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From: Julie Bell [redacted]
Sent: Monday, November 27, 2017 12:07 PM
To: doh.sm.1115Waivers
Cc: [redacted]
Subject: 1115 Public Forum Comment
Attachments: NYC DSRIP HIV Coalition PAOP Testimony_Approved 11.16.17.pdf

Hello,

Please see the attached testimony that was presented by the co-chairs of the DSRIP HIV Coalition, Mathew Baney and Terry Hamilton, at New York's 1115 Waiver Programs Public Comment Session on November 16, 2017.

Best,

Julie Anne Bell, MPH
Bureau of HIV/AIDS Prevention and Control
New York City Department of Health and Mental Hygiene
42-09 28th St, 21st FL Queens, NY 11101
Phone: [redacted] Mobile: [redacted]

NYC DSRIP HIV Coalition

New York State Department of Health
DSRIP Project Approval and Oversight Panel
November 16, 2017

Re: Implementation progress from NYC DSRIP HIV Coalition

Thank you for this opportunity to testify on behalf of the Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider Systems (PPSs) in New York City that are implementing HIV-related projects. Our names are Matthew Baney and Terry Hamilton and we serve as the Co-chairs of the NYC DSRIP HIV Coalition.

Eight PPSs in NYC have established a DSRIP HIV Coalition to coordinate efforts and share best practices as the PPSs work to implement their respective HIV projects. The Coalition has formed 'standing committees' focused on the exchange of information with respect to five key areas: the use of Electronic Medical Records (EMR) and Data ; opportunities to enhance HIV Screening and Linkage to Care; Peer Based Interventions; PrEP Implementation; and Viral Load Suppression (VLS) initiatives. Coalition and standing committee meetings are attended by a variety of PPS representatives, including staff from PPS lead organizations, PPS partners and stakeholders, and by technical experts and other guests, as appropriate. Collaboration with community-based partner organizations is an important part of the PPSs engagement in the HIV projects, and this is confirmed by the participation on each of the standing committees of staff from PPSs' community-based organization (CBO) network partners. Among the community-based partners who have been most active in Coalition and standing committee meetings are VIP Community Services, Housing Works, Bailey House, The Alliance for Positive Change, APICHA, Bridging Access to Care, and Brightpoint Health. NYC DOHMH acts as convener of the Coalition, and Amida Care provides technical assistance support.

Coalition meetings have helped to build the knowledge base and understanding of best practices that will be key to the successful implementation of the Domain 4 HIV projects. Highlights from standing committee discussions to date are summarized below.

EMR and Data Utilization

The Coalition and its EMR and Data Utilization committee have invited experts to meetings to discuss how Regional Health Information Organizations (RHIOs), the Statewide Health Information Network for New York (SHIN-NY), and private health information exchanges can help improve care coordination for patients. Mt. Sinai PPS, the Bronx RHIO, and Healthix gave presentations about benefits, challenges, and barriers to information sharing, and participants in those meetings were able to explore complex questions related to rules for accessing HIV patient information through RHIOs. Participants discussed the benefits of efficient sharing of information among both healthcare providers and others involved in a patient's care. We believe that smart, coordinated care decreases redundant tests and care, and results in decreased costs and better administration of care to patients.

In addition to the work on information sharing, the 2016 NYS DOH requirements for HIV Care Cascades were used as an opportunity for the EMR & Data Utilization Subcommittee to hear from organizations —New York Presbyterian, Housing Works, and Mount Sinai Institute of Advanced Medicine—about how each organization's Care Cascade was developed, what limitations were encountered, and how the Care Cascades are being used to inform HIV care.

HIV Screening and Linkage to Care

This committee is working to develop tools and resources that can easily be distributed among PPS members of the Coalition to support improvements in HIV screening/testing and linkage to care. The Screening and Linkage

to Care Committee has identified key tools that could be easily shared across organizations, and developed a set of standard points to be included with the dissemination of each tool, such as target audience, details on how the tool was developed and can be used, and the key messages that the tool is intended to communicate. The tools reviewed to date include a script for use in the ER when offering HIV testing, a sample Memorandum of Understanding for linkage and referral activities, and a sample Discharge Planning Note to address ongoing linkages to HIV care.

The group is planning to conduct key informant interviews with hospital and community-based HIV screening and linkage programs to identify best practices across five areas: identifying, reaching, and assessing high-risk populations; partnerships/collaborations; staffing; patient involvement and communication; and program evaluation. A report detailing the process and identified best practices will be shared upon completion.

Peer-based Interventions

The Coalition is advancing efforts to implement peer-based interventions as a strategy to improve wellness of people living with HIV. The Peer-based Interventions Committee has served as a key forum for the dissemination of information about existing resources, as well as about barriers to work for peers. Information was gathered and shared about NYC and NYS programs available to facilitate employment while maintaining critical public benefits. Organizations that already hire peers shared their experiences including successes and obstacles faced in hiring peers and facilitating their workforce development. The Committee hosted presentations from three programs with experience hiring peers: Bronx Health Access PPS, The Alliance for Positive Change, and Housing Works, and heard directly from a peer about the process he followed to obtain work, peer certification, and a full-time job.

PrEP Implementation

The Coalition is working to better understand the barriers to uptake and adherence among key populations. The PrEP Implementation Committee has heard several presentations related to PrEP programs at various organizations throughout the city, and had discussions on how to address uptake and adherence barriers among adolescents and persons of color in particular.

Viral Load Suppression

PPSs within the Coalition are taking different approaches to increasing VLS to achieve Ending the Epidemic goals and improve health outcomes. Participating PPSs, including both the Maimonides PPS, Community Care of Brooklyn, and the Mount Sinai PPS, have collaborated in the development of plans for their VLS initiatives, and have consulted with Housing Works and others to identify best practices that can be incorporated in PPS-specific programs. The VLS Committee has discussed barriers to achieving VLS, such as the impact of immigration status and past experiences of trauma on access to and retention in care. The group has also reviewed international best practices in achieving VLS and models for providing financial incentives to achieve VLS. Earlier this year, the Coalition hosted a presentation by Housing Works on the findings of a UPENN-led evaluation of *The Undetectables* program. Focused on sustainability, Coalition members have urged third-party payors to consider the net positive impact of spending on incentives for VLS initiatives on both clinical outcomes and the total cost of care, and we expect that there will further discussion of this in the months ahead.

Thank you for this opportunity to testify about our efforts to implement HIV related projects.

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From: Dentrone, Eric <[redacted]>
Sent: Tuesday, November 28, 2017 4:11 PM
To: doh.sm.1115Waivers
Subject: 1115 Public Forum Comment

Dear Members of the DSRIP Project Approval and Oversight Panel:

My name is Eric D'Entrone and I am the Associate Director of Regional Services for Arms Acres and Conifer Park. My organization provides inpatient and outpatient substance abuse treatment for both adults and adolescents. Our programs include medically supervised detoxification, inpatient (short term) rehabilitation, intensive outpatient services, clinic services, and Medication Assisted Treatment.

I was unable to attend the Public Comment Forum in NYC earlier this month and I would therefore like to submit a written statement on my organization's work with the Montefiore Hudson Valley Collaborative PPS:

It has been an absolute pleasure working with the team at MHVC and I commend them for their leadership, guidance, support, and expertise over the last two and a half years. There have been many valuable trainings, forums, and workgroups during that time, but I would like to highlight the following three areas from the last year:

1) Substance Use Disorder Redesign Workgroup: This workgroup met twice in the last year to discuss the process of discharge from inpatient to outpatient, a critical transition point for patients with substance use disorders. Participants were able to discuss current workflows and processes and candidly talk about barriers and limitations. We were then able to roll up our sleeves, and figure out ways to improve the process, moving our regional system of care closer to an ideal future state. MHVC's leadership in bringing many providers to the table and guiding the conversation in a way that was focused on solutions was exceptional.

2) ED Triage Workshop and Site Visits: Earlier this year, our organization was able to present our services to ED Triage Specialists from the entire region (professionals in the ED's who help patients in crisis and connect them to appropriate services). Following the workshop presentation, our staff was able to accompany MHVC staff to each ED in the network, which directly connected the staff in each ED to Regional Coordinators from our organization. It's this kind of relationship building, which MHVC has expertly facilitated, that has been truly valuable.

3) Innovation Fund Project: In September, Arms Acres was approved by MHVC to receive funds for its Innovation Pilot Project (IPP). With this funding, Arms Acres is hiring two Certified Recovery Coaches. The coaches will be introduced to patients at Arms Acres Inpatient who have been identified as having a high risk of relapse. If the patients agree, the coaches will develop an individualized recovery plan with the patients before they are discharged. The coaches will then support the patients in their communities as they navigate their early recovery. One of the goals of this Recovery Coach Project is to increase the rate at which patients make their first appointments at outpatient programs throughout the region. Another goal is to help patients to remain in treatment and adhere to their recovery plans. MHVC has provided extremely valuable technical assistance with this project's implementation and has been a true partner throughout.

Arms Acres is grateful for the partnership we have formed with MHVC over the last few years, and look forward to continued partnership in the years to come.

I'd be happy to speak further about our work with MHVC. If there were any specific questions, please feel free to contact me directly via email or phone.

Kind regards,

Eric D'Entrone, M. Ed., CRC
Associate Director of Regional Services
Arms Acres and Conifer Park

Phone: [redacted]
E-fax: [redacted]
Arms Acres Intake: 1-888-227-4641
Conifer Park Admissions: 1-800-989-6446, then 3,2
www.armsacres.com
www.coniferpark.com

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Disclaimer

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From: Douglas Berman <dberman@coalitionny.org>
Sent: Wednesday, November 29, 2017 4:06 PM
To: doh.sm.1115Waivers
Subject: 1115 Public Forum Comment
Attachments: 1115_waiver_comments_DY3Q2_11.29.2017(db_final).pdf

Attached please find the comments on New York's 1115 Waiver Programs by The Coalition for Behavioral Health. Should you have any questions or need additional information, please contact Christy Parque, President and CEO [redacted] or [redacted]. Thank you.

Doug Berman
Vice President for Policy
The Coalition for Behavioral Health
123 William Street, Suite 1901
New York, NY 10038
[redacted]
www.coalitionny.org

Register Here!

New York's 1115 Waiver Programs Downstate Public Comment and PAOP Working Session

Comments of Christy Parque, MSW

President and CEO

November 29, 2017

The Coalition for Behavioral Health, Inc. (The Coalition) is the umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit community-based agencies that serve more than 450,000 consumers. Our members serve the entire continuum of behavioral health care in every neighborhood of New York City, and communities in Long Island, Westchester, Rockland, and Orange counties. Coalition members provide access to the range of outpatient mental health and substance use services, supportive housing, crisis intervention, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Club Houses, education and nutritional services, as well as many other supports that promote recovery, reduce emergency room use, hospital readmissions, shelter stays and divert sentencing from prisons and jails. The Coalition trains on average 500 human services providers monthly on cutting edge and proven clinical and best business practices and receives generous support from the New York State Office of Mental Health, the New York State Office of Substance Abuse Services, the New York City Department of Health and Mental Hygiene, the New York City Council, and in conjunction with foundations and leaders from the behavioral health sector.

SUPPORTING SYSTEMIC TRANSFORMATION

The Coalition lauds the New York State (NYS) Medicaid Redesign and 1115 Waiver initiatives implemented over the past several years that have improved access to quality care and

facilitated integrated behavioral health and physical health care for Medicaid beneficiaries while reducing costs to the health care delivery system.

New York's 1115 waiver has been the driver for transformation of the behavioral health system by using Medicaid funds to expand community-based behavioral health services, create innovative managed care models to cover people with significant behavioral health needs, finance delivery system reforms and advance behavioral and physical health integration.

Although the use of 1115 waivers to restructure NYS's Medicaid program has achieved measurable improvement in health outcomes, sustainable cost control and efficiencies in the health care delivery system, continued system transformation will depend on fully utilizing the expertise and strength of our behavioral health providers to address social determinants of health and the mental health and substance use disorders and other needs in communities across the State.

REGULATORY MODERNIZATION FACILIATATE INTEGRATED ARRANGEMENTS

The Coalition has supported NYS's use of 1115 waiver authority to create new models of care that reduce fragmentation and improve outcomes in the behavioral health system by introducing managed care arrangements and accountability for behavioral health providers and by streamlining regulatory requirements to enhance integration of behavioral and physical health and coordinated care. Doing so has the added benefit of allowing for "one stop shopping" which facilitates client access.

The regulatory reform efforts by NYS DOH, OMH and OASAS to simplify the license process for providers that exceeded licensure thresholds who would otherwise have to be licensed by more than one agency have been welcomed by Coalition member organizations interested in providing both behavioral health and primary care services. New York is one of eight states that received federal funds to demonstrate the Certified Community Behavioral Health Center model which integrates primary care and FQHC services into community behavioral health clinic settings. While too soon to document outcomes, it is a promising model being tested in 13 New York sites. Should it prove its value, replication of the model will undoubtedly be facilitated by licensure modernization.

Significant challenges still remain for behavioral health providers due to the requirements of multiple State agencies in licensing and certification, physical plant standards in Article 28 facilities and billing inflexibility for physical health services on behavioral health claims.

- **We would support recommendations of the State's regulatory modernization workgroups to create a limited integrated license allowing existing Article 28, Article 31 and Article 32 outpatient clinics to provide a specific array of primary care services and full complement of mental health and substance use disorder services without obtaining a second license.**
- **Additional clarification may be warranted on the degree to which billing for behavioral health screening and treatment is reimbursable when behavioral health services and primary care services are provided during a single visit.**

Telehealth:

We seek to eliminate barriers for clients so that they can access their care that crosses between systems. There should be no wrong door for entry. We also support modification of the State's telehealth statute and regulations to include a patient's home as an eligible originating site, facilitating greater access to behavioral health consultations and care and an integrated care team to manage patients unable or resistant to accessing a clinic-based treatment site.

- **We strongly urge an alignment and standardization of the various state agency regulations that govern telehealth including the NYS Department of Health (DOH), NYS Office of Mental Health (OMH) and the NYS Office of Alcohol and Substance Use Services (OASAS).**

SUPPORT ACCESS TO HEALTH HOMES AND HOME AND COMMUNITY BASED SERVICES

Effective treatment, recovery and resiliency for people with behavioral health disorders includes an array of services that fall under the banner of social determinants of health. Our comments focus on how those services are provided and integrated into clinical service, and the problems our member agencies have identified with how those services were designed, the ramifications of not addressing those concerns, and potential ways to improve those deficits. Many of these recommendations are a revisit to our previous recommendations.

I would like to begin, however, by acknowledging the prescience of the NYS DOH in recognizing the importance of these services to realizing the goals of the Triple Aim, ensuring that the DSRIP program includes social determinants of health services, and the recent improvements in contracting and providing payment for those services by the PPSs.

Behavioral Health organizations play a key role in providing comprehensive care coordination for clients with mental health and substance use disorders and physical health co-

morbidities. They also directly provide or link them to recovery and services such as supportive housing and income assistance that are critical to addressing social determinants of health.

- **This expertise should be recognized and rewarded.**

Yet, several community based BH organizations have raised concern that they do not have sufficient client volume to support the staffing resources and infrastructure necessary to assess clients for Health Home eligibility and interest or make referrals for Home and Community Based Services (HCBS). For example, one of our members reported that for every $1.00 received they incurred $4.00 in costs. Another member shared that they have invested hundreds of thousands in agency dollars participating in both HCBS and DSRIP contracts but the return on investment is not there. They are not sure how much longer they can sustain supporting these programs.

- **Several of our members who provide these services expressed they are considering giving up their contracts.**

Similarly, they function on minimal margins, making it difficult for them to assume any form of risk or diminished reimbursement which may be passed down from their upstream partners.

Our members expect that starting an enterprise is time consuming and costly but are concerned that the rates for these services are insufficient and do not reflect the time, effort and costs of providing quality services.

- **We urge NYS to make funds and technical support available to develop the infrastructure to support data collection and analysis, contracting and credentialing, and importantly, adoption of electronic health records and participation in health information sharing platforms.**

The Coalition believes there are ways to drive access and volume through streamlining and efficiencies and standardization, expanding billable services, and accounting for secondary costs such as travel time.

- **Potential efficiencies will reduce staff burden, produce cost savings and increase quality. NYS DOH should consider the following adjustments:**
  - Standardizing protocols for prior authorizations, submitting claims, credentialing providers and contract language across managed care organizations.
  - Standardizing assessment and care plans tools and allowing additional types of providers to conduct them.
  - Allowing robust bottom up enrollment of potential HARP members.

- Pre-populating forms when possible, for example, using information from the HARP eligibility assessment to populated the HCBS assessment.
- Aligning workforce expectations with financial resources; for example, include travel time, allowances for tracking down no-shows, and compiling data reports in reimbursement rates.

WORKFORCE SUSTAINABILITY

We understand that achieving fully integrated behavioral and physical health care will take time and require changing administrative and operational processes and acquiring health technology systems to increase efficiency and improve outcomes for the clients we serve. Resources for our behavioral health providers will be critical to the success of this delivery system transformation. During the November 16, 2017 1115 Waiver Programs Downstate Public Comment and PAOP Working Session, a response to a question about "what was the biggest chunk" of PPS spending was Workforce and Health Information Technology. Community organizations have the same situation but have fewer options as community based organizations have historically been underfunded and have less resources.

- **Level the playing field with resources for behavioral health providers with our partners on the health care side so we can succeed together.**

Resources to support workforce development, training and wages that are comparable to other sectors will be essential for these community based behavioral health organizations to enable them to provide the clinical services and meet the requirements of managed care plans and health homes with which they are contracted. Without a vital robust workforce, consumers would be denied their right to high quality services and the objectives of Medicaid Redesign will be unrealized. Our members have consistently identified the discrepancy between salaries paid by other sectors, such as managed care organizations and government, as a real problem in recruiting and retaining good staff. Non-competitive salaries exacerbate the challenge of providing direct care to a high need vulnerable population with fewer staff, and the failure to secure an assured COLA exposes behavioral health provider staff to a diminished life-style as the cost of living continues to rise at an unprecedented pace.

- **Besides providing competitive salaries and regular cost of living increases, we believe there are ways to incentivize the behavioral and social services workforces through loan forgiveness programs, tuition reimbursement for aspiring non-profit sector professionals and reduction or forgiveness of licensing and other profession related fees.**

Similarly, the development of quality metrics that are widely used by the health care industry and factored into financial incentives should include measures that reflect the intensity of the work BH organizations perform in stabilizing clients and working with them over an extended period and that capture improved functionality and resilience and the impact on social determinants of health. With the numerous metrics required to be reported, we recommend prioritizing metrics for behavioral health and consider offering payment incentives to ensure provider and payer commitment to those measures.

The benefits or successes of the work of behavioral health agency staff are often not realized in a short period time such as monthly or quarterly, or even yearly. This has both an impact on creating an equitable business model in a value based system but also negatively affects the morale of the staff as they struggle to see the impact of their work if the benchmarks don't accurately represent the timeline or cycle of change from a clinical perspective. We recommend also capturing milestones that appropriately reflect the continuous work done by agency staff.

- **As we further develop behavioral health metrics we must bear in mind that sometimes the most difficult measures to define and apply are the most challenging but are the <u>right ones.</u> We are committed to working with our government and healthcare partners to develop thoughtful and meaningful metrics that reflect both the work of the behavioral health sector and the physical health sector.**

CHILDRENS TRANSITION TO MANAGED CARE

The Coalition looks forward to working with the State as it implements the comprehensive 1115 waiver amendment for children with significant behavioral health and home and community based service needs. Lessons learned from the adult behavioral health transformation and use of Medicaid managed care, health home care management and integrated care will be invaluable to improving clinical and recovery outcomes for children and youth and achieving efficiencies in the behavioral health care delivery system. Our experienced community based behavioral health providers who have historically provided quality care to these vulnerable populations must continue to be integral to the system as it transitions.

Within children's redesign we must protect the historical strength of these services and programs, their uniqueness and success in providing services to high need children.

- **We must make every effort to ensure that any transition does not result in gaps in behavioral health services or coverage for a child or their family.**

CONCLUSION

As we rapidly redesign the delivery and financing of Medicaid and cross the barriers into unchartered territories, our members encounter numerous barriers to innovating services, constructing and licensing delivery sites, and merging, integrating and cooperating with new and unfamiliar forms of partnerships. That being said, I want to make clear, that The Coalition and its members are absolutely committed to the vision and opportunities to provide truly holistic and client centered care that is afforded in the spirit of the 1115 Waiver.

We grateful for the funds that have been made available for infrastructure development and urge that this financial commitment continue. On behalf of The Coalition of Behavioral Health Agencies, I thank you again for the opportunity to provide you with our comments.

Respectfully submitted by:

Christy Parque
President and CEO

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From: Vreeland, Reed <[redacted]>
Sent: Wednesday, November 29, 2017 11:01 AM
To: doh.sm.1115Waivers
Cc: [redacted]; Virginia Shubert
Subject: NYS DOH 115 Waiver Public Comments - Housing Works - November 16th
Attachments: HW_Medicaid_Waiver_Comments_11-16-2017_final.pdf

Importance: High

Dear DOH DSRIP Project Staff,
On behalf of Housing Works and Charles King, I am writing to submit the attached public comments on the NYS 1115 Waiver to the DSRIP Project Approval Oversight Board (POAP) and the NYS Department of Health. These written Housing Works public comments are being submitted for the NYS DOH 1115 Waiver Public Comment Day on November 16, 2017.

Please email me to confirm receipt of these comments.

Sending many thanks,

Reed Vreeland

-
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Reed Vreeland
Director of Policy
Housing Works
81 Willoughby Street, 5th Fl.
Brooklyn, NY 11201

[redacted]

[redacted]

HOUSING WORKS 57 Willoughby St, 2nd Floor, Brooklyn, NY 11201 WWW.HOUSINGWORKS.ORG

NYS Department of Health 1115 Waiver Public Comment Day
Housing Works Public Comments
November 16, 2017

Members of the Delivery System Reform Incentive Payment (DSRIP) Project Approval and Oversight Panel (PAOP) and representatives of the New York State Department of Health (NYS DOH), thank you for the opportunity to submit public comments as President and CEO of Housing Works—a healing community of people living with and affected by HIV/AIDS. Founded in 1990, we are the largest community-based HIV service organization in the United States, and provide a range of integrated services for low-income New Yorkers living with and at risk for HIV/AIDS—from housing, to medical and behavioral health care, to job training. Our mission is to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of life saving services, and entrepreneurial businesses that sustain our efforts. Housing Works is also part of the Community Care of Brooklyn Performing Provider System (PPS) and the Mount Sinai PPS.

Housing Works strongly supports the State's Medicaid Waiver process and on May 4, 2016, submitted testimony at the hearing on the NYS Medicaid 1115 Waiver to highlight the ways in which the DSRIP Program has already removed silos, achieved progress toward its goals, and strengthened the State's ability to meet our historic goal to end our HIV/AIDS epidemic (ETE) by the year 2020. Housing Works also submitted testimony on January 31st, 2017, on the DSRIP Mid-Point Assessment Public Comment Day, urging the PAOP consider additional recommendations around engaging Substance Use Disorder (SUD) providers engagement to improve the State's response to the opioid epidemic.

Today, Housing Works reasserts our support for the State's healthcare reform process. However, we urge the PAOP and DOH to consider recommendations in the following three areas:

1. Continue to Improve PPS engagement with CBOs, Health Home, and SUD Providers

   Housing Works is familiar with the pivotal role of community-based organizations (CBOs) in connecting individual Medicaid members to the larger healthcare system, and we support the State's emphasis on including Tier 1 CBOs in Value-based Payment (VBP) arrangements and agree that savings should be allocated appropriately among providers, and that behavioral health, case management and Health Homes, long-term care and other community-based providers should not be disadvantaged. Lead Health Homes and Care Management Agency (CMA) Health Homes should be included at a greater level in PPS interventions. VBP networks should be encouraged to include qualified CBO's in ownership structures.

   We are encouraged that the DSRIP Mid-Point Assessment Process has helped to highlight and address the need for improved CBO and SUD provider engagement and payment. As a result of the Mid-Point Assessment Process, 14 out of the 25 Performing Provider Systems (PPS) received a "standard modification" recommendation to develop a detailed plan for engaging partners across all projects with a specific focus on Primary Care, Mental Health, SUD providers as well as CBOs. We support the specific focus on these provider categories and CBOs in PPS's action plans, and some progress has already been achieved. Between the Mid-Point Assessment and DSRIP Year 3, Quarter 1 (DY3, Q1) PPSs increased funds flow to CBOs by 134% and to SUD providers by 142%.[i]

   The PAOP and DOH should continue to support innovative methods of providing CBOs with technical assistance to foster participation in DSRIP and trainings on VBP readiness and sustainability. DOH must continue to focus on helping to prepare CBOs for participation in VBP arrangements, including the provision of technical assistance related to financial preparation, legal considerations, and contracting.

2. Continue to Address Social Determinants of Health

We applaud DSRIP and VBP plans for emphasizing the need to address social determinants of health and we thank the State for implementing the VBP Social Determinants of Health and CBO Work Group recommendations. Housing Works strongly supports housing for homeless and unstably housed people with chronic diseases as an evidence-based healthcare intervention. The inability to meet basic subsistence needs is a formidable barrier to consistent engagement in HIV care and treatment—and to management of other chronic illnesses. By ensuring that each eligible person with HIV is linked to critical enablers of effective HIV treatment, including a safe place to live, adequate nutrition, and the ability to travel to health care and supportive services, we can address the social drivers of the HIV epidemic and related health disparities.

We support the State's commitment to collect standardized housing data to track homelessness and housing stability among Medicaid recipients and to address these needs as part of health care delivery. We believe that the State should establish a plan to ensure that all Medicaid members receive some type of social determinants of health screening. We support the VBP Roadmap's plan that Level 2 and 3 VBP contractors should be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations share in the costs and responsibilities of the investment. We believe that the selection of the type of social determinant intervention to be implemented should be guided by individual members' needs and health goals, the impact of social determinants of health on their health outcomes, and an assessment of community needs and resources. We also recommend establishing a VBP Learning Collaborative to develop and share best practices to address social determinants of health.

3. Establish an Innovator Accountable Care Organization Focused on HIV Population Health

Housing Works strongly supports the proposal to establish a provider-led Innovator Accountable Care Organization (IACO) focused on HIV population health. This proposal already has the support of a range of partners, including two HIV Special Needs Plans, eight HIV primary care organizations, one large Designated AIDS Center (DAC) system, seven Federally Qualified Health Centers, and an Individual Provider Association consisting of over twenty-five AIDS Service Organizations and CBOs.

The IACO is needed because under the current Medicaid managed care model, 35,000 HIV positive persons with Medicaid (only) are members of eight different health plans, and many of these members experience disparate models of care that do not fully leverage resources to maximize viral load suppression, which has been shown to maintain optimal health and significantly reduce health care costs.

The proposed IACO will coordinate care under a single care model for 14,000 people with HIV in NYC in 2018—increasing to over 26,000 people statewide by 2022 (including negative individuals with high HIV risk, thereby better expanding and coordinating HIV prevention efforts as well). Through the innovative IACO model, 100% of Medicaid cost savings will be retained by the IACO for the first five years and reinvested to address social determinants of health (such as homelessness, housing instability, food insecurity and lack of employment opportunity), advance a quarterly viral load suppression consumer incentive, support the move from volume to value, stabilize the HIV continuum of care, and fund ETE priorities and innovation. It would also improve screening and treatment for mental health issues, substance use disorder, or co-morbidities such as hepatitis C. The IACO will become the State's new engine for health system transformation by capturing Medicaid savings to reinvest back into the health care and social services systems.

On behalf of Housing Works, I thank you for the opportunity to submit public comments on the State's 1115 Waiver. Respectfully submitted,

Charles King, President/CEO, Housing Works, Inc.

[i] NYS DOH, Medicaid Redesign Team. (October 2017) Mid-Point Assessment Action Plans: PPS Progress through DY3, Q1.

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From: Leslie Feinberg <[redacted]>
Sent: Wednesday, November 29, 2017 4:27 PM
To: doh.sm.1115Waivers; doh.sm.1115Waivers
Subject: RE: 1115 Public Forum Comment
Attachments: 1115 waiver public comment submitted by SOYAN.pdf

Attached are the comments of SUPPORTING OUR YOUNG ADULTS NETWORK, a group of over 200 parents, professionals and self-advocate individuals, supporting the journey of young adults embarking upon living a self-determined life with the supports of Self-Direction (OPWDD).

From: Leslie Feinberg [mailto:leslie.feinberg28@gmail.com]
Sent: Wednesday, November 29, 2017 4:02 PM
To: 1115waivers@health.state.ny.us; 1115waivers@health.ny.gov
Cc: 'Leslie Feinberg' <leslie.feinberg28@gmail.com>
Subject: 1115 Public Forum Comment

Supporting Our Young Adults Network is a grass roots group of concerned parents, providers and self-advocates with over 200 members.

We are offering our comments regarding the transition of services to I/DD population into the 1115 Waiver. Our specific concerns are with the implementation of Self-Directed services within the 1115 Waiver framework.

Leslie Feinberg
Organizer/Peer Facilitator
Supporting Our Young Adults Network (SOYAN)

SUPPORTING OUR YOUNG ADULTS NETWORK-1115 PUBLIC FORUM COMMENT

TECHNICAL ASSISTANCE

The IDD community requires several types of technical assistance to access services and in general would like to better understand how services will be provided and who will be responsible for aiding the IDD community in getting the services they need.

*Access to services such as large print, easy reader language, internet accessibility of all health care records attributed to the person

*In the past year a senior executive of Emblem Health recommended that individuals with OPWDD status be required to have Managed Care lock-in period for 2 years. This doesnot allow for "choice" and could also create problems for accessing specialists medical care; obtaining and maintaining housing and other supports; difficulties with using Self-Directing Services, and other barriers.

*Spell out the grievance procedure.

*What's NYS specific plan for phasing out the 1915c waiver? Does OPWDD have authority?

*IDD world has high costs associated with day treatments and group homes. The I/DD community has worked so hard to have society accept them not as 'other'. In the years since the closing of Willowbrook the I/DD population has been to a degree accepted as they are and are enjoying life in their communities. If I/DD service users are labeled "super-users" that need reduction of services, where will people live with dignity? How will they spend their days as productively as possible? Are we looking at Willowbrook or worse, homelessness.

*How does all of this managed care work if an individual is insured through parent's policy and uses OPWDD just for I/DD supports?

MSC's becoming Care Coordinators (CC's) for Care Coordinator Organizations.

***Please provide clarification on how the MSC will transition to being CC's and how things will work during the transition.

*Will there be funds to pay for continuing education to keep CC's informed and educated?

*Will the CC's be required to continue direct support to an individual to access and maintain Medicaid eligibility and public benefits (SSI, food stamps, etc.) and provide advocacy?

Person Centered Supports & Services

The transition of IDD services to being covered under the 1115 waiver raises many questions on how the Self-direction program will be administered and funded. This is a source of concern and anxiety in the IDD community which currently has services that will transition.

*Being able to use Self-direction budget authority to hire supports from a limited pool of applicants puts pressure on the person and the family. What initiatives are being created to address this issue?

*Self-Direction as an initiative has the concept of learning by structured scaffolding at its core. Where is this addressed in the 1115 Waiver?

*Stakeholder subgroups: FIDA as model doesn't match with Self-Direction and fluidity of life changes that take time for IDD population to achieve quality of life benchmarks that require lifelong supports not diminishing supports

*Addressing frames of references at the core of pursuing a managed care paradigm may prove enlightening. Looking at both individual and provider outcomes that last a full year may not be a useful tool with the I/DD population. Outcome measurements are over a longer period of time and if behaviors or skill enhancement are neglected, the ability to "fix" will expand. There is no recovery from I/DD.

*if Capitation is yearly how is that managed in the Self-Direction Model? Self-Direction is already a capitated model that provides a fluidity of resources based upon the ebb and flow of skill enhancements and needs assessment. There's a fluidity of expansion and reduction of appropriate services that will prevent higher costs and appropriately and gradually reduce costs and at the same time improve quality of life. A greater acuity of need is inherent in the ultimate goal of OPWDD supports: personal autonomy and community interdependence. There is no such thing as independence unless one lives alone on a tropical island.

*In the managed care model would each Self-Direction Plan be equivalent to a "provider" or "health home"?

*If managed care is all about addressing the "super-users" [those that go to the hospital often legitimately -including those with chronic medical conditions, substance abuse, etc- as well as for a cold.], then Self-Direction participants look like "super users" with all its support team players. Will Self-Direction eliminated to reduce costs of these "super-users"?

*In the Self-Direction service delivery there are Independent Brokers that assist the MSC with steering the Person and his/her family to supports and services that will address the Person's current needs because there is an ongoing relationship inherent in process of self-directing services. Independent agency FI's provide employer of record services, human resource supports, reimbursement of covered expenses, as examples. Will this be different in the managed care scenario?

*Transparency via IT access for Self-Direction Plan that includes accessibility for the user/individual and family. However not all individuals/families have access to the internet. How will this be addressed?

*Person-Centered planning at its core assumes a level of engagement and communication between the Person whose plan it is and the evaluator/coordinator. Future autonomy and present day supports hinge on the assessment process. Before assessment, there must be

access to advocacy training and supported decision making skill assessment and skill building, regardless if the person has a court appointed legal guardian.

*What is the plan for enabling and providing oversight between the managed care plans and the self-direction fiscal intermediaries? Specifically, how will necessary overhead rates that FI's require for their operation be handled in the 1115 waiver.

PERFORMANCE METRICS

There are many concerns and not enough available information on the proposed performance metrics and we would like addition information and help understanding how the metrics will work and be defined.

*DOH/DSRIP/VBP is creating a process to support social determinants to encourage wellness, including residential, employment and behavioral health supports as well as community relationships. A concern is that the current VBP would require a MCO to contract with only one CBO to address one of a menu of social determinants specified by the DOH. This appears to be inadequate to address the wide range of needs of people with I/DD.

* The individual must be included in all metrices determinations in order for the system to be person-centered and remain humanity driven. For example, the draft is not clear in terms of outcome measures for I/DD. Why are some of the POMS recommended for inclusion and why are others are left out?

*Reducing hospital stays is not a useful indicator in the I/DD population. Few doctors are knowledgeable and have the necessary bed-side manner. Family and self-advocates who are also professionals in related fields should be included in the DSRIP and VBP reform regarding the implementation of outcome measures, clinical guidelines and corrective action. Specific areas of concern include the challenge of addressing co-occurring behavioral issues in an appropriate manner that addresses the needs of I/DD population who may have language impairment, cognitive impairment, anxiety, etc.

*Failure of 1115 waiver to expressly recognize that living in a protected environment (group home or at home with parents) requires less individualized supports than providing supports and services for a person to live as autonomously as possible in the community. Particularly significant is that the Tiered Rate Setting for CCO/HH does not appear to adequately fund the needs of individuals transitioning out of a "protective environment".

*Life Plan goals must include quality of life measures that are person-centered and include the ability to diversify and manage person-centered resource allocation.

* Transition to Adulthood from the confines/constrictions of School District supports requires coordination of services beginning in adolescence. This front end planning must be coordinated with CCO's or HH's in order to achieve best outcomes upon reaching graduation or "aging out".

*Recovery model that guides the 1115 waiver implementation for HARP and behavioral health care does not specifically meet the needs of individuals with I/DD. 1115 Waiver should specify at

least semi-annual reporting requirements for utilization management. It is understood that this is a demonstration waiver and the results should also be shared publicly and in discussion with the individuals and families as well as CMS required reporting.

*A valid and reliable measures of family burden are available. A family burden metric should be used as a barometer of "performance value" of providers that are gathered from individuals and their families. Families and Self-Advocates must be members of all teams created to address any of the performance value metrics.

*We challenge Beacon Health's model of autism behavioral treatment:" if not found to meet clinical measures, reduce treatment". This can prove to be contradictory to the person's long-term well-being based upon best practices that are evolving.

*Noted in Attachment #1 to the NY-DSRIP program funding and mechanics protocol in Section III, item C-"statewide performances should be based on the top decile of performance for state and national data…."

--At odds is the scientific integrity of basing a metric only on the top ten percent of performances.

--How does this statement fit with the DOH's current integration of efficiency and quality scoring to assign financial rewards and penalties to MCO's and their partners?

-- How will quality of life measures will fit within the framework of the above quote?

Metric Targets:

We do not understand the current metric target and would appreciate more information and clarification on how they will impact services, particularly those impacting the IDD community and people currently funded by the Self-direction program.

doh.sm.1115Waivers

From: Joseph Guagliano [redacted]
Sent: Wednesday, November 29, 2017 5:04 PM
To: doh.sm.1115Waivers
Subject: 1115 waiver testimony

The Medicaid 1115 waiver or MRT (Medicaid Redesign Team) waiver is the method by which the state has implemented the initiatives of the MRT and all subsequent health systems reforms. This includes the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program's goal is to promote community-level collaborations and focus on system reform. Safety net providers will be required to work together to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. There must be greater transparency with the waiver. Outcomes must be clear and readily capable of analysis. Community-Based Organizations (CBO's) need full support to enable and foster their participation in DSRIP. DSRIP funds not allocated or fully spent by PPS's should return to the CBO's budget. Unspent DSRIP funds should be allocated to an Innovation Fund available to CBO's and other community-based entities for investment in community-oriented DSRIP-related activities.

Value Based Payments (VBP) must be understood by all stakeholders. There should be clarity in the process. Patient Recorded Outcome measures (PRO's) should be incorporated into VBP quality metrics. An important goal of the MRT is to capture patient experience, satisfaction and quality of life. After all the end result must be greater quality of life for patients. VBP arrangements must be held to the requirements that they contract with at least one CBO and employ at least one intervention to address a social determinant of health. CBO's will need support to enable and foster their participation in VBP arrangements. The State and VBP lead entities must provide funding to CBO's including but not limited to technical assistance and contracting for outside expertise. A majority of the changes to Medicaid Managed Care associated with implementing VBP will need to be incorporated into the Model Contract. This contract should be as transparent as possible.

The State's "Care Management for All' initiative, will require most Medicaid beneficiaries and services to be included in mandatory managed care, and must ensure access to true, meaningful care coordination. Special care must be paid to the rights of people transitioning between managed care plans due to plan closures and consolidations. Home and Community Based Services (HCBS) are essential in contributing to the well being of people with specific needs, particularly those with behavioral health issues who are served by Health and Recovery Plans (HARP's). Access to HCBS must be made more in a timely manner for the people who need them. Individual, independent consumer assistance services should be available to anyone in any managed care model. The Independent Consumer Advocacy Network (ICAN) should be sufficiently supported and expanded to realize this goal.

According to "Medicaid Matters New York", ongoing reductions in hours of care by a number of plans, with no justification for the reductions violates the law and Department of Health (DOH) policy. People should not be forced into nursing homes or other institutions. Additionally, continuity of care should be the focus. Whenever possible, the vulnerable in our population should not be left out in the cold. Significant savings in Medicaid dollars could be saved yearly and this is extremely important given the challenge of budgetary concerns. And pursuant to the US Supreme Court ruling in Olmstead, persons with disabilities have the Constitutional right to live in the "Most Integrated Setting" appropriate to their needs. New York must keep Medicaid funding a high priority in terms of Managed Long Term Care. The State saves money by community based living and our most vulnerable persons are able to live in their own homes. A win-win for the State and for individuals with disabilities.

Thank you for considering this testimony,

Joseph Guagliano

Joseph Guagliano

Legislative Advocate
Westchester Independent Living Center/Putnam Independent Living Services
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[redacted]
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www.facebook.com/PILSNews

I am a Family Peer Advocate a Medicaid managed care recipient and a care taker for two vulnerable individuals One with a developmental disability and the other with a serious mental illness.

The DSRIP Performing Provider Systems (PPSs) must include consumer and community
Representation in their governance structures, as they currently do not.

Consumers have the right to understand the implications of VBP and how it might affect them; yet nothing to educate them have been funded or done.

In addition to revisions to the Managed Care Bill of Rights, the State must ensure consumers; there advocates, and anyone charged with assisting them are informed about and conversant in VBP concepts.
Also CAG VBP Work groups should be transparent and meetings minutes of such work groups should be online and accessible. As they currently are not. The NYS DOH have not been clear on the number of workgroups or what they have been allowed to contribute.

The State's "Care Management for All" initiative, which must ensure access to true, meaningful care coordination. As of now no surveys or feedback has been collected from Health homes consumers at all which is a real shame since it's been in place since 2013.
Home and Community Based Services (HCBS) are an entitlement particularly those with behavioral health issues who are served by
Health and Recovery Plans (HARPs). HCBS Services as per Data from the MMCARP as of now almost 2 years later are seriously under utilized Access to HCBS must be made more expeditiously for the people who need them.

A private independent consumer assistance advocacy group should be available to children and The IDD population as they transition to a
Managed care model and or Health home/CCOs.

Special attention and engagement opportunities must be paid to the transition to Medicaid Managed Care for vulnerable populations, including children and people with intellectual/developmental disabilities.

Grievance procedures for consumers should be standard and available to those who are not being serviced by Health homes and should be available online and in conjunction with MCOs.

Furthermore Medicaid managed Care organizations and products such a HARPs and Medicaid managed care should be held accountable for their lack of care management services and plans of care development especially when health homes repeated failures on POCs as per MCO and DOH contracts.
Outreach should not go on over and over in that different Health Homes can bounce a consumers back and forth billing under outreach for an endless period for two to three months at a time.

Last a clearer defined role for New York State government entities like OPWDD/ OCFS/OMH and OSAS should have a clear and transparent role with lists of responsibilities and duties in this transition to managed care as well as Health Homes and CCOs

The same should also be said for all of the Local Councils of Mental Hygiene Directors and the Regional Planning Consortiums both of which New York Sate Department of Health's website offers little to no information.

There have been zero consumers advisory bodies/ committees engaged by CBO's Health Homes and Managed Care Organizations. Consumers have no idea what their rights are or how to obtain medical records from huge databases that often share information that may or may not be accurate.

Managed Care organizations and their employees have no idea about what is contained in their contacts with the NYS DOH. I have not been provided with any response from them as to how they will provide new HCBS services, care management Services or any clue what a health home does.

Thank you
Amber Decker

doh.sm.1115Waivers

From: Golden, Michelle (HEALTH)
Sent: Friday, November 17, 2017 8:54 AM
To: doh.sm.delivery.system.reform.incentive.payment.program; doh.sm.1115Waivers
Subject: Re: DSRIP Hearing Statembent - November 16, 2017

Thanks. Looping in waiver team.

Sent from my iPhone

On Nov 17, 2017, at 8:52 AM, doh.sm.delivery.system.reform.incentive.payment.program <dsrip@health.ny.gov> wrote:

> This was sent to Judy as well. Not sure what we are doing with written statements but I believe this is the only one we received.
>
> **From:** Anne Bove [redacted]
> **Sent:** Wednesday, November 15, 2017 6:32 PM
> **To:** doh.sm.delivery.system.reform.incentive.payment.program <dsrip@health.ny.gov>;
> [redacted]
> **Subject:** DSRIP Hearing Statembent - November 16, 2017
>
> *ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.*
>
> The Affordable Care Act (ACA) has done a great deal to improve access to health care at large. This current federal administration has made major attempts to dismantle ACA. Public and private sector hospitals rely greatly on ACA. To that end it must be preserved, but contingency plans for coverage need to be made if it is lost.
>
> The current approach that Health and Human Services (HHS) is undertaking appears to focus on value-based payments (VBP). This seems to be in conflict with New York State's goals. Subsequently, HHS has been canceling important Medicare bundled payments for cardiac and orthopedic procedures and moving to make other previously-mandatory programs voluntary. Frequently changing these directives makes it very difficult for hospitals to plan for the future. These agencies have also been participating in the DSRIP process incorporating VBP within their structure on a much larger scale. The current approach by this federal administration may be undermining many of these efforts.
>
> In addition, given that the goal of this 1115 waiver is to shift medical system towards value-based payments, there is concern that there may not be a renewal of the waiver. It is not at all clear that all hospitals will be where they need to be by year five and may require further support. Considering this, can the waiver be easily renewed? This seems quite doubtful.
>
> As the DSRIP Project Approval and Oversight Panel (PAOP) process develops, transparency in workforce is frequently queried. The DOH has chosen to share some of the workforce reports on the DSRIP website. However, none of the compensation and benefit reports from year one have been shared with the public. The reports have already been aggregated to ensure that no single employer was identifiable. Why are these reports not being shared?

Thank you for this opportunity to share my concerns.

Anne Bove', MSN, RN-BC, CCRN, ANP

New York State NURSES ASSOCIATION. One strong, united voice for nurses and patients

Comments on the MRT 1115 Waiver Process

My name is **Pat Kane** and I am a registered nurse and treasurer of the New York State Nurses Association. Thank you for the opportunity to appear before you this afternoon.

NYSNA has been actively involved in DSRIP since its inception. We serve on workforce, clinical, and governance committees for 20 Performing Provider Systems across the state.

As the PAOP is aware, we've consistently been asking for transparency in workforce reporting at various DSRIP hearings. We're very appreciative that DOH has chosen to share some of the workforce reports on the DSRIP website. However, none of the compensation and benefit reports from year 1 to date have been shared with the public. We do not understand this decision. The reports were already aggregated to ensure that no single employer was identifiable. We must ask: Why is this important part of the record-keeping not being shared?

The compensation and benefit reports from year 3 are going to be collected soon. These will provide valuable data on how compensation has changed from year 1 and what effect DSRIP is having on our workforce. It would be really unfortunate if DOH were to continue withholding this data from the public. We would like to request that DOH post the year 1 reports online and ensure that the year 3 and year 5 reports be shared as well.

You have made several recommendations to improve the PPS reporting for spending on the quarterly reports. There has been some improvement, but substantial gaps remain in what is reported so that funding for different categories can be tracked. We need to know exactly what the contracts with community-based organizations are for, potential payment and what was actually paid.

It seems appropriate that we know on what basis the rate of compensation was arrived at. Another category that needs additional attention is updated reports on primary care expansion in community-based settings. Overall, we have concerns that appropriate CBO projects be properly funded and supported.

I have served on committees of the Staten Island PPS and I see what constitutes a lack of full transparency on these committees. We are frequently making decisions without all the information that should be before us and this stands in contrast to the goals of the DSRIP process.

I would add, as well, that meetings have been cancelled on more than one occasion, undercutting the integrity of the process as well as our practical ability to carry out our responsibilities.

Thank you, again, for this opportunity to share our perspectives and concerns about this important effort.

New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Comments on the MRT 1115 Waiver Process

My name is **Judith Cutchin** and I am a registered nurse at Woodhull Hospital. I am also President of the New York State Nurses Association Health and Hospitals and Mayoral Executive Council.

NYSNA is an organization with 40,000 members across New York State, representing nurses in public and voluntary hospitals and other health facilities. We are committed advocates for our patients: fighting to improve the quality of health care and for universal access to care.

We are very concerned about the new approach that U.S. Health and Human Services appears to be taking to value-based payments, which seem to conflict with New York State's goals. Two serious examples: HHS has been canceling important Medicare bundled payments for cardiac and orthopedic procedures and moving to make other previously-mandatory programs voluntary. As nurses, we must express our objections to these changes that we believe put patients at risk.

The shifting ground of policy makes us very uncomfortable. Constantly changing directives make for great difficulty in planning on the hospital level. While hospitals have been pushing forward with the DSRIP process, changing structures and renewed efforts to figure out how to carry out value-based payments on a much larger scale become cumbersome.

All together, these changes constitute obstacles, in our view. We are disturbed that the current administration may well in fact be undermining many of the original goals of the DSRIP.

In addition, given that the goal of this 1115 waiver is to shift our medical system towards value-based payments, we are very concerned that a renewal of the waiver may be in jeopardy. It's not at all clear that all of our hospitals will arrive at required benchmarks, necessitating a continuation of the 1115 waiver.

We also want to express some concern about the state of the OneCity PPS. Previously, we had really appreciated our relationship with this PPS. They valued the input of nurses in the health care process, and NYSNA was well-represented on various PPS committees, including the governance and clinical committees. We were able to provide useful thoughts about how the PPS should function moving forward.

However, with the recent departure of top leadership from OneCity, the PPS cancelled several meetings, which is very frustrating for us. Along with other labor unions, we have expressed our concern about the lack of forward movement to the leadership of HH, but to

date have received no response. We are worried that leadership is not taking this problem seriously enough and wanted to advise the PAOP of these worrying developments.

Thank you for this opportunity to appear this afternoon.

R·A·I·N® REGIONAL AID FOR INTERIM NEEDS, INC.

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Jane Arce-Bello
Executive Director

James Carey
Program Director

#17

November 15, 2017

RAIN and Bronx Partners for Healthy Communities

Regional Aide for Interim Needs (RAIN) is a community-based agency that provides services to our communities that impact the social determinants of health. These services include Senior Centers, case management, home delivered and congregant meals, Alzheimer's support, information and referral for benefits and entitlements, home care, community health education and other services. RAIN is committed to improving the health status of its population and addressing the health care disparities related to the people we serve.

RAIN recognized the importance of DSRIP early on and began positioning itself to play a role in this endeavor. We have been a member of Bronx Partners for Healthy Communities since it began and we work closely with this PPS. Over the past three years, we have engaged with BPHC on many levels – participating in projects related to Care Management Transitions, Health Home at Risk and ED Care Triage. We also serve on the PPS's Workforce Subcommittee.

We are an active member of the PPS's Community Engagement Work Group and worked closely with BPHC and a core group of CBOs to develop its Community Engagement Strategy. As of December 2017, we will have completed our key projects. Our participation and collaboration with this workgroup has been a valuable and educational experience on many levels.

BPHC's Community Engagement Workgroup is made up of 20 participating CBOs. It includes housing, mental health, drug and alcohol, social services, community health educators, clinics and youth and senior services. Together, we worked with BPHC to develop an on-line database – which we call a Resource Directory – of CBOs for care managers and other clinicians, as well as for CBOs and the public to have a searchable database for service needs. We, the CBOs, have found BPHC to be very open and receptive to our ideas and input, conferring with the group every step of the way. This project was part of our Community Engagement Strategy.

The workgroup also collaborated with BPHC to create a community health literacy program designed to reach out to underserved communities in the Bronx to help them get health insurance, access care and connect to a health home or primary care provider. Our community educators were able to get valuable feedback from people in the Bronx on what barriers they experience in getting health care. This information was

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brought back to BPHC and by working with the group we were able to design and improve our outreach protocols that are effective and relevant to the people of the Bronx.

Seven CBOs, including RAIN, are now partners with BPHC on this project. RAIN has already reached more than 600 people.

Creating opportunities for collaboration and networking also an important part of our Community Engagement Strategy and the benefits have been ongoing for us and our clients. For example, RAIN Home Health Care had a patient that needed detox, but found it hard to help him because of his difficult personality. Because of relationships made within this workgroup, RAIN was able to find a service provider for him and was able to get him into a detox program eliminating the need for hospitalization. This person was also able to get follow-up services which helped stabilize his home care services. Our CBOs have so many examples like this one I just mentioned.

As a CBO, we see first-hand that many clinicians were not aware of the services available in the community, or how to make a referral to a CBO. Over the past three years, we've seen that clinicians are gaining a greater understanding and appreciation of a relationship with CBOs and a realization that thinking outside the clinical setting is critical for addressing the health care needs of the people of the Bronx. According to a recent Robert Wood Johnson Foundation study, only 20 percent of the factors that influence a person's health are related to access and quality of health care. The other 80 percent are due to socioeconomic, environmental, or behavioral factors –including unhealthy housing, poor diet, inadequate exercise, and drug and alcohol use.

Those of us in the CBO world know that the services we offer can have a dramatic and positive effect on the health and well-being of the people our programs serve, but we had no way to prove or validate our work. In order to be sustainable, we have to be able to show a return on investment (ROI) that we can in turn market to the Managed Care Organizations and Managed Long Term Care.

As we move to value based payments (VBP), it is our hope that, by collaborating with BPHC, we can get the data we need to show the payors that the services offered by CBOs can maintain their population's health and reduce the PM/PM costs. Our experience with BPHC is helping us down the road to VBP and is helping our agencies evolve to meet the future. For example, last year RAIN had several staff members certified to be Stamford Diabetes trainers and is currently conducting classes. This is an

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evidenced-based disease management program with quantifiable benefits. The agencies Senior Centers also include other evidence based programs which help control medical costs and which should be attractive to MCO's and MLTC's.