers and community resources; and monitoring health system performance to drive improvement. First, the diagnosis and treatment of hypertension is based on blood pressure measurements. PPSs should train and evaluate direct care staff on accurate blood pressure measurement and technique. Second, PPSs should systematically implement a hypertension treatment guideline that is evidence based. A treatment guideline should include appropriate recommendations for the diagnosis of hypertension, escalation in care to prevent treatment inertia, strategies to assess and address medication adherence, and effective use of self-measured blood pressure monitoring. To implement, PPSs should consider ways of embedding the treatment guidelines into the electronic medical records to optimize adoption; for instance, use a patient registry specific to the treatment guideline to identify patients with uncontrolled or undiagnosed hypertension. Third, reinforce the prevention and control of hypertension by partnering with patients, families, caregivers and community resources. PPSs should support self-management through patient education and referrals to community resources; for instance, in-between face-to-face encounters with the health care provider, encourage blood pressure monitoring using a home blood pressure monitor or by visiting a pharmacy that provides free blood pressure monitoring. Last, PPSs should monitor performance to drive improvement in primary care practices. PPS should support primary care teams to determine and review performance metrics on a routine basis to determine goals and gaps in care.

Community Health Workers Concerns
The shortage of CHWs would be best addressed with a concerted effort of PPSs to fund training. Ideally a partnership between local institutions and public agencies would build out a shared training center that the large health systems and PPSs support, and which CBOs can access at reduced or no cost. It should include coaching / communication skills (e.g., motivational interviewing) and social determinants of health assessment / advocacy (at least individual) training. Existing training is often about specific diseases, which is necessary but not sufficient. PPSs should also pursue models of delegating (with compensation) CHW work to partner CBOs instead of hiring everyone internally. The CHW shortage can also be addressed by adjusting down minimum education and/or training requirements in job descriptions and assuming that training will be done "on-the-job." They may be struggling to fill "case management" roles by looking for over-qualified personnel, and could be accomplish much of this work with CHWs with proper support. Bronx Partners for Healthy Communities (Health Home 2.a.iii) noted these issues. To convince hospitals & clinics, refer them to the recent NYU document that includes estimates of return on investment. Bronx Health Access said they were unsure they had the capacity and needed to build incentives to hire CHWs (Health Home 2.a.iii).

Referral system
Regarding a referral system, we recommend separating case management and referral functions. Most case management can be done within the EHR, and/or through a connected case management software solution. There are not a lot of good options that fill the needs of both case management and referral, because few referral options have a robust resource directory, are user-friendly, and are interoperable with both low-tech and hi-tech client records. Bronx Partners for Healthy Communities (Health Home 2.a.iii) noted these issues.

CBO Concerns
There needs to be more investment in CBOs regarding value-based payment / changes in reimbursement that CBOs may have access to if they are helped to navigate the health reimbursement bureaucracy that many are unfamiliar with.

PPS Acknowledgements

New York Presbyterian 3.e.i Project: This assessment is of NYP's REACH project, which is incredibly impressive in its approach to system-wide changes to improve HIV outcomes in their PPS. Their focus on settings such as Emergency Departments and improvements to their IT systems is both appropriate and incredibly impressive. We have seen them present project REACH logic models and plans on several occasions, including at NY State-organized NY Links meetings, where their approach was received by an audience of their peer organizations with great interest and enthusiasm. Further, the DSRIP HIV Coalition, which was initially comprised of only 4.c.ii projects, decided to invite them to join the coalition, in large part due to how impressive their peers find this program model. Their self-reported challenges indicate that they are making progress, and doing substantial work to address any challenges. Further, their low scores on CBO and clinical engagement are being measured against their own (very ambitious) targets rather than an objective measure. There are no other HIV 3ei projects, nor is there an industry standard, so there is nothing to which to compare them. They set ambitious goals for their project, and are being transparent about challenges that are characteristics of a rapidly growing program.

Public Health Principles: We would like to specifically mention some PPSs that have successfully implemented some core public health principles that our agency supports. We set forward the following principles that we feel should be adopted by all PPSs.

Principle	Benefits for Public Health
Invest in community health worker workforce development, in partnership with existing training resources	Community health workers understand patients and their context, and are effective in providing cost-effective support. Local educational institutions are responsive to their learners' needs. **Supporting PPSs:** Staten Island, Community Care of Brooklyn, OneCity Health and ACP.
Invest in and deploy community health workers in settings outside the clinic walls	Patients with the worst outcomes and highest utilization benefit from community health workers who are able to meet patients where they are located. **Supporting PPSs:** New York Presbyterian, OneCity Health, Advocate Community
Optimize partnerships with community-based organizations (CBOs), particularly in addressing social determinants of health	CBOs are responsive to community needs and priorities, providing a local, trusted, cost-effective source of services. **Supporting PPSs:** Staten Island, NYP, and Community Care of Brooklyn, Bronx Partners for Healthy Communities, OneCity Health and ACP.
Engage primary care in value based payments (VBP) (Especially small practices)	Smooth transition to VBP for PPSs will depend on institutional investment in IT and personnel and engagement of all practices in the care delivery system. ***Supporting PPSs:*** *NY Presbyterian, and OneCity Health*
Optimize partnerships with public institutions	Health in all planning includes health as a key outcome of policies across public sectors. ***Supporting PPSs:*** *Community Care of Brooklyn*
Investment in resources to support expansion of primary care	Institutional financial commitment and detailed plans of implementation can assure sustainability beyond DSRIP. ***Supporting PPSs:*** *OneCity Health and New York Presbyterian*
Outreach for engagement of patients not engaged in primary care	Connecting patients with primary care can dramatically reduce preventable hospitalizations and ED visits. ***Supporting PPSs:*** *OneCity Health*

Principle	Benefits for Public Health
Strengthen Primary Care to develop Integrated Delivery System (IDS)	Development of IDS will position PPS for success in DSRIP initiative and will prepare it for transition to Value Based Payments. ***Supporting PPSs:*** *New York Presbyterian and OneCity Health*

DOHMH appreciates the opportunity to comment on the PPS Primary Care Plans and Midpoint Assessment Results, and we thank you for your consideration.

Sincerely,

Oxiris Barbot, M.D.
First Deputy Commissioner

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December 21, 2016

To Whom it May Concern:

Hudson River Healthcare (HRHCare) is pleased to submit comments regarding the primary care plans recently submitted by Performing Provider Systems (PPSs). HRHCare is a network of nearly 30 federally qualified health center (FQHCs) locations in the Hudson Valley and Long Island of New York. HRHCare provides comprehensive primary, preventive, behavioral, mental health and oral health care services to 135,000 patients annually. HRHCare, a PCMH Level III Medical Home, holds leadership positions in a number of the PPSs including the Montefiore Hudson Valley Collaborative and the Suffolk Cares Collaborative.

We commend the state for requiring PPSs to develop primary care plans, recognizing the central role of community-based primary care services in delivering on the overarching goal of reducing potentially preventable hospital activity. While we believe these plans are a crucial first step, we would add that it is difficult to compare the plans, as most of the PPSs have submitted feedback in very different formats. In addition to this overarching point, we would submit the following more detailed comments:

1. **Promote greater consistency and transparency in how dollars are directly allocated to independent primary care partners and advance reasonable limits on PPS self-pay to augment primary care and for non-primary care purposes**

We appreciated that several of the plans describe extensive training opportunities and other resources outside of direct funding that will be made available to primary care network partners. This is important work, however, it is still nearly impossible to discern how many dollars PPSs across the state are devoting directly to independent primary care providers achieving DSRIP milestones. Some of the PPSs have combined resources being channeled to community-based organizations (e.g. social service providers) alongside resources being allocated to other types of primary care providers. Additionally, in some cases, PPS leads are supporting the development of ambulatory resources that are their subsidiaries (active/passive parent) or clinical affiliates.

We would strongly urge DOH to require PPSs to report upon financial resources going to independent primary care partners, so that it is clear how funds are growing a collaborative, but separate network of providers vs. being used to augment the ambulatory presence of historically inpatient networks of care. While

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DSRIP is a collaborative enterprise among independent partners, we would suggest that the inability to disentangle funds flow in this way allows for PPS self-investments that may compromise the competitive advantage of existing resources.

With the information that is available, however, it also seems as though primary care may well be underfunded amidst other program activities. The October 2016 progress report to the state showed that a third of PPSs allocated more than half of funds to central project management offices and almost a quarter devoted more than half of funds to hospital providers.[1] With consistent, transparent information, we would encourage DOH to place reasonable limits PPS leads may be paying themselves, including subsidiaries, at the expense of primary care related activities.

2. **Align VBP arrangements with primary care goals**

As many of the PPSs form IPAs to support the transition to value based payment, it is critical that underlying agreements incentivize and enhance primary care. Because very few PPSs in the state are led by standalone primary care providers or physician groups, many PCPs across the state will join IPAs led by larger, multi-faceted health systems typically led by hospitals. In such arrangements, it is important to ensure that downstream shared savings allocations or pre-payments provide appropriate resources to primary care providers, particularly given the enhanced role they will play to support care management, integrated behavioral health models, and reduce potentially preventable hospital admissions. To that end, we would strongly urge the state to take steps to ensure that IPAs offer primary care providers a notable portion of the savings associated with reduced hospital-based costs. We would advance a concept where half of savings associated with reduced hospital are shared with primary care providers in such downstream partnerships as a potential approach, contingent upon quality performance.

Thank you for your consideration. Should you have any questions, please feel free to contact my staff member, Hope Glassberg, Vice President of Strategic Initiatives & Policy (hglassberg@hrhcare.org, 845-745-5842).

Sincerely,

Anne Kauffman Nolon, MPH
President & CEO, HRHCare

[1] http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-10-07_pps_progress_report.pdf

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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**

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[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.

additional qualitative narrative where necessary. For example, the state should require that all 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.

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[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

New York State Office of Alcoholism and Substance Abuse Services
Comments on DSRIP PPS Primary Care Plans

In response to the DSRIP PPS Primary Care Plan Reports (Reports) the New York State Office of Alcoholism and Substance Abuse Services (OASAS) offers the following recommendations for consideration and action:

Use of Screening, Brief Intervention, and Referral to Treatment (SBIRT)

An overarching theme in the Reports was a lack of incorporation of SBIRT into primary care practices. A small number of Reports provided a vague explanation of the way in which SBIRT was being incorporated into primary care practices, but many more failed to mention SBIRT and/or screening for substance use disorder at all. New York State is in the midst of a heroin/opioid epidemic epidemic. Moreover, risky or unhealthy substance use and substance use disorders are among the leading drivers of hospitalizations and admissions. Screening for substance use disorder should be incorporated into every primary care practice in our state in an effort to combat addiction and prevent needless overdose deaths. OASAS recommends that PPS Primary Care Plans require use of SBIRT within all primary care settings.

Integration of primary care and behavioral health care

Two additional overarching themes in the Reports was the lack of local behavioral health providers and a lack of association between primary care providers and the local behavioral health providers. This often means that when individuals are identified by PCPs as needing SUD treatment services, the PCPs are unable to refer them for appropriate treatment.

OASAS providers certified pursuant to 14 NYCRR Part 822 have the authority to deliver SUD services off-site. This novel concept was intended to expand access to addiction treatment services for those individuals that do not currently access services. OASAS strongly encourages each PPS take advantage of this enhanced regulatory flexibility and vigorously pursue the creation of partnerships between substance use disorder treatment providers and primary care providers OASAS-certified providers and credentialed staff already have the skills in place to effectively deliver addiction treatment services and should be incorporated into primary care practices in a meaningful way, with full PPS support and engagement.

Expansion of Medication Assisted Treatment (MAT) for substance use disorder

Physicians must seek an additional authorization to prescribe the medications used for MAT, such as buprenorphine. The Reports only limitedly addressed the need to expand the number of physicians trained to prescribe buprenorphine. In addition, new federal changes expanded the ability to prescribe buprenorphine to nurse practitioners and physicians

assistants, presenting a valuable opportunity to make increase access to MAT, in conjunction with behavioral therapy, to achieve the DSRIP triple aims.

OASAS strongly encourages each PPS to rapidly implement a plan to increase physician's ability to prescribe, connect those physician's with in-network providers already prescribing for this purpose (such as a mentoring program) and build a connection with community-based SUD treatment and recovery providers to ensure continuing care, including complementary therapies and recovery supports, that should be used in combination with medications

Preparing PCPs for VBP

The Reports evidenced little to no discussion of how they plan to get the PCPs ready for VBP. We are concerned that this lack of readiness among PCPs translates to, or at least reinforces, a lack among SUD treatment providers. PPSs should begin now to promote connectivity between PCP's and our specialty treatment providers, as well as with community-based organizations addressing social determinants of health, so that networks can position themselves to provide a continuum of care in a VBP contracting environment. This connectivity will be especially important for the Total Care for General Population and Integrated Primary Care Chronic Care Bundle arrangements.

PPS Funds Flow and support for PC strategies

The Reports similarly evidenced little to no discussion of how the current (or plan for) PPSs funds flow supports their PC strategies. Without adequate funding, PCPs, many of whom are already overburdened and understaffed, will not be able to fully implement clinical integration efforts such as EHR exchanges, SBIRT, and promotion of connectivity across the care continuum. OASAS recommends PPSs develop innovative funding vehicles that will promote investment in workforce development and infrastructure of a more integrative care delivery system. Workforce development and capital seed funds should be combined with P4P incentives that target PCP system transformation. Strategically aligned incentives will require, in turn, investments in data collection and reporting capabilities that use timely and actionable data and information that support a CQI process.

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Community Health Center of Buffalo
Erie County Medical Center
Evergreen Health Services
Jericho Road Community Health Center
Kaleida Health
Neighborhood Health Center
People Inc. Elmwood Health Center
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Frank Azzarelli, Ex Officio
Associate Vice President
People Inc. Elmwood Health Center

Comments on the WNY Regional PPS Primary Care Plans
December 20, 2016

Thank you for the opportunity to comment on the Primary Care Plans of the two Performing Provider Systems (PPS) which serve the eight westernmost counties of the state: Millennium Collaborative Care (Erie County Medical Center Corporation) and Community Partners of Western New York (Sisters of Charity Hospital).

The Safety Net Association of Primary Care-Affiliated Providers (SNAPCAP) of Western New York represents the majority of the primary care providers that primarily serve the Medicaid beneficiaries in this region. Member organizations are all NYSDOH-certified Article 28 primary care clinics spanning Federally Qualified Health Centers, hospital systems, and free-standing provider groups, and are therefore at the very center of delivery system reform efforts.

SNAPCAP emphasizes the importance of the following points which must be addressed by the WNY PPS Primary Care strategy:

- *Support for community-based primary care expansion.* Even amidst the regional primary care provider shortage, current care capacity could be significantly and quickly expanded if there were support for facilities expansion of existing safety net primary care practices. Nearly all SNAPCAP member organizations consistently report severe and persistent facility space shortages that limit the ability to provide patient care. While current PPS Primary Care Pans do detail intent to expand hospital-based primary care access (i.e. on-site at Sisters of Charity Hospital), it is essential for patient outcomes to ensure that expansion is focused on community-based primary care as well. These existing care settings are already well-integrated in neighborhoods and patients' lives.

- *Population health management interoperability.* Both WNY regional PPS Primary Care Plans detail plans to implement separate population health management health IT tools (i.e. Cerner Healtheintent and Crimson Care Management for Millennium Collaborative Care and Community Partners of WNY, respectively). While both show promise for PPS-driven activity and reporting, there are remaining concerns surrounding each tool's ability to be efficiently and meaningfully integrated into the comprehensive spectrum of all patient care activities, as this broader focus rightfully remains central to SNAPCAP member organizations. Additionally, the risks of duplication of resources and effort toward maintaining two separate, similar systems within one WNY region should continue to be examined thoughtfully.

- *Strengthened behavioral health capacity in primary care.* All SNAPCAP organizations have integrated behavioral health services into primary care. The degree of integration ranges from screening and referral policies to on-site providers sharing space and working together in care teams. SNAPCAP commends the WNY regional PPS Primary Care Plans for detailing support to build this capacity to the highest level of operations across all providers, and urges NYSDOH to

continue its examination of the regulatory supports which can be put into place to expand behavioral healthcare access to all patients in need.

- *Expanded lawful access to claims data and the Medicaid Analytics Performance Portal (MAPP) to primary care partners.* SNAPCAP member organizations employ a significant data and analytics workforce which would benefit greatly from expanded access to the data currently held by the PPS. SNAPCAP would openly welcome an expansion of working partnerships across this workforce and PPS staff to examine trends in these data and draft strategies in response to improve population health for all attributed patients. This would enable innovation and grant PPS partners an opportunity to further develop their analytics capacity prior to entering into value-based payment (VBP) contracting, of which access to actionable patient data is an essential component.

- *Clear, transparent guidance for VBP readiness.* All PPSs and PPS partners across the entire state are rapidly approaching the VBP deadlines set forth by NYSDOH in its VBP Roadmap. Many are evaluating changes to business structure, both publicly and privately, as a way to prepare for this transition. SNAPCAP would like to take this opportunity to emphasize the importance of the role of the PPS as a neutral entity which promotes the VBP readiness efforts of all partners, irrespective of the known or unknown future business structure development of key stakeholders. This is important to the PPSs' continuation of their success in serving as a critical connection between policy at NYSDOH and implementation in the community.

Respectfully Submitted,

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Administrative Director
Safety Net Association of Primary Care-Affiliated Providers (SNAPCAP) of Western New York