Family Planning Advocates
of New York State

July 13, 2015

Mr. Jason Helgerson
New York State Medicaid Director and Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower
Albany, NY 11237
Comments submitted electronically to dsrip@health.ny.gov

Comments on the Delivery System Reform Incentive Payment (DSRIP) Program, the 1115 Waiver and Medicaid Managed Care

Dear Mr. Helgerson:

A catalyst of innovation and progress, the 1115 waiver has propelled the State forward in the delivery of critically needed services to a growing and diverse number of New Yorkers. As the state prepares for approval of the new waiver, Family Planning Advocates of New York State (FPA) appreciates the opportunity to comment on issues impacting family planning providers.

FPA represents the state's family planning provider network. Our members include the state's nine Planned Parenthood affiliates, hospital-based, county-based and freestanding family planning centers that collectively represent an integral part of New York's health care safety net for uninsured and underinsured individuals. Family planning centers provide critical primary and preventive care services such as family planning care and counseling, contraception, pregnancy testing, prenatal and postpartum care, health education, abortion, treatment and counseling for sexually transmitted infections, HIV testing and prevention counseling, as well as breast and cervical cancer screenings from funds that include the state's family planning grant, Medicaid and private insurance. This provider network is essential in the state's efforts to reduce the rate of unintended pregnancy, through the provision of a wide range of contraceptive methods including Long Acting Reversible Contraception (LARC). It is estimated that by assisting clients in avoiding unintended pregnancies, reproductive cancers, and STIs, New York's publicly funded family planning centers saved $605.8

million in public funds in 2010.[1] Family planning providers are located in rural, suburban and urban regions of the state and serve more than 308,000 patients yearly.[2]

Through the delivery of a robust array of health and educational services, family planning providers are a natural, and relied upon access point to health care and coverage. More than 86% of patients receiving care at family planning grant funded agencies in New York have incomes below 200% of the federal poverty level, with nearly two-thirds being below 100%.[3] A critical component of the state's safety-net, family planning providers understand the inherent value of a system that is rooted in the primary and preventive health care needs of a diverse Medicaid population. As the state builds upon the progress of redesign efforts within the Medicaid program, we urge further emphasis on fashioning a delivery system that recognizes the broad needs of those within Medicaid, and values the role of community-based providers with expertise in delivering culturally sensitive, confidential primary and preventive health care services.

Recognizing the critical role of reproductive and sexual health care in primary care

Reproductive and sexual health care is primary care for millions of women and men in the state of New York. Reproductive health care needs and concerns are often a driving force for individuals accessing health care services, especially young people. For those who are relatively healthy – or lack the ability to obtain care elsewhere – reproductive health focused providers are often the first and only door that patient may walk through. This affords a unique opportunity to connect individuals to coverage through onsite enrollers, address unmet needs through an array of screening tools, education and counseling services, and deliver needed primary and preventive health care services. By successfully meeting the primary and preventive needs of individuals and appropriately triaging and referring, reproductive health focused providers can bring immense benefits to reform efforts creating a truly collaborative system.

The ability to access affordable, quality and confidential services is a known factor as to why individuals seek care from reproductive health focused providers. Their expertise, availability through same-day appointments, and range of services delivered in a non-judgmental confidential setting tends to attract a predominately physically healthy population that is often on the periphery of both the health care delivery system and the focus of system transformation efforts. Failure to meaningfully engage these providers and populations in integrated care networks jeopardizes the overall goals of Medicaid redesign.

While many of our members have had success in partnering with Performing Provider Systems (PPSs) throughout the state, the fact remains that the often-narrow focus on specific project metrics by PPSs, such as the ability to obtain PCMH level-3 status, has stifled innovation and greater engagement. For

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[1] Frost JJ, Sonfield A, Zolna MR and Finer LB, Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, *The Milbank Quarterly*, 2014, doi: 10.1111/1468-0009.12080, <http://onlinelibrary.wiley.com/enhanced/doi/10.1111/1468-0009.12080/>, accessed Sept. 15, 2015.

[2] Data from the Department of Health, Bureau of Women, Infant and Adolescent Health. New York State Family Planning Program Overview of Client Characteristics from 2011 to 2014. Obtained Sept. 15, 2015.

[3] Ibid

example, across the state, many of our Planned Parenthood members are actively engaging with community partners to connect patients with behavioral health services, based on screening and needs assessments. However, some have faced uphill battles attempting to formally participate in primary and behavioral health care integration projects. This is an unfortunate missed opportunity for PPSs, given the fact that young women, a key patient population for reproductive health focused providers, are disproportionately impacted by depression, anxiety and substance use. Further, it is the early experience of our members who are engaged in behavioral health screenings, that women are more comfortable seeking care at reproductive health focused providers because these providers are known as a place where one can seek confidential, non-judgmental care.

The lack of innovative engagement by PPSs has often marginalized both the important role that reproductive health focused providers' play in delivering primary and preventive care and the services they provide within DSRIP projects. One-quarter or women of reproductive age in New York are insured through Medicaid.[4] Guaranteeing the substantive inclusion of these critical primary and preventive health care providers in significant DSRIP projects is essential to both the preservation of access points to needed health care services and the overall success of the program. The failure of PPSs to view projects through a lens of innovation confines the impact of reform efforts by limiting the ways in which providers connect their patient population to the integration initiatives within their region.

FPA recommends that the State, at every possible juncture, reinforce the significance and value of innovation within system transformation and the diverse and active participation of both provider and community-based organizations within the networks of PPSs.

Fostering a system that safeguards patient confidentiality

While the benefits of system integration and the robust sharing of health information are undeniable, we cannot lose sight of the importance that many patients place on confidentiality. Research underscores the fact that confidentially can play a key role in whether an individual will obtain sensitive health care services. This is a particular concern for minor patients[5], a well as women obtaining abortion care.

It is indisputable that across the country the issue of access to reproductive health care is a highly politicized matter. Ideological beliefs that these services are immoral or controversial can inappropriately color an interaction a patient may have with a health care provider, or between a minor and a parent or guardian when a provider inadvertently – or advertently – discloses receipt of

[4] Kaiser State Health Facts: Health Insurance Coverage of Women Ages 15-49. (n.d.). Retrieved July 11, 2016, from http://kff.org/other/state-indicator/health-insurance-coverage-of-women-ages-15-49/?state=NY

[5] *See,* Jones RK et al., Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception, *Journal of the American Medical Association,* 2005, 293(3):340-348, available at: http://jama.jamanetwork.com/article.aspx?articleid=200191; Reddy, D, Fleming R and Swain C, Effect of mandatory parental notification on adolescent girls' use of sexual health services, *Journal of the American Medical Association,* 2002, 288(6):710-714; Kaiser Family Foundation, *SexSmarts: A Series of National Surveys of Teens About Sex. Sexually Transmitted Disease,* 2001.

sensitive services. The ramifications of these interactions can range from uncomfortable to dangerous elevating the value patients place on access to confidential reproductive health care services.

As providers of these services, our members have witnessed first hand how the fear of emotional or physical harm, or stigma can influence how one seeks and obtains reproductive health care. For some, the fear of disclosure will deter care. This can cause significant and adverse consequences for both the individual and for the achievement of important public health goals such as reductions in unintended pregnancy and sexually transmitted infections and improvements in maternal and infant health outcomes.

It is because of the concerns for patient privacy along with concerns that patients will be dissuaded from seeking treatment, or be subjected to stigma, that the reproductive health field has long had concerns over the prospect of uploading patient information.

While reproductively focused providers recognize the significance of sharing clinical information, the current inability of systems to allow for episodic data sharing raises apprehension in regards to the potential impact on patients, especially in situations where data is revealed to other providers that may not be clinically relevant to the care being provided. The great emphasis being placed on providers connecting to Regional Health Information Systems (RHIOs) and the Statewide Health Information Network for New York (SHIN-NY), presents serious challenges to safeguarding the receipt of sensitive services – a concern that is not limited to areas of reproductive health care, but also extend to behavioral health services.

Ideally, system capabilities would enable data for sensitive services – including minor consent services – to be tagged and segregated to avoid disclosure. *FPA urges the state to incentivize systems to adopt functionality that enables, per episode of care, patient determination of whether the information is uploaded to the RHIO and SHIN-NY.* We believe this could be a positive evolution of the current "opt-out" approach, successfully balancing the sharing of clinically relevant information with the need to preserve the confidentiality of sensitive health care services. Undoubtedly for this to become a reality, it will require financial resources and commitment on behalf of the State and developers within the RHIOs and the EMR systems. However, we believe this investment will result in great benefit to the system reform at large.

The State should also encourage PPSs to proactively educate providers, particularly those who are not generally involved in the provision of reproductive health services, about the laws regarding the confidentiality of minor consent services, prohibitions on revealing such information to parents or guardians and the importance of being sensitive to patient concerns about their ability to receive reproductive health services in confidence.

Ensuring Continued Stakeholder Engagement in System Transformation

FPA applauds the State for their attention to stakeholder engagement in both the development and implementation of reform initiatives that have taken place to date. *We urge the State to seize every opportunity to capture robust and diverse stakeholder feedback as the transformation to our health*

care delivery system continues forward. Further, we are aware of national research in its early stages, which reinforces the fact that for women, reproductive and sexual health care is primary care. We look forward to sharing the findings of this research with you as it speaks to the needs and preferences of a large segment of the Medicaid population – women of reproductive age.

In conclusion, FPA appreciates your consideration of these comments and is at your disposal should you seek clarification or further discussion either on the points raised here, or other areas related to the provision of reproductive health care services in the state of New York.

Sincerely,

Bowman Kim Atkins
Board Chair
Family Planning Advocates of New York State

American Cancer Society ☙ Children's Defense Fund-New York ☙ Coalition for Asian American Children and Families ☙ Community Service Society of New York ☙ Empire Justice Center ☙ Make the Road New York Medicare Rights Center ☙ Metro New York Health Care for All Campaign ☙ New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority ☙ Young Invincibles

July 14, 2016

Jason Helgerson, Director
New York State Medicaid

RE: 1115 Waiver Public Comment Request

Dear Director Helgerson:

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.

Thank you for the opportunity to comment on New York State's 1115 Waiver. As of the due date for public comments, no drafts of the waiver are available and so HCFANY is unable to provide comments on any proposed changes. The Department should undertake another public comment period when the draft waiver has been made public.

The following comments refer to other aspects of New York's Medicaid program. Many of these comments and recommendations echo those of Medicaid Matters New York.

Delivery System Reform Incentive Program (DSRIP)

- The Performing Provider Systems should be systematically engaging consumers in their efforts, including representation in governance structures. Consumer experiences should be used to continuously improve the projects. As with other delivery system reform efforts, consumer experiences and patient-reported outcomes should be a major component in assessing whether or not DSRIP has succeeded.
- The Department should post quality information publicly and on a regular schedule for the PPSs, similar to the quality information you presented to at the United Hospital Fund's 2016 Medicaid Conference. However, the quality reports should be linked to specific PPSs. Sharing this information publicly would increase accountability to the public. It would also create more investment in the DSRIP effort from the affected communities.

- Funding for DSRIP and other health reform activities should be transparent. Definitions should be provided for the categories of spending included in the PPS funds flow reports.

Health Care For All New York
c/o Amanda Dunker, Community Service Society of New York
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- Community-based organizations (CBOs) should receive significant resources for the non-clinical services they are providing in support of the PPS projects. The Community-Based Organization Planning Grant was a positive step towards providing the support that CBOs need to negotiate fair rates with the PPSs. DSRIP funds not allocated or fully spent by the PPSs should go to CBOs.

Value-Based Payments

Some brief comments are included below, but please also see the attached letter for more detailed feedback on the value-based payment roadmap. Those comments were submitted to the Value-Based Payment Workgroup in April.

- Consumers have the right to know about how their care is paid for, whether or not their providers are participating in reform efforts, and what those reform efforts are meant to achieve.
- Consumer experiences and patient-reported outcomes should be used to assess the success of value-based payments and other health reform efforts.

Managed Care

- Everyone should receive care that is coordinated and efficient, especially people who are in mandatory managed care.
- There should be more standardization in the definitions of care coordination used by different state programs so that the state can more effectively hold payers and providers accountable. Beneficiaries who are entitled to care coordination should be informed about what that means, for example by sharing the services that are included in plan and provider contracts.

Consumer Assistance

- Individual, independent consumer assistance should be available to everyone in managed care. The Independent Consumer Advocacy Network (ICAN) should be sufficiently supported to achieve this goal.
- ICAN should be required to provide regular, public reports on its activities and trends.

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

Sincerely,

Amanda Dunker, Policy Associate
Community Service Society of New York

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HOSPICE AND PALLIATIVE CARE ASSOCIATION OF NEW YORK STATE

Public Comments on New York State's 1115 Waiver Programs

July 12, 2016

Thank you for the opportunity to offer comments on New York State's 1115 Waiver Programs. The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the work of the Department of Health to develop an innovative approach to reforming the health care system in New York State. Hospice and palliative care embody the Triple Aim—patient-centered, quality, cost-effective care. Using an interdisciplinary model, hospice and palliative care provide case management and quality patient centered care—they are the perfect partners to help advance DSRIP's objectives, and they bring great value to the Performing Provider Systems (PPS's).

Last year, the Hospice and Palliative Care Association of New York State (HPCANYS) established a DSRIP Coalition as a way to support hospice and palliative care providers in working with PPSs in their respective regions. Recently, we have partnered with the Center for the Advancement of Palliative Care (CAPC) in an effort to improve communications collaboration between providers, advocates and educators in palliative care, PPSs, and others interested in working together to expand access to quality palliative care under the DSRIP projects. We are excited about the ongoing work of our coalition. HPCANYS also offers its support through its Innovations/Managed Care Task Force and a new Hospice and Palliative Care/Managed Care Collaborative.

Looking back, when the Department of Health's Medicaid Redesign Team (MRT) undertook the project of restructuring Medicaid, enhanced access to palliative care was addressed under initiative 109 and greater utilization of hospice was formally advocated as policy under initiative 209. These policy changes were respectively enacted in statute in the 2011 budget and in the Hospice Modernization Act of that same year.

In 2010, the Legislature and Governor enacted as Chapter 331 of the Laws of 2010 (codified as Pub. Health Law section 2997-c) the Palliative Care Information Act (PCIA). That statute requires that, beginning in February 2011, "attending health care practitioners" offer to provide to patients with a terminal illness appropriate information

and counseling regarding palliative care and end-of-life options. The statute specifically provided that those practitioners who were not willing to provide this information and counseling themselves were required to make arrangements for another practitioner to do so.

Similarly, on April 1, 2011, the Governor signed into law Chapter 59 of the Laws of 2011 (codified as Pub. Health Law section 2997-d) the Palliative Care Access Act (PCAA). This statute expanded on the Palliative Care Information Act by making its terms applicable to health care facilities, home care agencies and certain types of assisted living arrangements. In addition to the requirements of providing information and counseling on palliative and end-of-life options to those with a terminal condition, the scope of this statute was expanded to include patients with "advanced life limiting conditions or illnesses who might benefit from palliative care."

As clear statements of public policy, these statutes mandate unambiguously the active and consistent application of hospice and palliative solutions to some of the most vexing issues inherent in chronic disease management and end-of-life care. Unfortunately, while these statutes (and the MRT initiatives that preceded them) have consistently declared the state's policy goals, the on-the-ground implementation of these initiatives under DSRIP has been underutilized.

Though very few PPS's chose palliative care projects, all PPSs will need robust palliative care and hospice partnerships to realize their goals. These partnerships are the keystone of success under DSRIP and post-DSRIP. In order to assure that hospice and palliative care providers are true partners—and not just "in name only"—it is imperative that programs providing these services are not marginalized. These programs, some of which are designated as Vital Access Providers (VAP), should not be excluded from project funds. Hospice and palliative care providers will need greater access to capital funds to expand technical capacity and assure clinical capacity and sustainability. This issue is especially concerning since the low metrics assigned to the palliative care projects could negatively impact access to adequate funding.

Appropriate and seamless transitions of care are a key component to the success of the PPS's as well. Indeed, we must recognize the key role of palliative care in helping people with chronic illness avoid unnecessary readmission to the hospital. Although there is a body of research on the savings to Medicare that come from palliative care and hospice, we have little information on how this translates into the value those programs provided to the Medicaid population. Medicare data could be used to extrapolate projected Medicaid savings, and HPCANYS offers its resources and expertise to assist with such a project.

Crucial to the success of DSRIP is the relationship between managed care and Hospice and palliative care. It is strategically imperative that assuring seamless access to hospice and palliative care within the managed care environment be made a priority. We continue to urge setting aside dollars for hospice to integrate their electronic health record with the regional data sharing systems needs to be implemented across all

PPS's. Additionally, all PPS's should be encouraged to use their local hospice and palliative care providers as a resource.

Hospice utilization in New York is abysmally low. Nationally, hospice utilization is 44.4%; in New York State it is 30.3%, and in some counties (Allegany) as low as 16.6%. Median length of stay (LOS) is 23 days nationally and 16 days in NYS, based on 2014 Medicare data. According to National Government Services 2014 statistics, median LOS in New York is closer to 11 or 12 days. Making a concerted effort to increase hospice utilization and length of stay will likewise contribute to the success of the PPS's.

Moving forward, we must do better to ensure access to hospice and palliative care, a critical place in the health care continuum, is available to all. Specifically, we urge a stronger commitment for the following:

- Development of a payment structure for community-based palliative care;
- Provide capital funding for hospice infrastructure and technology updates;
- Establishing Vital Access Provider status for hospices in New York State; and,
- Advancing the common mission of both DSRIP and of hospice for patient-driven care provided through the empowerment of families in the home environment

Hospice and palliative care services can and should play a much larger role in improving the health care delivery system under DSRIP process. We urge the New York State Department of Health to emphasize hospice and palliative care as well as continuing the integration of palliative care and hospice into the Value Based Payment (VBP) Roadmap.

We stand ready to work closely with DOH and PPSs and others in moving forward in achieving our shared goals, based on the Triple Aim, of the State's DSRIP program.

Thank you.

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Statement on New York State's Implementation of Medicaid Section 1115 Waiver

Introduction

LeadingAge New York represents nearly 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout New York State. We are pleased to provide comments on New York's implementation of its Medicaid Section 1115 waiver authority, which seeks to utilize a managed care system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, extend coverage to certain individuals who would otherwise be without health insurance, and restructure the health care delivery system through the Delivery System Reform Incentive Payment (DSRIP) program.

For decades, the State has focused on curbing Medicaid long-term care (LTC) spending by reducing provider reimbursement and more recently by shifting to a managed care system for service delivery and coordination. Investments or regulatory changes that would support the development of new capacity or lower-cost models of LTC have not been a priority, nor has investment in programs that would help seniors to avoid or delay enrollment in Medicaid.

On the contrary, as the State has pursued an ambitious effort to provide care management for all and reduce avoidable hospital use, only a minuscule fraction of the billions of dollars invested in the health care delivery system through DSRIP and other infrastructure programs has been invested in the LTPAC sector. Instead, funds have been targeted at primary care and behavioral health care and essentially compensating hospitals for lost volume. As currently structured, the State's DSRIP program and value-based payment (VBP) initiatives are not only unlikely to drive new investment in LTPAC and senior services; they are likely to have the opposite effect unless the approach changes.

Rather than investing new funds in the LTPAC sector, the State has indicated that it will continue to fund its managed long-term care (MLTC) quality pool and its nursing home quality initiative through withholds of payments and that these withholds will grow exponentially in conjunction with VBP initiatives. Furthermore, the State has indicated that it intends to rely on savings generated through VBP arrangements as the source of new investments in health care delivery, community-based organizations, and affordable housing. However, because the overwhelming majority of savings derived from the LTPAC sector will accrue to Medicare (rather than Medicaid), there will be little, if any, savings to be invested in that sector. As a result, if the State pursues this strategy, the LTPAC sector will experience only reductions in revenue and no new investment, despite a rising population of older New Yorkers.

Although they have not been given a central role in the State's health care reform efforts, LTPAC providers and MLTC plans are well-positioned to contribute to New York State's initiatives to transform care and reduce avoidable hospital use. They serve medically-complex and frail elderly and disabled individuals, who experience high rates of hospitalization and frequent transitions between health care

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settings. With longstanding experience and clinical expertise in the care of seniors and people with complex conditions and functional limitations, LTPAC providers have been at the forefront of innovative models of coordinated and person-centered care.

Our remaining comments focus on two areas central to the future of LTPAC providers and MLTC plans and their ability to advance the goals of the State's 1115 waiver authority.

Strategic Investments in Health Information Technology

Success in today's LTPAC operating environment depends heavily on a robust health information technology (IT) infrastructure. The ability to collect, share, and analyze clinical and financial information electronically is integral to all of the new models of care and payment embraced by the State and federal governments under health care reform and as part of the State's 1115 waiver authority. Providers need the capacity to collect and share information electronically with care partners securely and efficiently, in order to coordinate care, avoid unnecessary utilization and optimize outcomes. Data and analytics capacity is also critical to quality measurement and improvement efforts and to population health management initiatives. As the State and federal governments move from fee-for-service payments to VBP arrangements, effective health IT solutions that link clinical, cost and expenditure data across settings are needed to assess and manage the risks associated with these new payment arrangements.

Despite the clear need for sophisticated health IT in today's health care environment, public investment in the health IT infrastructure needed by LTPAC providers to succeed under MLTC and VBP has been negligible. Given their heavy reliance on Medicaid and Medicare revenues and their shrinking margins, many LTPAC providers have not been able to self-fund the substantial investments in robust electronic health record (EHR) systems, health information exchange (HIE) and data and analytics tools necessary for these new initiatives.

While general hospitals and physician practices have benefited from concerted federal and State efforts to fund investment in EHRs and HIE, the LTPAC sector has been largely overlooked. DSRIP payments through performing provider systems (PPSs) are unlikely to fill this major gap in health IT investment. Based on our analysis of the PPS first quarterly reports, only 4.2 percent of DSRIP incentive payments are projected to flow to nursing homes over the next five years, only 3.6 percent to community-based organizations, and only 1.1 percent to hospice programs. More recently, State infrastructure grant initiatives (e.g., Essential Healthcare Provider Support Programs, etc.) have excluded LTPAC providers.

The heavy reliance on public payers in the LTPAC sector, together with progressively shrinking margins, has prevented necessary development of IT infrastructure. This gap will inhibit the adoption of new models of care and payment by LTPAC providers and the ability of the State and federal governments to advance the Triple Aim and the objectives of the 1115 waiver.

Like hospitals and physician practices, LTPAC providers require a substantial public investment in IT infrastructure. The adoption of EHRs and broad participation in health information exchange among LTPAC providers will be critical to their success in VBP arrangements and the State's DSRIP efforts. LTPAC providers will also need public funding for technology to support the management of financial

risk, quality measurement, and performance improvement efforts under VBP. LeadingAge NY is recommending that $100 million be made available for EHR adoption and HIE in the LTPAC sector. A significant portion of these funds should be dedicated to expenses that cannot be capitalized, such as software leases and licenses, and associated training costs.

In addition to investing in EHRs, HIE and systems to support data and analytics, the State should make funding available to expand access to telehealth and remote patient monitoring tools. These technologies can improve access to care, while reducing transportation expenses, home health nurse visits and avoidable hospitalizations. These modalities are especially useful in rural areas, where telehealth and remote patient monitoring can allow for more efficient use of a limited workforce.

Medicare-Medicaid Alignment

The centerpiece of New York's efforts to rein in LTC costs while producing better outcomes has been mandatory enrollment in MLTC plans. The decision to institute mandatory enrollment in MLTC was based on the assumption that MLTC could reduce spending and improve outcomes by rationalizing provider payments and providing care management and utilization controls that would produce more coordinated care and reduce unnecessary services. Managed care quality reports indicate that MLTC plans are, indeed, making available high-quality care through care management and contracted networks of providers. The plans' care coordination activities with physicians and hospitals are believed to be effective in reducing avoidable hospitalizations and improving outcomes.

However, MLTC plans' ability to reduce LTC utilization is limited by the intensive needs of the beneficiaries they serve and various State policies. Unlike mainstream Medicaid managed care plans which serve a mix of beneficiaries in good health and poor health, and can generate savings by reducing duplicative services and avoidable hospitalizations, MLTC plans, by definition, serve beneficiaries with complex conditions and functional limitations, the vast majority of whom would otherwise qualify for nursing home placement. MLTC plans' only options for producing savings within their benefit package are to substitute lower cost services for higher cost ones or to limit LTC service utilization. Even these options are severely limited by the State's continuity of care and fair hearing policies. Likewise, the plans' ability to generate savings by reducing the prices they pay for services is limited by State wage and provider rate requirements.

Although MLTC plans and their network providers have limited ability to generate savings on Medicaid-covered LTC services, there are opportunities for those plans and providers to generate reductions in Medicare spending on acute and post-acute care. LTPAC and senior services providers have the clinical resources and expertise to meet the needs of complex patients and residents with multiple co-morbidities and functional limitations in multiple settings. LTPAC and senior services providers generally also have far more intimate and ongoing knowledge of their patients and residents, their living environments, their caregivers, and their support needs than a typical physician practice or hospital.

However, the separation of LTPAC funding streams and associated policies between Medicare and Medicaid represents a significant impediment to real reform. Because MLTC plans are not paid by Medicare, there is no common pool of expenses from which Medicare and MLTC plans can share savings. In fact, if LTC providers and MLTC plans succeed in reducing inpatient and post-acute

utilization by dual eligible beneficiaries, they will only drive up Medicaid LTC utilization and associated spending. Every day that a dually-eligible beneficiary is in the hospital or receiving post-acute care services represents a day covered by Medicare, rather than Medicaid. If those Medicare-funded acute and post-acute days are reduced, Medicaid will have to fill in the gap. Thus, the Medicare-Medicaid divide at best creates perverse incentives, and at worst it can lead to cost shifting and lack of accountability for delivering care in the most appropriate setting.

New York is seeking federal approval of a VBP Medicare alignment proposal to enable the State to "virtually pool" Medicare and Medicaid payments so that providers and plans can share in the risk of overall health and LTC spending, regardless of the payer source. This concept will be key to the successful engagement of LTC plans and providers in VBP initiatives. However, we understand that the federal government has not yet shown interest in moving forward with this virtual pooling concept.

Without such a construct, LTPAC providers and MLTCs may be deprived of the opportunity to generate meaningful VBP shared savings. This could lead to continued stagnation in the level of Medicaid payments, which would further threaten access to high quality LTPAC services throughout the State and undermine the goals and expectations of the 1115 waiver.

Conclusion

LeadingAge New York is appreciative of the opportunity to provide input on New York's 1115 waiver authority. We look forward to working with the State and federal governments on these critically important issues. Please do not hesitate to contact us at (518) 867-8383 with any questions on our input.

July 13, 2016

Comments from The New York Academy of Medicine

To the DSRIP Project Approval and Oversight Panel

Tuesday, July 12, 2016

Albany, New York

Comments delivered by:

Dr. Angel Mendoza, Director, Center for Health Policy and Programs, Institute for Urban Health, The New York Academy of Medicine

At The New York Academy of Medicine, we are dedicated to advancing the health and well-being of people living in cities. We do this through our Institute for Urban Health, home of interdisciplinary research, evaluation, policy, and program initiatives; our world class historical library of medicine and public health and its active programming in history, the humanities, and the arts; and our Fellows, a network of more than 2,000 experts elected by their peers from across the professions affecting health.

In New York as in the United States, there is overwhelming evidence that the traditional health care system – clinical care – is only a minor determinant of overall health outcomes.[1] Our health is, in large part, determined by social and economic factors and behaviors like what we eat, how we move, and where we live. Yet, most of our spending is on traditional health care. The U.S. spends more than any other nation in the world on health care, and New York ranks relatively high in health care spending within the U.S.[2] New York State Medicaid spending was approximately $8,223 per beneficiary in 2014.[3] This contrasts with the New York State public health spending of $95 per capita in FY 2014-2015.[4] This relative underinvestment in prevention is a missed opportunity to improve the population health of New Yorkers; an analysis by the New York Academy of Medicine and the Urban Institute suggests that an additional investment of just $10 per person per year in evidence-based community interventions would carry a 7:1 return on investment for New York.[5]

Importance of Alignment to Leverage Investments across Population Health Activities

The State's health reform efforts, including DSRIP, represent an opportunity to better align spending with factors that influence population health. However, to-date, the bulk of the DSRIP funds are being spent within the health care system – on clinical transformation efforts – and not on the broader determinants of health in the surrounding communities. Partnering with community based organizations (CBOs) that provide services linked to the broader determinants of health, such as housing and access to healthy food, is a promising solution. CBOs are already trusted providers within the neighborhoods they serve and have a deep understanding of the factors that influence people's lives. Yet, there are challenges to creating viable partnerships between PPSs and CBOs.

Currently, there is a cap established in the waiver that no more than 5% of overall DSRIP funds can go to non-safety net providers, a definition that includes all organizations, like CBOs, that do not regularly bill Medicaid. Furthermore, hospitals and CBOs, who may have little history working together, must tackle reimbursement, quality management, reporting requirements and accountability, if they are to partner together. Despite these challenges, it is critical that PPSs work with those in the community that focus on broader determinants of health if the triple aim of better health, better care, and lower cost is to be realized. Indeed, a recent report funded by the Commonwealth Fund notes that, "without sufficiently targeting the social determinants of health, many PPSs are missing an opportunity to reduce costs and improve outcomes."[6] That's because focusing on the health care delivery system alone will not achieve the desired

[1] See, for instance, McGinnis et al, 2002.
[2] Commonwealth Fund State Scorecard, 2014
[3] NYS DOH OHIP DataMart, 2015
[4] Trust for America's Health analysis, 2016
[5] See Trust for America's Health, "Prevention for a Healthier America," 2008, available here http://healthyamericans.org/reports/prevention08/Prevention08.pdf , last accessed July 6, 2016.
[6] Bachrach, et al, "Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform," April 2016. The Commonwealth Fund pub .1871.

improvements in the health status of all New Yorkers nor health equity in the State. There must also be an investment in the health of geographic communities to support (social and built) environments that help prevent disease and promote health and health equity. A doctor's order to a patient to lead a healthy lifestyle has no meaning if there is not easy access to healthy options, resources and services in that patient's community. An investment in community resources that bolster health will increase the effectiveness of clinical programs, help improve health and health equity, and foster long-term cost control.

The Prevention Agenda 2013-18 identifies evidence-based interventions to improve community health. Hospitals, local health departments, community organizations, and other partners in counties across the State have selected Prevention Agenda priorities and are working together to implement related interventions. In addition, each DSRIP PPS was required to select at least one (max 2) projects that draw directly upon the Prevention Agenda. These "Domain 4" projects tie to four priority areas: promote mental health and prevent substance abuse (MHSA); prevent chronic diseases; prevent HIV and STDs; and promote healthy women, infants and children. Several PPSs are already investing in these "population wide" projects, including four PPSs in the Bronx and Brooklyn who have pooled investments to strengthen MHSA infrastructure in schools. While these efforts are laudable, there is skepticism about whether the Domain 4 projects will be enough to "move the needle" on population health. There is no minimum required investment and there is no accountability for improvement in the population health metrics (compared to the other domains, where DSRIP payment is dependent on performance).

Aside from DSRIP investments, non-profit hospitals in New York State report spending over $260M on "community health improvement" and "community building" within their community benefit portfolios.[7] However, these investments may not always align with the Prevention Agenda and DSRIP population health activities proposed by the same hospitals.

In order to maximize the potential impact of these three activities and related hospital investments, Prevention Agenda, DSRIP, and community benefit efforts should be aligned, focused on evidence-based interventions addressing local community needs, and include greater accountability for results.

Specifically, we ask that you:

a. Reinforce Commissioner Zucker's November 2015 letter to hospital CEOs and local health department commissioners that encouraged alignment of DSRIP Domain 4, Prevention Agenda, and hospital community benefit investments.

b. Request PPSs specifically report on their DSRIP population health activities, as well as how they align with local Prevention Agenda goals, at all meetings of the DSRIP Project Approval and Oversight Panel.

c. Consider adding financial incentives related to performance on DSRIP Domain 4 Project population health measures.

[7] As per a review of 2012 IRS Form 990 Schedule H submissions by NYS non-profit hospitals.

2015

LOCAL HEALTH DEPARTMENTS AND PERFORMING PROVIDER SYSTEMS: POTENTIAL PARTNERS IN IMPROVING POPULATION HEALTH

A Survey of Local Health Department Involvement with Performing Provider Systems under New York's Delivery System Reform Incentive Payment (DSRIP) Program

November 2, 2015

The New York State Association of County Health Officials (NYSACHO) represents all 58 local health departments (LHDs) in New York State (within 57 counties and the City of New York). LHDs are local government entities responsible for delivering population health services to their communities in order to promote health and wellness and prevent disease, disability and injury throughout the state. Local health departments deliver core public health services, including: community health assessment and improvement planning, chronic disease prevention, communicable disease control, family health services, environmental health services, and public health emergency preparedness and response.

Through a federal Medicaid waiver, New York State is implementing the Delivery System Reform Incentive Payment (DSRIP) program, to "promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement."

DSRIP funds have been awarded to Performing Provider Systems (PPS's). The work of a PPS encompasses four domains:

Overall project progress (Domain 1)

System transformation (Domain 2)

Clinical improvement (Domain 3)

Population Health (Domain 4)

Each domain many include significant engagement of the health care delivery sector in improving population health.

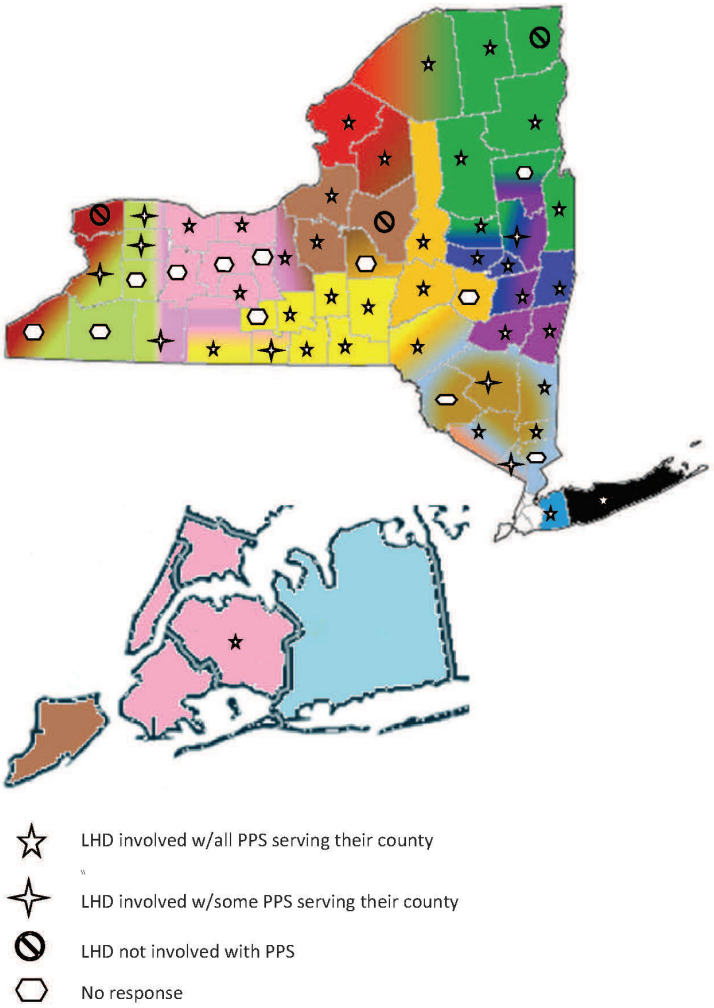
NYSACHO recently surveyed its LHD members to learn more about how and where local health departments are engaging with the Performing Provider System(s) serving their county or municipality, and what types of services LHDs provide that fall under the various DSRIP domains and could support DSRIP goals.

The survey results indicate a significant variation in engagement from LHD to LHD and from PPS to PPS. Even those LHDs that already serve on PPS committees vary in their level of involvement. However, the results also indicate that, in many cases, the population health expertise and the programs and services offered by LHDs have the potential to make significant contributions to DSRIP efforts undertaken by Performing Provider Systems.

This aggregation of the survey results provides a closer look at how LHDs can contribute to DSRIP population health objectives.

Survey Results:

A total of 45 of the 58 local health departments responded to NYSACHO's DSRIP survey in October 2015. Of the 45 respondents, 41 LHDs reported that they have some involvement with their local PPS. Of those 41 reporting, 19 LHDs are in counties served by two or more PPS. The remaining 26 have only one PPS in their jurisdiction.



LHD Engagement with PPS

Adirondack Health Institute, Inc.	
Albany Medical Center Hospital	
Alliance for Better Health Care, LLC	
Bassett Medical Center	
Central New York Care Collaborative, Inc.	
Finger Lakes Performing Provider System, Inc.	
Millennium Collaborative Care	
Montefiore Medical Center	
Nassau Queens Performing Provider System, LLC	
Refuah Community Health Collaborative	
Samaritan Medical Center	
Sisters of Charity Hospital of Buffalo, New York	
Southern Tier Rural Integrated Performing Provider System, Inc.	
Advocate Community Providers, Inc.	
Bronx-Lebanon Hospital Center	
Maimonides Medical Center	
Mount Sinai PPS, LLC	
NYU Lutheran Medical Center	
SBH Health System	
The New York and Presbyterian Hospital	
The New York City Health and Hospitals Corporation	
The New York Hospital Medical Center of Queens	

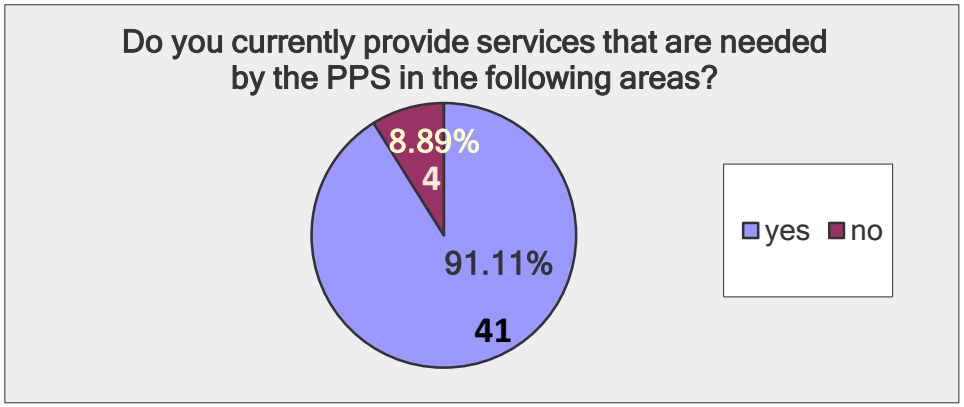
Source of Map graphic: NYSDOH. LHD information added

Total survey respondents: 45 of 58 LHDs

Of the 41 local health departments responding that they were engaged with one of more PPS, 37 participate formally, either as part of the governance structure or through committee participation by both local health officials and LHD staff. A total of six local health officials reported serving on their PPS board and 26 serve on a committee. Three LHDs report that they have staff (other than the Commissioner/Director) serving on a PPS Board, and 24 LHDs have staff participating on a committee. Eight of the LHDs served by more than one PPS report participation on either the board or committees of multiple PPS. The number of staff participating with PPS activities ranges from zero to nine, with 34 LHDs reporting between 1-4 staff persons involved with their PPS.

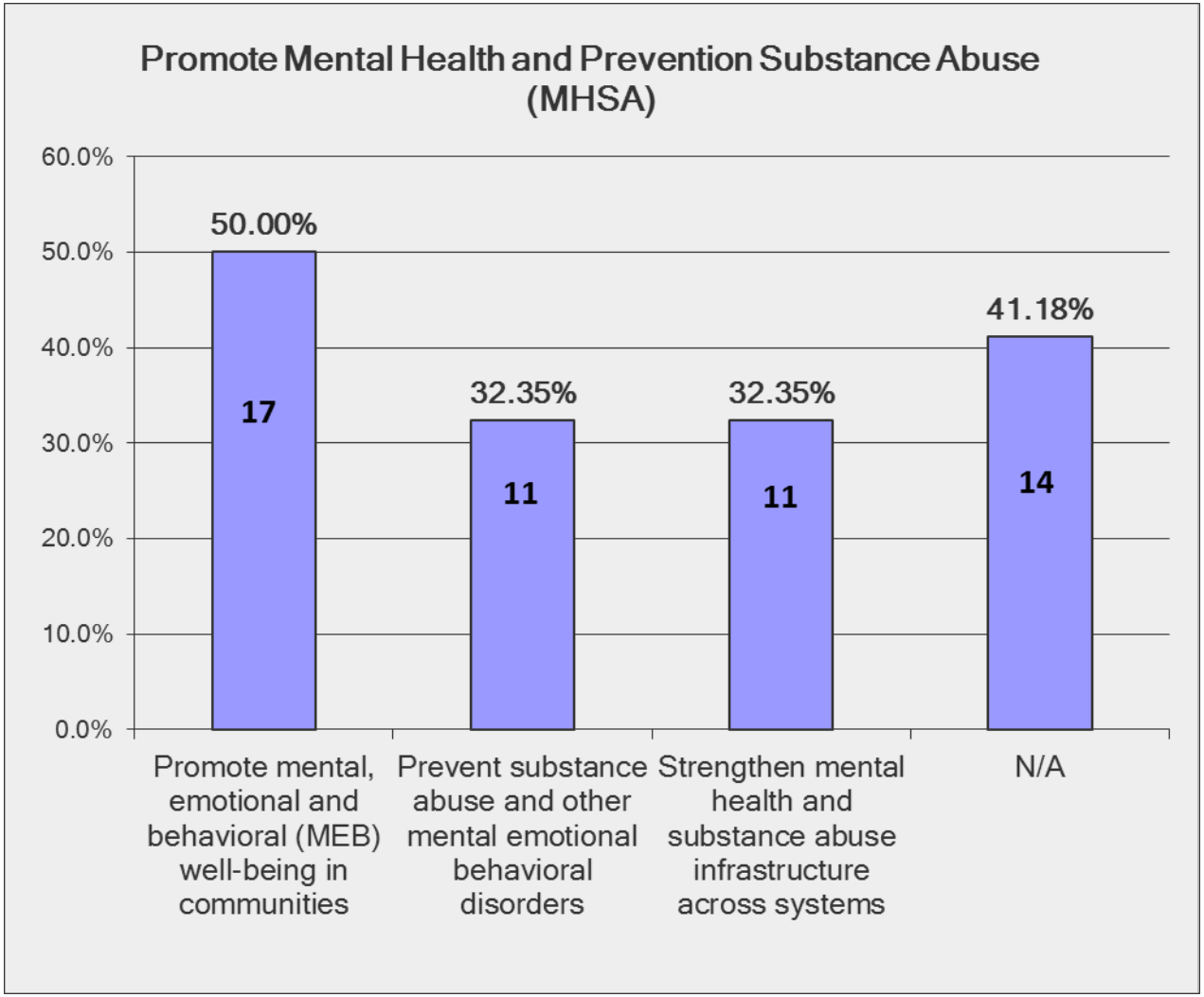
16 LHDs indicated that they anticipate a potential subcontract between their LHD and PPS. Of these, three of those served by more than one PPS have possible subcontracts with all PPS's in their county. 35 LHDs reported that they would be willing and able to contract to provide services to their PPS and 41 report that they provide services related to one or more of the following service areas:

- Promote Mental Health and Prevention Substance Abuse (MHSA)
- Prevent Chronic Disease: Promote Tobacco Use Cessation
- Prevent Chronic Disease: Increase Access to High Quality Chronic Disease Preventive Care & Management in Both Clinical and Community Setting
- Prevent HIV and STDs
- Promote Healthy Women, Infants and Children
- Development of community-based health navigation services



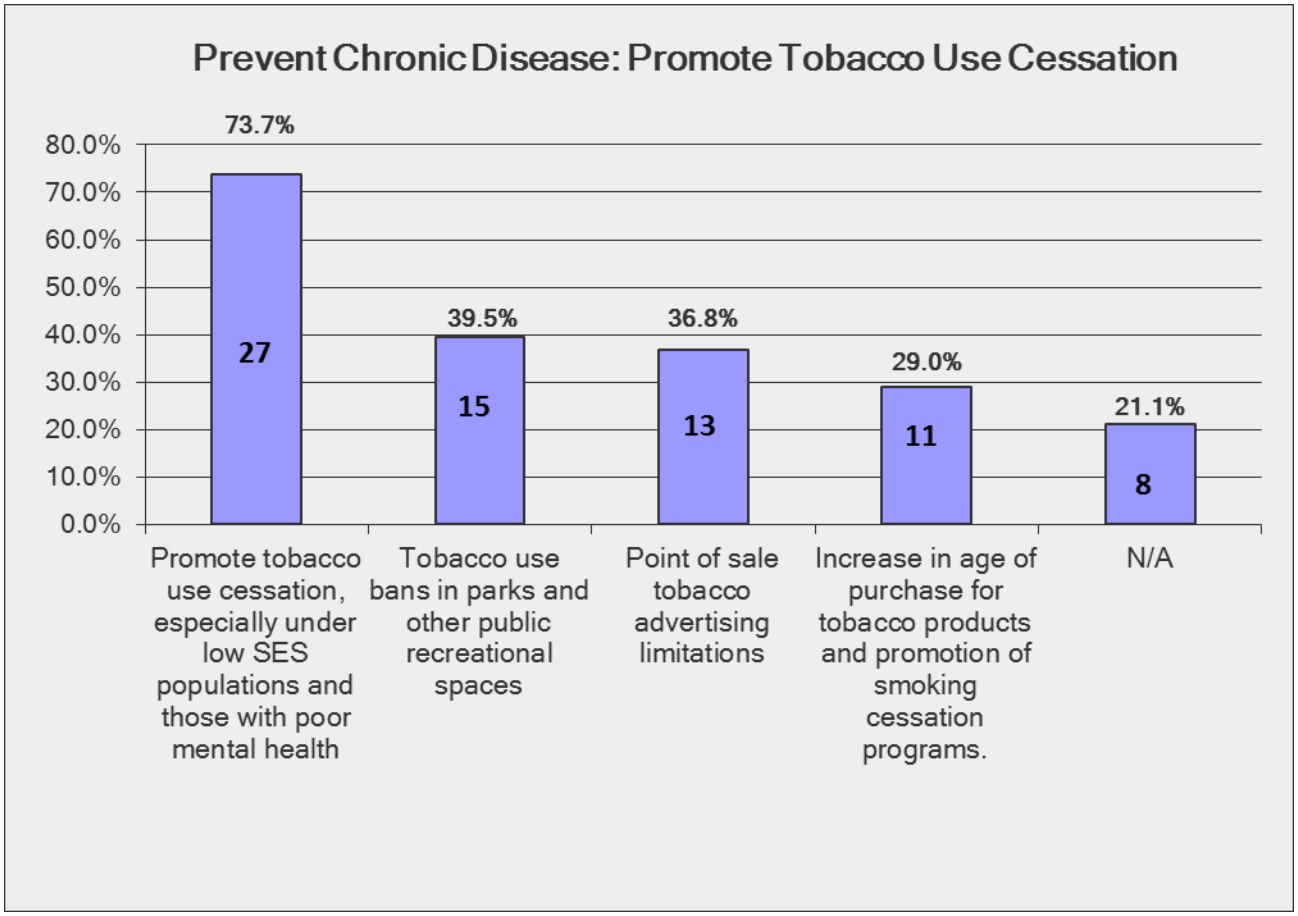
Common barriers/challenges to contracting with PPS included: County Legislative or Board of Supervisor approval of any contract; lack of designation as safety net provider; lack of adequate funding in the subcontract to cover expenses; lack of information; slow speed of PPS in making contract information available; reaching acceptable contract terms; possible union or civil service obstacles.

91 % of LHDs responding indicated that they provide services that may be needed by the PPS. Of these, 49% provide services that promote mental and/or prevent substance abuse, 73% provide services to promote tobacco use cessation, 95% LHDs provide services to increase access to high quality chronic disease preventive care and management in both clinical and community settings, 75.6% provide services to prevent HIV and STDs, and 97.5% provide services to promote health women, infants and children. Additionally, 17% reported that they have developed community-based health navigation services. The following pages include graphs and trends indicating the types of services that LHDs provide in each area listed above.



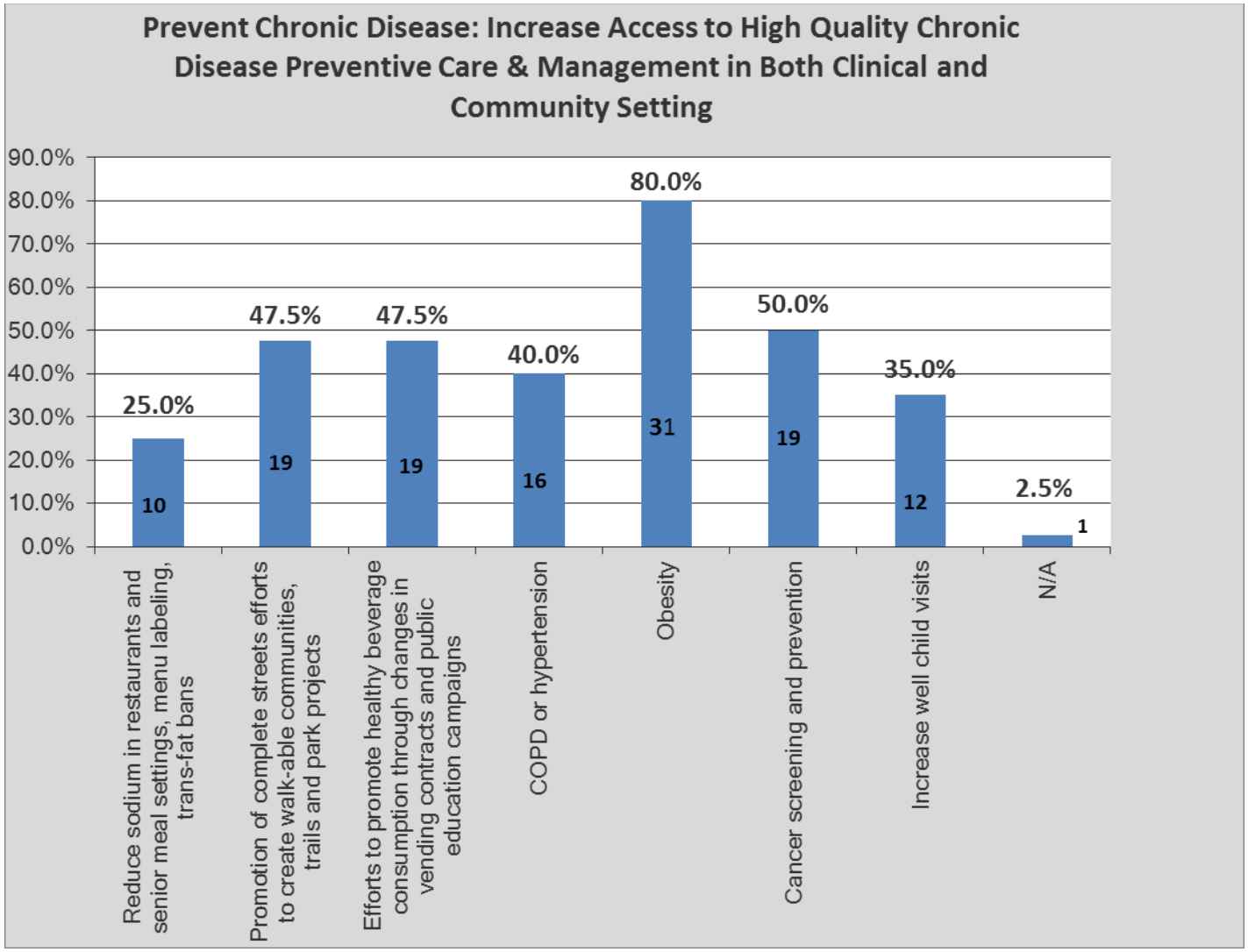
Common Trends:

- Public Health Educators engaged in schools, community partners, and collaborative outreach
- Participation in Opiate Prevention Coalition
- Mental health clinics, home care services/visits
- Work collaboratively with County Mental Health Agency



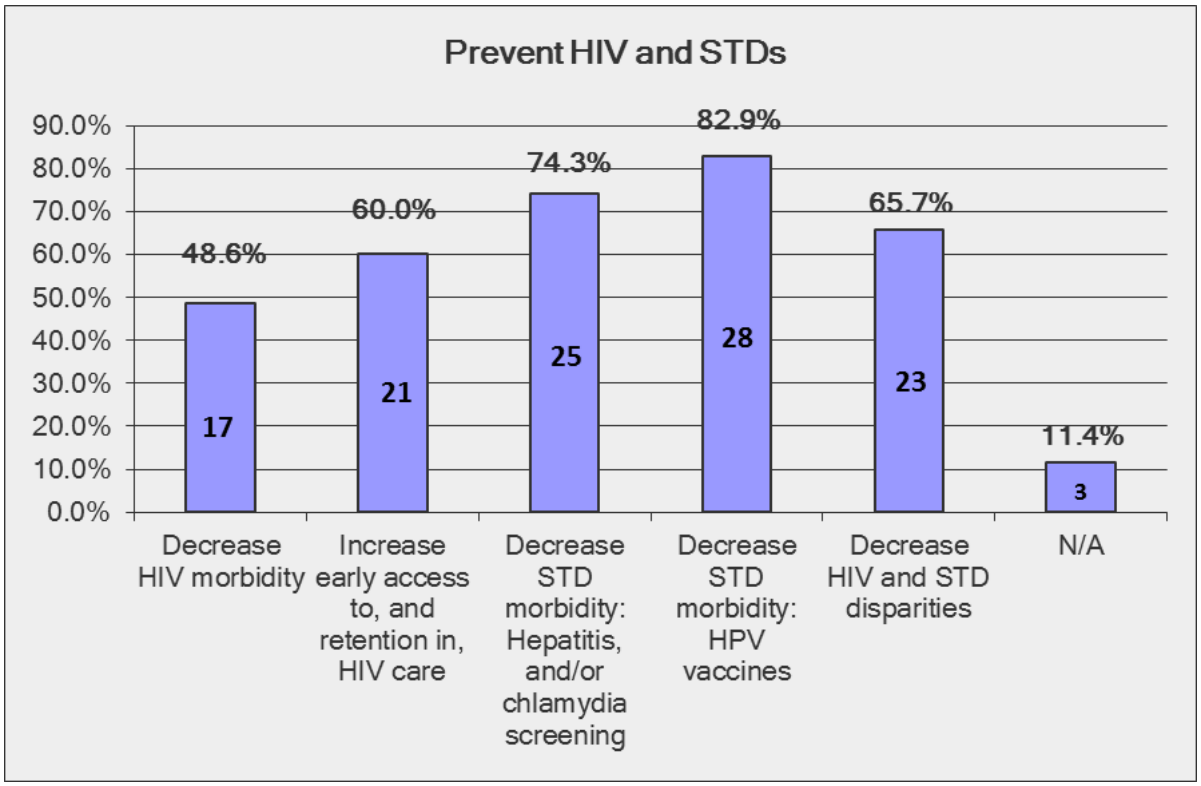
Common Trends:

- PH Educators are engaged in schools and community partners
- Tobacco cessation classes
- Members of Tobacco Coalition
- PHN home visits
- ATUPA enforcement



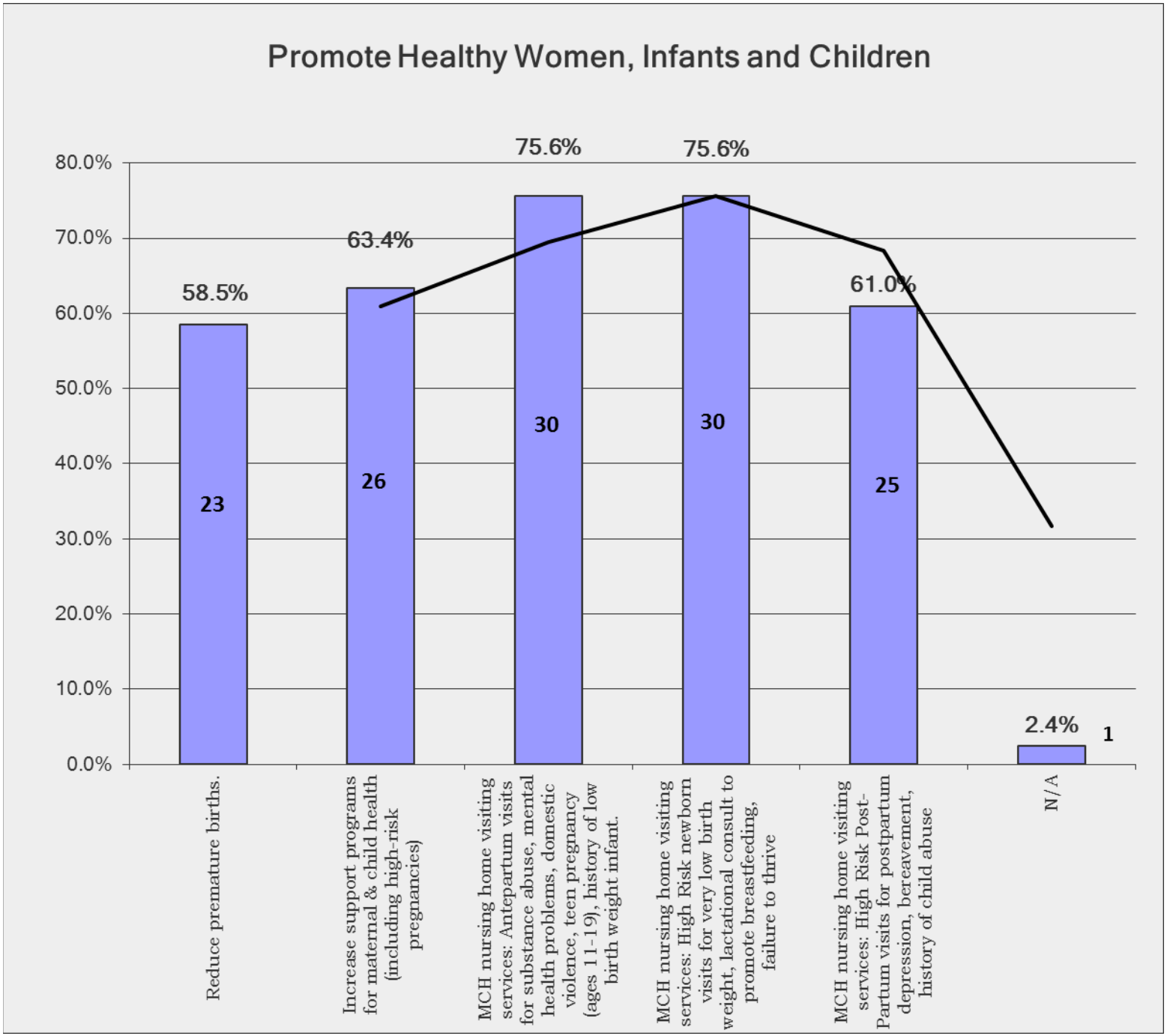
Common Trends:

- Promote Healthy Communities, Healthy Families, Healthy Meal Plans
- Sodium reduction in communities
- Obesity Prevention
- CHIP projects
- Chronic Disease Self Management
- Hypertension education



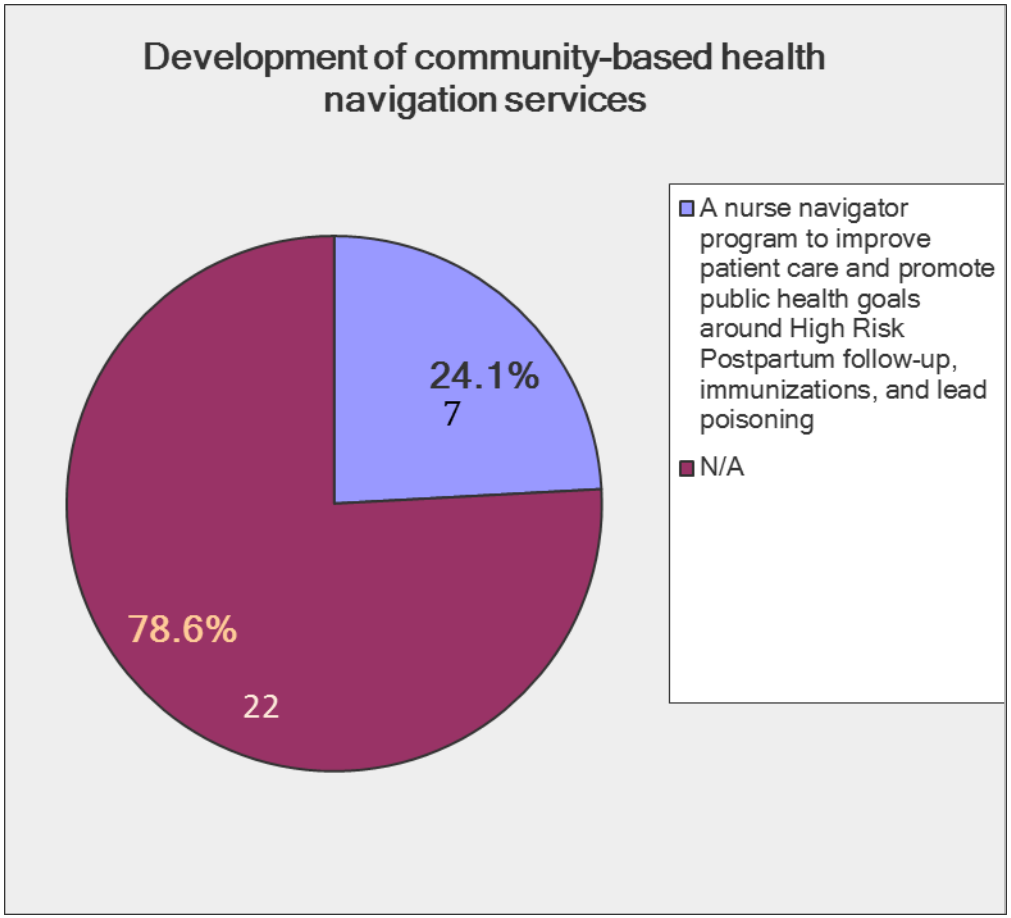
Common Trends:

- HPV vaccine promotion and administration
- Teach sex education
- HIV & STD Testing services/clinics & programs
- Immunization Clinics and Health Education
- Family planning, communicable disease
- PH Nurses, medical staff



Common Trends:

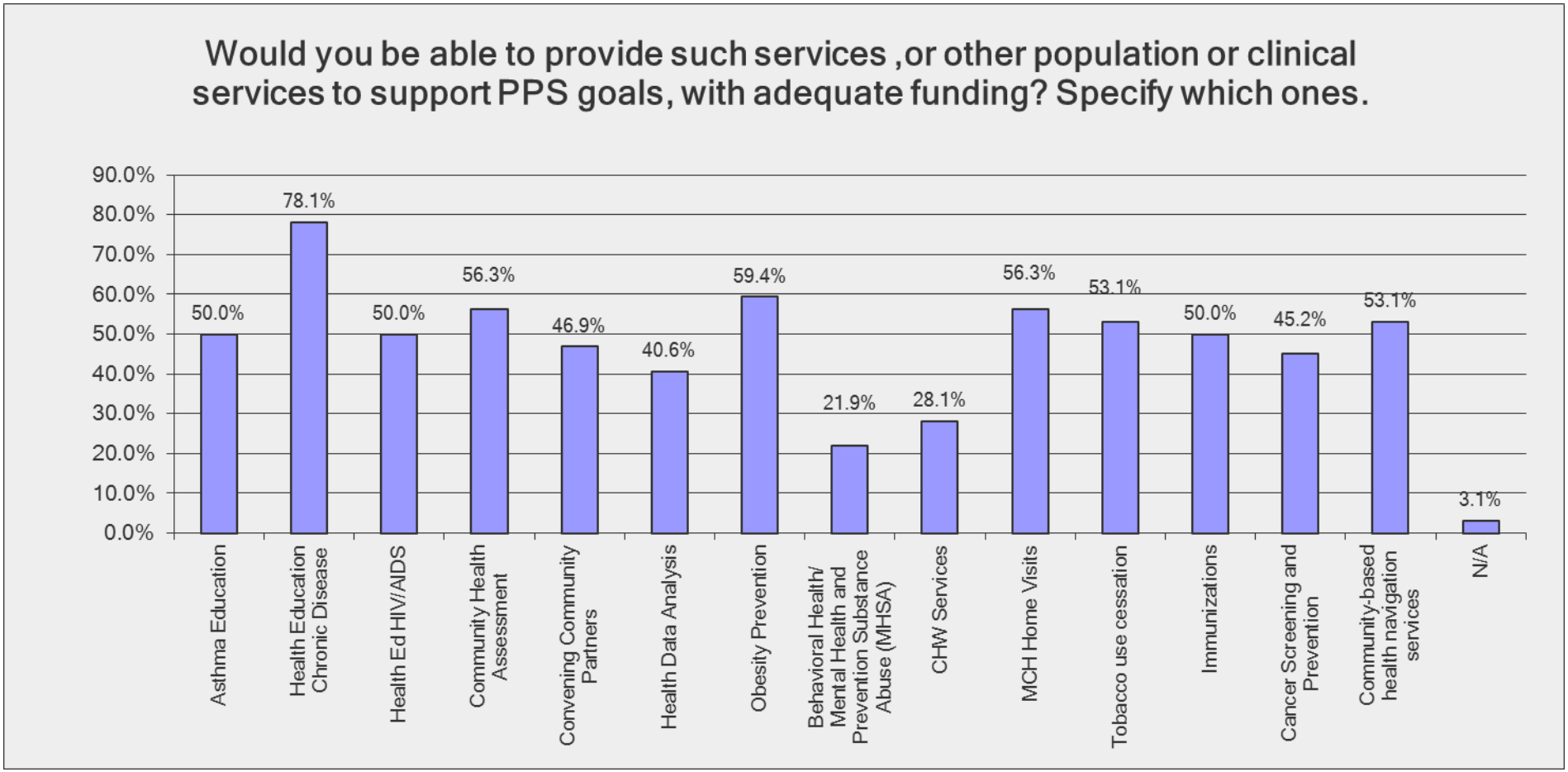
- PHN & MCH Home visits, coalition partnerships
- PHN Assessments
- MCH staff through MCH program
- WIC program for at risk children and parents



In addition to traditional public health services, some Local Health Departments have developed community/nurse navigator programs or provider similar type services through current public health programs. These include:

- Community Health Workers
- Screening by MCH staff, with referral to navigator if necessary
- Nurse Navigator services provided to high risk prenatal patients at a local obstetrician office
- Navigators to educate and assist in insurance enrollment through NY State of Health
- NY Connects Program
- Navigator program to improve patient care and promote public health goals around high risk and postpartum follow-up, immunizations and lead poisoning
- Nurse navigation type services for Immunization program, Prenatal program , Community workers and minority health office
- Services provided through divisions of Early Intervention and Nursing (through a CHHA)

LHDs were also asked if they could provide services, or provide additional services other than ones previously indicated, if they received adequate funding



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July 12 DSRIP Hearing

Thank you for the opportunity to give our comments on the DSRIP process today.

The New York State Nurses Association is the union that represents 37,000 registered nurses in New York State. We are committed advocates for improving the quality of health care and for providing universal access to care to all residents of New York. We are involved in twenty Performing Provider Systems around the state, including ten of the ones we will hear from today.

In order for DSRIP to be successful, frontline workers like nurses must be involved. We can help shape clinical projects, as well as the broader PPS structure and implementation. However, the level of participation that we are permitted to have in the governance of the PPS's has been inconsistent.

NYSNA is on the Board of the Millennium PPS, where we can influence broad PPS decision-making. None of the other upstate PPS's have allowed this level of participation, and we really appreciate the transparency that Millennium brings to their Board.

Unlike the downstate PPS's, we are not allowed on any of the upstate clinical committees. Nurses have valuable input to offer about how best to run and staff projects, but we have had little opportunity to do that.

We're especially concerned, ~~though~~, that we have not been able to participate in several of the upstate workforce committees. We have made multiple requests to be added to the Community Partners of Western NY workforce committee, without success. Leatherstockings appears to have just created a true workforce committee. It is not clear what level of participation we will be allowed ~~though~~h.

We firmly believe the process will be more successful with our meaningful participation across committees, as well as with the full participation of local communities, health care advocates, and community-based organizations. We want to emphasize that we believe that CBOs are critical partners in communities that suffer disproportionately from chronic disease and need to be fully included. We are concerned that not all of the PPS's are living up to DSRIP's democratic and inclusive goals.

We remain troubled by the lack of transparency in the program. The quarterly reports tend to be vague, making it difficult to trace how projects are being implemented. They also have no standardized levels of disclosure about certain items, like detailed lists of committee participants and identification of organizations that are lead participants in the PPS's. Indeed, we continue to be unsure about who is really participating in PPS's and on what level. The membership lists of PPS networks posted on the DSRIP website appear to be incredibly broad, with some organizations listed as belonging to more PPS's than seems reasonable.

We also seek clarity on certain patient care issues. Care management is expected to be an important part of DSRIP and of the restructuring of our delivery system as we move forward. But it seems that many important decisions have yet to be made about who these care managers are, what their titles and roles will be, and what kind of training, education, and certifications they

will require. It is also unclear how they will interact with clinical staff at acute and sub-acute facilities.

We continue to worry that some of this care management work may involve RN functions, including, among others, the clinical assessment and teaching of patients. Without being able to serve on clinical committees, it is very difficult for us to assess whether the roles being assigned to care managers, or patient navigators, or community health workers, are actually appropriate. When we have raised questions about this on the committees we are on, they have generally been ignored.

Thank you again for allowing me to make these comments on behalf of the 37,000 members of NYSNA. We hope that we will have an opportunity to publicly comment specifically on PPS quarterly reports in the future. As we observe the effects of the DSRIP process on our patients, communities, and workforce going forward, we believe public input will be essential to a successful process.

OSWEGO COUNTY HEALTH DEPARTMENT

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July 13, 2016

A Local Health Department's Experience in and Thoughts on DSRIP

When my colleagues and I first heard about the DSRIP's vision and goals, we were very excited. We perceived DSRIP as a significant move in the new era of the healthcare model change from individual health to population health and anticipated being actively engaged. It would be an exciting journey that would set healthcare and public health working side by side. We were determined to be part of DSRIP and studied the eleven domains to find the best fits and identify which of our capacities would be useful in achieving the DSRIP goals.

As DSRIP rolled out, we discovered that DSRIP became less and less relevant to local health departments (LHDs). We, however, still participated in the weekly call and other activities. We were waiting for our opportunities to contribute. For some unclear reasons, we were not included in the prevention premature birth domain.

When it came to the palliative care and hospice domain, we felt that we would be able to make powerful impacts because we have the only county-based hospice program in Oswego. Our program has been providing services, covering most of the county territory, for many years. Our county has low hospice usage rates. It would be the time to promote hospice services to help cut the healthcare costs and improve people's end of life experiences in the county. I quickly contacted the palliative care and hospice working group and asked to join. But I was told that "we are in full capacities already." I never bothered to find out what the "full capacities" meant. Was it the capacities of the group or the organizers? Was it the capacities of the palliative care or hospice services in the region? But I do know that it is well documented that hospice programs reduce patient's re-hospitalization and cut the cost. And I do know that capacities of a local health department were not included in DSRIP and the potential savings in a significant portion of a rural county would not be realized.

At this point in time, population health is still loosely defined and relies on user/author's scopes. But it is a reached consensus that the dominant human diseases have changed from infectious disease to chronic disease. As DSRIP focuses patient population with certain chronic diseases, we need to realize that local physical environments, social services, and public health programs can make huge impacts on these patients' daily activities, health behaviors, and disease outcomes. Many existing resources in LHDs are essential to reaching local communities for achieving DSRIP's goals. Just take Oswego County Health Department as an example, we have, at least, the following resources that are closely relevant to DSRIP's domains:

- Health Educators, who are active in communities, such as schools, assisted living, senior nutrition centers, etc.;
- Registered Nurses, who take care of people in the womb (prenatal) to before tomb (hospice);
- Certified evidence-based chronic disease self-management trainers and training sites;
- Diabetes education;
- Tobacco cessation programs; and
- A hospice program to serve hundreds of patients and families each year.

To leave these existing resources aside and to build new capacities somewhere else are what DSRIP has been doing to me. I hope DSRIP realizes that there are tremendous resources useful to reach its goals already existing in LDHs. The earlier local health departments engage in the DSRIP process, the earlier DSRIP's goals can be achieved and the more savings can be realized.

Jiancheng Huang
Director of Public Health