
November 1, 2019

Donna Frescatore, State Medicaid Director
Office of Health Insurance Programs
NYS Department of Health
Corning Tower (OCP-1211)
Albany, NY 12237

RE: New York State Medicaid Redesign Team (MRT)
1115 Research and Demonstration Waiver #11-W-00114/2
Delivery System Reform Incentive Payment (DSRIP) Amendment Request

Dear Ms. Frescatore:

The New York eHealth Collaborative (NYeC) is pleased to provide these comments in response to the Draft DSRIP Waiver Amendment. NYeC is a 501(c)(3) and New York's State Designated Entity (SDE) charged with the governance, coordination, and administration of the Statewide Health Information Network for New York (SHIN-NY). In this capacity, NYeC works as a public/private partnership with the New York State Department of Health (DOH) on the development of policies and procedures that govern how electronic health information is shared via the SHIN-NY.

The SHIN-NY is a "network of networks" consisting of Qualified Entities (QEs) or regional health information networks (HIEs) and a statewide connector that facilitates secure sharing of clinical data from participating providers' electronic health records (EHRs). Participants include hospitals, clinics, labs, radiology centers, ambulatory physicians, home care agencies, nursing homes, long-term care facilities, public health departments, health plans, behavioral health providers, DOH, Federally-Qualified Health Centers (FQHCs) and some community based organizations (CBOs). The commitment from NYS has made the SHIN-NY a national leader in HIE. Today, the SHIN-NY connects all hospitals in New York State, is used by over 100,000 healthcare and community-based professionals and serves millions of people who live in or receive care in New York.

NYeC's mission is to improve healthcare through the exchange of health information whenever and wherever needed. Numerous studies have demonstrated the value of using QE services in both better health and lower costs. With the SHIN-NY as a critical tool, we strongly believe that HIE is fundamental to the overall level of transformation aspired to in the Draft Amendment, including implementation of the high-priority DSRIP promising practices. As we move forward, the SHIN-NY needs to be more aggressively leveraged – *the QEs have been and continue to be uniquely positioned to support value driving entities (VDEs) and social determinants of health networks (SDHNs).*

We applaud DOH and the Performing Provider Systems for the tremendous success in improving Medicaid patient outcomes and reduced cost during the initial iteration of DSRIP. Thousands of healthcare providers became SHIN-NY users during this unprecedented endeavor. The impressive results are at least in part a testament to the extent by which interoperability is essential to Value-Based Care (VBC).

While the success is remarkable, a great deal of work remains to maximize the SHIN-NY as a tool to transform the NYS Medicaid as outlined by the ambitious goals set forth in the Draft Amendment as well as the Value-Based Payment (VBP) Roadmap. The SHIN-NY offers free services, called “core services,” to its participants that can support VDEs and social determinants of health networks (SDHNs). These free core services include, but are not limited to, patient record look-up for comprehensive clinical information with consent, alerts when patients are admitted, discharged or transferred from the hospital, and secure messaging. The State should consider adding a strong statewide governance mechanism for spending on IT and IT-related functions so that systems and platforms are more integrated, interoperable, and not duplicative of the QEs and the SHIN-NY.

It is further worth reflecting on the history of interoperability at the state and national levels with significant investments over the last decade to build the foundation of healthcare providers, mostly based on the Meaningful Use program. The American Reinvestment & Recovery Act from 2009 included the “Health Information Technology for Economic and Clinical Health (HITECH) Act”. The HITECH Act included the concept of EHRs and Meaningful Use, which was implemented by Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). As a leader, NYS embraced the federal initiatives and made major strides in advancing interoperability by creating a strong statewide foundation for health information technology, particularly for those healthcare providers who were eligible.

Because of that foundation, NYS is now able to shift the focus towards targeted information gaps like long term post-acute care (LTPAC), behavioral health, and social determinants of health (SDH) as well as the optimization of workflows to not only improve patient outcomes and reduce healthcare costs, but also alleviate provider burden. The “quadruple aim” is achievable and so are the ambitious statewide targets for VBC, but it is imperative that NYS keeps leading and aggressively pushing interoperability to connect the complete care continuum for Medicaid beneficiaries. *We urge DOH to dedicate resources for “left behind” sectors in interoperability (i.e. LTPAC, behavioral health, pharmacies, CBOs) that focus on financial incentives, regulatory relief, and technical assistance. We also believe that there should be similar consideration for small physician practices, especially pediatricians, and their specific needs as it relates to the goals of the Draft Amendment.*

QEs have supported PPSs in a variety of ways. One lesson learned from DSRIP should be to explore other avenues for claims data sharing. The SHIN-NY is currently seeking CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) Certification for Medicaid claims integration, as well as exploring opportunities with Medicare claims. One of those potential opportunities for collaboration could be BlueButton 2.0. Opportunities for patient access and engagement with this type of alignment could significantly streamline information and reduce burden for dual eligible beneficiaries who often have complex and co-morbid conditions to manage. *We strongly advocate for alignment and dedicated resources for clinical and claims data integration to leverage current SHIN-NY activities related to Medicaid claims and potentially patient access.*

We appreciate the reference to using SHIN-NY data in defining the population and opportunity for improvement. Over the past decade, QEs have built deep and broad clinical data and expertise and with the addition of claims data, are well positioned to do quality measurement. In particular, over the last couple years, the SHIN-NY has assisted the DSRIP medical records review process and as part of the NYS State Innovation Model (SIM), QE pilots have demonstrated a rapidly expanding capability with a focus on two use cases that directly support VDE purposes. One is providing more real-time quality performance monitoring, including gaps in care, to providers. The other is increased engagement with health plans in support of quality reporting. The engagement has led to a collaboration with the National Committee for Quality Assurance (NCQA) to explore the development of a program to validate an HIE for standard supplemental data for Healthcare Effectiveness Data and Information Set (HEDIS), which would be the first of its kind in the country. For these reasons, *the SHIN-NY role for quality measurement should be more explicit in the Draft Amendment and we strongly advocate for alignment and dedicated resources for quality measurement by the SHIN-NY.*

The increased engagement of CBOs is integral to the formation of SDHNs. In the Draft Amendment, we appreciated the emphasis on SHIN-NY as a strategic partner of Value-Driving Entities (VDEs) in sustaining and enhancing the partners' bidirectional data exchange capabilities. In addition, we strongly advocate for the same distinction with regard to the "Social Determinant of Health Networks" (SDHNs). The SHIN-NY has played a pivotal role in the advancement of this innovative work in communities across NYS. We believe that a coordinated statewide approach going forward will be instrumental to success based on SHIN-NY history. *We advocate for the SHIN-NY role with SDHNs to be made more prominent in order to leverage the existing framework for both policy and technology.* In our experience, governance and standards are paramount to the infrastructure required for the comprehensive data sharing envisioned for VDEs and SDHNs in the Draft Amendment. Furthermore, VDEs and SDHNs could benefit significantly from the sharing of SDH related state and local government data, and the SHIN-NY is a potential vehicle to assist in this area. It is also worth reiterating how dedicated resources for CBOs will also be needed for support such as technical assistance.

Successful implementation of *the Draft Amendment should include work on related policies*. The SHIN-NY is working to modernize many of our current policies that were developed a long time ago. We support an emphasis on implementing the specific recommendation of the DSRIP VBP Patient Confidentiality Subcommittee regarding an opt-out model for general clinical data sharing with a robust educational curriculum and outreach campaign. Our work also includes developing best practices for access to the SHIN-NY by HIPAA non-covered entities such as many CBOs and patients themselves.

We also support the alignment with other federal statewide quality improvement activities, such as the upcoming Clinician Quality Improvement Contractor (CQIC) Program and the previous Transforming Clinical Practice Initiative (TCPI) via the NYS Practice Transformation Network).

Thank you for the opportunity to provide comments. We are confident that we can be even stronger partners in the next phase of DSRIP and lead further improvements in the health of our communities. We look forward to our ongoing discussions.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Grey". The signature is written in a cursive, flowing style.

Valerie Grey
Executive Director

New York eHealth Collaborative (NYeC) Detailed Comments

Robust Health Information Exchange

The first iteration of DSRIP fueled an extraordinary amount of connectivity across the care continuum and it was a remarkable accomplishment. However, to extend that to the complete care continuum as the Draft Amendment stipulates and full transformation necessitates, a concerted effort and dedicated resources are needed. NYeC makes the following suggestions:

- DOH should offer financial incentives and regulatory relief to increase adoption of CEHRT (or health information technology specific to that part of the care continuum with the appropriate standards) and participation in HIEs;
- DOH should incentivize providers to collect and exchange data elements to enhance value of interoperability across the care continuum;
- DOH should offer support for technical assistance programs;

We must collectively work to engage “left behind” sectors to advance interoperability. We support incentive payments to encourage non-meaningful use providers to adopt CEHRT or health information technology specific to that part of the care continuum with the appropriate standards. While we feel incentives are necessary, many long-term and post-acute care (LTPAC) and home and community-based service providers (HCBS) avoid adoption of EHRs due to lack of IT staff and education or assistance on how to meaningfully use these products. Pharmacies have also lacked the resources and incentives to participate in HIE. The availability of funding through dedicated programs could allow for investment in advancing interoperability among these sectors and could be used for both incentives and technical assistance.

Such investments could build off previous efforts like the Regional Extension Centers (RECs) which provided on-the-ground technical assistance as well as state efforts like the New York State funded behavioral health information technology (BHIT) grant. With the support of a \$10 million BHIT grant, NYeC was able to assist 114 organization across 52 counties by providing technical assistance to implement their EHR systems. Further investments in such efforts would yield greater adoption, improve usability and work toward CMS’ goal of reduced provider burden.

DOH with support from CMS, established the Data Exchange Incentive Program (DEIP) to increase HIE adoption across the state for Medicaid providers. Participating organizations are incentivized to contribute a pre-defined set of data elements to the SHIN-NY through a QE. This program is designed to help defray the cost for an organization when connecting to their local QE. NYeC coordinates the rollout of the program and the incentive payments on behalf of DOH. This program was just expanded on a limited basis to pharmacies. We recommend that the design of VDEs and SDHNs encourage pharmacies to participate in the SHIN-NY to accomplish the goals for Addressing the Opioid Epidemic as outlined in the Draft Amendment.

Community-Based Organizations & Social Determinants of Health

NYeC applauds the recognition in the Draft Amendment of the extraordinary impact that CBOs have on improving the outcomes of Medicaid beneficiaries and would encourage supplementing these efforts with additional specificity and dedicated resources. We also want to recognize the continued leadership in the creation and work of the NYS Bureau of SDH. We believe that the alignment with federal initiatives, especially interoperability standards, will greatly assist in forming and achieving the objectives of SDHs. Over the last couple years, and as a direct result of DSRIP, the SHIN-NY has prioritized CBO engagement and the incorporation of SDH information through a multi-sector data sharing lens.

The 2020 SHIN-NY Roadmap identifies SDH as additional data in supporting VBC and the creation of a CBO and VBC Advisory Groups to facilitate continuous statewide feedback. For the past year, the group has met quarterly to advise NYeC on the intersection of CBO services and SDH, with HIE and HIT, and the associated challenges and opportunities in to improve health outcomes in the context of VBC. This includes advocacy and awareness-raising efforts with CBOs. The advisory group is comprised of CBOs, PPSs, and healthcare leaders from across NYS.

The group has already quickly begun significantly informing SHIN-NY initiatives. For example, the SHIN-NY Policy Committee is currently exploring ways to increase CBO participation in the SHIN-NY to further integration into the care continuum for Medicaid beneficiaries, as well as improve their ability to engage with VBP. An immediate focus of the SHIN-NY Policy Committee is non-covered HIPAA entities.

The SHIN-NY currently supports communities across the state advancing innovation in this area. We believe that a robust governance structure is crucial to success and should include Medicaid beneficiaries and a mix of CBOs, including both early adopters and safety net, in order to achieve the intended improved outcomes. While governance is a prerequisite to the overall collaboration and the comprehensive data sharing contemplated in the Draft Amendment, long-term success will depend on the development and implementation of interoperability standards. Below are just a few of the many SHIN-NY examples already underway from across NYS:

- The Bronx RHIO is engaged in several initiatives to address SDH and CBOs, including obtaining SDH data elements such as homeless/housing status, employment status, and correctional health registration data. Bronx RHIO is also participating in the Bronx FUSE Initiative, which will identify homeless high utilizers in health plans and set them up with housing opportunities with coordination by the Corporation for Supportive Housing (CSH).
- Healthix, located in the New York City area, is also working on several CBO & SDH-involved initiatives, including a pilot project to standardize and incorporate SDH screenings from FQHCs.
- Hixny, in the Capital Region of NY, is working in partnership with the Alliance for Better Healthcare PPS on a Consumer Directed Exchange project aimed to assist vulnerable populations into care.

- The Rochester RHIO has begun to add other data sources into the HIE to support clinical quality care, including data from corrections and law enforcement, housing, and public health.
- HealtheConnections in the Central NY region has created the myData Platform, which is in the beginning stages of adding a SDH report that incorporates ICD-10 Z-codes. It is anticipated that the PCMH Registry and the Preventive Care Registry will incorporate the SDH table in the User Interface to assist with care management opportunities at the practice level.

The history of the SHIN-NY and interoperability standards provides lessons learned to leverage in exchanging SDH data. Cross-referencing federal standards like the Common Clinical Dataset has proven to be an effective strategy in scaling on a statewide level. We are actively engaged with national efforts to standardize SDH data and multi-sector data exchange through the Gravity Project, San Diego Community Information Exchange models, and the Robert Wood Johnson Foundation-funded All In Network/Data Across Sectors for Health. We would urge the inclusion of national standards in program implementation such the following:

- International Classification of Diseases, 10th Revision (ICD-10) Health Factors (z-codes); and
- HL7 Fast Healthcare Interoperability Resources developed by National Institutes for Health and North Carolina for an SDH Assessment.

With the existing SHIN-NY governance structure and advocacy for interoperability standards, the SHIN-NY could play a major role in supporting SDHN activities.

Clinical and Claims Data Integration

Bi-directional information exchange with health plans will be tantamount to the attainment of the outcomes set forth in the Draft Amendment. NYeC applauds the recognition of health plans as having a critical fundamental role in achieving the objectives outlined in the Draft Amendment. There are many statewide initiatives to increase health plan engagement in the SHIN-NY such as the creation of a health plan advisory group and a project to coordinate a statewide approach to patient care alerts for health plans. Additionally, the recently proposed CMS Interoperability and Patient Access regulation would require that certain payers participate in trusted exchange networks. Claims data integration was also identified in the SHIN-NY 2020 Roadmap as a valuable tool to support VBC and could streamline the data sharing assumed in the Draft Amendment.

We would urge that the priorities envisioned for health plans maintain their alignment with and leverage other current ongoing state and federal initiatives such as the following:

- SHIN-NY goal of CMS MARS-E Certification and Medicaid claims integration;
- CMS MyHealthEData, including Medicare BlueButton 2.0 and the Data at Point of Care Pilot; and
- the CMS Interoperability and Patient Access Proposed Rule.

QE claims integration pilots during the initial iteration of DSRIP identified a variety of important use cases and led to the prioritization of SHIN-NY Medicaid claims integration as a statewide goal. The use cases span, but are not limited to, the following:

- Quality measurement;
- Increased accuracy for gaps in care;
- Attribution;
- Data completeness and improvement;
- Enhancement of diagnosis and procedure information;
- Potentially assist in medication reconciliation with pharmacy claims; and
- Patient registries.

In this context, we also encourage the consideration of patient engagement opportunities to empower patients to control their own data and provide an asset to assist in the management of their health. We believe that these tools could be instrumental in achieving many of the aims identified in the Draft Amendment, including the Long Term Care Reform. NYS could build upon the prior work toward Medicare alignment and BlueButton 2.0- which aims to reduce patient burden, streamline information about different types of care over time, and access and monitor health information in one place.

NYeC recently released a Request for Information for Patient Access to Health Information. We have also recently funded two pilots to further explore options and ultimately inform a longer term strategy. We believe that the SHIN-NY can play a pivotal role in these important patient access and engagement activities in addition to the other important benefits from claims integration for health plans, providers and Medicaid beneficiaries.

Quality Measurement

Quality performance is clearly focal to both the current Waiver and this Draft Amendment, and since the last Waiver was approved, there have been major strides in both SHIN-NY data contribution as well as the capability in terms of quality measurement. VBP depends upon the contractors access to quality measurement and the SHIN-NY not only could provide a robust dataset, but also one that is more real time than claims, which enables healthcare providers and CBOs to take action.

Over the last couple years, the SHIN-NY has prioritized quality measurement and dedicated significant resources to accelerate the capability to support. Beginning in 2018, DOH and NYeC designed quality measurement pilots to support NYS Patient Centered Medical Home (PMCH) practices with the calculation of quality measures from the NYS PCMH Scorecard as part of SIM. The pilots focus is on two use cases.

The first use case is calculating quality measures for NYS PCMH to use for ongoing performance feedback on quality measurement activities to physicians. The second use case focuses on data delivery to health plans, which led to a collaboration with NCQA. NCQA is presently analyzing three QEs' current state in exploring the development of a standard that can be used nationally to validate HIE data as standard supplemental data for health plans in their HEDIS reporting. This is

the first work of its kind in the country, and we are hopeful that the SHIN-NY will be the first to be validated.

The ultimate output of the pilots will be used to inform consensus building and a SHIN-NY Quality Measurement Workgroup that should be leveraged in the structure of the VDEs. For the ongoing performance feedback use case, the QEs have identified a subset of NYS PCMH Scorecard measures to focus on and begin measure specification/data contribution analysis. In addition, the QEs are working to identify target primary care practices.

Further, this past year, NYeC and QEs were involved in a collaborative effort to assist Medical Record Review (MRR) vendors with PPS performance measurement. This pilot aimed to evaluate the feasibility of the QEs in linking clinical data with Medicaid claims data and integrating this data into existing MRR workflows and providing measurement impact reports. This pilot spanned all 25 PPSs and demonstrated how the SHIN-NY was impactful for several measures. For example, one PPS measure improved 20%. This work continues through this final Measurement Year.

We strongly advocate for dedicated resources and a prominent function in the measuring quality performance for the VDEs as well as the SDHNs. We would also urge for the SHIN-NY to play a specific role in standard supplemental data for health plans in VDE support. Overall, we believe that the SHIN-NY should be an integral strategic partner in coordinated population health with vital real time information on performance.

Alignment with Other Statewide Federal Quality Improvement Activities

NYeC supports the aims identified in the Draft Amendment, particularly the DSRIP promising practices. Indeed, there are a variety of ways that NYS' goals are synergistic with other federal initiatives to support quality improvement and cost savings. This alignment is demonstrated by the similarities between the goals of the Draft Amendment and the following two CMS quality initiatives as examples: (1) the upcoming CMS CQIC Program, and (2) the previous TCPI via the PTN.

In the DSRIP Amendment Request, the State says it will create VDEs, across the state, to implement high-priority DSRIP promising practices. Under the CQIC Program, CMS says it will create CQIC entities across the country, that are tasked with achieving quantitative targets for maximum reach under four specific aims identified in the Program. Both programs task the VDEs and CQIC contractors respectively, to leveraging community coalitions, including community-based organizations, to drive improvement across similar areas of healthcare quality improvement. CQIC and DSRIP are similar with respect to some of its specific aims. Both the State and CMS are committed to addressing opioid misuse and overdose through a variety of initiatives. One aim of CQIC is to "Improve Behavioral Health Outcomes, including a focus on Decreased Opioid Misuse." Comparatively, the Draft Amendment states that it will address the federal priority area of Substance Use Disorder (SUD) Care and the Opioid Crisis, through two of its nine promising practices: (1) Integration and expansion of Medication-Assisted Treatment in primary care and ED settings, and (2) Partnerships with the justice system and other cross-sector collaborations.

Both CQIC and DSRIP have goals to improve care transitions in order to reduce hospital admissions. Specifically, CQIC's aim is to "Increase Quality of Care Transitions," by improving community-based care transitions to reduce Medicare hospital admissions nationally by 4.1% and Medicare hospital readmissions by 5.4%. New York State says it is well on its way to meeting its 5-year goal of reducing avoidable Medicaid hospitalizations by 25%, by posting a reduction of 21% through measurement year 4 in the first iteration of DSRIP. The Draft Amendment identifies the goal of continuing the promising practices of primary care and behavioral health integration, as well as care coordination, and care transitions, that led to meaningfully reducing avoidable Medicaid hospitalizations in the first iteration of DSRIP.

There is also an alignment between the quality improvement work proposed under the Draft Amendment and the work of New York's Practice Transformation Network (PTN) under the Transforming Clinical Practice Initiative (TCPI). This CMS initiative supported efforts to develop and implement comprehensive quality improvement strategies by aligning their practices with broad payment and practice reform in primary care and specialty care, promoting care coordination between providers of services and suppliers, establishing community-based health teams to support chronic care management, promoting improved quality and reduced cost, and developing a collaborative of institutions that support practice transformation. This type of work has been spread statewide by the PTN program and we believe this experience will strengthen VDEs going forward. We applaud the identified objectives and activities in the Draft Amendment for its alignment to federal initiatives of quality improvement.