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April 18, 2016

Jason Helgeson, Director
New York State Medicaid

Dear Director Helgeson:

Thank you for the opportunity to comment on the first annual update to the Value-Based Payment Roadmap. Health Care for All New York (HCFANY) is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected. Several of our members were represented on the value-based payment subcommittees. Please find our response to the Roadmap below.

Protection Against Under-Service and Patient Selection

Value-based payments will reduce incentives to over-treat and increase incentives to provide preventive and primary care services. However, because no quality measurement system will be perfect and because wide-scale use of value-based payments is still an untested way of providing care, the next Roadmap should include a robust plan for preventing, monitoring, and responding to new negative incentives. Risks to consumers include: (1) under-service by providers concerned about their financial exposure and (2) patient selection, when providers reject patients with complicated needs that may hurt their quality outcomes.

The Roadmap includes a fundamental protection against under-service, which is that plans and providers are disqualified from financially benefitting if their quality outcomes worsen overall (p. 20). Risk adjustment provides some protection against patient selection (p. 26).

The Roadmap also includes some discussion about protecting access to services that are clearly beneficial for patients but may not be cost-effective within the timeframe of a typical contract, such as vaccinations and long-acting reversible contraceptives. The Roadmap suggests the State will develop a list of those services, and count fee-for-service spending on them towards value-based payment goals (p. 32). The Roadmap also suggests that the provision of some of those services will be measured for assessing care quality.

The discussion provides a helpful description of a negative disincentive stemming from value-based payments, which is to avoid services that impose upfront costs without immediately

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producing savings or measureable quality improvements. However, the proposed strategy of separating those services from care bundles deserves more public discussion. It appears that this discussion took place either internally within the State or within the Clinical Advisory Groups, which did not include consumers or advocates.

Further, if a public discussion results in the pursuit of this strategy, developing the list of services and determining which should count as quality measures should also be a public process that includes consumers and consumer advocates. The Roadmap does not currently describe how the list would be developed, and it implies that quality measures have already been selected by the Clinical Advisory Groups (p. 11). HCFANY echoes the recommendations of Medicaid Matters New York and other advocates that the quality measures be made available for public comment before any final decisions are made.

The Roadmap does not include any of the recommendations made by the Advocacy & Engagement Subcommittee for informing members about their providers' incentives or educating consumer assistance programs about the repercussions of value-based payments. Consumers who understand their providers' incentives will be better equipped to identify instances where their care has been compromised. The next version of the Roadmap should include a plan for ensuring that consumers are aware of their rights and how to assert them regardless of how their care is paid for. It would be most appropriate for a new subcommittee to develop this plan. An example workgroup exists in Connecticut, where their Equity and Access Council released a report on safe-guarding patients under shared savings arrangements.¹

Additional protections will likely be developed as the State updates the Managed Care Bill of Rights (p. 43). The Roadmap does not describe the process, but it is important that consumers and consumer advocates are represented in that effort, as they were when the Bill of Rights was originally adopted under the Pataki Administration. Consumers and consumer advocates should be represented in proportion to other stakeholders, and should have a leadership role.

Quality Measures and Risk Adjustment

As mentioned above, there should be a public process for assessing the recommendations made by the Clinical Advisory Groups. The Roadmap says that playbooks with the quality measures per value-based payment arrangement will be released, but not that the measures will be publicly assessed (p. 13). It is appropriate to have heavy clinician input into the design of the bundles and their outcome measures, but it is important that patients and advocates have a chance to review their conclusions.

The Roadmap acknowledges that Patient-Reported Outcomes are a missing link (p. 35). Patient-Reported Outcomes are an important way of ensuring that consumers are truly benefitting from value-based payment. Clinical quality measures are vital, but they will never be able to perfectly capture all of the things that are important to consumers. As Medicaid Matters

¹ Connecticut State Innovation Model Equity and Access Council, "Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements," June 25, 2015, http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf.



New York and other advocates have also recommended, Patient-Reported Outcomes should be collected for all patients, not just subpopulations. Any development process for quality measures meant to capture patient’s experience should include patients and advocates.

Moreover, the Roadmap does not guarantee that consumers will have access to any quality information, whether clinical or patient-reported. Consumers need that information to make good health decisions. Disseminating quality information in a way that supports decision-making should be addressed explicitly in the Roadmap.

Risk adjustment is important to protect providers who care for less healthy populations, and removes an incentive to avoid those patients. However it can also mask disparities. The Roadmap describes a continual improvement process for risk adjustment (p. 26). As this occurs, the State should ensure that risk adjustment does not mean disparities are going unmeasured. The National Quality Forum convened an expert panel on this topic and recommended that measures adjusted for socioeconomic factors be available for stratification to make disparities visible.² Their full set of recommendations should be reviewed for future Roadmap updates.

Member Incentives

The guidelines developed by the Consumer Advocacy & Engagement subcommittee are very important for protecting members from discriminatory incentive programs (p. 39-40). There was extensive discussion in that subcommittee about the appropriateness of member incentives, and the Roadmap includes positive provisions for designing culturally competent member incentives, measuring their outcomes, and ensuring that negative incentives like co-pays are not used. The discussions that were held in the subcommittee were a great first step.

However, the Roadmap does not fully reflect the reasons that some advocates are uncomfortable with the emphasis placed on member incentives as a way of making value-based payments work, which is the implication that poor health outcomes are predominantly the result of easily changed lifestyle choices. The overemphasis on member incentives is illustrated by the fact that the State will offer financial incentives to plans for developing member incentives but not for addressing social determinants of health. It is also illustrated by the fact that the subcommittee devoted to Consumer Advocacy & Engagement spent almost no time discussing consumer protections, instead focusing almost entirely on financial incentives to change consumer behavior. As New York City Health Commissioner Dr. Mary Bassett has argued, health disparities are not “about choice – it’s about the fact that people don’t have enough choice.”³ The lifestyle “choices” blamed for poor health outcomes are often the result of constraints imposed by poverty and disability. Similarly, member incentives for choosing high-value care are based on an assumption that members have good information and freedom to choose providers or services. This is frequently not the case.

² National Quality Forum, “Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors: Technical Report,” August 15, 2014, http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.

³ Mary Bassett, “Lifestyle Choices’ Doesn’t Explain Why Black Americans Are Dying Younger and in Higher Numbers,” <http://bigthink.com/videos/mary-bassett-on-new-york-city-health-disparities>.



The Roadmap states that this issue will be explored further in a workgroup, and HCFANY recommends that such a workgroup be led by consumers who have a realistic understanding of what choices truly exist for Medicaid managed care beneficiaries.

Public Reporting

The Roadmap says that the State will measure impacts on patient-centeredness, population health, and social determinants of health at the delivery-system level (p. 17). These, and other quality measures, should be publicly available so that there can be a public, informed discussion about the impact of value-based payments. As mentioned above, public reporting of outcomes is also an important part of consumer engagement in health care. Consumers cannot be asked to make better health decisions or to choose high-value providers based only on costs – they need access to accurate quality information about providers.

Stakeholder Engagement

The State is to be commended for undertaking such an extensive stakeholder engagement process and hopes that this will continue. For future workgroups and subcommittees, the appointment process should be very clear and membership lists and meeting minutes should be posted publicly. The value-based payment webpage provides a great amount of information, but adding those missing pieces would allow stakeholders not participating directly in the work to follow along. It is also important to increase the proportion of consumers and consumer advocates on these groups. An open process, for example with public postings for openings, would make it easier for consumer groups to organize and identify nominees with the right expertise to fully contribute.

Thank you for your attention to these comments. Please contact me with any questions at adunker@cssny.org or 212-614-5312.

Sincerely,

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