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OK. I think we can start. Hi everybody I'm Donna Frescatore. I'm the New York state Medicaid director and executive director of New York state of health. Our state's health insurance marketplace. Thank you for being here today. We're going to begin as we do with a very brief overview of the the 11 15 Medicaid waivers. This is mostly background information. It will be familiar I'm sure to many of you. And then I want to make certain that we open this up as quickly as possible to hear from you today. So as many of you know Section 11 15 demonstration waivers are a provision in the federal Social Security Act that gives the secretary of Health and Human Services the authority to waive certain provisions and regulations and to allow Medicaid funds to be used in ways that are not otherwise permissible under federal rules. They in effect grant states including New York flexibility to innovate projects into advanced objectives of the Medicaid program by waiving certain compliance requirements of federal Medicaid laws. Generally a waiver can be approved for a five year period and a state may request subsequent extensions. Each of the waivers including New Yorks are governed by something called special terms and conditions or STC's and those terms outlined the basis of an agreement between the state and the Centers for Medicare and Medicaid Services, CMS, including waiver expenditure authorities. That is what the state is permitted to spend federal funding on. The SDC's specify the states obligation to CMS during the life of the demonstration. These are generally called demonstration projects including both our general and our financial reporting requirements and a timetable of state deliverables. As part of the waiver we submit quarterly and annual reports and an independent evaluation is completed at the end of our demonstration. Under provisions called budget neutrality federal Medicaid expenditures under the waiver cannot be more than what the federal government would have spent without the waiver over the course of the demonstration. And most recently there were some new federal rules that we are reviewing currently that made some changes making this test a little bit more strenuous than it had been in the past. So a little bit about the history of New York's 11 15 waivers. The waiver the New York state Medicaid redesign team or MRT waiver formerly called the Partnership Plan waiver has been in operation since 1997 and I can tell you that was actually when I joined the Department of Health and Medicaid program for the first time that waiver was only a few months old. Judy's shaking her head she remembers that too as many of you might. New York's MRT waiver was renewed last on December 6th of 2016 and it is effective through the end of March of 2025. That's the five year demonstration period I referenced earlier. The goals of the waiver obviously important to all of us to improve access to care for the Medicaid population, to improve the quality of health care services delivered to our Medicaid enrollees, and to expand coverage with resources generated through managed care efficiencies to additional low income New Yorkers. And New York has for many years led the nation in Medicaid expansions even prior to the Affordable Care Act. So our current 11 15 waiver authorizes several programs and I think we'll go through these quickly and you will see hi. You'll see kind of the scope of the program. The first is that it provides comprehensive health care services including all benefits available through the state Medicaid plan to low income uninsured individuals. It provides an opportunity for enrollees to select a managed care organization whose focus is on preventative health care. Under the umbrella of the Medicaid managed care program there are several programs including what we call the mainstream Medicaid managed care plan. Can't actually tell you where the word mainstream came from but pretty well part of our dialogue now. Health and recovery plans or HARPs, in home and community based services, and the managed long term care program as well as long term services and supports. New York's 11 15 waiver has also been the vehicle for our delivery system reform Incentive Program more commonly known as DSRIP. DSRIP provides incentives for Medicaid providers. We've been competing here with the sirens this morning to create and sustain an integrated high performance health care delivery system that can effectively meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by improving quality of care, improving health outcomes, and reducing costs. We spent this morning working with our PAOP panel and we have if you were able to be here we appreciate it. We hope

you found the information that was shared helpful and informative. We've also webcast that panel presentation and it will be available on our Web site where we discuss the status of the current DSRIP waiver in in very great detail thanks to Joe Weber and Greg Allen who's here at the table. We have several pending amendments to the 11 15 waivers. Gonna pause here for a minute. But just very briefly talk about what those pending amendments are. There is an ongoing process to be able to amend your current waivers through an approval process with CMS open to public comment. First the children system transformation which is currently under review by CMS. Provides mandatory managed care authority for the proposed children's consolidation waiver. The goal is to provide a comprehensive health home like care management for children who would not otherwise be eligible for health home to transition behavioral health benefits to a managed care system and to transition children in foster care placed by voluntary foster care agencies into managed care as well. A second pending waiver with our colleagues at CMS is an OPW DD an office for people with developmental disabilities voluntary managed care transition. In this case the amendment is a request that's consistent with OPW DD reform and redesign initiatives developed in collaboration with the commissioners transformation panel and stakeholder engagement. And the waiver amendment request CMS to approve concurrent 11 15 and OPW DD 1915 C waivers to provide managed care authority and demonstration services. Those demonstration services that would be permitted under this waiver if and when approved by CMS would include crisis intervention services including systemic therapeutic assessment resources and treatment or START as that is known for all planned enrollees in the fee for service delivery system. The third waiver amendment pending before CNS we refer to as the cost sharing proposal. This waiver request or amendment request to continue to exempt mainstream managed care enrollees from cost sharing. Most often we call those copayments except for those that are applicable to pharmacy services. The exclusion of copayments for this population has been a longstanding program design element that was intended from the very early days of the waiver to eliminate barriers to accessing care. The current practice reduces the administrative burden for providers who would otherwise need to collect those copayments and thus helps maintain an adequate network of providers for managed care enrollees. The next pending waiver amendment is for nursing home and managed long term care plan. There is a lock in proposal it was enacted as part of this year state state budget. The amendment was submitted to CMS on September 12th of this year. It is patterned after a lock in policy that has been in the mainstream Medicaid program nearly since its inception. And here's essentially what that amendment requests. That members who switched from one manage long term care plan to another would have a 90 day period in which to make in which to decide to transfer to a different managed long term care plan and then after that 90 day period except for good cause reasons or hardship would remain in that managed long term care plan for the remainder of the 12 month period. The second part to the pending waiver amendment with CMS also based on state law enacted as part of this year's budget would limit the nursing home benefit to three calendar months of long term nursing home care for enrollees who have been designated as permanently placed in a skilled nursing or residential health care facility. These changes do not impact the Medicaid managed care plans that is the mainstream plans or the integrated managed long term care plans including FIDA which is the fully integrated dual alignment program or Medicaid Advantage which is an integrated product for both Medicare and Medicaid or programs of all inclusive care for the elderly what we refer to as PACE. We had a request following our submission of this amendment to extend the comment period for the public and we opened that comment period up through November 23rd. So it just closed this week. A little bit on DSRIP then we're going to move quickly to to hear from all of you. One of the terms and conditions of our 11 15 waiver identifies four four measures that we must achieve under our DSRIP waiver. You see them here. I won't go through this in detail but they have to do with how many of the measures these are quality measures or performance measures are improving or maintaining versus worsening, how many of the measures have been successfully implemented such that there have been federal dollars awarded through the waiver, how total Medicaid spending statewide for inpatient and emergency room services per member per month has changed with a goal of decreasing unnecessary hospitalizations in avoidable

emergency room use, and that a certain percentage in thiis case and during this measurement period that 10 percent of total managed care expenditures are in value based payment arrangements. Those arrangements ensure are part of our transition to reimburse for services based on their value to the consumer and not the volume of the services. In order to pass this milestone the state had to pass all four of these measures. I'm pleased to tell you that in fact all of those measures were passed and that information has been publicly shared. These measures are on our website and we have reported that to our partners at CMS. I'm going to wrap up here quickly by just telling you that we have a number of resources to learn more about the 11 15 MRT waiver resources on our website, on the off the OPW DD transition Web page on our website as well. Our full terms and conditions for our waiver on our Web site as well as our quality strategy and information on CMS's Web site as well. So I understand we have 25?

31 speakers today. We're going to ask you if you would like to speak and you haven't already please sign in at the table. We're right here Phil's right here so if you haven't signed in just just see him motion to him. He'll make sure he gets you signed in. You should have if you've signed and you should have received a number. So we will call the number and then we would ask you to please come if you would like to one up the microphones or we Phil will get a microphone to you. We are going to time the comments. We're going to ask you to please limit your comments to five minutes and then at the end I guess we're collecting the numbers when when you leave. In addition to comment today today we will gladly accept written comments. They can be submitted at the registration table. You can also send your written comment to us by December 7th please at this address: 11 15 waivers at health dot NY dot gov and please note in the subject line of your email that you are your MRT public comment and if you later want this information we'll make sure that you have it out at the registration table. So with that thank you again for being here. We look forward to hearing from you. I'm going to take place at the table and we will begin with comments comments from speaker number one.

Good afternoon. My name is Daniel Johannsen. I'm the chief executive officer of ACMH a not for profit serving adults in New York City with serious mental illness, substance abuse disorders, and other chronic health conditions. ACMH provides care coordination, supportive housing, and other home and community based rehab and recovery oriented services. We are an active partner in five PPS's. I was asked that I'm pleased to speak to you this afternoon about one collaboration since January of this year with the Mt. Sinai PPS. In order to expand our MRT enriched crisis respite and transitional housing pilot and to hone our crisis respite proof of concept. That's the purpose of the collaboration. The Mount Sinai PPS has provided three critical things. First funding enables us to serve non HARP enrolled adults. Second the PPS has opened doors for us to its hospital partners and non hospital partners in order to educate what is a crisis respite and in order to facilitate referrals. And third they've helped us in establishing metrics and in analyzing data. The opening of doors has borne fruit. Since April when we started tracking the PPS attribution of our respite guests the highest percentage by far now is 45 percent of the Mt. Sinai PPS. And the PBPS is already reporting and this I'm quoting the PPS pretty great data showing ED diversion and were just fresh into it but of course that's the purpose of the of the pilot is to do the proof of concept. Respite for those who are not familiar with it is more than just rest. Staffed around the clock by peers who have lived experience with mental illness respite guests as we call them work on strategies to avert or better manage the precipitator of crisis. Their symptoms, their relationships, or other social determinants. They also work with peers and a care navigator on staff to engage or re-engage with community supports and services. 92 percent of our guests consistently report having learned or practice strategies during their respites stay that they can use to help them cope. When asked if they would have this is by self report gone to the emergency room if respite weren't available 54 percent answer yes and another 14 percent maybe. In November on November 19th there was a piece in The New York Times maybe some of you saw it titled When will we solve mental illness with this tagline biology was supposed to cure what ails psychiatry. Decades later millions of people with

mental disorders are still waiting. This is a piece by the health reporter Benedict Carey and he concludes this piece quoting Gail Hornstein from Mount Holyoke College and I quote When people have an opportunity to engage in ongoing in-depth conversation with others with similar experiences their lives are transformed. The medical model and this is our ACMH perspective and DSRIP put practically all their eggs in the basket of biology. At ACMH we believe that peer support, supportive housing, and other transitions of care modalities that prioritize listening to and engaging the individual need to be given the opportunity to demonstrate their value in saving dollars and in healing lives. So we are appreciative of this pilot and are looking for other opportunities especially in the behavioral health community that has really been disadvantaged going into value based payments to have an opportunity to demonstrate value. Thank you very much.

Just one other process point for our speakers. Simone from our team has timing cards up here. So to avoid the awkwardness of having to shut people off if you can keep an eye over on Simone we'll keep you honest too but it's it's more helpful if people self manage. Thank you.

I am Robert Alsaberdo, a member of independence care system. Donna probably knows about this and I'm also with the civics league of disability rights. Most MLTC's focus more on the needs of senior citizens. I'm here to advocate for the disabled community because only ICS understands the needs of people with physical disabilities. ICS has been the only managed long term MLTC plan in New York that regularly authorizes up to 12 and 24 hours of home care for people who need it and now as we all know from our year of advocacy on behalf of them ICS is in danger of being closed because of the high cost needs of some of its members. Ideally all MLTC's would be able to afford more home care hours for High cost members if the state would only create a separate rate taking this high needs population into consideration. This is a long term problem that will only get worse as New York New York's population ages. I'm here to ask for support for this cause which is important to the well-being and diversity of New York City. Thank you very much.

Thank you. Speaker 3.

Good afternoon everyone and thank you for the opportunity to address those in attendance and the panel. My name is Joe Conti. I'm the executive director of the Staten Islan PPS. And the 75 partners that comprise our CPS are really reshaping the healthcare ecosystem in our community. Our partners are saving lives. Staten Island has gone from having the highest per capita death rate from opioid overdose to the lowest after two years of concerted efforts with cross-sector partnerships including our law enforcement and district attorney. We have enormous support from our behavioral health and substance abuse partners and several of them are here today and we hope to hear from them a little bit later. We have tripled the number of community members receiving medication assisted treatment and are working closely with OMH and OASAS every day to advance this work. Integrated Care is now the standard of care in our community. This was unheard of four years ago. Patient centered medical home practices have increased tenfold in the four years since DSRIP started and all nursing homes or engage with palliative care and readmission reduction initiatives focused on quality of life. This work is being accomplished by implementing a data driven system of care that creates a synergy with all stakeholders in our community. Our approach has enabled a seamless cooperation between community based organizations, health systems, private practices, and local governmental units. Today our PPS has an EMC diversion project operating with New York City Police Department and New York City Fire Department. We have a housing initiative with the city Department of Housing and Human Services that allows us working with community based organizations to reach out to individuals who have lost permanent residents are now living in shelters and bring them back to homes in our community. The first individual to take advantage of this program was a pregnant mother with two children who left their hospital and came back to permanent housing instead of going back to a shelter. This kind of improvement in the

quality of life of the individuals that we are serving really paints a great picture of how cooperation between cross-sector partnerships changes lives and is what DSRIP is all about. The whole program working with our great district attorney on Staten Island Mike McMahon has transformed lives of over 500 individuals. These were Justice involved people who were likely to go on to have a law enforcement record and all the impacts that go with it in terms of employment, housing, and family and instead have gone from jail and instead into treatment. This kind of work through cross-sector partnerships has really transformed everything on Staten Island. We're working through food, insecurity with City Harvest. We are working with multiple partners to deal with things like social isolation in our community and the Workforce efforts that we have taken place have reached over 10000 health care workers on Staten Island over 35000 hours of training and the College of Staten Island has been a great partner of ours. Two weeks ago we graduated the 30th individual from our group to receive certified peer recovery counseling services. Four years ago there were two certified peer recovery coaches on Staten Island. Now there are 90. Our PPS has provided scholarship and employment support for them as they find their way into roles in our hospitals, in our resource and recovery centers, and we continue to strive to find ways to make employment opportunities available to address these important social determinants of health factors. Last week we started a program at the College of Staten Island to bring New York City Housing Authority residents into CHW classes so that they can work in their own buildings to reach out to the partners and individuals that they work with to get them involved in health care. This is the kind of work that many PPS's throughout the state are engaging in. We are just one example. I think the important part of what I want to bring forward today was a little bit of an echo of what I heard earlier and that is the trajectory of improvement is one that needs to be sustained past April of 2020. That the work that everybody is doing has a great forward impact on the communities that we serve. And I look forward to the opportunity to speak to you all in the future. Thank you.

Thank you. Speaker four.

Good afternoon. My name is Anthony Feliciano. I'm the director of the Commission on the public health system. But more importantly we are part of a large coalition called community together for health equity that had the opportunity to do real discussions into planning as part of a grant that was offered by the state to really inclusion of committee based organizations and the idea of social determinants of health coming to a real reality into the being addressed. I just want to focus my points around community development and planning and sustainment. Community development often focus on equality and inclusion by promoting the voices of those communities who are less often heard. It can mean community involvement in or leadership of or any of the stages of service planning from identifying needs to implementing and evaluating services. I want to say that there has been not a true completely systemic way of looking at that and thinking that through. I think the state has appointed leadership and looking at that with the PPS's and the managed care organization but involving really the community based organizations around design and thinking about that planning. I think it's important to know that we have CTHE had completed their first part of the planning report and I think we need to ensure that the state as they're reviewing that report that they have a deliberate thinking through with our partners and other community based organizations is how that's going to be implementable, how are they going to be incorporated into the work that's being done right now to the PPS's and how that means there are sustainment of good work but also improvements that need to happen in terms of delivery of care and the quality of care particularly around addressing social determinants of health. Particularly around community based organization. Defining how their real role important role within this which some PPS has done better than others but we need to have a systemic approach around those issues. There's also this idea that sustainment has to also include ideas about what's going on right now in our current climate. Includes a public charge, includes a tax on healthcare. Those have to be thought through. What's the impact of sustaining the work of campaigns to be able to implement recommendations are important moving forward with changes. I understand the flexibility that the state wants to provide to managed care

organizations and PPS's or whatever entities come right after. But there needs to be balanced out with the idea that community based organizations have to be in that design. It has to be a way of looking at not just and I want to just say metrics. I think the value of those organizations what they can do and how they can move forward addressing the determinants. And and many times it becomes very lopsided. And so we need to really look at how the decision making structures in the government moving forward incorporates community based organizations. We have two other entities that have gotten funding through this grant and one we want to make sure that we have a comprehensive approach all together as the state reviews those reports. The state thinks about that. And I commend that with the department social determinants of health. that bureau has done some good process and progress in terms of looking at these things but we need a real systemic approach. We need to really address what are the needs of our communities and what they're going through and that's going to be important. It's not just community based organizations and the design is our ability to bring those communities to the table to address those needs. And how does that work with the hospitals moving forward. This has to be not just trying to figure out how can we maybe they can help them managed care to get more members or figure out delivery of care. It has to be a real deliberate way of designing programs and services that are not siloed episodic but really systemic in terms of the care of communities. That is critical. And if we don't have that that's going to be a huge loss in opportunity for all groups not just the issue of diversity has to really be reviewed. The issue of community based organization defined and functionality within this process has to be better done in a way that improves the quality and the delivery of care for our communities. And the communities have to hold accountable issues around transparency around the information that's provided. Not to community based organizations but to communities in terms of how that care is being delivered, resourced, and decided upon. And that's critically important if we really want sustainment to happen. Thank you.

Thank you. We invite speaker number five to the microphone.

[Inaudible]

Thank you. We invite speaker six.

Good afternoon. My name is Mike Guglielmo and I am the director of parish and interfaith outreach for Arch care the health care ministry for the Archdiocese of New York. I'm very pleased to be here to champion our efforts on Staten Island under the auspices of the Staten Island PPS and it's leader Mr. Joel Conti who spoke earlier. Arch care's work with the Staten Island PPS has a two pronged approach. Promotion of health literacy and launching the time bank, a reciprocal voluntary exchange program both served to improve the overall population health on the island. In terms of health literacy the biggest impact we have had on Staten Island is making connections and building networks. We partner with community based organizations in interfaith communities throughout Richmond County. We have provided health education to individuals in the community on topics as varied as blood pressure control to diabetes prevention to healthy aging among many others. This is just one way we support healthier lifestyles all while increasing participant understanding of health literacy. Through our health literacy outreach we've encountered over 11000 Staten Islanders. We also leverage our health literacy programs to encourage participants to make sure they either have health insurance or if covered utilize it properly. Helping to reduce ED's as the points of primary care. This helps the PPS ensure that Staten island residents have a primary care physician or health home. So if we offer flu shots we also make sure community members know how to connect with a provider or enroll if needed. In addition to the wonderful collaboration on Staten Island with the PPS Arch care has also invested a great deal of effort throughout the city with other D DSRIP partners. One example is the recognition we received at a DSRIP citywide Project Advisory Committee meeting where arch care was complimented for excellent patient care management services provided to the one city health PPS. This was related to the care transitions program at

Harlem hospital. Overall Arch care believes in a personalized approach to health care and one of the best ways we achieve this is through a time bank program where individual needs are met and social isolation is addressed. I am now then very happy to introduce Mashi Black number seven time bank director to tell you more about Time Banks time banks impact on the Staten Island and other New York City communities. Thank you.

Vertically challenged here. Good afternoon. I'm really delighted to be here. For those of you who are not familiar time banks are networks of individuals providing key assistance with concrete services including instrumental activities of daily living as well as essential emotional and social support. Members of the time bank give whatever they can and then they can request what they need. It's a reciprocal exchange system where members earn an hour for every hour provided. No money exchanges hands just time. Currently the arch care time bank has close to two thousand individual members and 113 organizational members. 62 percent of our members are over the age of 60 and most have very low incomes. Half of our members do not speak English. Almost 80000 hours of exchange have been recorded since the arch care time bank launched in 2014. Through DSRIP Time Bank has focused on filling in the gaps in the formal services and addressing loneliness, a public health epidemic and a critical social determinants of health. Escorts to the doctor, shopping assistance, errands, cooking, post hospitalization support are just a few of the services time bank members provide to each other. With enthusiastic support of the Staten Island PPS the Arch Care Time Bank launched and now operates a vibrant time bank network on the island. Key support from Bronx partners for Healthy Communities allow the time bank to more than double its Bronx membership primarily in the South Bronx. And we also received key training on outcome measurement. Timing is also working with NYU Brooklyn PPS. With families dispersed, with an aging population, and with shrinking resources we all know how critical it is to identify innovative strategies to support those at risk. Individuals can join the Arch Care time bank today and have almost 2000 people on their team. Social workers and nurses from LMTC and Pace are now referring individuals at risk who are lonely and Time Bank matches them for weekly calls and sometimes visits based on interests, language, and in some cases geography. We're in the process of collecting pre and post data measuring loneliness and distress. Retrospectively nearly 100 percent of these individuals who referred who are engaged for six months with the time bank report they benefited. 77 percent said their mental health improved. 44 percent report their physical health improved. If you can get a 70 or an 80 year old to report that health is improving that's pretty exciting. And 79 percent report the time bank helps them feel less alone. We are very very grateful for all the support the Arch Care time bank has received and hope to have the opportunity to continue to work with the PPS's to expand, innovate, and improve health outcomes. Thank you very much.

Thank you. I want to make sure we don't miss anyone here. Were you were you 7 or were you OK. So we invite speaker number 8 please.

Good afternoon. My name is Anahaita Kotval. I'm the executive director of a nonprofit based in Westchester County called lifting up Westchester. And we serve homeless and other extremely low income individuals in the county. About 35 hundred a year. I'm actually here today to share with you are incredibly positive experience with the DSRIP program in our area. As you can imagine those who are living on the streets or living in shelter have significant barriers to accessing almost any of the services and other important functions in life that we all need whether it's education, employment, and particularly health care. And so our number one mission is to stabilize house those individuals so that they can start to rebuild their lives and reengage in their communities whether it's with their families, employment, et cetera et cetera. And one of the big gaps that we discovered is that while we have significant funding for providing services when our clients are in shelter and while there are some housing programs that provide supportive services to individuals with particular disabilities that are diagnosed. For the vast majority of homeless people who leave

shelter they are then no longer eligible for case management and other support services. So we were experiencing having you know done the great work of getting someone ready to move into their own unit or their own apartment and then we have to let them go because our case managers were not funded to stay with them during that transition period. And there was no follow on service to kind of help them through what for many is a very very difficult transition from community living and food being provided. And a lot of care and support and transportation to living by themselves usually in an apartment that which they can afford means in a neighborhood where they know no one with almost no disposable income or any of the other resources we all used to make ourselves at home in a new location. So we were finding a significant number of people falling back into shelter. And we had a funding gap because we couldn't find any traditional supportive services for those clients. We were then introduced to the DSRIP team at Westchester Medical Center. And in conversations as we explain this issue they understood that not only does this have a significant impact for the long term trajectory of these clients ability to be independently housed but also would affect their ability to access and the cost of them getting any kind of quality Medicare. And we work together on a partnership that has just launched between ourselves and the health home in Westchester called Mental Health Association of Westchester where they're funding a pilot position for us to have a housing retention coordinator who will work with the health home rep as a joint team with people moving out of shelter to stabilize their housin. Our housing coordinator will teach the health home person what we do to stabilize people in housing. Things like budgeting and housekeeping and learning how to comply with a lease and budgeting cetera etc. and the health home our folks will learn from the health home people how to stabilize people's medical management. And the hope is that the protocols and the materials that we create together will be ones that we can share around the county and maybe in other parts of the state but that it will allow both teams to have that dual capacity and we have already gotten some assurances that if the pilot proves to be successful in stabilizing housing then our traditional funding sources will add this position as part of our county shelter budget and maybe to the other shelters in the county. So I just want to commend the program both obviously for the funding itself but for also some of the expertise and the thinking and collaboration and the convening power that DSRIP provided in really getting us to a very clever solution to a problem that had seemed intractable a couple of years ago. Thank you.

Thank you for sharing your comments. Speaker 9. Already on the way.

Good afternoon. My name is Logan Lewis. I'm the chief compliance officer for Kamelot of Staten Island. And I'm here to talk to the panel and to the audience about thae Staten Island DSRIP which Joe Conti is executive director of the benefits that we've received from that. Kamelot provides a substance use disorder services on Staten Island. We have adult and adolescent residential treatment programs. We're in the process with the support of Staten Island DSRIP and Commissioner Sanchez and opening up the first residential woman's treatment program for substance use disorder on Staten Island community residents on Staten Island. But the benefits that we've had from DSRIP is for years we've been just a substance use disorder treatment agency. Through the DSRIP we were able to get integrated a25 care license so that now we are now outpatient facilities we can provide substance use disorder treatment, mental health treatment, and primary care and receive Medicaid revenue for that. That's a that's a tremendous help. Biggest help has been really don't think of not for profits as competing with each other. We do right or we have. A substance use disorder treatments agencies, mental health agencies competing for the same clients. And what DSRIP has done is it's help us to coordinate services to bring all those community based agencies as well as the hospitals, primary care practitioners, mental health substance use disorder to the same table. We've coordinated through the to the clinical clinical services committee that we have there with providers from representing all the various aspects of behavioral health and primary care and mental health to come up with solid clinical standards through the through the Rios, through the HELPX, and through psyche's to be able to monitor our clients to be able to really have a share in improving the

quality of the services that our clients receive because we're sharing information about clients with reduced duplication of services. We've really reduced the number of emergency emergency room presentations for substance use disorder. We have a system of care where there's a warm handoff from the emergency room to community based providers where we can pick people up who have had a substance use disorder episode right from the emergency room instead of giving them a piece of paper and referring them out. And that coordination of services. So from my point of view I've been at this for like 43 years has tremendously helped us in the provision of services to the individuals. We keep talking about agencies and how the agencies work together and all of those things are good. But the whole idea of us being here is about helping the people. And this is really the DSRIP has really helped us to provide a better quality of services because there is trainings to our ground level staff. There are people who come out of my program and other programs who go to the community college of Staten Island to learn to be peer recovery counselors and recovery coaches so they have a career path to work on in this field as well as other kinds of vocational incentives that are part of this whole operation. And as smaller community based agencies try to negotiate through this new world of Medicaid managed care, value based payments, negotiating with insurance companies, trying to figure out which IPA you want to be a part of, the Staten Island DSRIP is an excellent vehicle for handling those kinds of things and for helping these agencies to go forward and it would be a real disservice to the people that we serve for this to come to an end in April of 2020. Thank you very much.

Apologize.

OK. Its that working. Light's on. Thank you. So thank you very much. Before we go on to our next speake I missed the top here of not acknowledging and thanking Commissioner Sanchez from OASAS for being here today. So thank you. He spent the entire day here with us. And we very much appreciate your partnership. Thank you. Go ahead.

Good afternoon. My name is Hannah McIntyre. I'm the chief operating officer of the Arab American families support center. At the Arab American families support center we have strengthened immigrant and refugee communities since 1994 by promoting wellbeing, preventing violence, getting families ready to learn work and succeed, and communicating the voices of marginalized populations. Our organization serves anyone who is in need but over nearly 25 years of experience we have gained cultural and linguistic competency serving the growing population of Arab Middle Eastern Muslim and South Asian communities in New York. We're an active member of the Brooklyn arm of the Citywide community is together for health equity where Brooklyn perinatal network is lead and Caribbean Women's Health Association is co-lead. We have over 20 agencies representing the diversity of the borough of Brooklyn in our hub. While we have 20 member agencies we still have more small CBOs that need to be meaningfully engaged in this health care improvement process. Our member agencies are diverse geographically and linguistically and there is a plethora of social determinants of health negatively impacting the most vulnerable populations in Brooklyn. Our hub members address a wide range including but not limited to adult education and literacy, job training programs, Case management and crisis intervention, Food security, social family and community support and a host of other services. Our approach is multigenerational serving individuals from birth to senior citizens. In our 18 plus months working together we have made great strides through the CBO grant funding. However we have also identified many gaps and we want to stress three areas today. First the need for meaningful CBO inclusion in the healthcare delivery system at all levels including governance structure and decision making which we believe is vital to the improvement of the healthcare delivery system. Second there must be a shared agenda for health equity inclusive of community engagement and its development. Third there is a need for improved an increase CBO capacity that must be taken seriously. We cannot expect small CBO's that often see the most vulnerable populations to continue to exist and function with so little human and financial resources.

Investment must be made in these communities. We recommend the following actions in Brooklyn. Improve the referral mechanism between CBOs to link to each other through I.T. systems for improved communications service coordination and service gap reduction which we believe can improve health outcomes. Second localize the connection between CBOs, PPSs, and MCOs. Please note that some of us do have a great relationships and involvement with some of the Brooklyn PPSs such as CCB Brooklyn serving on the community engagement commune committee, NYU Langone and involvement with one city. We need to continue to improve relationships and leverage resources to strengthen all. We also believe that we need to enable CBOs to influence policy around housing and its impact on healthcare. Examples are recommendations to the state include taking strong leadership to ensure that small CBOs are not excluded from the table with the belief that they're not able to provide high quality care. What that results in as large organizations are being considered only during major planning and funding opportunities. Second identify and find funding for the continuation and sustainability of the Citywide CTHE. Third ensure that we protect New York's immigrant population that may be impacted against the proposed changes and public charge. And finally facilitate the all transparent by direction communication occurs with CBOs, MCOs, PPS and the state. Thank you for your attention to this matter. As always we will stand strong and ready to work with you on this issue.

Thank you. Speaker 11.

Good afternoon PAOP members. Thank you for the opportunity to speak with you today. My name is Kristen Schaal. I'm with the Alliance for Better Health PPS based in Troy New York serving about 150000 Medicaid members in six counties in the capital region. I have one message that I'd like to deliver today and that is DSRIP is working. So what I would like to just talk about today are some examples of that. I'm here with my colleague Manmeet Koor who is the founder of City Health Works. She'll be speaking next and talking about her amazing work that her and her team have done with both with both us and the Mt. Sinai people PPS. We're Excited to be launching this program in the capital region right now. In addition to the City Health Works program that we're launching in the Capital DSRIP DSRIP. I'd also like to share some of our other initiatives that have made some tangible positive changes for the people that we serve. The first is the launch of a Troy medical respite program. So this is a couple of miles from our office in Troy. We work with the staff at the interfaith partnership for the homeless who recognize that some of the homeless folks that they serve who are discharged from the hospital but we're not healthy enough to be safe in the shelter. They're often readmitted shortly after discharge. So two years ago we initiated the support of a facility that accepts these folks and provides them with a safe place to recover more fully with a nursing presence until they can transition to permanent housing. A couple important facts about this program. One and most importantly the program is working. It's preventing readmissions and it's connecting people to primary care, some who have not been connected to primary care in years if ever. Connecting them to to behavioral health services and to health homes. Secondly we've helped the the team at the interfaith iterate toward organizational excellence. We've helped them develop measures of success. We've helped them change their process to help reduce length of stay thereby maximizing the number of people that they can serve. This is an extraordinary program run by extraordinary people. We're privileged to work with them. We're now working with them to facilitate contracts with MCOs to help evolve the program towards sustainability. Another program I'd like to talk about is what we call our Healthy Together network. So Healthy Together is implemented in collaboration with another PPS, one of our collaborating PPS's in our region. So what we've done is implemented a technical platform for closed loop referrals from medical providers to human service organizations such as CBOs that address the social determinants of health. And then very importantly is that the CBOs then can respond back to the medical care providers so we have CBOs referring to CBOs, medical providers referring to CBOs all in a systematic way so that so that folks are not falling through the cracks. People know what's happening with their clients with their patients. This infrastructure helps to connect service

providers with all kinds of services, enables the community to prevent people from slipping through the cracks, and has really helped us to efficiently and reliably connect people to the services that they need the most. As part of the Healthy Together network and this closed loop referral system we've also launched a program called circulation. So circulation is a transportation platform that uses the lift network to transport patients or clients to appointments that address social determinants of health. So our partner organizations in the capital district are very excited about this program. They use it to get their patients to housing, food, support group appointments. Additionally I'd like to just mention quickly that we are helping facilitate Primary Care connections so early in early DSRIP we focused on the DSRIP projects one of which was the Pam program. Pam program was administering Pam tool to patients and then conducting coaching which was valuable. What we found is that the best measure of success for this program is a PCP visit. So we've evolved our program to a network of CBO providers who are laser focused on that key event which is making sure that the patient gets to the primary care appointment. So these are a few of the many innovations and programs both partner led and PPS led in our area that we wanted to talk about. We're laser focused. We're working hard. There's a lot more work to do so as Dr. Conti said we would love to see the evolution of DSRIP beyond April 2020. Thank you for the opportunity.

Thank you.

Good afternoon. My name is Manmeet Kaur and I'm the founder and CEO city Healthworks. Our organization started here in Harlem five years ago truly to help deliver on the promise of health reform by forming as a partner and an extension of primary care, by hiring people from the communities that we serve who we highly train to become health coaches and who serve in partnership with existing primary care clinics to send that coach home with that patient after they've been given a set of prescriptions, a set of instructions, overwhelming diagnoses and are struggling with figuring out how to live with these conditions amidst this constraints of poverty. We send these coaches into the home to sit down with them in a calmer and relaxed environment and to ensure that the information provided by their provider in that visit is something they understand and that they can be successful in implementing. We do this by hiring people from the community and super having them supervised by clinicians and then embedding these coaches as partners to existing clinics. We launched in 2013 here in Harlem in close collaboration with the Mount Sinai health system. Along also with Metropolitan Hospital and a number of FQHC's. Over these five years we've benefited from PCMH and DSRIP support alongside philanthropy to thoughtfully take evidence based protocols for how to be successful in chronic care management and to operationally figure out how do we meaningfully integrate this community worker that's employed by us in a way that delivers delivers measurable value to those patients as well as to those referring providers who are very busy and very constrained. I want to highlight our work. One of the pilots have been doing with the Mt. Sinai PPS to pair a patient with congestive heart failure at the bedside during a hospitalization and then send them home with this health coach who is highly trained on how to work with them around self-management. We through the partnership with the PPS we very carefully over about a month or so worked with the inpatient nursing team to figure out how should referrals be made, what topics did they think were really typically missing in the knowledge of these patients. What were the what was the cadence of sequence of communications they wanted back with. How can we support that 70 follow up visit. And what are the metrics that would define success and that upfront code design over two months resulted in the nursing team feeling very clear about what kind of patients to send. Who would benefit and informed from us alot of feedback. What was working not working. It also helped highlight for all of us how important medically tailored meals are for congestive heart failure patient that's coming back and forth to the emergency room every month. As an example the first patient we worked with knew fluid restriction was important was doing it with water. Didn't know to do it with soda and tea. She knew to weigh herself but didn't know how to turn on turn on that scale because of something complicated. And so at the end of the day what we believe is that that piece of knowledge and

impart information about how to self manage and how to be a skilled self manager is a critical ingredient for any patient success. Over the last five years of refining this approach here in Harlem we've begun expanding to other sites. This summer with the Alliance for Better Health it's been a really wonderful experience in terms of the power of DSRIP is in the form of our work with the PPS where they have brought us as a brand new organization into a community we've never worked with. It has moved at lightning speed truly. I've never expected to have already trained and hired an integrated our care team into two clinics in Schenectady in about four or five months. And what's been particularly important is the role I've felt of a new organization coming in with the facilitation of the PPS and figuring out how can we get to know the relevant existing community services so that on both ends there's clarity that this is not a redundant new service and that that we can figure out a referral pathway that ensures that we fit within the ecosystem that they've been facilitating meaningfully so that it's taking the form of regular conversations between us and the primary care providers and that's the main social service provider to determine for patients who are more in need of homeless support who are homeless and need a stabilization where do they go. And for someone who is ready to engage in primary care and actually pay attention and focus on their diabetes or their asthma this is the right type of coaching service at that point in their care. So I want to also highlight that it's been an important process to work with the PPS that's been doing this for siltation over the past two years in that geography because they know the community members, they know the partners, and they are thoughtfully figuring out how to orchestrate that ecosystem. Thank you.

Thank you for sharing your comments. Speaker 13.

Right here.

Hi good afternoon. My name is Mahmood Khan. I'm here to talk on behalf of independence care system as well as other issues. My name is he fought Mahmood Khan OK.

My name is Ifat Mahmood Khan. I'm a person who has a permanent disability that requires use of a motorized wheelchair.

Thank you. Requires Use of a motorized wheelchair for mobility purposes and have several other ailments. I rely on the services provided by the managed care long term care organization independence care system which has supported my health care and mobility needs for the past 13 years but now it is in danger of closing. Why. Why is it that the disabled population is the last group to be thought of about or even considered when funding allocations are discussed and decided upon. Children have access to community programs such as mommy and me after school programs and services as well as local community centers for socialization and recreational activities. The elderly population has access to companioned services, Meals on Wheels, senior centers that provide daily meals, as well as socialization and recreational activities. These services the services these populations receive are absolutely beneficial and offer enrichment as well as fulfill a need in the community. So why is it that people with disabilities are still not considered to be valuable enough members of the community when it pertains to our needs for living independently. This includes the need for quality health care and support services with predict with respect to traditional home care such as home health aides, personal assistance under consumer directed personal assistance services. Not to mention that these workers deserve a decent living wage for all the care and concern that they provide on a daily basis. ICS fills that gap for people with physical disabilities. It offers community based services such as health care and personal care services to over 6000 people with physical disability disabilities who live within four of the five boroughs throughout New York City. ICS is unique based on the fact that this group this organization is the only one of its kind. In addition ICS also offers service providers who deliver as well as assist with repairs and replacement of assistive devices including mobility aids, motorized wheelchairs, manual wheelchairs, and durable medical equipment just to name a few examples. These supports are what assist people with

disabilities to maintain their quality of life at home and in their communities. Furthermore the people who work at ICS really have a vested interest in the members they serve and support. As a member of ICS it's an integral part of my life. I'm extremely grateful that it is in existence. This they assist me with my living my life in my own home and within my own community as independently as possible. Most of the people who work there can attest to how much I appreciate the services and activities that are offered. One person I have been fortunate enough to know and had the privilege of working with is Ms. Anna Núñez who has been my social worker and care manager for over almost a decade. With her support we have developed a long lasting relationship and of trust and understanding over the years. She has been the best advocate on my behalf pertaining to my needs for home care services, medical appointments, medical supplies, and follow up on things related to mobility devices I use. She is also compassionate, caring, and concerned for me. I've truly appreciated her sincere interest in how I'm doing as a person. What I respect most about Ms. Núñez is her ability to listen and the fact that she is she really here's what I'm saying listening and hearing are two rare traits in a person. But she has them both. She is truly unique in her style which is truly a breath of fresh air. If organs if organizations like ICS no longer exist people with physical disabilities moments of feeling have moments of feeling and adequate and invisible and helpless will only increase their moments. Their moments of feeling inadequate, invisible, and helplessness will increase. The impact of ICS closing would be an immense burden on me, my family, as well as all the other thousands of people with physical disabilities in New York City. If anything ICS should be expanding to all five boroughs not closing down. Or it is people with physical disabilities or is it that people with physical disabilities represent a burden to society. Are we half people because we are not considered physically normal enough. Are there not enough of us to care. Or are there not enough of us to care. I refuse to believe that any of this is true and I have no idea where I'll go if ICS closes its doors. Unfortunately there is no other place that will provide the same level of care of services and resources as ICS. While visiting nurse Services of New York is on the table as an alternative option it's for profit and primarily focused on healthcare. The bottom dollar will always come before quality of service and the quality of life of its clients. ICS focuses on the needs of people first and finds a way with its resources to make sure its clients live the best full life they can maintaining. ICSis so important and vital for people with physical disability and to take it away is like serving our lifeline independence and living our lives with integrity. I appreciate your time attention and consideration. Thank you.

Thank you for sharing your comments. Speaker 14.

Good afternoon. My name is Walt Priest and I'm the CEO of Family Health which is a tier 3 CBL federally qualified health center which we're privileged to serve about 20000 individuals. Eight thousand of those individuals who are Medicaid lives. I'm also the vice chair for care compass network the PPS serving nine counties in upstate New York. And I have a few brief comments and I'm glad they're brief becasue I'm getting very nervous about Simone over there with the cards. So let me tell you a little bit about CCN first care compass network. It's a nine county survey and over 200 partners in a region spanning about 1 8th of New York State. It's a tremendous geographic coverage. It's a complicated landscape including five health systems, nine hospitals, three regional health information organizations, and over 100 community agencies. Right now I think our funds flow is working. We're happy to report the care companies network has distributed 60 percent of its earned funds and of the funds distributed eighty percent has gone to nine hospital partners. And speaking as a CBO and one of the reasons I want to get you up here today is that I would like to take a moment and we've heard from others that had similar experiences to say what an enriching experience has been as CBO. Family Health Networks participation and care compass network has opened the door to numerous opportunities to work with other partners to serve our population differently. As you can imagine if you span nine counties the opportunity to work with other people is fairly limited. I will share with you as an attempt to brag also as we just had our triennial audit of family health network and we were fortunate enough to achieve a perfect score. One of the major

components of that is the ability to be integrated with other organizations to have the ability to coordinate services to be able to have continuity between the organizations that PPS has accomplished much of that. And I really do owe debt of gratitude to them. That being said we are highly engaged organization. I believe family health network is with care compass network and many of our members who contribute many hours. And this is very hard work as you all know that takes time and consistent commitment. We have to balance our bandwidth and cannot spend all the time all at once to do the things that we'd like to do. But I do believe our PPS is progressing. And again Im proud to be a member. As a CBL board member and I stand it I feel that I stand and so do other CBO members in equal standing with the hospital members of the board. Our organization has been involved for actually since it started when I had the pleasure of working with Robin Kinzel Eleven's here in an auditorium filled with people wondering what the heck DSRIP was. It has come a long way. CCN has balanced the DSRIP requirements made opportunities unilaterally on the basis of the needs of the Medicaid members in our region. We're extremely proud of what we accomplished and where we are today. The strategic planning now was a wonderful effort. I wish we had videotaped because the CBOs were highly involved in that process. Everything we've done has been through full collaborative collaboration from our partners. While that level of collaboration has taken time to mature as all things do it is currently yielding important results. For example supporting regional adoption of value based payment plans through a blend of level one and level two arrangements covering over 75000 lives in our region. DSRIP as you know and healthcare evolution is about transformation and by default it's about learning. Here's what I've learned. I've learned there is no effective value based payment transition without value based care. And right now care compass network as in the other DSRIP organizations are learning the basics of how to make their work. I would implore that that continue and that funding and the efforts and the organizational efforts of all the PPS's continue well beyond 2020. Thank you.

Thank you. Speaker 15.

Good afternoon. My name is Kathy Connerton. I'm the CEO of our Lady of Lourdes in Binghamton New York. I'm also the chairperson of the PPS that Walt just spoke of, Care compass network. And I'm here today to really add on to what Walt said and to add a few comments that I think are important that haven't been said yet today. As we established our PPS we brought together five competing health systems in our community who never really spent a lot of time together and competed mightily. This DSRIP project brought the forum to bring those five health systems together to force a conversation that needed to be had for many many years. In our region that Walt spoke of the nine county region despite all the resources that the hospitals have expended over decades our health status has gotten worse not better. And what we have come to recognize because of DSRIP and the form that has represented is that we can't change health status alone. So today I stand to advocate for the extension of the waiver past April 2020 but also equally important is to continue funding in an opportunity for the community based organizations in all of the state of New York to continue to be funded and have a voice in this care model. We cannot change health status in the state of New York without community based organizations like the ones you heard from today and 150 others of them in our PPS that are not here today but have large voices and should have large voices. Nothing speaks more clearly to me than a story. So as you looked at your spreadsheets today and the funds flow that you start to see you have to look behind the spreadsheets and you have to look behind the regulations that the federal government and the state have given us to operate in. 95 5, the CRFP grant funding have all created the idea that the funding is going only to the hospitals and that just isn't true. In our PPS I'm excited to say that 80 percent of what has been earned has gone to community based organizations and will continue to. Our board of directors has more members from community based organizations than it does hospitals. And that was deliberate. But the story that I wanted to tell you about is a pilot project that we have in my hospital that has taught us a lesson is Our Lady of Lourdes but is also creating a different relationship for primary care providers to have in our communities. We have a pilot project going

on now with a with a population of patients that has not yet diabetic but certainly has all the characteristics of becoming diabetic and we're trying to stop that and we're trying to find ways to do that. And the endocrinologist in our community who's leading that effort came to my office one day and said I don't know how much longer I can do this. I'm burned out. My staff spent countless hours trying to take care of social determinants to which we don't know where to send patients. We don't know who to connect them to and we're not able to do our job and we're not able to create a better environment for our patients. And then came DSRIP and now I'm proud to say that all the patients that are in his pilot study trying to prevent patients from having diabetes they're all improving their A-one C and they're not going down the road of becoming another diagnosis of a diabetic but because because of the efforts of DSRIP and now the 57 community based organizations that he and his nurse navigate or work with with this patient population to ensure that people are getting transportation to the services that they need, to grocery stores where they can shop for food that's healthy for them, for cooking classes and other things that they need to start to change their health status is a reality. So in our PPS I'm proud again to say that I partner with Walt and many others and the hope is that we can continue this and not stop it here. We're only starting to learn what this can change and change takes time and culture takes time to change. And for our health systems in our community who have competed mightily for many many years we're learning together that we can't do it alone. We need every single one of these community based organizations to have funding, to have the capability to have enough workforce to help us take care of the population that we have. If we can continue to keep this going forward and we can continue to raise up the capacity of the community based organizations in our state we can change health care. Thank you.

Thank you. Next speaker 16.

Can you hear me. Ok I timed this so I'm like 20 seconds over five minutes. Good afternoon. My name is Emily Rogan and I am Health and Welfare Council of Long Island manager for Health Equity. I manage the CBO planning grant for the Hudson Valley and Long Island. Thank you for the opportunity to speak today on behalf of Health Equity Alliance of Long Island, a coalition of over health 80 health and human service agencies representing our entire region from Montauk to Elmont. For over 70 years the Health and Welfare Council of Long Island has been supporting communities through direct service and advocacy work, policy, and by convening our membership of nearly 200 agents nonprofit agencies across our region. We are very grateful for the funding provided by the CBO planning grant. It has enabled us to assess the infrastructure of the nonprofit sector on Long Island and to work with our partners developing a strategic plan to connect health and human service agencies in our region, to improve technology, and share data. In addition we've been examining how services are delivered to clients throughout the region and where improvements can be made. Since beginning this work we've identified three key areas which the state can impact. Number one. As we look at integrating services and data sharing on Long Island we believe that departmental data and reporting systems at the state level need also be integrated and improved. For example a high needs child with food insecurity might appear in three separate systems WIC through the Department of Health. Snap through the Office of Temporary and Disability Assistance, and the school meals program through the Department of Education. Three funding streams 3 systems. No communication or integration to serve the child. We believe that systems change must happen at all levels in order to better serve people. Number two. Managed care organizations, health care providers, and community based organizations all tell us there is a significant gap and tremendous need for care coordination and navigation of client services. We know that clients are overwhelmed by the complexity and disconnect within the human services sector alone. They find themselves visiting multiple sites, completing redundant intake forms, and rushing from location to location in a region desperately lacking adequate transportation systems. Clients experience parallel challenges within the medical sector and as a result referrals are dropped and appointments are missed. The system as it stands is not designed to help people get the comprehensive care they need and deserve. CBOs are uniquely positioned to fill that gap. We know

our clients and communities and we have the expertise to put a community care model in place. The planning grant has provided the financial support to identify an appropriate model and develop a business plan. However implementation funding from the state would enable us to put that plan into action and develop or purchase the necessary technological infrastructure to help clients navigate and access services. Number three. There should be guidance and messaging from the state to managed care organizations to contract with a consortium of CBOs addressing a full range of social determinants within a community and not cherry pick CBOs. If we are truly to tackle poverty and support an infrastructure of health and human services on Long Island there needs to be an investment in all social determinants of health through a holistic person centric system in which medical services are just one piece of the support puzzle for families and communities. In fact around the country state governments, managed care organizations, and health providers are boldly investing upfront dollars in social determinants of health and community based organizations convinced that the result will be improved health outcomes and reduced Medicaid costs. Here are some notable examples. In Toledo Ohio a partnership between LISC and pro Medica led to an investment of 45 million dollars in under invested neighborhoods promoting economic development and targeting the region's unemployment challenges. In Utah Intermountain Healthcare has committed 12 million dollars upfront investment in the alliance for determinants of health focusing on two counties with the intent to replicate the model throughout the state. In Michigan person centric multi sector collaboration with an equity lens are driving most of the Medicaid reform initiatives. In Denver Colorado United Healthcare is investing millions of dollars in Affordable Housing including nearly 15 million dollars in a Denver non-profit that provides education, training, and support for children and adults with developmental and intellectual disability. And since 2010 California's health in all policies ensures a focus on health equity and sustainability in policy making across all sectors. According to a recent publication by the Robert Wood Johnson Foundation quote state Medicaid programs can only be truly successful if they are responsive to the needs and priorities of the clients they serve not providers but patients and their families. End quote. We applaud New York State for the work to date moving towards a health care delivery system that values improved outcomes as much as dollars saved but there is much more work to be done and we hope our recommendations will help steer the next phase. Thank you.

Thank you. Speaker 17.

Good afternoon. My name is Mary Somoza and I am the mother of four adult children including my 34 year old twin daughters Alba and Anastasia. Both of my twins are quadriplegic with significant specificity due to their cerebral palsy. They cannot walk, sit up in bed, turn in bed, transfer from bed to their wheelchairs, or bathe or bathing bathing seat, dress themselves, feed themselves. Alba has a gastronomy feeding tube or do any of the things most of us here today take for granted and do without thinking. They depend on home care assistance 24/7. Nonetheless they both lead meaningful lives in the community working part time and paying taxes. Alba teaches at a school in Harlem for severely disabled children, paints a studio in in Chelsea, and lectures at universities around the city and state. Anastasia is the first disability coordinator of the city council working for speaker Corey Johnson first disability coordinator in history. They can only work part time as if their income goes up they lose the benefits that keep them out of institutions or nursing homes. That includes their home care. I also came here to support the many participants from ICS who are now in danger of losing their 24 hour coverage. Losing the support system provided by ICS that also who keeps them in the community where the quality of life and and common sense supports such as a wheelchair clinic on site. As all people who depend on wheelchairs know if your chairs not working your quality of life comes to a standstill. ICS knows that and provided quality services to the individuals they serve. And because of that they are now at risk of closing because the Department of Health did not calculate appropriate rates for high need cases. Most of whom flocked to ICS as the plans would not accept their level of care care or hours. Many of the people at ICS are our friends. They are advocates who have made things possible for my twin daughters. That my

twin daughters benefit from today. Many anre now aging dependent on ventilators and experiences and not only difficulties of their disability but the health consequences of getting older. They should never have to go through the anxiety that they are now now feeling and that they will eventually end up in a nursing home which incidentally cost the state far more than supporting people with disabilities so they can live at home. My daughters have a developmental disability and now OPW DD and the state are pushing us at breakneck speed into managed care. Despite all the euphemisms about better health outcomes we all know that the real reason is to save money and that means cutting services. OPW DD and DOH are on a fast track to most the most vulnerable population into a system that will invariably diminish the quality of life of our family members. I am a governor appointed member of the office of people with developmental disabilities commissioners Advisory Council appointed by every government since 1991. Originally appointed by the father of our present governor Governor Mario Cuomo, a great governor by the way. I have seen such a tremendous lack of transparency coming out of this whole stealth operation to put our family members under control of CCOs, a disaster happening as we speak and eventually managed care. Parents are terrified as many of us are also aging and wondering what will happen when for profit entities decide what level of care our children and young adults will have when we are no longer around to advocate for them. I don't ask you to take my word for this. There are two reports New York Lawyers for the public interest, disability rights of New York that have brilliantly laid out all the faults of these fast track rush into managed care. I will include copies with this testimony. Every family member with the stakeholders like us every family member who has a child adult child with a developmental disability have not been brought into the decision making process. We have not been informed of where we are in the process until it is too late and we simply find ourselves overwhelmed with the speed at which this is occurring. We are looking at what happened to ICS and Guildnic. Both are now bankrupt because they provided care to the highest needs individuals with disabilities and we are seeing the writing on the wall of where this is all going. You have overwhelmed family members who have dedicated their lives to keeping their children in the community. Many of them will give up surrender to the nursing home industry. Is that what you want. I ask you to reconsider the track the state is on right now. And think about that infamous word Willowbrook. Remember what happened there when you make decisions that affect us down in the trenches. In the age we live in it could still happen. Please do not let that happen. Thank you.

Thank you all. Speaker 18.

Good afternoon. My name is Cathy Penacacus. I'm the CEO of Human Development Services of Westchester. We are a partner in CBHS, an IPA in the Hudson Valley. We are active participants in two PPS's in the Hudson Valley, the Montefiore Hudson Valley collaborative and we are here today on behalf of the Westchester medical health CRHI and a program which they sponsored for us in Innovation Fund project. We should also say that Montefiore also assisted us in Innovation Fund grant as well. But the medical center saw a vision and assisted us to get it off the ground and Monte followed suit. Our living room crisis a respite program is a non hospital crisis respite service which addressed project 3 AII crisis stabilization. It's designed to provide a comfortable calm relaxed environment for individual individuals in escalating behavioral health crisis who need a safe place to support their behavioral health. It's an alternative to emergency department and offers both certified peer and professional support to develop short and long term planning strategies. We provide best practice services and interventions which are used to address immediate crisis. We provide a setting for crisis prevention and safety planning to prevent a higher level of intervention. Our living room model followed the best practice models that are around the country. It's staffed by certified peer New York state certified peer specialists, Case X, registered nurse, and a licensed clinical social worker which oversees the program. We should say that we do have a psychiatrist on call although in the year and some months that we've been open we've not called that psychiatrist. We apologize for any psychiatrists that are in the room but we've not needed that service. The living room has met the following the PPS metrics of BH community crisis stabilization post hospital care

transition. We've been providing stepdown services for people as they've come out of hospital integration of primary and behavioral health care. We've linked guests to providers who provide integrated services. Diabetes management are nurse teaches and links guests to diabetes care and tobacco cessation. Our guests come from many different places. They Self refer. They come from residential providers, care management agencies, clubhouses and community centers, from clinical providers, from law enforcement, medical providers, step down from hospital and nursing rehab. We've been open since July of 2017. Since then we've provided 4251 hours excuse me of face to face services. That that equates to 1443 unique visits to 102 people. Most of our guests come to avoid emergency department visits. As our first speaker spoke about respite these are self reports. We also asked our guest as they come is your visit deflecting an emergency department visit and 83 percent of our guests report that they would have gone to emergency department if not for the living room. We've been paying it forward. Our living room now is being replicated in a number of counties throughout the state. One of our guests wanted to be here today but she couldn't. So although my speaking to you might be interesting we thought her words would be more important. I wanted an opportunity to talk about my experience. This is her words. I wanted an opportunity to talk about my experience in the living room and why it is important to me. During my worst days my team came to action and gave me the tools the love and the patience I need to keep fighting for my life. The living room gave gives me space to shelter from chaos not only from the outside world but from the deepest phase of space of my soul. The living room has saved my life. Living with trauma has funded fundamentally changed how I view this world and how I live in it. This year has been particularly harder than others. I have been suicidal, hopeless and helpless. The worst part is that nobody wants to talk about it. Prior to the living room I was having difficulty sharing my feelings and thoughts without people calling 911 and the inevitable trip to the emergency department. I feel grateful that I have a place where I can get to be me where I feel safe and I get to talk and heal. The living has become my home. It has become the place where I go to find connection love and compassion. I can say that I would not be standing here alive if I were not if it was not for the living room and the staff. I feel safe and free to be me. I enjoy rest, sleep, fun, and laughs and sometimes good coffee. I get to be quiet or interact with others and sometimes I give support to other guests when I can. This is what matters to me. The living room has given support to help me manage full time college, part time work, my trauma treatment, relationships and sustaining my life. So as you can see this program has really made a difference in the people we serve. We want to thank our WMC partners for trusting in our vision that this would make a difference in emergency department and hospital diversion. And we understand that we will continue our relationship with them and hope that we can continue to see CBOs continue to enjoy the relationships with DSRIP. Thank you very much.

Thank you for sharing your comments and the words of your guests. We do appreciate it. OK speaker 19.

Good afternoon. I'm Matthew Bernardo. I'm the president of Housing Works. Housing Works serves people living with HIV and AIDS and other chronic conditions as well as having great thrift stores and bookstores across the city. We want to talk today about our involvement in the CCB domain for work group and some of the innovation that's come out of that. Since 2017 CCB has supported 3F QHC's and three hospital based systems to implement the undetectable which is the viral load suppression program that has been studied by UPENN and has been implemented since 2013 at Housing Works and has been proven to lower viral load suppression rates as well as incentivize clients for their own health. Over 700 people at the sites across CCB have been enrolled in the undetectables. The sites have high have reported high rates of client engagement and proving rates of HIV viral suppression. Recently Medicare announced that they are launching their own version of the undetectables and it is thanks to efforts like CCBs from CCBs among others that a Medicare understood the importance of this program and took steps to replicate it. This is crucial to the overall sustainability of undetectables. And programs like the undetectables are key tools if we

want to end the AIDS epidemic by 2020. Other other items in the work group we have looked at peer work and the importance of peers in delivery of these services and interventions. The work group is currently exploring new ways to train and support providers around sexual health and the concept of you equals you, undetectable versus un transmittable. Thank you.

Thank you Matthew. Speaker 20.

Think I'll have to lift this up a little bit. There we go. Good afternoon all. And to the panel thank you very much for allowing me the opportunity to say a few words about our experience with DSRIP. My name is Mark Grame. I'm the vice president of program services with an agency called coordinated behavioral care or CBC. CBC is a membership organization. We were formed in 2011 and we are made up of 55 nonprofit organizations across the city of New York and provide services in all five boroughs across the city. Our primary focus is behavioral health though our member agencies provide fruit, substance abuse treatment programs, they run clinics. They have education programs or housing providers and of course run care management services. And CBC is known as the second largest health home in New York City. Our agencies formed and formed CBC and really to become more integrated themselves to break down some of the silos that were in our communities and to share the expertise that they had and really saw that there were a lot of gaps in our communities where people were needs were not being met. And really felt very important that we build a continuum of care management services because the existing services were not sufficient in themselves. When DSRIP came along we really saw DSRIP as an opportunity to partner with our hospital colleagues to transform the system and to develop new levels of care for individuals so that all Medicaid recipients particularly those with behavior health were not being left behind. And probably like a lot of you we were a little initially a little apprehensive when we got the surveys and about whether this was going to be more of an administrative exercise. But we've had some very very positive experiences over the last four years and I want to speak briefly about three of those today. In the first year of DSRIP as one of the projects and we were able to partner with Staten island PPS on their Health home at risk project. And health home at risk I think a lot of people initially thought it'd be a very light touch intervention. And to me and to our colleagues at CBC it was very important intervention. There are a lot of individuals who are in need of support. The ultimate risk is for those people one chronic condition but at risk of developing a second. And a lot of times in our society we do not do enough work around preventative care. And so ultimate risk being able to get established in Staten Island. We've served over 4000 people over the last three and a half years. And what a very nice part of it is is that every year we can go back and revisit that individual and do as a care management agency a check up to ensure that they're getting the ongoing physical health care and specialist care that they need in their community. And our second partnership that I would like to highlight because it's a different level of intervention is with Mt. SInai PPS. Fom the outset Mt. Sinai PPS have really sought not just ours but all community providers perspectives. Brought us around a table to hear what our experiences had been but also to work with us and recognize where there were gaps within our communities. And then used in their later years and in this year for us some of their funding to set up and develop new innovative programs. And with Staten Island or with Mt. SInai PPS In July of this year we launched a community outreach for recovery and engagement project which looks at individuals who are really the high utilize of our services. Individuals who are not being needs are not being met by local community providers, by health home services, by clinics or care managment services. And with Mt. Sinai the ability to use data we're able to identify people who are using ER services so to be eligible for the program you have to have had six E.R. visits in the previous year or you have to be someone who has had hospital the number of hospital admissions in the in the system. And our teams funded through the PPS are multidisciplinary teams. I've got my one minute so I will be quick. Our Multidisciplinary teams have been able to provide very intensive outreach persistent outreach to these individuals to ensure that they get connected with services. And to date we have a 62 percent enrollment rate which is incredibly high. It is hard to reach group. And finally very very

quickly and up in the Bronx we've been able to do a project with Broms partners for health to communities to work with homeless individuals. And so just to summarize and to end our experience as a group of community organizations and nonprofits has ultimately been very very positive. And we have really seen more Medicaid people engage in the system of care in the city of New York which really the quality of care that has improved in the system of New York and for that reason you know we are very supportive of DSRIP and its ongoing work. Thank you very much.

Thank you. Speaker Twenty-One.

Good afternoon. My name is Leticia Gibbs. I'm a special projects coordinator for health people. I'm a member of communities together for health equity and I am a Medicaid consumer. So I'm happy to be here to be able to speak to you all. First I would like to say that if we are serious about transforming our health system and hospitals we have to be able to address people's social determinants of health as well like housing, education, and food and social support. Don't get me wrong there has been progress but there's still a major need for change because it is because it is still not where it needs to be. We may need to accept that it will take a bit long beyond 2020. So CBOs are the key to reach in our community members which I hope is still the goal of DSRIP. Health Systems and hospitals must work with CBOs and assure that they have the much needed funding so that they can continue to reach the most vulnerable communities that are highly impacted by the lack of resources like my borough in the Bronx. For example like I just mentioned the Bronx rates last on multiple indicators compared to no other compared to other counties in the state and there is a huge need for more focus on how to locate and work with the communities and populations they need. Populations that are tough to reach such as immigrants especially the undocumented, the LGBTQ community, people who are homeless in shelters, our seniors, our youth, people who are working but just scraping to just get by and need that little bit extra for food, people who have asthma and diabetes, cardiovascular disease, behavioral and mental health issues or become pregnant. CBOs are well positioned in the whose hearts and minds but we need funding to continue and ongoing relationships that we establish with the health systems and hospitals to get people the services, resources, and care they need at this right at this time. I have the opportunity to work with one city health on one of the innovation funds where were doing now the referral system. We're going into shelters now and it just amazed me of how many people who are in the shelters who have diabetes who have heart disease who have asthma who can't readily control their health condition because of the unstableness of where they are. Some of them are not in shelters in bed. Some of them are in drop in centers who are sleeping in chairs. Who can't who don't even have a bed to lay down at night. So I mean going in to there to be able to adjust their social needs, referring them to places that where they could get coats, shoes. I mean this one lady just thanked me so much and really touched my heart to be able to help her to go out to refer to some place that will give her something for free and help her. I pray that you know the funding is there to address the social needs and to continue to address the social needs. Thank you.

Thank you. Speaker 22.

My name is Loretta Fleming. I am a diabetes peer leader and coach working for the community based organization Health people where the executive director is Chris Norwood. We are located in the South Bronx. I along with my colleagues go around in the South Bronx teaching diabetes self-management classes. I am also a type 2 diabetic. At one time I thought that diet that diabetes was a death sentence but by educating myself taking diabetes self-management classes offered by health people I I now know and realize how to control and manage my diabetes. Diabetes is a very big epidemic especially in the South Bronx. The percentage of pre diabetes, diabetes, and amputees from diabetes is at a all time high. What we need and what we need very much is funding for diabetes education. By people learning about diabetes, learning how to control their a 1 c, learning

how to eat better, learning how to count their carbs and calorie counting and so many other aspects of diabetes self-management people will realize that their diabetes can be controlled. Doctors don't have the time to teach patients all they need to know about diabetes. That's where diabetes self-management class has come into play. Education is the key. Please consider funding for diabetes education. Educate. Don't amputate. Thank you so very much.

Thank you. Speaker 23.

Good afternoon. My name is Randy Redken. I'm director of legal health which is a division of the New York Legal Assistance Group and I'm here today to speak briefly about our CBOs experience with DSRIP and in particular with the Mount Sinai PPS. By way of background legal health is the nation's largest medical legal partnership or MLP. And an MLP is an intervention where legal and healthcare professionals collaborate to help patients resolve social and environmental factors that contribute to health disparities. Legal help has free legal clinics at 36 hospitals and community health centers, organizations throughout New York City and Long Island, and has partnerships with five PPSs. In the last fiscal year we served over 7000 clients in over 9000 legal matters and in addition to onsite legal clinics we train health care professionals to recognize legal issues that may negatively affect medical outcomes. Many socio economic and health care disparities have legal solutions. For example people who have difficulty maintaining stable housing are less likely to have regular medical care and are more likely to postpone treatment and to use the emergency room for treatment. An attorney can assist those patients with eviction prevention. As another example of there are often legal remedies available to assist patients with obtaining maintaining and increasing important benefits which help people afford medication and other out-of-pocket expenses while keeping up with current bills and maintaining healthy food options. We believe that our services set off a chain reaction and better patient health, a decrease in unnecessary hospital readmissions, and a decrease in health care spending which is why we became involved in DSRIP. We have been partners with Mount Sinai health system since 2001. In fact Mount Sinai was our first partner and when DSRIP began we expanded our partnership to the PPS. The Mount Sinai PPS polled their partners regarding what social needs they were seeing with their patients and legal needs were one of the biggest concerns. In response we recently collaborated with the Mt. Sinai PPS to house a legal clinic at two federally qualified health centers, settlement health and the Ryan center. Staff at the FQHCs have been trained to identify the need for legal intervention and make referrals to the legal health attorney who is located right on site at the at the federally qualified health center every other week. Once a patient is referred the legal health attorney will conduct a thorough intake, provide advice, counseling, or direct representation to address their various legal needs while also working closely with the staff. The PPS has provided logistical and financial support and has worked hard to make this new endeavor a success. It is also helping us to track the legal clinic data to get a sense of the number of patients served and the value of our services. Through this partnership with the Mt. Sinai PPS we've already changed patients lives. For example we had one patient who came into the clinic with a serious mental health and physical disability. Yet his application for Social Security benefits had been denied. We were able to prepare the patient for his disability hearin,g help him obtain the necessary medical documentation and there after the client won his hearing. With this increase in income it is more likely that this patient will regularly access medical care and focus on improving health. Although DSRIP will soon be coming to an end as far as we all know we are hopeful that our work with PPS's like the Mt. Sinai PPS will be able to continue whether it be through value based payment arrangements or exploring other funding sources with the FQHC's such as through HERSA. We know that this has been a long process for many especially the CBOs but we are hopeful that DSRIP has opened the door for new CBO hospital collaborations like ours. Thank you for your time.

Thank you.

Good afternoon. My name is Faven Araya and I'm here on behalf of the Arthur Ashe Institute for Urban Health and as a member of the committees together for health equity also known as CTHE. Similar to many community based organizations the Arthur Ashe Institute works with vulnerable communities by meeting them where they are to connect them to information tools and resources they need to make informed health decisions. Through our partnerships with school, Barbershops and salons we've developed trusted relationships that have allowed us to witness the complex real life experiences and what structural and institutionalized racism, social and economic inequities and neglect have defined the quality of their lives. Despite these conditions our organization and organizations like ours have humanized their experiences, prioritized and serviced their needs and advocated for the human rights regardless of their race, sex, nationality, ethnicity, language, religion or any other status. Recognizing the failures of the healthcare system and the absence of community voices coalitions like CTHE have come together with a shared understanding that community engagement is an essential component for healthcare transformation. Without it health disparities will continue to persist. Though through DSRIP progress has been made cross-sector partnerships that value and integrate community input has led to new approaches to addressing Social Determinants of Health and projects like CCB's part which have facilitated communities identifying and prioritizing their own needs and lead to the investments in neighborhoods otherwise neglected. The recognition of the role cultural competency in health literacy plays in whole in health outcomes and the collaborative efforts of NYU and CCB with CBOs to ensure diverse populations are comfortable and informed in their health decision making process. The creation of innovation funds, the inclusion of organizations like ours and governance structures, the state's investment in the strategic planning grant that has led to the formation of the CTHE, the creation of the Bureau of Social Determinants of Health have all shown signs of progress. But this is not enough. True transformation comes when value and community. True transformation comes when value in community and health equity becomes inherent. Transformation occurs when communities are equitably represented in governance structures where decision making occurs, when CBOs have the support and resources to build capacity to have sustained engagement in the healthcare delivery system and want a shared agenda for health equity is practiced and implemented. State leadership is state leadership to facilitate these approaches to transformation has the power to make systemic change. Thank you for your time.

Thank you for your comments.

Good afternoon everyone. My name is there Derek Mondoso. I am a patient navigator. I represents Sposas Latinas. Sposas Latinas is a committee raiser conversational kid in Queens and the reason I'm over here is to support my colleagues she just mentioned. We need support as a community based organization. And I'm just going to share a few things that we consider is very important to be aware of that Queen's is the most ethnically diverse county in the nation and has a higher percentage of foreign born residents in New York, according to the census 2016. Queens has the highest percentage of adults with not health insurance, 40 percent, the highest rate in all New York City. As a patient navigator I assist clients different ethnicities and I see different needs and how well Sposas Latinos have a long reach over 3000 immigrant Latinos annually and enroll 500 immigrants to health insurance, Connect over hunded to primary health annually regardless of their immigration status. All we looking for is increase CBO inclusion in health care delivery systems, governance, structure, and decision making. CBO's are important because we have direct access to community. The staff have that relationship. People identify with the staff and feel safe. We are a culture of competency and we understand the need of the community. CBO's need resources in I.T. that are based to make sure outcomes a hospital needs. We need to work together and I strongly believe that you are the right person to sepak to. Thank you very much.

Thank you. Speaker 26

Hi good afternoon. Good afternoon. I'd really like to thank the panel members who are here and who were listening to people it's very important. And I'm Chris Norwood executive director of Health People and also we are head of the Bronx hub of community together for health equity. All the focus of Health People is to implement accessible effective programs which are not just community based but community delivered. Under DSRIP the most groundbreaking we have done is our community based diabetes self-management program. We have endured more than 1000 Medicaid patients with type 2 diabetes in the well recognized Stanford succession self-management program. I believe that is a record. It is only occurred because of DSRIP but it's also important to recognize how hard it was to do that. It actually took us two years and more than 300 meetings some on the phone thankfully to get this implemented. We are very happy for ou PPS especially Bronx partners for healthy communities which has supported this but I think what we have to recognize now and you've seen really an extraordinary range of wonderful community programs today that there is still basically no real mechanism to bring up these community programs a part of health reform. They either have to fight for it or perhaps someone somewhere administratively says this is a great idea. But there is no mechanism and there are dire consequences for that. I'd like to give two examples. We've had DSRIP it will be five years and 8 billion dollars. During that period two particularly dire things have gone on. The rate of diabetes related foot amputations has gone up in New York State 48 percent since 209 and the rates of maternal death and morbidity have also soared during this period. It's hard to think of any two health disasters for the person which are also a disaster in cost and utilization for the system or anything worse that could happen to communities then losing their mothers and losing their feet. And yet somehow through this whole system that exists we have not been able to coherently respond to perhaps the two worst things that have increased and are driving hospitalizations and emergency room visits. A large part of the reason for that is that communities are still not integrated. They cannot bring in what they see on the front line. Some community groups are putting doulas in place. We are able to do some foot care education but it's not systemati for the whole thing so I would like to strongly suggest for the time we have left a mission and a focus for the state and everyone is develop mechanisms that when something is going on and we have this system we can you know get a response into this system and equally with the range of important community programs you've seen here today we have to figure out a way to save them. If they all collapse at once at the end of this I mean I'm not even going to think about that. I would like to mention we did hear from an upstate PPS that it integrated its community groups in the city. I'm very aware of what one city is doing. They now have borough committees and they have stated they are putting as much of their remaining funding into innovation fundings which will go through these local committees which actually do recommend on funding and programs. And that's really the first time I've seen that in the city that it's been brought to a local level like that where every well not everybody but you know everybody from medical directors to community groups are sitting on the same committee and trying to say what should we do now. What's most important. I think the state has the moral authority to make sure that every PPS for the remainder of this has a mechanism that includes community groups and starts getting funding out to these obvious but you know unaddressed problems. Thank you very much.

Thank you speaker twenty seven.

OK is 28 ready speaker 28 right here in the front. Thank you. Thanks Chris.

Hi good afternoon. My name is Robbie Idei. I am the daughter of a member of ICS who receives a lot of hours of home care. I took the day off of work to come because I figure it's going to impact my life if ICS shuts down so I just want to impart that on you. My mom she's she was here. But she had to catch her ACCESS-A-RIDE so she's she left. I'm sorry if I ramble on this is the first time I've ever done something like this. So my mom is one of those people who receives a lot of home care hours. I understood it's my understanding that there's a rumor going around that ICS is shutting down. It's going to be a problem for me. I kind of have been up all night thinking about this so and I

know that there's a lot of members and family members in ICS who are also concerned about this so I just wanted to kind of get you know from a family member's perspective put put it out there. Before we joined ICS we really didn't have any kind of quality of care service. We were a part of a managed care organization that didn't do much. We my mom is unable to move herself in a wheelchair. After about ten years of me begging for a motorized wheelchair we joined ICS and we were able to get one. They provide a service that most care companies don't understand because if you're a long term person with the long term disability you really need special services. You're not someone who's just old and frail and ICS is the only organization that I've dealt with that really understands that and customizes that care towards that. So since my mom's joining ICS she's lost weight, she's had less E.R. visits, I've had more sleep. I don't have to push the manual wheelchair up and down hills. So that's good for my back and I'm happy about that. And that keeps me out of the hospital. So you know there's a lot of reasons why ICS is a good organization. I actually hadn't intended to come to say anything so I'm sorry if I'm rambling but I just wanted you to I just wanted to impart that it's a really really really good organization. And those of us who are family members of those who are disabled we really really rely on that organization. So if there's anything that can be done to keep it around I'm all for it. So thank you. Thank you.

Thank you for being here and thank your mom for being here earlier as well. OK are 27 ready. If not is speaker 29 ready. Hi want to come on up to the mike.

OK. The acoustics are terrible in this room by the way. OK. My name is Philip Bennett. I'm a home care worker going 43 years. Also a person with a disability and I'm also a disability rights activist and I support the higher reimbursement rate for ICS. I can tell you as a Hands-On provider there was no service like ICS and I enjoy providing a service. I'm not in this so much for the money and I can't understand why anybody would like to close down when it does so much. I don't have to go through the list. I won't take up time there. I mean compare it with the highly challenged folks at visiting nurse service. I mean who would want I mean it must be political or something that is causing this. And also why would people want to close down ICS and when it's inevitable that it will raise the population in the institutions. How many people here would prefer living in a nursing home rather than your own home. You could raise your hands OK that's one. OK. How many people how many people would prefer living in a nursing home rather than your own home. Anybody. Let the record show that nobody has raised his or her hand. And so I can understand that. I mean and the cost. My aunt was in a nursing home. It cost the taxpayers Five hundred and fifty dollars a day for that one person. I got her out of that place. Got her home, set up home care unfortunately was visiting nurse service. But that was what was available. The cost a hundred and forty eight dollars a day. That's almost 400 dollars a day savings for one person. I mean what the heck. And I and I also just want to mention the shortage of home care workers as you probably have heard about that that everybody's talking about the population aging and we are driving home homecare workers out of home care. I know I'm really looking forward to my retirement when I I'm dreading I have already taken a big hit with that shell game that was set up with overtime and as a result of the new overtime regulation which the governor pushed down our throats. I now make less money. I used to work 48 hours a week average. Now I work 36 hours a week average. I mean again what the heck is going on here. I have to say that it's because the majority of my sibling workers are immigrant women of colors. I mean the racism, sexism, and chauvinism in the industry is just monumental. I'm a Caucasian male born in the United States and I have gone to home care agencies which said Why are you doing this for a living. You're a white man living and born in the United States why are you doing this. There must be something wrong with you. I mean it's just racism and sexism and chauvinism are just so out in the open. And it seems with all the the war against immigrants we're going to be needing to import a lot more people who I mean again it's crazy and I'd just like to close that if you really want to understand people with disabilities I recommend a show called Speechless which is now on Fridays 8:30 to nine ABC. It really gives a good story about the lives of people with disabilities. Happy day.

Thank you. Twenty seven ready. OK.

So I'm a family peer advocate I have a child with autism spectrum disorder and I want to provide public comment today on the transition of the 1915 waiver population under OPW DD into the 1 0 1 5 waiver. CCOs which are care coordination organizations slash health homes are required to meet the following health information technology standards in the delivery of care management core services. CCOs are required to meet the final standards within six months from program initiation and for those of you don't know that has started already as of July 1st 2018. We're now a month away from the deadline that and there has been nothing but crashes and failures repeatedly from Medicaid which is the current EHR as a part of the health information technology standards that all 7 care coordination organization Health Homes utilize. The Care Coordination organizations Health Homes manual provider policy guidance manual refers to quote requiring an employing a standardized care plan to be used by care managers which will be known as the life plan to develop and meet the care planning requirements of the health home program. This statement alone is enough to understand the role of CCO Health Homes. The care plan is not used by the consumer but by the care manager. In fact the very concept of managing one's care seems to aim at data control and health care not health care education utilization and advocacy family support services aim to facilitate access to inclusive options. Medicaid service coordinators known as MSCs did the job of navigating OPW DD eligibles so that at least three fourths of the 100000 currently live in the community. As the health home IDD application stated to develop and meet the care planning requirements of the health home program versus the consumers and the individual's needs. This does not even begin to sound like a promise or commitment to person centered planning nor the valued outcomes of the OPW DD and programmatic objectives of the people's first transformation. Health Homes health home services or I'm sorry Health and Human Services has already paid CCO Health Homes over 200 million. Yet tens of thousands of participants have been not been assigned to care manager. CCOs Health Homes are months behind their schedule of creating new life plans such as that it is highly unlikely that a hundred thousand will be completed by June 30th 2019 which is their targeted date. The provider policy guidance manual again further asserts quote the individualized life plan is accessible to the individual and their family representative and is based on the individual's preference of either electronically and or via e-mail. I know that I and no one that I know has been provided access to their life plan as of yet. The question remains as to what will happen if life plans are not created by the anticipated due date which is June 2019 according to OPW DD. So I developed a survey in which I surveyed 120 individuals with OPW DD eligibility and found that 120 person out of 120 participants only 16 percent have completed a life plan that's 19 out of 123. We've asked state how many life plans have been completed since July 1st 2018 with no response. It clearly seems that families individuals that see the state does not have control over the CCOs. OPW DD has no idea what the CCOs are doing and this was really felt all like hype. The details certainly have not been looked into. Managed care and the capitation makes it impossible to detect Medicaid fraud. As is already the OIG is going to look into this. In fact this feels very much like a corporate and privatization of a vulnerable population who are being exploited. How can we allow such a monopoly to take place. Healthy competition was the 500 MSE mom and pop agencies. The new monopoly of the CCO's takes aim at inefficiently inefficiently replacing humans with robots and setting non evidence evidence based assessments as barriers to services time and time again as we repeat it repeatedly for too long have seen in the current health and recovery programs as far as HCBS delivery and many it almost seems like many of these algorithms do not work nor have they nor should they be replaced by the clinical expertise of a qualified impartial party. Indeed the promises of meaningful person centred service planning and care management for all as is currently being implemented through the managed care in New York state is filled with lies. Nor does it aim at meeting standards that are in HCBS final rules and this will be a huge mass for this highly vulnerable population. The complete absence of care coordination for tens of thousands of participants who had previously had an MSC cannot be described as better care as it has been

replaced by care management. Does the Medicaid redesign team know that MSC's previously cost less than 300 million per year whereas CCOs are on target to cost over 600 million per year. The OPW the most OPW DD and the state seem willing to acknowledge that there's been some challenges and glitches but they seem to fail to acknowledge the result that the CCO rollout has created huge confusion. If time allows I would share I'd like to share a few anecdotal as on what participants from our survey of 120 OPW DD participants and their caregivers have just said.

If I could you're a bit over so we might be able to accept that after.

OK. I don't know.

Thanks so much.

If you'd like to submit the results of your survey to us put that website address back up or Phil or someone at the table.

If it's the 1 1 1 5 Waiver address.

You have it?

Yes ma'am. Okay thank you.

We'd be happy to look at that.

Good afternoon. I'm Alberto Brown. I'm part of the Arthur Ashe initiative urban health and I'm one of the members of the community together for health equity. We are one of the lead organizations and part of a joint collective leadership of the coalition. I think all members and many people have said the same thing today and I just want to kind of huge opportunity to summarize it. One that CBOs have invested a lot of time effort to bring one knowledge own experiences from the ground to inform this process to make sure that this design to transform to value based can really get transform to value based quality care. And as we all have said in many ways a coalition that represent all different sectors of the five borough cover many area of health. One of the things we learned in this process as we collaborated with all the PPS's, MCO's is still there and no clarity of the role of CBOs not just to address illnesses but how you have a holistic concept of wellness and therefore the issue of social determinants is still very slow. And there's no concrete real program in action. We also said that recognizing that we've been doing a lot of work with the borough for social determinant and their developing conversation to break the silo where we talk about because one of our slogan is that you can't design it for us without us and we are trying to make sure that every institution and I think the state has to play a leadership need to incorporate CBO in the most systemic way to co design these programs that impact our communities. We don't want to react any more we want to participate at all level. The positive experience for us is that we have worked we worked with many PPS's who understand that we don't want to just address illness we want to codesign wellness. How you integrate social determinant, how you use practice from the ground and scale them and finance them beyond the small community that we only have the resources to do. And in all of our boroughs is the same message. We are willing to continue working. We are waiting to respond to our strategic plan. Our people continue to meet and work with all the different state holder from the PPS's to the MCO's. But what is missing and we hope we get that soon is what is next after 2020. How are you integrating these eight billion dollars that we spend and the sustainability of the people that are the only answer to keep us updated at the reality on the ground. And I would end with this because a good example is what just happening now with the issue of public charge. Most institutions have an idea how that is impacting the different population. Only people working with that population know that people are not going to go to the emergency room.

People who are concerned about their kids are going to take risk. An increase of mortalities. If we don't include these communities you will not have access and we are not able to explain or convince them that there is a safety net in the system that would protect them and they should still continue to seek the best care. So we're hoping three things. One that there is sustainability of all will work because I think there's a lot of time put in and people are still excited to work. Two that we have a more systemic integration of CBOs from the governmental level and in all the different structure that PPSs and the MCOs. And thirdly that we are invited not at the end of the process but to codesign and bring our knowledge and or communities voices to address the complexity of health not only ilness but wellness and the intersectionality of racism and transportation and population and language and all those cultural competency stuff that matters at the end how we deliver care. So thank you very much and we hope that this is the beginning of a process and that 2020 is the next stage of transforming this system. Thank you.

Thank you for sharing your comments. Speaker 30.

Good afternoon. My name is Suzanne Toman and I'm the director of workforce development at the College of Staten Island. I'm here today specifically to speak with you about the prolific partnership between the College of Staten Island and the Staten Island performing provider system also known as SIPS. The work that the PPS has done with the college is transformative not only to our learners but ultimately to the populations they serve on Staten Island and throughout New York City. First the PPS has been instrumental to the growth of the two colleges schools, the School of Health Sciences and the School of Business. Not only has the PPS generously generously funded scholarships for students in both schools but it has been key in developing a new master's degree program in healthcare administration with the school of business that will meet the need for professionals in this role. However the PPSs worked with the college spans far beyond the matriculated programs. In fact in my role I am most grateful for the work the PPS has done to advance the opportunities offered to nontraditional adult learners seeking workforce training in social services and healthcare. With the PPSs support the college has been able to develop and launch training for community health workers or CHWs and recovery peer advocates. What are these positions and why has the PPSs work to develop and implement these programs so critical. To understand that let's take a brief look. A CHW is trained to work directly with Medicaid recipients who may have difficulty accessing healthcare providers, systems, or medicine due to cultural, language, or socio economic bear barriers. The college is currently offering its fourth customized CHW program fully funded and free to participants by the PPS. The latest version of the program is being offered right now. The program was launched by the College of Staten Island in the PPS in collaboration with NYCHA's office of resident economic empowerment and sustainability. In this cohort residents of Staten Island'sNYCHA developments seeking employment in health care and social services received customized training and intensive job preparation support. In addition to the CHW training the PPS has also partnered with the College of Staten Island's Office of Workforce Development to launch recovery peer advocate training. As you already know opioid use has elevated to crisis levels on Staten Island. To support the fight against this epidemic the PPS again financially supported the college design and launched a training program where individuals in recovery or otherwise impact by substance abuse disorders could attain the skills to reduce substance abuse disorder and to find job placement for them. In fact employer needs for this role are so great we are planning to offer this program again in early 2019. Finally we are in the works to offer the first federally approved Registered Apprenticeship for the certified nurse's aide or CNA role. This leads me to the additional benefit that the college has enjoyed because of its partnership with PPS. Because of the PPS's connections to local employers the college can partner with employers in program development to create training programs that hone the skills required for job success. It is needless to say that the College of Staten Island will benefit from the continued existence of the Staten Island PPS. However more importantly is how greatly the residents of Staten Island both those seeking to work in health care and all of those who benefit from the healthcare on

Staten Island will benefit from the continued work of the PPS. Thank you.

32. That's. OK.

Thanks.

My name is Cindy F. Staigle. I currently live in Brooklyn. I go by the pronouns she or her. For purposes of this meeting I represent Independents care system and Soul grow Incorporated of which I am chairperson of the board. Whether it is the right whether it is a profit company, a non-profit organization or the state of New York the organization needs a budget to provide programs and or services. Now I have been attending a writing group at ICS for about three months with Will, Allen, and Philip. The ladder here in disassembly. Writing helps me cement what I learn elsewhere in my mind. It is fun relaxing and therapeutic to this paranoid schizophrenic mind. If ICS were to close the writing group would end. May maybe I would write threatening letter through the mail again and back in federal medical center for life. Where would that be. Well of the organizations I have heard about here today. Up a river in a can canoe without a paddle. My organization my corporation markets my conceptual designs. These are in my opinion are valuable to the state,, country and the world. Extremely valuable. I wrote a letter to state assembly person Diana Richardson to that effect. These conceptual designs are for sale to New York State and could provide funds for programs and services. That's it.

Yes good afternoon.

Hi.

Good afternoon everyone here at this convention support for public health issues. I would like I would like to I would like to introduce myself first. My name is Nelson Bagley and I represent health people, an organization that has been around for a very long period of time. I stand here firmly in your presence to call for your assistance in furnishing the health people organization in the present and in the long run to continue to assist in educating and guiding the community to right resources as well as the health people organization in which I represent in this moment of need and always will look forward in this moment of need for assistance and struggle hard to provide accurate and concrete health information and accurate health. I say this because I am a living example. I am a living example of that degenerated and you know practicing bad habits like drug habits just of that nature but health people brought me back. Health people brought me back alive. A long time ago I was not looking like this. Healthy People Health People brought me back here. In a better civilization and for me to fit in the community. Without your help without your funding without your assistance how can we help anyone else in the street. We need your assistance to help us help them if it's possible. Thank you.

Oh thanks Judy. Anyone here who would like to speak that we haven't heard from yet. Okay so seeing none. Thank you. Thank you took our PAOP Panel members many of whom are still here or are left you know just very shortly. Thank you to all of you. We know that many of you waited a fair amount of time here to speak with us and make your comments. We appreciate that. Appreciate your patience. Greg Allen here and Peggy Chan and I have taken I think very careful notes of what we heard here today. So thank you. Enjoy the rest of your day and.

Okay so just I want to make certain the webcast we're still being webcast?

That the Web that the Web cast can hear Judy West's question which is she's asking what what happens to the comments that were here today. Greg do you want to address that question.

Actually I'm going to have to phone a friend in terms of the process we're going to follow after this Phil with the comments.

Why don't you come to the mike Phil and just.

Yeah. Thank you.

Yes so this is Phil from the office of health insurance programs.

The DOH website along with any written testimony and any other comments as well as the presentation slides so you can look for those hopefully over the next one to two weeks.

And I also want to say that we probably should be encouraging people to listen in. And I want to just say thank you to those who stayed who are still here to hear. There's a lot of courage for a lot of the personal testimony that happened here today. Just want to reflect appreciation for that courage and we did hear you loud and clear. And just want to thank everybody for the energy that was put into today. I think this is a worthy thing to listen to and we certainly will be taking action on what we heard today.