Comments on the PPS Organizational Application

1199SEIU United Healthcare Workers East represents 275,000 healthcare workers throughout New York State, working in a broad range of healthcare settings, from hospitals and nursing homes to ambulatory clinics and the home. We applaud the emphasis that the DSRIP PPS Organizational Application places on engaging the frontline workforce in the transformation of the healthcare delivery system as well as the recognition that organizational and financial resources must be invested in the workforce in order for DSRIP projects to be implemented successfully.

As we have discussed workforce strategies with partners and leads in various PPSs, we have noticed confusion regarding some of the questions in Section 5. We believe the clarifications below would be helpful to ensure that PPS workforce strategies will be clearly articulated by the PPSs and evaluated by reviewers.

1. PPS Leads are confused about the flow of workforce money.
   a. While Section 5 calls for a commitment for spending on the workforce strategy, it is unclear how these dollars are reflected in the overall budget outlined in Section 8.
   b. There is a question about whether dollars spent on training and other workforce providers will count against the 5% cap on funds to non-safety net providers, and some PPSs are considering distributing the training dollars to partners instead of contracting with one centralized training and workforce provider in order to ensure there are sufficient dollars for the non-safety net partners. We strongly recommend clarifying that workforce dollars will not count against the 5% cap.

2. It may be helpful to ask applicants to articulate how they identified the skills and competencies that will be required to implement the DSRIP projects, and how they will assess those skills and competencies. That question could be added to the first question on detailed workforce strategies.

3. It is important to carefully define the parameters of the information the application seeks in order to avoid applicants interpreting the questions in different ways.
   a. In the first question, it may be helpful to define "retraining" and "redeployment" as follows: Retraining (New skills/training for incumbent workers who will stay in current job titles and settings but whose functions might change) and Redeployment (Training for incumbent workers who need to take different jobs, including those who will maintain the same title but work in a new setting, for example an RN who will move from an inpatient floor to an outpatient clinic)
   b. In the second question, the application requests an analysis of impacts according to the percentage of employees to be redeployed, retrained and newly hired. It would be helpful to clarify the denominator here – is it the total number of employees employed by all the partners in the PPS? For new hires, is it a percentage of the total number of employees expected at the end of the DSRIP process (after any layoffs, etc.) or at the beginning?
   c. In the second question, the bullet points could be changed slightly to reflect the definitions of "retraining" and "redeployment" above. The second bullet should say "Please indicate whether the retraining will be voluntary and whether an employee will be required to pass an assessment to retain their position." The fourth bullet under "Retraining of Existing

Staff" should read "Articulate the ramifications to existing employees who refuse retraining or fail an assessment".

d. We suggest that the table on Partial and Full Placement is more appropriate for redeployment rather than retraining, and should be moved under the Redeployment section and the header changed to read "Percent of Employees Targeted for Redeployment Impacted".

4. Under "New Hires," we suggest using paraprofessional and mid-level titles as well as professional titles in the examples, ie : patient navigator, outreach worker, medical assistant, community health worker, community health educator.

5. We remain concerned about the potential for the DSRIP process to encourage replacement of family-sustaining jobs in institutions with low-wage, no-benefit jobs in ambulatory or community settings. This would not only increase income inequality in our State but can have a negative effect on the quality of services provided in the ambulatory setting. In order to accurately assess the potential for this problem, it is necessary to know the level of wages and benefits in the newly created positions. If it is not appropriate to include in this application, we urge the Department of Health to require that level of detail in the workforce plans to be submitted April 1st as well as any subsequent project-by-project workforce impact analyses.

Adirondack Health Institute

101 Ridge Street
Glens Falls, NY 12801
(518) 480-0111

October 29th, 2014

Dear New York State Department of Health Delivery System Reform Incentive Payment Program:

The Adirondack Health Institute (AHI) is pleased to have this opportunity to submit comments on the *NY Draft DSRIP PPS Plan Application and Scoring Guide.* Comments reference specific page numbers within the documents where possible.

1. **DSRIP PPS Organizational Application,** Page 3 – asks the applicant to indicate if the PPS is applying for a COPA as part of the application, and if the PPS is applying to become an ACO as part of the application. Please provide guidance as to the nature of the application process for COPA and for ACO certification.
2. **DSRIP Project Plan Application Domains 2, 3, 4,** Page 2 – Project Requirement #7: meet NCQA 2014 PCMH Level 3 certification by DY 03. In some places it is noted that either NCQA 2014 PCMH Level 3 or NYS DOH Advanced Primary Care Model be demonstrated. While the NCQA standards provide a valuable compass for Primary Care Practices, other standards (URAC) may achieve the same goal at a lower cost to the practices. Given that the Advanced Primary Care Model is still in development, essentially the only option to meet the requirement is NCQA. Please consider providing additional options for the type of PCMH accreditation/certification that would meet the requirement.
3. **DSRIP Project Plan Application Domains 2, 3, 4:** Each Project includes a description of what constitutes "actively engaged patients". The definition refers to the number of "participating patients". The definition of "participating patients" received much discussion during the Independent Assessor's Conference Call and we anticipate the revised Application will include a detailed definition of the "participating patients".
4. Please clarify the relationship between "DSRIP Year" and "Demonstration Year".
5. We respectfully request consideration of an extension of the December 16th due date for Project Plan Applications. We appreciate the resources made available at the DOH website and via the DSRIP Support Team, and are working closely with a range of consultants. However, the availability of key items, such as the Draft Project Plan and the Final Project Plan, has been significantly delayed and made the timeframe that much more challenging. Additionally, the many supplemental applications that have not yet been released, or were just recently released, including the CRFP and the Financial Stability Test, have made it challenging to effectively gauge resource needs to complete all the materials to the best of our abilities in the allotted time.

Thank you for the opportunity to comment.

Sincerely,

Cathy Homkey, CEO

North Country Behavioral Healthcare Network

PO Box 891
Saranac Lake NY 12983
www.behaviorhealthnet.org

(518) 891-9460 Phone
(518) 891-9461 Fax
info@behaviorhealthnet.org

Serving the North Country since 1997

Attention: DSRIP Application Team
Subject: DSRIP Application Public Comment

October 28, 2014

The North Country Behavioral Healthcare Network is a coalition of 23 non-profit behavioral health provider agencies serving seven of the state's northern most counties. Our region spans both the AHI and North Country Initiative PPS territories. Thank you for the opportunity to comment on the DSRIP draft application and to provide recommendations for the final document.

Health care reform will touch the lives of every New Yorker in one way of another. Though DSRIP is now specifically targeting the Medicaid population, the SHIP envisions that the emerging PPS and advanced primary care practices will become the system of the future for all payers. It is vitally important that the lead agencies engage in a project selection and planning process that is both inclusive and transparent. Clearly this was the State's intention, but as the DSRIP team has heard as it has traveled through the state for various presentation, most recently at the ASAP conference in Saratoga Springs, lead agencies are not uniformly embracing the notion of stakeholder inclusion.

There is a concern that more than a few DSRIP lead agencies have been slow in engaging in the planning process particularly when it comes to the integration of behavioral health with primary care related projects. Additionally, at last week's DOH Rural Health Council meeting DOH representatives heard from council members that important input from some of the state's 35 Rural Health Networks has, in many cases, been unwelcome by lead agencies. As a lead off recommendation for the final DSRIP application we would like to see a requirement that the lead agencies demonstrate that they have sought meaningful input from each of the NYS Department of Health Rural Health Networks that operate in their catchment areas.

Other General Comments
There are a number of features within the current application which appear to put rural communities at a disadvantage.

Scoring: Scoring applications based on the raw number of providers participating not in relation to the number of providers in the PPS service region disproportionately disadvantages rural PPSs. A PPS serving a large geographic rural region with every provider participating, with strong governance and well-formed clear measurable objectives based on population need will score lower across every project simply based on rurality. DSRIP project funding is per-member-per-month (PMPM) thus larger urban PPSs will, and should, receive more funding because they have more concentrated populations and more attribution, they do not need a secondary advantage by scoring rural PPS's lower automatically reducing the PMPM potential of the rural project initiatives.

The concept that large urban providers will need a greater PMPM to serve their attributed patient population does not conform to the logic used to reduce PMPM as the greater number of projects are undertaken due to economy of scale. It will take all of the PMPM to consistently and measurably achieve the outcomes of the projects for both the largest and the smallest PPSs. Significant reductions in this based on scoring will put projects at risk.

Application scoring should be based on the ability of the PPS to effectively carry out the proposed activities to transform the health system and improve the health outcomes of the total attributed population served.

Funding Distribution – Application Scoring Impact: Section 8 budgeting and funding distribution percentages will be based on PMPM project expectations. Project implementation costs and revenue losses are fixed costs to achieve DSRIP outcomes. If application scoring causes a significant reduction in PMPM, the percentage of payment required to cover fixed costs will increase which will decrease the remaining percentage available for incentive payments to internal PPS providers. It is clearly understood by the NYSDOH DSRIP team that realigning provider incentives is the key to Delivery System Reform success. This unintended consequence of the scoring mechanism and its impact on valuation must be thought through if the DSRIP is to be successful.

Specific Comments

3.a.i. Integration of Primary Care and Behavioral Health Services
Domain 1 DSRIP Project Requirements Milestones and Metrics:

Pages 62 (Model 1) and 64 (Model 2) Project Requirement 1 – The Metric/deliverable is defined as "**co-located services during all practice hours**". **When asked during Q&A, both Jason Helgerson and the NYSDOH OPCHSM, indicated this is not intended to be the requirement, thus it is our understanding this is an error on the application that requires a simple modification.** If not, a requirement for co-location of primary care and behavioral health during all practice hours will preclude the integration of primary care and behavioral health in all but the most urban settings. It would be an inefficient use of resources to place a primary care provider at a BH clinic during all hours of operation as there would not be sustainable volume to utilize the capacity or vice versa.

Pages 62 (Model 1) and 65 (Model 2) Project Requirement 3, and Page 67 (Model 3) Project Requirement 5 – The metric/deliverable of **"100% of individuals receive screenings (SBIRT, PHQ(etc) at project sites" is unattainable**. There is no certifying or quality agency that requires 100% screening as a metric – this requirement would preclude any PPS from meeting the deliverable. The NCQA 2014 requirement for documentation of PHQ-9 (or other depression screening) is a practice generated report (or medical record review if EMR cannot generate the report) with a numerator and denominator based on unique patients in a 3 month period, that indicates that more than 50% were screened. Since each of these screenings are meant to be periodic preventive screening tools it would be unnecessarily burdensome on both patients and providers to expect screening at every visit without evidence of improved outcomes over periodic screening. We **recommend that the NCQA 2014 requirement of more than 50% of**

unique patients seen in a 3 month period be adopted as the appropriate metric/deliverable for this project.

3.a.i. Integration of Primary Care and Behavioral Health Services

Program application page 87 section C. IMPACT Model 4. Designate a "Psychiatrist" and

Domain 1 DSRIP Project Requirements Milestones and Metrics:
Page 67 (Model 3) Project Requirement 4

Based on the new scope of practice under the Nurse Practitioner Modernization Act which takes effect January 1. 2015 which allows Nurse Practitioners with > 3600 hours of practice to operate without a Written Practice Agreement and the shortages of Psychiatrist across NYS, we would request that this section be modified to read a "Psychiatrist or Psychiatric Nurse Practitioner".

Again, thank you to all on the NYS DSRIP team who are leading the way along a very difficult process. Thank you for your consideration of our comments.

Respectfully submitted,

Barry Brogan, RN, MAPP
Executive Director
North Country Behavioral Healthcare Network

CONTINUING CARE LEADERSHIP COALITION CCLC

555 WEST 57TH STREET, NEW YORK, NY 10019
212.258.5330 P 212.258.5331 F

October 29, 2014

By email: *dsripapp@health.ny.gov (copy to jah23@health.state.ny.us)*

Jason Helgerson
Deputy Commissioner and Medicaid Director
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Subject: Comments on the Draft Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS) Plan Application and Scoring Guide

Dear Mr. Helgerson:

As you are aware, the Continuing Care Leadership Coalition (CCLC) represents the not-for-profit and public long term care provider community in the New York metropolitan area. The members of CCLC provide services across the continuum of long term care (LTC) to older and disabled individuals, including skilled nursing care, home care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. Our members have also had a significant impact on the development of innovative solutions to long term care financing and service delivery in the United States, including having played pioneering roles in the development of managed long term care programs in New York and Medicare managed care and PACE programs for dual eligibles at the national level.

On behalf of our members, I appreciate this opportunity to comment on the Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS) Organizational Application, the Project Plan Application, and attendant documents. This submission is intended to complement the comments CCLC submitted during July 2014 concerning the Project Advisory Committee (PAC) process.

Context-Setting Comments on the Role of Not-for-Profit Post-Acute Care Providers in Accomplishing DSRIP Goals and Objectives

In New York State, not-for-profit and public long term care providers have demonstrated a record of leadership in working with health system partners to reduce avoidable hospitalizations and re-hospitalizations. Since 2009, they have been actively implementing the national

INTERACT (Interventions to Reduce Preventable Acute Care Transfers) program, which helps organizations timely identify significant changes of condition in nursing facility residents and implement measures to prevent the need for avoidable hospitalizations, and which, in New York, has led to average reductions in hospitalization rates of more than 17%.[1] Such providers have also been engaging in collaborative work to reduce avoidable hospitalizations through the IMPACT (IMprove Processes and Care Transitions) to Reduce Readmissions Collaborative and the NY-RAH (New York – Reducing Avoidable Hospitalizations) partnership.

Consistent with their engagement in new collaborative models to improve population health, not-for-profit and public long term care providers have been shown in published research to be characterized by a demonstrated commitment to innovation[2] and person-centered models of care,[3] and to be pace-setters as measured by overall quality scores, avoidance of unnecessary hospitalizations,[4] and achievement of low nursing staff turnover rates,[5] all of which translate into higher-quality care for older and disabled individuals.

Not-for-profit and public long term care providers also offer unique expertise to manage the complex conditions of diverse populations requiring chronic care, serving effectively as a safety net for many of the hardest-to-serve individuals requiring ongoing care, such as pediatric residents, those with ventilator dependency, and individuals living with HIV and AIDS. These are among the key populations whose care the DSRIP program seeks to enhance, and PPSs will benefit from the expertise of providers with tested track records serving such populations.

Comments on the Draft DSRIP Application Materials

Below please find CCLC's specific observations on the draft materials:

Governance

CCLC supports the emphasis that the State has placed on governance in the organizational application, as reflected in the 25% value assigned to this domain in the Overall PPS Structure scoring. We further support the emphasis that has been placed – in the section on Governance Members and Governing Process – on testing whether applicants have designed a governance structure that provides "sufficient representation with respect to all of the providers and community organizations included within the PPS network." We would encourage the State to consider parallel language in the Project Advisory Committee (PAC) section that follows,

[1] Tena-Nelson R, Santos K, Weingast E, Amrhein S, Ouslander J, and Boockvar K. Reducing potentially preventable hospital transfers: results from a thirty nursing home collaborative, J Am Med Dir Assoc. (2012 Sep)13(7):651-6.
[2] Mead, R. "The Sense of an Ending: The Sense of an Ending: An Arizona nursing home offers new ways to care for people with dementia," The New Yorker, May 20, 2013. Accessed 3/19/2014 at http://www.newyorker.com/reporting/2013/05/20/130520fa_fact_mead?currentPage=all.
[3] Grabowski, DC, Elliot, A, Leitzell, B, Cohen, LW and Zimmerman, S. Who Are the Innovators? Nursing Homes Implementing Culture Change, in Transforming Nursing Home Culture: Evidence for Practice and Policy, The Gerontologist (Feb 2014) 54 (Suppl 1). Abstract accessed on 3/19/2014 at http://gerontologist.oxfordjournals.org/content/54/Suppl_1.toc.
[4] Grabowski, DC, Feng, Z, Hirth, R, Rahman, M and Mor, V. Effect of Nursing Home Ownership on the Quality of Post-Acute Care: An Instrumental Variables Approach, J Health Econ. (Jan 2013) 32(1): 12-21. Accessed on 3/24/14 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538928/.
[5] Castle, NG and Engberg, J. Organizational Characteristics Associated with Nursing Home Turnover, The Gerontologist (2008) 46 (1): 62-73.

stressing that the State is seeking to see evidence of the inclusion of representation of different provider types.

While the State underscores there may be a variety of forms of governance because one size will not fit all, any PPS governance structure will be incomplete if it lacks an outlet for a meaningful voice for the not-for-profit long term care community. Some PPSs have come to this determination on their own, but others may benefit from State encouragement. We therefore urge the State to identify ways purposefully to encourage development of governance structures that are fully engaging of the not-for-profit long term care community's guidance and input. This is important to achieving true integration, and avoiding silos of independent activity. It is also critical to building PPSs with the needed focus and leadership to capitalize upon the opportunities for both savings and improvements in patient care that flow out of careful management of the clinically complex and potentially high-cost populations that require coordinated and high quality post-acute services.

Project Valuation

Although the Project Plan Applications on which the State is seeking comment focus on the scoring within the internal structure of given projects, nevertheless CCLC thought it important to comment on overall project valuation more broadly because it will drive final PPS project selection. The valuation of projects arguably has led PPSs away from those projects that explicitly address the needs of those who require long term care services, or are in transition between acute and long term care settings. Illustrative of this, one long term care organization has reported that a potential PPS partner indicated that it was only seeking to engage long term care partners in the "Medical Village/Alternative Housing Using Existing Nursing Home Infrastructure" project, and that the decision to limit participation in this area was driven by the PPS's conclusion that this project was the only long term care oriented project that was valued sufficiently to make it worth the PPS's time and investment. We are concerned that valuation decisions appear to steer PPSs away from prioritizing effort around the long term care population -- particularly in view of the high projected growth in the population of older adults in our State -- and will hamper the potential for DSRIP projects to fully accomplish the program's goals and objectives. We therefore encourage the State to revisit the program's scoring methodology to assign greater value to initiatives such as, "2.b.vii Implementing the INTERACT Project (Inpatient Transfer Avoidance Program for SNF)," which are designed specifically to achieve health improvements among older and disabled individuals who could benefit from enhanced care management in the context of a PPS system's activities.

Attribution Process Improvements to Account for Community Based Long Term Care

We ask the State to reconsider whether community based long term care deserves its own "swimming lane" in the attribution process. The State made the determination to attribute permanently placed nursing home residents based on their contact with their nursing home – a move that may encourage PPSs more affirmatively to select projects encompassing of those residents in effort to reduce avoidable hospitalizations among the group. Yet we are concerned that a similar determination has not been made when it comes to community based long term care providers. The work of those providers often offers a similar anchor to an individual – and

the attribution process should, in our view, reflect that reality. An agency's regular visits to a home may well be a linchpin that prevents an avoidable admission, and we believe strong consideration should be given to reflecting this in the attribution process.

Data Sharing

Within the PPS Organizational Application (which accounts for 30% of a PPS's score), a PPS's score for 5 percent of that section is based on the PPS's data transparency communication capabilities. CCLC concurs with the State's focus on this aspect of PPS development, but believes it could be leveraged in order to foster the development of more robust data exchange technology among the long term care partners within a PPS. Consequently, CCLC asks the State to add language to the application that references the need for PPSs to support their long term care partners in their development of electronic communication structures.

Wider Uptake of Palliative Care

We support the State's efforts to integrate palliative care into nursing homes, particularly through the vehicle of Project 3.g.ii. That said, palliative care is viewed as increasingly appropriate across the health care continuum, and this uptake should not be limited to the nursing home setting. Moreover, palliative care is no longer viewed solely as closely tied to hospice and individuals with diagnoses that suggest they are nearing the end of life, but is appropriate as an extra layer of support for individuals living with serious and chronic illness, including those continuing to access curative therapies.[6] Indeed, community based long term care providers such as home health agencies are among the cohort well positioned to ensure that palliative care is made available to individuals and in support of their caregivers. As such, we ask the State to broaden the scope of this project.

Capital Restructuring Finance Program

Although the State is seeking comments separately on the Capital Restructuring Finance Program, contextually, we thought it important to raise our observations in these comments, as well. CCLC is delighted that the State has made available a pool of capital funding that will bolster PPS development. According to your office, "A competitive Request for Applications ("RFA") is expected to be released this Fall by which eligible entities as described below participating in the DSRIP (as well as those eligible entities not so participating) may apply for CRFP funding."[7] As this solicitation is scored, CCLC emphasizes the importance of capital being awarded for projects to strengthen long term care partners and to help them implement capital projects supportive of DSRIP goals. As the Department has stressed publicly, long term care entities are "essential to the overall success" of DSRIP. Ensuring that such providers have access to capital for appropriate projects is therefore vital, and highly germane to achieving DSRIP objectives.

---

[6] See, e.g., the resources of "GetPalliative.Org," furnished by the Center to Advance Palliative Care and available at http://getpalliativecare.org/ (last accessed October 29, 2014).

[7] New York State Department of Health, Capital Restructuring Financing Program, available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/drsip_capital_restructuring_financing_program.pdf (last accessed October 28, 2014).

CONCLUSION

For the foregoing reasons, we view it as essential that PPSs enrich their commitment to their PPS partners from the not-for-profit and long term care continuum, recognizing – as the Department has stressed on multiple occasions – that cross-continuum collaboration is essential for PPS success. Should you need further information, or if you have questions about these comments, please contact me at CCLC.

Sincerely,

Scott Amrhein
President
Continuing Care Leadership Coalition
555 West 57th Street, Suite 1500
New York, NY 10019
(212) 506-5409
amrhein@cclcny.org

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

DSRIP PPS Plan Application Comments

The Community Health Care Association of New York State (CHCANYS) respectfully submits these comments in response to NYS' Draft DSRIP PPS Plan Application and materials released on September 29, 2014. We appreciate the opportunity to comment on the application. CHCANYS is very supportive of the overall goals of DSRIP and its recognition of the need for a transformed health care system in New York—one that sustains and enhances our primary care foundation and shifts away from the historic emphasis on inpatient care. As major Medicaid safety net providers and comprehensive care providers, FQHCs are ready and well-equipped to play a central role in the development and implementation of DSRIP PPS networks, as well as lead or participate in projects that drive transformation. CHCANYS looks forward to continuing to support FQHCs in their chosen PPSs and ensure that they are able to fully contribute to the outcomes the new systems must achieve. As discussed in greater detail below, we have some concerns about the application as written and how it will affect PPS partner organizations, including FQHCs.

General Comments

Word Limitations

The word limits on application sections (often 500-1500 words) will make it difficult for lead PPSs to provide details that demonstrate meaningful inclusion of partners in the PPS design, structure, and payment.

Timing and Flexibility

It is our understanding that the State expects a level of detail on numbers (e.g., staff, beds, attributed lives, types of providers, etc.) throughout this application that may simply not be available to most PPSs at this time, and also that a PPS will be held to any numbers represented in its application. This approach is not logically consistent with the actual iterative process PPSs are undergoing to develop partnerships and projects. Much of the detailed information the State seeks likely will be become apparent during the development of the detailed implementation plans, due on April 1, 2015. We encourage the State to allow PPSs flexibility in providing information on certain specific numbers, and instead – consistent with our comment below – focus in this application on the substantive nature of the partnerships the PPS is building.

Application Does Not Appear Constructed to Capture Substantive Nature of Partnerships

The State has emphasized repeatedly that DSRIP is about collaboration and clinical integration among providers in New York's health care system. However, in multiple places throughout the application the required benchmarks focus on what appears to be nominal inclusion of partners rather than requiring demonstrated meaningful partnerships with providers. This focus on simply listing partners is evident in several sections, including, but not limited to:

- Governance: applicants are required to describe a governance model and list the types of providers included, but are not asked to comment on how a PPS's governance model ensures meaningful contributions from and voice of the PPS members;
- Project advisory committee: applicants are not asked to comment on how they will ensure meaningful contributions from all committee members;
- Financial organizational structure: again, applicants are not asked to comment on how their financial structure will ensure meaningful participation from all partners;
- Path to reimbursement reform: applicants are not required to identify how the PPS partners have been engaged in developing this plan, if at all;
- Proven Population Health Capabilities: applicants are only required to identify a lead or partner with experience, not to describe how these capabilities will be used in a meaningful way; and
- Integrated Delivery System: applicants must only identify the types and numbers of partners and issues around HIT connectivity and are not asked to identify how the integrated delivery system is likely to operate with meaningful participation from its component parts.

C**omments on Specific Application Sections**

1. Regulatory Relief

The process for requesting regulatory waivers must not be limited to just the PPS lead's application. Although we appreciate the opportunity to request waivers of regulations that would impede the PPS' ability to execute their reform projects, the waiver request process is an exacting one that requires PPS leads and project leads to be much further down the road with projects then they likely will be by the time the application is due. For example, in order to accomplish the goals necessary to integrate behavioral health into primary care, the PPS lead may request waivers that would impede the co-location of an Article 31 behavioral health provider into a separate Article 28 primary care provider's facility. At the time of application, the project leads may have a rough idea of the space requirements and needs at the Article 28 facility but without a thorough architectural review of the space, they may not be able to provide a complete list of necessary waivers. It is unlikely that project leads will have enough time to complete this assessment by the time the PPS lead application is due. Likewise, plans for this type of capital project often change as providers move through the process. Therefore, there should also be an avenue to make changes or additional requests for waivers once the process is underway.

2. PPS Workforce Strategy

While CHCANYS agrees that it is critical for PPSs to provide a workforce strategy related to existing staff, the application overwhelmingly emphasizes the impact on existing staff and does not include questions related to evidence-based workforce strategies that result in patient-centered, integrated care and improved patient outcomes. Because advanced staffing models such as interdisciplinary patient care teams are an essential part of a transformed delivery system, the organizational application should include specific questions about how the PPS will redesign workforce/staffing configurations and how those new configurations will transform the delivery care across the new network and achieve DSRIP outcomes. The application should include questions about how staff and providers will be trained to operate effectively and

efficiently within these new models of care. The application also should include questions about PPS recruitment and retention strategies for providers and staff, including potential new positions such as community health workers, care coordinators, and patient navigators that will support population health strategies in clinical and community settings.

The organizational application also requires PPSs to provide specific numbers and percentages of staff that will be retrained and redeployed as well as new hires. Yet the application also states that PPSs will be expected to complete a comprehensive assessment on the impact to the workforce on a project-by-project basis in the immediate future as a Domain 1 process milestone for payment. Given that many of the details of the PPS infrastructure and projects will evolve after applications are submitted on December 16, requiring exact numbers and percentages now is premature. CHCANYS proposes that PPSs be required to propose a range of numbers and percentages for the application submission and then provide precise numbers after the comprehensive assessment is completed. Optimally, the comprehensive assessment also will include an assessment of the current adoption of advanced care delivery models and staffing and provider gaps.

CHCANYS believes it is imperative that workforce training, retraining and recruitment programs under DSRIP be coordinated on a statewide basis. Relying on each PPS to identify and develop workforce initiatives for its regional programs may result in a fractured workforce strategy rather than a comprehensive, coordinated statewide plan. PPS networks' regional workforce training, retraining and recruitment programs should be coordinated statewide to ensure that curriculums are consistent and recruitment efforts support the delivery of quality care in all regions. This will be particularly important in rural areas, which tend to have fewer resources to leverage but often struggle the most with workforce capacity. These areas may need additional resources beyond what other, more resource rich areas have, to develop their workforce capacity and ensure that their programs are fully implementable and successful. Building upon the recommendations of the Medicaid Redesign Team Workforce Flexibility and Scope of Practice Work Group, New York State should identify best practice curriculums for training and retraining practitioners to work in allied professions work with educational institutions across the state to identify relevant training opportunities and develop additional training resources for PPS networks. Embedding into DSRIP a coordinated, statewide workforce strategy that meets the comprehensive health care needs across New York State will be critical to the success of the program.

Finally, in order to recruit, retain and support the additional healthcare workforce that DSRIP seeks, New York State must establish ongoing funding for the Doctors Across New York (DANY) program and the Primary Care Service Corps (PCPS). Both these programs have been successful at placing much needed primary healthcare staff in underserved areas of the state. However, they require a predictable and sustained funding source in order to achieve DSRIP's articulated workforce goals.

3. Community Needs Assessment

The application asks for a succinct summary of the current assets and resources that can be mobilized and employed to help achieve many of the DSRIP projects. This question should specifically ask PPSs which partners will play what roles within each project and should be asked consistently across projects. For example, project 3.a.i Integration of Primary Care and

Behavioral Health Services asks for "the total number of PCP sites, behavioral health provider sites, substance abuse provider sites, and all other sites the PPS intends to include in the project by the end of Demonstration Year 4, or sooner as applicable." However, project 2.a.iv Create a Medical Village Using Existing Hospital Infrastructure only asks for "the number of Medical Villages this project will establish by the end of Demonstration Year 4, or sooner as applicable." It should also ask for the total number of community-based providers, including PCP sites, behavioral health provider sites, substance abuse provider sites, and all other sites, the PPS intends to include in the project as part of the new medical village.

Additionally, community needs assessments tend not to identify the particular needs of special populations, including people who experience homelessness, have HIV/AIDS, live in public housing, have developmental disabilities, are migrant and seasonal farmworkers and/or are LGBT. The presence and prevalence of special populations should be an important part of PPS deliberations concerning medical service constellations and deployments of other essential services designed to facilitate access to needed care, promote good health outcomes and avoid unnecessary costs. Applicants should be required to discuss how they plan to serve special populations, identify the systems of care that are already in place for these populations and describe how PPS services will be integrated with and build on these existing systems of care.

4. Data-Sharing, Confidentiality, & Rapid Cycle Evaluation

As part of its Center for Primary Care Informatics (CPCI), CHCANYS operates a statewide data warehouse which reports on many of the DSRIP required measures and includes functions that support population management and advanced care delivery models. Currently, 34 FQHCs are connected to the CPCI, which is over half of all FQHCs in the state, and 17 more are in the pipeline. This represents over a million lives. The PPS leads should be aware of this existing resource as well as other PPS partners' current IT capabilities and leverage those systems to advance their objectives rather than ask partners to create new data reporting systems.

Additionally, any technology (e.g., health information exchange, care management software) that will be available and/or required by DSRIP outside of RHIO services should be made available at an affordable rate or at no-cost to FQHCs and other community-based providers. Ensuring unfettered access to technology will enable a system to operate as an integrated delivery system and should be considered a core operating cost.

CPHS Comments on documents outlining the application process for Performing Provider Systems (PPS).

The Commission on the Public's Health System is very aware that waivers, particularly this new iteration of New York State's waiver, usually involve millions or billions of dollars in federal and state funding, and therefore the process becomes rigorous. The amount of time it took to approve this Medicaid waiver is a direct indicator of the complexity of the process and how more complicated it will get. How the plans will be laid out with methods, measurements, and accountability is critical, especially recognizing the impact it will have on underserved communities. Additional concern is attached to the fact that while the approval process was lengthened, the application process seems abbreviated; hence there is a growing apprehension that important gaps may not be addressed.

In the plans for implementing projects, the PPS must include how they plan to reach out to those who are not engaged in the system and/or are not easily reached by health messages. Addressing social determinants of health should be an integral part of all the projects.

CPHS wants to ensure that the projects chosen and approved take into account not only past successful non-clinical community-driven and informed approaches (community health worker and peer-led models) to improving quality and access to health care, but, also the major gaps that have exacerbated unequal delivery of health care services. In theory, that will be reflected in the community needs assessments done by the PPS but as outlined below, there is a growing skepticism that outcome can be achieved. The projects chosen must operate in a culturally and linguistically competent way. True transformation must address existing barriers (i.e. waiting time; provider –patient communication; and attitudes of those providing the service). That is why DSRIP will not be successful without consistent, strong, clear, and defined partnerships with local community-based organizations, faith-based organizations, and the front-line health care workforce. CPHS comments are focus on the community/consumer-related provisions of the waiver.

Comments related to Community engagement

We are pleased that working with community-based organizations is mentioned within many of the domains and projects. As noted in the beginning, working with community organizations will be an important determinant for ensuring the goals of DSRIP are accomplished. However we have several concerns. They are:

1. Community-based organization should have been involved earlier in the development of the community needs assessment (CNA). There should be more deliberate guiding principles or spelling out of the community engagement process, including the planning.

2. A very small percentage of the overall scoring in attributed to the section on Stakeholder and Community Engagement on Page 14

3. There is no membership requirement detailed, including how representative the membership is in Section 2 – page 6 of the DSRIP PPS Organizational Application – The Project Advisory Committee scoring process.

4. The listing of community resources on pages 11 and 12 of the DSRIP PPS Organizational Application is not broad or encompassing enough.

5. In Section 8, DSRIP Budget and Flow of Funds on page 27 list services to contract with and dollars that will flow, but community-based services and community-based organizations are not listed.

6. In Section 7, cultural competency and health literacy are placed together. There is a connection but they are not one and the same.

7. Project 11 (2.d.i) in the DSRIP application will need strong involvement from community organizations to ensure that connection is made with this population. The parameters of this project are just available in the DSRIP Project Tool Kit (pages 41-45). A potential problem exists in that the methodology for this outreach is limited to an evidence-based methodology, the Patient Activation Measures (PAM). In spite of this concern, the detailed description of activities and outcomes in this section are an important guide to reaching hard-to-reach residents. Implementation of Patient Activation Activities to Engage, Educate and Integrate the Uninsured low/non-utilizing Medicaid Populations into Community Based Care – page 80. Once again the reliance on Patient Activation Measures (PAM) as the sole methodology is troubling and should be reviewed. There is again a recommendation for development of navigators but no absolute requirement and no understanding that there have been little resources given to do outreach and education focused on coverage and options to accessing health care.

Recommendations

1. The application needs to require outreach in a culturally competent manner and changes to the system to make services more accessible based on community needs.

2. Require the PPS to

    - Provide details of expectations of representation by type of CBO, race, ethnicity, disability and more.

    - Elaborate on the details on how they reached out to a broad and trusted number of community organizations and institutions. PPS should work with the stakeholders to define the relationship and document it in the application, so that the assessment reflects more accurately how community engagement is being done and will be done going forward. PPS must explain specifically and

coherently the process they took to engage communities and what that engagement will look like in the future. Circumstances may change, so this should be periodically part of the reporting.

- Contract with community-based organizations. Transitional Housing – page 5`of the DSRIP Project Plan Application is perhaps the only project where there is recognition of the need to contract with community organizations to provide the housing. This arrangement should also be implemented in the section about Creation of a Community Based Health Navigation Service to Assist Patients" on Page 70. There cannot be room for assumptions related to a PPS understanding of the benefits of contracting with CBO's. There are many CBO's with proven track records working with hard-to-reach populations, and underserved low-income, immigrant and communities of color, people with disabilities, children, women, people with chronic illnesses, the uninsured and under-insured.

3. Broaden the list of community resources to immigrant serving organizations, organizations based on race and ethnicity, faith-based organizations.

4. Cultural competency and health literacy are should be separate and assessed separately. Improve health literacy as it pertains to prevention, healthy living, chronic disease management, patient-centered health care, and health disparities are depended on understanding cultural competency. Health literacy is only one tool in how to communicate information. Understanding the cultural, social, and linguistics barriers and how to address them is more critical.

5. Allow for more time and flexibility on choosing other tested methods besides PAM in conducting outreach to the uninsured. It may not be the only or the best way of reaching this population.

6. There should be a mechanism for reporting problems faced by patients, which has either been lacking or minimally not followed-up with in many other programs (i.e. Charity Care, State Navigator/Exchange).

Governance

The lead organization will be the critical component to ensuring collaboration and success. This organization will need to be innovative and flexible in how it will operate and function with other partners in the provider coalition. They will need to share power and decision-making responsibilities and tasks with others, especially with community-based organizations. Our concern is that the large health institutions don't know how to work well with and give due

regard to community-based organizations. Sustaining this over five years will be challenging, but must be done and monitored by the state and CMS. .

In the governance document, it states “The size of the PPS will influence how the governance seats are filled. A PPS with a large number of partners will need to limit the number of participants on Boards and Committees while maintaining representation” This raises a red flag because maintaining the right community voices is critical. Very little is mention in governance about CBO’s. Too many times, we have seen governance structures (Berger Commission and MRT) lack a fair and equal proportion of health care facilities representation and community-based organizational representation. Representation on those very same commissions was riddled with conflicts of interests. This is why also the state must carefully weigh the creation of one PPS per borough versus several. CPHS is inclined to think the latter is better for community engagement and addressing community health needs.

,

Recommendations

1. The structure of the PPS must clearly spell out the relationships as well as the power relationship with smaller community-based providers like FQHC’s and community-based organizations.
2. Again, it is important to include a requirement that the PPSs contract with community-based organizations -.The CBOs need appropriate financing to ensure that they are partners and are doing a thorough job.
3. The state should be requiring the PPS to meet with the CBO’s to discuss and identify the skills or types of expertise needed for the Provider Advisory Committee. Those skills, expertise and experience should be focus on health disparities, disabilities, needs in low income medically underserved communities, immigrants, language access, and cultural competence.

Health Needs and Health Disparities

We can emphasize enough the importance of projects meeting people and communities where they are. This is particularly important to the Medicaid, uninsured and underinsured populations that this waiver seeks to address. It is not enough to just do surveys. Where a person lives, eats, works, plays, engages with the health system are critical components to address gaps in access and quality of health care.

There also needs to be more clarity on specific reduction related to active or “staffed beds” CPHS has worked with many other advocates on the issue of what is the right methodology for looking at the number of beds needed in a community. However, many times the rational for reducing beds has led to closing of hospitals in predominately low-income neighborhoods.

Health care facilities rational have been inadequate. They have not addressed the needs of community nor explain what would be the alternative. Creating a Medical Village Using Existing Hospital Structure – found on page 16 proves that this is all about setting up “mini Bergers” or little hospital closing commissions.

In New York City, a concern we had was that many of the PPSs contracted with the same consultant organization to perform their individual assessments. Since important decisions will be based on this project, the outcomes are clearly critical to every community. A requirement is the involvement of stakeholders in the development of the CNA, including labor, Medicaid beneficiaries and local community based organizations. Yet, it is unclear how many, if any, of the PPS’s actually involved these stakeholders.

Then other concern that most of these CNA’s were done over a large geographic area and likely to mask some critical problems that affect smaller segments of the population, and therefore not be chosen as one of the projects to pursue.

Recommendations

1. PPS must be required to compliment clinical models or approaches with other modalities that are not medical in nature, but still have successful track record in managing diseases. This can only be done if the PPS has a broad representation of organizations that have demonstrated success in reducing the prevalence of preventable diseases and health disparities in their community (i.e. infant mortality, HIV/AIDS, Diabetes’s, etc.). Non-clinical but evidence based approaches could prove successful on projects described on page 61 and 64 in the DSRIP application plan (Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care and Evidence-based strategies for disease management in high risk/affected populations).

2. State needs to provide more guidance and ensure the health care facilities are accountable when it comes to details related to proposed bed reductions, especially in under-served, low-income, and communities of color. Community representation on the PPS and those communities being served by the PPS must be directly involved at the early stages of any proposed reductions of beds. There should be a process after services are developed and new patterns of care are identified, to review where excess is located. It will be too easy under this provision to target safety-net providers in medically underserved immigrant and communities of color, as has been done in the past.

3. Section 3 on page 9 of the DSRIP application plan. The description of the Community Needs Assessment should be required to reflect the differences among and between

neighborhoods in the geographic area, and how determination was made on how to focus and choose projects based on targeted need.

4. Page 13 of the DSRIP application plan must include other important barriers that are not listed in the resources section, e.g. language access, and the waiting time to get an appointment

Assessment and Evaluation

The PPS application submitted has some of the most complicated components but the shortest of the four to five documents regarding the application. It also does not appear on the website of Public Consulting Group (PCG), the state contracted Assessor that they have experience or have focused on evaluation of services.

Recommendations

1. For accountability and transparency, the state should post on the DSRIP website what expertise or rational was given to contract PCG

2. There is a strong need to add evaluators from New York State to the evaluation team who are more than professionals. A process of choosing residents/organizations with no conflicts of interest should be begun immediately so that they could be available on time for the process of evaluating the PPS applications early next year.

In conclusion, the health care system could be transformed in a positive way, but only if it can get to people who face the most difficulty and incorporates community from beginning to end.

.

105 East 22nd Street
New York, NY 10010
PH 212.254.8900
FAX 212.260.6218
www.cssny.org

Community Service Society | Fighting Poverty Strengthening New York

David R. Jones
President & Chief Executive Officer

Steven L. Krause
Executive Vice President &
Chief Operating Officer

October 29, 2014

Mr. Jason Helgerson
Deputy Commissioner, Office of Health Insurance Programs
NYS Medicaid Director
Corning Tower, Empire State Plaza
Albany, NY 12237
Via email at dsripapp@health.ny.gov and jah23@health.state.ny.us

RE: CSS comments regarding DSRIP Project Plan Application documents

Dear Mr. Helgerson:

The Community Service Society of New York appreciates the opportunity to comment on implementation documents for the state's Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP aims to transform the state's health care delivery system to promote better care and better health at a lower cost (i.e. the Triple Aim) through funding Performing Provider Systems (PPSs) to address significant health needs in their region of the state. CSS operates a Health Initiatives program to expand access to affordable, quality health care for all New Yorkers, through advocacy and consumer assistance. To that end, CSS respectfully submits the following recommendations to strengthen consumer engagement and consumer protections in the DSRIP PPS application documents.

In our comments below, we provide suggested consumer-friendly standards to which Performing Provider Systems should be held, followed by specific points in the application where these standards can be more fully addressed.

Ensure PPSs account for the needs of traditionally underserved communities and the uninsured

PPS projects must address the needs of those who lack health coverage, as well as traditionally underserved communities like low-income people, immigrants, people with disabilities, and LGBT people to truly achieve the goal of transforming the delivery system.

Specifically, we urge the state to address this standard in the following areas of the application documents:

- **Organizational application, Page 5, Governance Members and Governing Process.** We applaud the requirement that PPSs describe stakeholder engagement by their governing bodies. In addition to Medicaid members, PPSs should be required to describe how they will engage uninsured community members.
- **Organizational application, Page 12, Community Demographics.** In addition to the demographics data that is listed, the PPS should include demographics information about LGBT people.

Ensure transparency of cost and care arrangements

Consumers must understand the cost of health care services, in order to make informed decisions about their care. Price information should be published for consumers on a publicly accessible website that allows apples to apples comparisons. Additionally, consumers should be informed of the changing structure of the delivery system, including their participation in a structure such as a PPS or ACO. Finally, consumers should be advised of risk-sharing financial arrangements, such as withholds and penalties for excess specialty care, which might affect the frequency, duration and nature of their access to services.

Specifically, we urge the state to address this standard in the following areas of the application documents:

- **Organizational application, Page 7, Compliance.** As part of its compliance plan, a PPS should be required to outline a consumer compliance complaint process and provide disclosure to consumers about this process. Consequently, we urge the state to include a fourth bullet in this section to this effect, such as: "Please describe how community members, Medicaid beneficiaries and uninsured community members allocated to the PPS will know how to file a compliance complaint and what is appropriate for such a process."
- **Organizational application, Page 8, Oversight and Member Renewal.** The PPS should outline strategies for consumer disclosure and engagement as a part of its Oversight and Member Renewal process. Specifically, the PPS should be required to indicate how Medicaid beneficiaries and their advocates can provide feedback about providers to inform the member renewal and removal processes. Additionally, the PPS should describe its process for notifying Medicaid beneficiaries and their advocates when providers are removed from the PPS.

Ensure public accountability

Performing Provider Systems must maintain accountability to consumers through the disclosure of their records based on quality measures and outcomes, broken down by each PPS's

record concerning key demographic groups. PPS quality benchmarks should be posted in a timely manner on a publicly accessible website. Additionally, each PPS should establish a public reporting system with regular opportunities for public input.

Specifically, we urge the state to address this standard in the following area of the application documents:

- **Organizational application, Page 8, Governance Milestones.** CSS applauds the state for requiring PPSs to supply periodic reports with progress updates on PPS and DSRIP governance structure. The application should further specify how the PPS will share these reports with PPS members and the community.

Ensure meaningful consumer engagement

PPSs must educate consumers about the DSRIP and how it will impact people and their access to services. Consumer education should include attention to those with low literacy and English-language learners. Further, each PPS must provide consumers with multiple opportunities for meaningful feedback during the planning (including community needs assessment), implementation, and reporting stages of the project. Such opportunities could include focus groups and surveys, as well as consumer representation on advisory boards and work groups.

Specifically, we urge the state to address this standard in the following areas of the application documents:

- **Organizational application, Page 5, Governance Organizational Structure.** The Governance Organizational Structure narrative should include a description of how consumer and advocate input will be gathered, shared and incorporated regularly into the PPS governance structure on an ongoing basis.
- **Organizational application, Page 14, Stakeholder and Community Engagement.** This section should be allocated a larger percentage in the overall scoring, as it is critical to developing meaningful community outcomes. Additionally, the PPS should be required to spell out additional specific details about consumer engagement, including information shared with the community at public engagement sessions, timing and location of events, and language accessibility (including materials translation and live translators). Accordingly, this section should be allotted a higher maximum word count (e.g. 1000 words) to allow for a more robust description of stakeholder and community engagement efforts.
- **Organizational application, Page 31, Bonus Points.** We urge the state to develop an additional bonus point category for PPSs that contract with community-based

organizations that have proven track records in providing services that are culturally competent and display excellence in health literacy.

Ensure a high quality workforce

Each PPS must design a strategy to promote a high quality workforce that meets the needs of consumers, especially traditionally underserved communities. This includes designing compensation structures to ensure the hiring and retention of well-qualified professionals in hospitals and ambulatory care settings. Additionally, PPSs should formally contract with community-based organizations with proven track records in culturally competent services as these local, trusted groups are integral to achieving the desired outcomes of the PPS. Further, PPS should institute mechanisms to hire and contract with Community Health Workers, who play important roles in community-based care coordination, health literacy, and culturally competent health services.

Specifically, we urge the state to address this standard in the following area of the application documents:

- **Organizational application, page 27, DSRIP Budget and Flow of Funds.** PPSs should be required to contract with community-based organizations, including those providing important non-clinical services. Unfunded partnership agreements are insufficient given the critical role community-based organizations will play in DSRIP outcomes. These organizations should be added to the following language in the draft application: "Describe on a high level on how the PPS plans to distribute funds among the clinical specialties, such as primary care vs. specialties, and among organizations along the care continuum, such as SNFs, LTACs, and Home Care."

Thank you for the opportunity to provide these comments, and for carefully considering how the draft DSRIP PPS Project Applications and Scoring Guide can be improved to more fully address consumer engagement and the needs of the uninsured and underserved populations. If you have any questions regarding our comments, please contact Elisabeth Benjamin at ebenjamin@cssny.org or at (212) 614-5461 or Amanda Peden at apeden@cssny.org or at (212) 614-5541.

Very truly yours,

Elisabeth R. Benjamin, MSPH, JD
Vice President, Health Initiatives

Amanda Peden, MPH
Health Policy Associate

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Westchester Medical Center and its Center for Regional Healthcare Innovation (CRHI) recommend that **NYSDOH conceptualize "Transitional Supportive Housing Services" in a way that aligns with current national best practices for addressing homelessness.**

Addressing the housing needs of chronically ill Medicaid super-utilizers is daunting. Our PPS is one of the few, if not the only, DSRIP applicants in the state that is ready to tackle the issue.

Our plan has been developed in consultation with regional leaders trained by national experts in how to meet housing needs of people with complex care needs using existing housing resources. These leaders are already implementing innovative housing strategies successfully.

The reason this issue is daunting is because our nation has a huge housing crisis. Millions of private housing units are aging and dilapidated. Public housing authorities need tens of millions of dollars to address deferred capital needs. Millions of people have to choose each month between paying rent and having enough money to buy food. Housing subsidies have diminished and waiting lists for public housing and Section 8 are often closed for years.

The housing crisis is especially severe in our region, which includes some of our nation's most expensive housing markets. For example, in our region's largest city, the Yonkers Housing Authority's Section 8 program waiting list was closed for over 6 years. In 2012 the Housing Authority opened its Section 8 waiting list for just 10 days. During those 10 days it received **11,000** applications – enough to fill all their Section 8 openings for the next **35** years.

Clearly our regional housing needs are much too large to be solved by our healthcare system. Fortunately we do not have to solve our region's entire housing crisis in order to help ensure that our chronically ill Medicaid super-utilizers are able to get – and keep – housing.

Most of the homeless and unstably housed Medicaid super-utilizers in our region have managed in the recent past to *get* housing. However they haven't been able to *keep* it. They have lost it, sometimes for financial reasons, sometimes for behavioral reasons, often for both. We can help stabilize their housing by providing time-limited transitional housing support services while they are living in any kind of potentially permanent housing arrangement.

This comment consists of three main sections:

1) An explanation of how current national best practices for addressing homelessness have moved away from traditional transitional housing models toward Housing First and Rapid Rehousing strategies, including "transition in place" models that provide time-limited transitional housing support services in permanent housing settings,
2) A detailed description of our recommended model of Transitional Supportive Housing Services that aligns with these national housing best practices, and
3) A detailed recommendation of how our recommended model can and should be presented in the framework of NYSDOH's Transitional Supportive Housing Services application.
4) Comments on Domain One Requirements Milestones and Metrics for Project 2.b.vi.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

1) The New Best Practice: Rapid Rehousing instead of Traditional Transitional Housing

The traditional model of Transitional Housing is specialized time-limited housing that people go to in order to "get fixed" so that they can become ready for permanent housing. It consists of housing specifically dedicated to this purpose, sometimes using a scattered-site approach but often using a facility-based approach. It is often limited to a fixed number of housing units.

HUD and other national housing advocates have decisively rejected this approach in favor of Housing First models. Housing First means that you move people rapidly into permanent housing and there provide them the services they need to retain the housing.

The fact that HUD has rejected the traditional model of transitional housing can be seen most clearly in the funding priorities it has established for its Continuum of Care (CoC) program. This is HUD's largest program for the homeless and annually provides **$1.83 billion** for **7,100** local homeless housing and service programs across the U.S.[1] HUD offers tens of millions of dollars each year in competitive CoC funding for new housing. **None** of this competitive new funding can be used for traditional transitional housing. HUD allows CoCs to reallocate funding from existing programs to create new programs that better meet current needs. These reallocated funds can only be used for expanding Homeless Management Information Systems or creating new permanent housing. Again, not a penny of this reallocated CoC funding can be used for traditionally defined transitional housing.

HUD's CoC funding was dramatically transformed in 2009 by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. HEARTH established "a national goal of ensuring that individuals and families who become homeless return to permanent housing within 30 days."[2] It established criteria for "High Performing Communities" that included that their average length of stay in homelessness must have declined by at least 10% from the year before to be below 20 days.[3] These goals mean that communities are expected to move away from long stays in transitional housing and instead focus on moving people into permanent housing within days of initial contact with them.[4]

---

[1] Since 1994 HUD has required communities that want to access this funding to create regional or local planning bodies called CoCs that coordinate all housing and services funding for all types of homeless families and individuals. Over 460 CoCs have been formed representing large cities, large counties, and multi-county regions. Each CoC submits a single comprehensive application each year. No applications for CoC funding are accepted unless they are part of these local or regional consolidated applications. (Excerpted from "HUD's Homeless Assistance Programs: Continuum of Care 101", U.S. Department of Housing and Urban Development, June 2009.)

[2] HEARTH Act Purposes – Sec. 1002(b), cited in "Understanding the HEARTH Act" presentation by Norman Suchar for the National Alliance to End Homelessness' Center for Capacity Building.

[3] "Homeless Assistance Reauthorization – National Policy Update: Summary of the HEARTH Act", National Alliance to End Homelessness, June 2009. See also "Performance Measurement of Homeless Systems", Tom Albanese, Abt Associates, prepared for HUD's Office of Community Planning and Development.

[4] A detailed discussion of how transitional housing programs can transform themselves can be found in "Retooling Transitional Housing", Kay Moshier McDivitt, National Alliance to End Homelessness.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

The U.S. Interagency Council on the Homeless published the first comprehensive national strategy on addressing homelessness in 2010. This plan makes explicit the Federal push to move away from traditional transitional housing. One of its specific recommendations is to "Encourage communities to transform transitional housing programs to permanent supportive housing or transition-in-place models where appropriate." It defined transition-in-place models as:

> "models that allow people to transition in place, that is, to move into permanent housing and have transitional supports that end when someone has connected to mainstream community supports."[5]

We recommend that NYSDOH **conceptualize "Transitional Supportive Housing Services" in a way that aligns with current national best practices for addressing homelessness by allowing use of transition-in-place models as defined above.**

Other Advantages of Transitional Housing Services in Permanent Housing Settings

We will help Health Homes, hospitals and other healthcare providers develop toolkits of transitional services in each county that can be tailored to an individual patient's needs, rather than trying to create multiple transitional housing facilities in each county. Focusing on services that can be added to housing rather than transitional housing facilities has several advantages.

1. Services cost less than facilities. Most transitional housing facilities, whether in nursing homes or homeless shelters, have 24/7 supervision, an expensive service not needed by most unstably housed, chronically ill Medicaid super-utilizers.
2. Services can be created faster than facilities. Mobile services can be rapidly created for scattered-site housing, while creating facilities for people with behavioral health issues usually takes years and is often delayed or blocked by community opposition.
3. Service volume can be adjusted to meet fluctuating need more readily than facility size. The volume of transitional housing services needed for super-utilizers will vary widely over time. It is easier to adjust a service caseload than it is to add or remove facility beds.
4. Scattered-site services can be more readily tailored to individual needs than facility-based service mixes. Facilities' service mixes are designed to serve a particular population. It would not be possible to have available facility-based capacity for every type of patient without maintaining excess capacity in multiple facilities.
5. Mobile services can overcome geographic barriers to housing utilization. Our 8-county service area spans **4,878** square miles. Even if we could create exactly the right mix of transitional facilities, their geographic distribution would be a barrier to effective utilization. Counties like Putnam, Sullivan and Delaware have little public transportation. Moving a patient who doesn't own a car to another community cuts them off from their support systems. In more urban counties like Westchester and Orange, people often resist moving even temporarily into neighboring communities perceived as unfamiliar or unsafe. The most effective way to overcome geographic barriers is to bring services to the housing where the patient feels most comfortable and has the most available support.

[5] "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness – 2010", page 50, United States Interagency Council on Homelessness.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

2) Our Recommended Transitional Supportive Housing Services Strategy

The following section lays out specific recommendations on how a Transitional Supportive Housing Services model should work.

The Challenge: NYSDOH wants DSRIP projects in this category to provide long-term housing stability but the DSRIP funding is time-limited and cannot be used to pay for housing.

Our Strategy: Our strategy focuses on building the capacity of existing Care Coordinators to provide transitional services that effectively stabilize housing for high-cost Medicaid users with acute or chronic housing instability. We will partner with Care Coordinators from 5 systems:

1. Our target area's 3 Medicaid Health Homes,
2. Patient-centered medical homes,
3. Hospital-based programs including discharge planners,
4. Managed Care Organizations, and
5. Other Medicaid funded care coordination not yet rolled into Health Homes or Managed Care.

We are building on the strengths of these five systems in order to build a system that is both cost-effective and sustainable.

Target Area: We have divided our 8-county target area into four quadrants.

Quadrant 1	Westchester and Putnam
Quadrant 2	Rockland and Orange
Quadrant 3	Sullivan, western Ulster, and Delaware
Quadrant 4	Dutchess and eastern Ulster

Target Population: Our project will target 3 groups of Medicaid recipients with major housing needs:

1) People who are homeless, *i.e.* living in shelters, on the streets, in cars, or places not meant for human habitation,
2) People who are living in housing that is unsafe due to physical characteristics of the housing, threatening behaviors of other tenants, or unsafe neighborhood conditions, and
3) People who are unstably housed, *i.e.* have moved at least twice in the prior 12 months.

Proposed Tool for Assessing and Prioritizing Housing Needs: We propose using a brief housing needs assessment tool that is becoming a national standard. It is called the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT).[6] It prioritizes housing needs on a 15-point scale and divides homeless people into 3 categories.

[6] The "SPDAT and VI-SPDAT Evidence Brief provides "brief outline of the extensive evidence and testing base for the Service Prioritization Decision Assistance Tool (SPDAT) and its short, street-based evolution, the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) (a pre-

- At one extreme there are people who will be able to find housing on their own with limited assistance, e.g. directories, housing lists, brief referrals.
- At the opposite extreme, there are a group of people (estimated at roughly 10% of the total homeless population) who are likely to need permanent supportive housing, quite possibly forever.
- Most homeless people fall in the middle category. They need more than a simple referral but they can be housed with a Rapid Rehousing approach. HUD defines Rapid Rehousing as time-limited services (usually up to 2 years), sometimes but not always accompanied with time-limited housing subsidies, that are individually tailored to help a person rapidly get and keep permanent housing.

Strategies for Finding Permanent Housing

Given that none of our 8 counties have enough high-quality housing that is easily affordable, it seems at first that it must be nearly impossible to help people find permanent housing. Despite that shortage, most low-income people in every one of our counties have permanent housing tonight. Opportunities to get permanent housing are always constantly available in every county for the simple sad reason that in every county there are always people being evicted. This "churning" means that, no matter how tight the vacancy rate, apartments are always available.

A few low-income people are lucky enough to secure subsidized housing through Section 8, public housing, CoC and other housing programs. Most however survive without subsidies.

Many do so by paying much more than 30% of their total income for housing.[7] It is not uncommon for low-income households to pay 40%, 50%, 60% or more of their total income for housing, often leaving them without enough money for food and other necessities. Thousands get by using emergency food programs like food pantries or soup kitchens to help them make it through the month. Our PPS partners can help DSRIP participants make their household budgets more sustainable by making sure that participants are aware of and use all local food programs. There are over **310** emergency food programs in our target area. Most have limited hours and limits on the number of food pantry bags a household can have in one month, but use of multiple existing food programs can make it possible for participants to pay rent without going hungry.

Many others throughout our region share housing. Older and younger family members often live with family members because they can't afford housing on their own. Thousands of individuals and families live in less stable shared housing arrangements. Some move frequently between family members, friends and even acquaintances as they wear out their welcome, in a process colorfully known as "couch-surfing". These shared housing arrangements can wind up lasting long-term, especially if service providers help teach the couch-surfers to resolve or avoid interpersonal conflicts with their hosts and to contribute in some way to the host household,

---

screen assessment)." The Evidence Brief can be downloaded at http://100khomes.org/resources/spdat-and-vi-spdat-evidence-brief.

[7] HUD has long recommended that households ideally should pay no more than 30% of their total income for housing. HUD considers anyone who pays more than 30% as 'housing cost-burdened." HUD now recognizes that millions of American households spend more than 30% of their income on housing, and nonetheless manage to retain their housing.

either financially (which can often be much less than full rent would be) or by helping with household maintenance, childcare or other needed tasks.

The tremendous need for safe affordable housing is a pressing problem whose solution lies beyond the health care delivery system. These approaches will make the most of the housing that is available and help people with chronic health needs become and *stay* housed.

Housing Needs To Be Addressed

There are many combinations of circumstances and needs that can make it difficult for high-risk patients with medical and/or behavioral health conditions to manage their health condition in the community and when hospitalized to safely transition back. We will identify Medicaid beneficiaries whose health is compromised by unstable housing through relationships with PPS partners throughout the continuum of care. We will triage patients' needs into 3 tiers.

Tier 1: Patients in Tier 1 need to access one or more available community supports that they are willing to accept. They need someone to find these resources, help ensure that the patient can access them, and coordinate initial service delivery. Many Health Home and other Care Coordinators are not aware of the full range of housing-related support services available because housing has not been a primary focus of their prior professional work and because the housing services are often scarce, fragmented, and operating in uncoordinated silos.

One example of a Tier 1 patient would be someone who will for the first time be wheelchair-bound when they leave the hospital, but their current housing is not wheelchair-accessible. The patient's problem might be solved with housing accessibility modifications, such as widened doorways and installation of bathroom railings and an entrance ramp. Another option of course is to find the patient alternative affordable wheelchair-accessible housing, but many patients would prefer to remain in their homes if they can be made accessible.

Another example of a Tier 1 patient could be an individual who needs to be linked to a home health aide or personal care aide to assist with activities of daily living, two local food pantries (each with limited give-outs each month) to help ease the constant necessity low-income people face to choose between paying rent and having enough money to buy food, and a senior center that offers support groups and, when the patient is ready, individual counseling for depression.

Tier 2: Patients in Tier 2 need to access one or more available community supports that they are not yet willing to accept consistently.

One example of a Tier 2 patient would be someone who consumes dangerously large amounts of alcohol or recreational drugs. These individuals are often very familiar with local networks of treatment agencies. They may have dropped out or been thrown out of many local treatment programs. Most substance abuse treatment programs don't do street or community outreach. They wait for individuals to arrive ready to acknowledge that they have a substance abuse problem and willing to accept some form of structured treatment.

Another example of a Tier 2 patient would be someone with schizophrenia who functions fairly well when they consistently take their prescribed psychotropic medications but rapidly decompensates when they stop taking their medications. Mental health clinics and individual mental health clinicians know when patients are no longer getting prescriptions for their

medications but they usually have no mobile staff who can track down the patient and try to re-engage them in treatment.

Care Coordinators from Health Homes, hospitals and the other types of health systems listed above could be the people who work fairly intensively with Tier 2 patients to encourage them to engage or re-engage in treatment. There are two major barriers to the Care Coordinators being able to successfully fill this role. The first is large caseloads that make it difficult or impossible to provide sustained mobile outreach to build a relationship of trust with these patients and help motivate them to accept treatment. The second is often a lack of training in evidence-based interventions such as Motivational Interviewing that can help them be more successful in producing behavioral change.

Tier 3: Patients in Tier 3 have the most extreme and complex needs. They are often severely mentally ill, heavy substance abusers with multiple poorly managed major chronic and/or acute medical conditions. These are often (but not always) the highest-cost Medicaid users. They are often the people who have the most emergency room visits and the least stable housing. Many of them bounce between jail, detox, hospitals, shelters, brief periods of "couch-surfing" when they are lucky, and living in cars, abandoned building, sheds, garages and parks.

Most Health Home, hospital and other Care Coordinators don't know how to find and engage these people. These patients have no stable address and no consistent phone number. The Care Coordinators don't have the street-level connections to find them using soup kitchens, police captains, and informal social networks on the street. Many Care Coordinators would not feel comfortable trying to find and engage someone in jail, on a park bench, or under an overpass. Many don't have the street credibility and "street smarts" to engage and win the trust of these patients and over time persuade them to make dramatic lifestyle changes.

Housing Stabilization Services To Be Provided

We will provide 3 major services to address these 3 tiers of need.

***1. System Builders (for Tiers 1, 2 and 3)*:** We will assign a System Builder to each of our four service area quadrants. Briefly, System Builders will :

- Help Care Coordinators understand and access the full range of locally available services,
- Give Care Coordinators opportunities to begin establishing personal relationships with key service providers,
- Encourage providers to give priority access to DSRIP participants, and
- Work with local providers to expand services and fill service gaps.

The System Builders will enable us to impact housing outcomes for the largest number of DSRIP participants. The System Builders will help Health Home Care Coordinators more effectively serve DSRIP participants from Tiers 1, 2 and 3.

2. Care Coordinator Team Training (for Tiers 2 and 3): A second form of housing support that we will provide will be training Care Coordinators and their community partners in evidence-based interventions that have been proven effective in helping service providers overcome clients' resistance to accepting recommended treatment and making recommended lifestyle changes.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

3. Housing Stabilization Counselors (for Tier 3): We will help Health Homes address Tier 3 needs by developing Housing Stabilization Counselors who will work as part of Health Home care coordination teams. We will help fund Housing Stabilization Counselors to be based in four of our target area's major urban centers.

The role of the Housing Stabilization Counselors will be based on that of Managed Addiction Treatment Services (MATS) care managers as the MATS model shifted to Health Home care management. MATS Care Managers proved effective at saving Medicaid millions of dollars by stabilizing housing and services for high-cost Medicaid substance users and reducing utilization of high-cost inpatient detoxification. They were able to identify and engage high-cost Medicaid recipients who were homeless or unstably housed substance users found in shelters, jails, emergency rooms, and on the streets. The MATS workers helped these high-risk patients stabilize their housing and access substance use treatment, entitlements and primary care.

Advantages of the Proposed Model for Key Stakeholders: Our model will produce major benefits for all of the major relevant stakeholders.

Consumers: Consumers will benefit dramatically from this project. Their Care Coordinators will be able to link them to a wider variety of support services. Their Care Coordinators will be better trained and better able to engage with them in more sensitive and effective patient-centered ways using evidence-based interventions such as Motivational Interviewing. Those with the most severe needs will receive intensive, sustained, flexible and mobile support from our Housing Stabilization Counselors who will understand housing and entitlement issues as well as mental health, substance use and medical issues. Most significantly, more high-need consumers will have stable housing with all of the practical, emotional, physical and social benefits that brings.

NYSDOH: NYSDOH will benefit from having us pilot and test sustainable engagement and service strategies to provide stable housing for chronically ill Medicaid super-utilizers who are homeless or unstably housed. NYSDOH will be able to use the lessons learned from our project to formulate and disseminate best practices for integrating housing supports with healthcare.

Medicaid Health Homes: Our project will help the new Medicaid Health Homes better achieve their triple aims of improving patients' experience of health care, improving population health, and reducing per capita health care costs. Our project offers the Health Homes 3 main benefits:

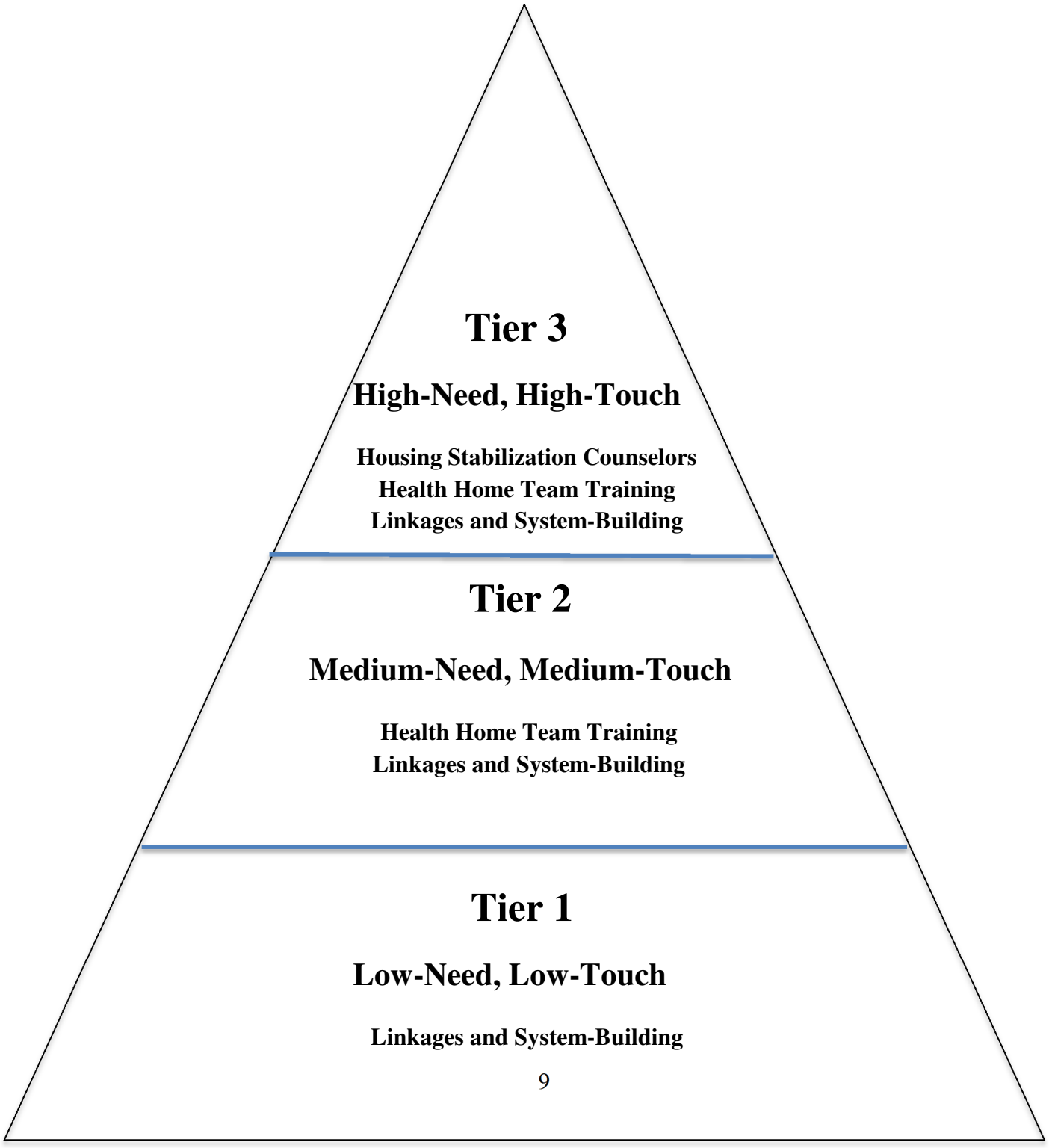
- More information in user-friendly formats their Care Coordinators can use to link their members to more types of housing-related support services,
- Free or reduced cost training for their Care Coordinators in evidence-based interventions that have been shown to enhance housing stability, and
- Additional staff that will work as an integrated part of their care coordination teams to handle members with the most severe and complex housing needs.

Hospitals: Hospitals will benefit from having increased access to housing-related support to help them reduce their rates of preventable readmissions and the associated financial penalties.

Our Healthcare System: Our project will benefit the healthcare system by improving outcomes and reducing overall costs. We will also pilot and evaluate strategies that could potentially be replicated nationwide.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

verview of Housing Stabilization Services by Tier: The following diagram gives an overview of how our three main DSRIP housing stabilization services will be targeted to the three Tiers of patient needs.



Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Community Consultation: Our model has been developed after extensive consultation with the Westchester County Continuum of Care. We are now consulting with housing providers throughout the 8 Counties served by our PPS to learn how the model will be modified to meet local needs in each sector of our region. Westchester is the largest county in our target area. Its CoC is the second largest in New York, trailing only New York City. It has New York's second largest homeless population, second only to New York City.

The Westchester County CoC has been trained in community mobilization and rapid rehousing techniques by Community Solutions' 100,000 Homes Campaign and the Rapid Results Institute (RRI). HUD and the VA have funded the 100,000 Homes Campaign and the Rapid Results Institute since 2010 to provide training and technical assistance to communities to help them achieve rapid progress toward rehousing veterans and the chronically homeless.

Our model also incorporates extensive community input from throughout our 8 county target area. We have solicited input from Medicaid Health Homes, hospitals, behavioral health and mental health providers, County Commissioners of Mental Health, housing providers, and community advocates.

3) How The Recommended Model Can and Should Be Presented in NYSDOH's Transitional Supportive Housing Services Application

We urge NYSDOH to conceptualize "Transitional Supportive Housing Services" in a way that aligns with current national best practices for addressing homelessness by allowing use of transition-in-place models that provide time-limited transitional housing support services in permanent housing settings. We seek confirmation that the approach outlined below is an acceptable interpretation of what is required to complete the application.

2a. Project Scale: Number of Transitional Beds Established for High-Risk Patients: We propose to calculate this number as the maximum estimated point-in-time active caseload for the number of high-risk patients who will be actively receiving Tier 2 or Tier 3 services. We will define high-risk patients as Medicaid recipients identified by our PPS as having major housing needs because they are:

1) Homeless, *i.e.* living in shelters, on the streets, in cars, or places not meant for human habitation,
2) Living in housing that is unsafe due to physical characteristics of the housing, threatening behaviors of other tenants, or unsafe neighborhood conditions, OR
3) Unstably housed, *i.e.* have moved at least twice in the prior 12 months.

The count of beds will be the number of housing beds occupied by high-risk patients who are:

a) Being actively served by Care Coordinators who we have trained in evidence-based interventions such as Motivational Interviewing (Tier 2) who are using those skills to help persuade the participant to accept previously-refused services or to make previously-refused behavioral changes
b) PLUS those being actively served by our Housing Stabilization Counselors (Tier 3).

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Being actively engaged will be defined as having had a face-to-face or telephonic contact within the last 90 days that was structured to achieve initial engagement, assessment or reassessment, or to address a specific housing-related need.

2b. Patient Scale: Targeted Population To Benefit From Project: This number will be calculated as:

a) The cumulative unduplicated count of high-need Medicaid recipients who have received housing-related services from either DSRIP-trained Care Coordinators (Tier 2) or DSRIP-funded Housing Stabilization Counselors (Tier 3)
b) PLUS an estimated cumulative unduplicated count of high-need Medicaid recipients who have been referred to a housing-related service identified by DSRIP.

3b. Patient Engagement Speed:

Expected # of Actively Engaged Patients: This will be defined as the anticipated point-in-time caseload of high-risk patients actively receiving Tier 2 or Tier 3 services.

% of Patients that are Actively Engaged: This will be defined as the actual point-in-time caseload of high-risk patients actively receiving Tier 2 or Tier 3 services divided by the total number of participants who have been identified as high-risk and who still fall into one of the three risk categories, *i.e.* excluding those who have been successfully rehoused.

4) Comment on Domain One Project requirements and Metrics for this project.

Item 2: Develop protocols to identify chronically ill super-utilizers.

Agree with Metric/Deliverable, however the listed data source inclusion of documentation of NCQA certification for physicians/practitioners is misplaced. We agree whole heartedly with the importance of pursuing PCMH for ALL affiliated PCPs. However, while primary care practitioners will be ONE source of identifying those with unstable housing they will not be the only and probably not the best source for such documentation. Moreover, we expect to the extent the primary care physicians do identify patients with unstable housing we would not want to wait until year three of this project for them to begin to notify us. This requirement could needlessly delay implementation of a comprehensive program that could otherwise be put in place much more quickly.

Item 4: Establish coordination of care strategies with MCOS,

Agree with Metric/Deliverable, however the listed data source inclusion of documentation of a CONTRACT with an MCO is not the right form of agreement. An MOU would be more appropriate. And MCO is not likely to CONTRACT with a PPS that is not an incorporated entity and it is not necessary to have a contract to effect coordination. Again this requirement

could needlessly delay implementation of a comprehensive program that could otherwise be put in place much more quickly.

Item 6: Ensure Medical Records and post-discharge plans are communicated

Agree with requirement, however the listed Metric/Deliverable and data source inclusion EHR meets meaningful use could needlessly delay implementation of a comprehensive program that could otherwise be put in place much more quickly. Agree that when MU use requirement kicks in in year three it should be used to transmit records. Also the Data source of MU certification does NOT ensure that it is being used to transmit discharge summaries. An audit will be required to support that this is being done.

Thank you for the opportunity to comment.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

American Federation of State, County & Municipal Employees, AFL-CIO
125 BARCLAY STREET • NEW YORK, NY 10007-2179

District Council 37 AFSCME AFL-CIO

Telephone: 212-815-1000

EXECUTIVE OFFICE
FAX COVER SHEET
Executive Office: 212 815-1516

To: Jason Helgerson

From: Lillian Roberts

Number faxed to: (518) 486-1346

Date: 10/29/14

Number of pages to follow: 2

Phone number of sender (212) 815-

( ) F.Y.I.
(✓) Please handle
( ) As per our conversation
( ) Please call upon receipt

Comments:

DC 37 Comments on 1115 Waiver.
Please confirm receipt at bedmondsa dc37.net.
Thanks for your prompt response.

If there are any questions or problems about this fax please call (212) 815-_____.

American Federation of State, County & Municipal Employees, AFL-CIO
125 BARCLAY STREET • NEW YORK, NY 10007-2179

Telephone: 212-815-1000

District Council 37 AFSCME AFL-CIO

October 29, 2014

Mr. Jason Helgerson
NYS Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Comments on Delivery System Reform Incentive Program

Dear Mr. Helgerson:

On behalf of DC 37, AFSCME, I am writing to comment on the draft document for the Delivery System Reform Incentive Program. DC 37 represents over 18,000 employees in the public hospital system and thousands of our members use HHC services for their health care.

A major concern is that the changes to the delivery system take into account the workforce development needs of our members. Workforce development must be sufficiently supported with time and resources so that staff will have the opportunity to learn the required skills, not just surface training. We represent titles from entry level housekeeping to highly skilled professionals in respiratory therapy, psychiatry and social work, all of whom have roles to play in effective patient care. The widening use of Community Health Workers or employees functioning as CHW is welcomed and we anticipate that we will represent these employees as HHC staff.

Another concern is that the programs are designed in order to make sure HHC is properly credited for and compensated for the care of the uninsured. Project 2.d.i – care and engagement of the uninsured and low utilizers of Medicaid is a critical project for HHC. We can make great

progress with the health outcomes of this population if this project is properly supported and resourced. We have already discussed ideas with HHC about how to jointly access our networks to reach out to this population.

The Health Home At Risk Intervention program (2.a.iii) is itself at risk if it relies on the same staff and limited funding per patient as the Health Home project (high users of behavioral health and emergency medical) , which in our experience is understaffed and under resourced based on the caseload that they are expected to carry. This population is difficult to reach and effectively monitor and therefore requires extra attention. It is important that the next level of patients, the At Risk group, not be lumped together for the same staff to follow.

Finally, we agree with the comments of the Ms. Judy Wessler and organizations that are making similar comments regarding the lack of specific community based organizations involvement. System change will require many hands, including the on the ground community based organizations to educate and involve patients in an appropriate manner. These organizations must be supported as well.

Thank you for the opportunity to comment on this plan.

Sincerely,

Lillian Roberts

Lillian Roberts
Executive Director

DSRIP PPS Project Plan Application Comments

Overarching comments:

Implementation Plan and Milestones and Metrics

- Clarification is needed as to the extent and type of timelines and project plans that PPS should include in the Plan Application as opposed to the implementation plan.
    - On p. 4 of the Organizational Application and elsewhere, it is noted that the implementation plan will be due April 1, 2015. The Draft DSRIP Project Plan Application website notes that for Domain 4 projects only, PPS will also be providing detailed milestones in an implementation plan due April 1, with the format and content to be provided by Independent Assessor.
    - The Milestones and Metrics document includes Domains 2 and 3; Domain 4 projects are not included. However, the Domain 2, 3, and 4 Plan Application, e.g. p. 168, states in reference to Domain 4 projects that "The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, Domain 1 DSRIP Project Requirements Milestones and Metrics, which will be used to evaluate whether the PPS has successfully achieved the project requirements."
    - Reference is made to the implementation plan for other domains, e.g. p. 5 and elsewhere in the Domain 2, 3, and 4 Plan Application: "By April 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application". In the Domain 2, 3, and 4 Plan Application, it states that PPS project reporting will be conducted in 2 phases – the implementation plan and ongoing quarterly reports – for all projects.
        - With reference to p. 9 and 37 other instances in the Domain 1 Milestones and Metrics document regarding Domain 2 and 3 projects: "Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application"

HIT Adoption and Implementation

- Applications should explicitly address the health information technology (HIT) needs of the PPS and lay out strategies and resource allocations for meeting HIT needs. The applicant should indicate findings from an analysis of their healthcare resource landscape and strategies for mitigating gaps including a timeline, dedicated staff, and areas of investment in order to achieve the project requirements by the end of Demonstration year 3.
    - Applications should address the need for data collection and information exchange in advance of the Year 3 goals; a plan should be in place for meeting DSRIP performance metrics during implementation of Integrated Delivery System structures (e.g. utilizing existing claims data and use of alternative data sharing mechanisms) and should reflect the need to transition from interim systems once Integrated Delivery System functions are ready for use.
    - Meaningful Use of EHRs is noted as a component of several projects and is implicitly required for the success of other projects; the applicant should indicate findings from an analysis of their healthcare resource landscape and strategies for mitigating gaps including a timeline, dedicated staff, and areas of investment.
    - The applicant must discuss the process for transitioning providers across the PPS onto an EHR if they are still on paper or using an EHR with limited functionality, connecting all EHRs within the PPS to share data with each other using a secure messaging platform, and connecting EHRs to other data sources like public health registries and auxiliary services like labs, imaging, and radiology.

- Overall DSRIP success relies heavily on the efficient and meaningful use of EHRs to support data capture and information sharing.
    - The following requirement is repeated for all Domain 2 and some Domain 3 projects, with equivalent requirements incorporated in other projects: "Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3."
        - Suggest replacing the term "EHR systems" with "EHR data" to better reflect the actual need to share data with health information exchanges.
        - EHR adoption, or switching from one EHR to another, can take several months and can affect practice functioning due to time required for training and workflow redesign. Some PPS participating providers will need to adopt EHRs; many more may need to transition to a different EHR vendor in order to enable interoperability and integration with other providers or to ensure that their EHR meets the standards set by DSRIP.
    - Clarification is needed as to whether the intended requirement is for EHRs to be certified as 2014 Certified EHR Technology under the EHR Incentive Program. The current phrasing states "Metric/Deliverable: EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria)" which does not map to the CMS terminology.

Data Collection and Analysis

- Strong applications will clearly state plans to dedicate resources or contract with consultants to handle data collection and coordination across the entire PPS for the duration of the proposed plan. This will require looking ahead to plans to obtain data from other segments of the clinical network, including community providers, and plans to modify and evolve templates and strategies as needed. PPS will need data for key metrics for internal processes as well as external reporting requirements, enabling assessment, evaluation, and improvement of integrated delivery system structure and function.
- Numerous projects reflect the deliverable "Use EHRs or other technical platforms to track all patients engaged in this project." PPS responses should reflect the need for interim solutions to achieve these deliverables while long-term plans are implemented. While the PPS is working towards delivery system integration; external platforms may be necessary as interim solutions while bidirectional data feeds are being developed. For example, PPS may elect to use 3rd party vendors that can integrate claims data for all services and clinical data from all providers or otherwise utilize alternative solutions.

Health Information Exchange

- The Domain 1 Milestones and Metrics document includes "EHR demonstrates integration of medical and behavioral health record within individual patient records." as a metric/deliverable for numerous projects. Some types of information which may be included as behavioral health data (e.g. substance use disorders) are covered by federal regulations (42 CFR Part 2) which affect how such information can be shared as well as by HIPAA. PPS should include plans to ensure appropriate privacy and security protections while facilitating sharing of information where necessary.
    - Sharing health information across multiple settings requires managing patient consent and a process for tiering access to patient records based on provider type. Applications should specify plans to developing protocols to ensure that data are accessed and shared in ways that adhere to all applicable law and regulation, with particular emphasis on the SAMHSA 42 CFR Part 2 regulations.
    - PPS should demonstrate plans to manage and monitor sharing of sensitive clinical data, like HIV status or substance use disorder diagnoses, as well as demonstrate awareness that restrictions on data sharing may impact plans to coordinate care across settings.
- The Domain 1 Milestones and Metrics document includes "EHR meets connectivity to RHIO's HIE and SHIN-NY requirements" as a Metric/Deliverable for numerous projects. The data sources associated with this Metric/Deliverable do not directly address the question of whether PPS providers are actively interfacing with the RHIOs and conducting bidirectional data exchange as a routine part of clinical practice. Propose the addition of a metric/data source to address the need for bidirectional information sharing. Providers who join and exchange data with a RHIO receive a confirmation letter documenting that the

implementation of bi-directional data exchange is complete; this would be important documentation to indicate that the practice is actively participating in data exchange. Suggest adding a metric regarding the % of providers in the PPS contributing data to a RHIO to further document the active engagement of PPS providers in health information exchange.

- PPS responses should indicate plans to connect to one or more public HIEs. Current RHIO participation rates are low (~11% in NYS, ~2% in NYC) and PPS responses should reflect awareness of potential challenges as well as plans to achieve high participation rates.

Meaningful Use and PCMH

- PPS applications should clearly document plans for investment in practices, including investment in new technology as well as investment in training, technical assistance, and quality improvement interventions.
    - PPS should include a clear timeline for achievement of practice transformation goals; the timeline will be tight due to the need to:
        - 1. Adopt a 2014 Certified EHR Technology product,
        - 2. Develop and routinely use advanced functions such as running registry reports and bidirectional health information exchange
        - 3. Achieve 2014 Level 3 PCMH standards by the end of Demonstration Year 3 (DY 3).
    - Support for workflow redesign, development of and staff training on protocols for standardized clinical documentation, quality improvement, and administrative and paperwork management, as well as plans for identifying and prioritizing practices in need of additional technical assistance will be critical to achieving the ambitious goal of reaching 2014 PCMH Level 3 by the end of DY3.
- Meaningful Use achievement is not an explicit requirement for PCMH Level 3 2014 standards. However, Meaningful Use Stage 2 objectives and measures are closely reflected in the Level 3 standards. Suggest that PPS responses consider the potential benefits of supporting providers to achieve Meaningful Use as a stepping stone towards overall practice transformation

Organizational Application

Section 1 - Executive summary

- P. 3 of the Organizational Application asks whether the PPS is applying to become an ACO as part of this application. NYS DOH recently published proposed regulations regarding the establishment of standards for issuing certificates of authority to ACOs; however, in the absence of the ACO application referenced on P. 4, the Organizational Application is unclear regarding the intent of this question. ACOs can be Medicare or commercial payer ACOs and can be structured in a variety of ways (shared savings or shared risk). How will existing ACOs that participate in a PPS would be affected by this choice?

Domain 2

2.a.i:

- This project requires primary care practices to achieve 2014 Level 3 PCMH by the end of Demonstration Year 3. Achieving this goal will require a clear and realistic project plan, including timelines that reflect barriers and needs including provider attrition, disengagement, and timelines for ramp-up.
    - Achieving PCMH Level 3 can be a year-long process for practices, and those who have not yet achieved Meaningful Use will require significantly more advance planning. Applications should reflect plans to address these potential barriers and commit needed resources for technical assistance and application support.
    - Practices may experience decreased volume and revenue during the transition process due to the need to spend time on training and workflow redesign; PPS responses should include plans to mitigate this issue with particular attention to the needs of safety-net practices with tight margins for whom temporarily decreased revenue flow may be a major hardship.
    - As new providers join the PPS, what is the timeframe in which they will need to meet these requirements – e.g. 3 years from joining? Or will providers who join at year 2.5 be required to achieve the same requirements by year 3?

- Achieving the goals of this project will require demonstration of a plan to develop and use advanced HIT capabilities, as well as dedicated staffing or consultant resources to assess the need for and ensure capacity to appropriately conduct:
    - Data aggregation across multiple episodes, time periods, and settings; plan for data extraction, transformation, and loading into data warehouse; strategy for patient matching.
    - Data analysis, including provider benchmarking, utilization analyses, cost analytics, predictive modeling, and performance audits.
    - Quality improvement monitoring and reporting, including role-based access to reports, plan for development of QI intervention and targeting, clinical outcomes management.
    - Patient engagement, including referral alerts and tracking, patient portal/personal health record.
    - Connecting to community resources and public health agency resources, including use of personal health records and referral tracking and management to assist in care coordination.
        - PPS should include plans to develop or identify systems to track data from community programs and non-clinical providers.
- Regarding Requirement 10: clarification needed as to whether this refers solely to providers who are in salaried employment with PPS organizations or if this is an expectation that the PPS will negotiate with MCOs, commercial payers, etc. on behalf of other providers.
- Regarding Project Response & Evaluation, 1. Project Description and Justification, item d., PPS should coordinate with neighboring PPS regardless of overlapping service area – even in the absence of geographic overlap, patients may see providers in multiple PPS.
- A strong application should:
    - Include behavioral health providers and behavioral health consumers of all ages, including children, in the participating entities in the governance model
    - Specify how behavioral health records will be incorporated into EHRs and health information exchange, addressing issues of consent and other restriction in accord with federal protections
    - Integrate peers, people with lived behavioral health experience, including family peer advocates, in an integrated delivery system

2.a.ii

- Requirement 7: clarification needed as to the types of staff who need to be trained in PCMH or APC models; do all staff need to be trained or can staff be selected for training based on roles and responsibilities?
- Requirement 8: tobacco screening and treatment should be listed as an example of behavioral health screenings in addition to the listed screenings (PHQ-9 and SBIRT).
- A strong application should demonstrate integration with Domain 3.a.i. In particular, incorporation (including training, workflow development, and plans for tracking/treatment/and referrals)

2.a.iii

- Requirement 7: PPS responses should clearly describe plans to engage health homes and asses need for financial or logistical support to enable the health homes to provide services to this expanded population. This requirement indicates that local health homes must engage with the PPS and expand their role to include the patient population referred to as “the movers”.
- Requirement 8: Suggest the inclusion of local jails/local jail health providers with other examples of government units.
- Requirement 9 tobacco use should be listed as an example of a risk factor that can be addressed through evidence-based practice guidelines.
- Project Description and Justification b: Suggest inclusion of language suggesting criminal-justice involved population as possible target population.
- A strong application should include:
    - behavioral health as a key aspect of proactive management
    - evidence-based practices for engaging patients with substance use, depression/anxiety, and tobacco use as key drivers of the “mover” population
    - early identification and early intervention of behavioral health conditions and tobacco use in children and youth using standardized screening tools

2.b.i

- A strong application should:
  - Specify how behavioral health needs will be identified and addressed in the model, ideally via co-location rather than referral to network services.
  - Include behavioral health metrics as part of the quality metrics.

2.b.iii

- A strong application should demonstrate how providers will establish and make behavioral health connections for their patients of all ages, including children.

2.b.iv

- A strong application should:
  - Describe how providers will address behavioral health needs, will incorporate behavioral health needs into the care transitions intervention model.
  - Send protocol updates to behavioral health providers (not just primary care providers).

2.b.vi

- Requirement 1: Strong applications will include plans to address environmental health risks such as tobacco smoke in the development of transitional supportive housing for high risk patients, and will document plans to work with housing providers to establish and enforce smoke-free housing policies.
- A strong application should demonstrate an understanding of the current housing availability and resources for patients with these needs and how the PPS and housing provider will implement chronic disease management, including behavioral health management

2.c.i

- A strong application should include behavioral health peers, and family peer advocates for families of children and youth

2.c.ii

- A strong application should demonstrate innovative ways to expand access to behavioral health services including:
  - the ECHO model to deliver behavioral health specialty care within primary care settings,
  - models of telemedicine care to delivery behavioral health services to individuals unable to travel to traditional treatment settings,
  - identification of special populations that would especially benefit from telemedicine in behavioral health and
  - the use of telemedicine to supplement and support traditional office-based behavioral treatment in order to improve treatment engagement.

2.d.i

- Requirement 3: Suggest including language suggesting local jails as “hot spots” in addition to emergency rooms due to the prevalence of UI, NU and LU.
- Requirement 6: Include language that these lists should be shared with “hot spots” to facilitate reconnection of beneficiaries to designated PCPs.
- Requirement 9: Clarification needed as to who will be responsible for administering the PAM. The Domain 1 Milestones and Metrics document states: “The PPS will NOT be responsible for assessing the patient via PAM® survey.” However, requirement 9 states “On an annual basis, assess individual members’ and each cohort’s level of engagement, with the goal of moving 9 beneficiaries to a higher level of activation.”
- Requirement 11: Clarification of the use of the term “community navigator” is needed. As written, the term does not correspond to existing insurance or other navigator programs and that this is intended to be a new resource. How will community navigator credentials be defined and what types of navigator roles and credentials will be accepted?

Domain 3

3.a.i

- Achieving project goals at both primary care PCMH site and Behavioral Health site will require use of the infrastructure created when integrating the delivery system, i.e., use of EHRs in standardized way, sharing data across providers within and outside of the PPS, and across services (pharmacy, labs, etc.).
    - Before the delivery system is fully integrated (all providers on EHR and sharing data) at the end of Year 3, an interim plan must be in place to meet the requirements of this project with a timeline that demonstrates the transition.
    - Strategies must be in place for achieving consistent documentation of data in structured formats, for example implementation of tobacco and behavioral health screening templates in the EHR.
    - Strong applications will include strategies for data sharing between primary care, behavioral health, and community service providers that are supported by PPS resource allocation.
- Strong applications for all integration models will include screening for tobacco use among all individuals with behavioral health diagnoses as a core preventive care screening and reflect plans to integrate targeted cessation treatment. Strong applications will indicate capital resources for HIT for behavioral health sites lacking EHRs offering care coordination and health information exchange functionalities.
- Requirement A.3: Clarification needed as to what preventive care screenings fall under 'industry standard questionnaires' and suggest that PPS include plans to implement smart forms and other workflow supports to support transformation of preventive care.
- Requirement 4: Strong applications will reflect assessment of the current technological landscape and plans to ensure necessary technology is adopted and implemented. Behavioral health EHRs and clinical EHRs can be very different in terms of the standards and structure of the technology; bi-directional interfaces will be challenging without agreed-upon data standards.
- PCMH Service Site: Performing provider systems undertaking this project will develop behavioral health services onsite at their 2014 NCQA level 3 PCMH or Advance Primary Care Model practices.

Successful applications will cover the following areas:

- Routine screening for behavioral health conditions (PHQ-9, GAD-7, AUDIT-C) at primary care visits to identify individuals requiring full assessment
- On site assessment leading to diagnosis of behavioral health conditions
- Inclusion of behavioral health conditions in patient's treatment plan
- Development of treatment plan, goals and objectives by collaborative, interdisciplinary team including physicians, nurses, behavioral health professionals and peers
- Inclusion of patient input and preferences in treatment plan development
- Engagement of family in patient's treatment and family support services provided on site if indicated. Partnerships with community family support organizations identified
- Demonstration of competency in a range of evidence-based behavioral health interventions including pharmacotherapy, brief treatment, cognitive-behavioral therapy, motivational interviewing, trauma-informed care and peer services
- Full integration of patient-centered, wellness-based treatment models
- Evidence of team collaboration at all levels, including warm handoffs between providers when consultation or follow up is required
- Contingency plans for crisis management and relationships with community crisis providers
- Strategies for collaboration with the LGU to identify community behavioral health providers and resources for off-site referrals when more intensive behavioral health services are required
- Knowledge of regulatory requirements in the delivery of integrated care and procedures for waiver application as needed
- Utilization of a fully integrated electronic medical record across provider specialties, including all visit documentation, prescription capabilities, electronic connection to pharmacy, integration of laboratory systems, ideally connected to a RHIO

- Detailed quality improvement plan, beyond basic data collection, that demonstrates understanding of the quality improvement process (e.g., PDCA cycles), preferably based on rapid cycle intervention to demonstrate impact on outcomes
- Use proven strategies including routine screening with validated tools, motivational counseling, effective pharmacotherapy, and care management to treat alcohol use disorders (including initiation of or continuation of effective medication), tobacco use, and opioid use disorders (including using buprenorphine; and co-prescription of naloxone to prevent overdose).
- * Innovative proposals will consider extending this model beyond adults with high priority public health needs as supported by the evidence such as to pediatric practices and adolescent care for common behavioral conditions, and to targeted capture as well of subgroups such as parents with depression.
- Behavioral Health Service Site: It is anticipated that the components of this project will mirror of "1" above with the exception that primary care services will be placed within behavioral health clinics. There are additional specific aspects in the first bullet point that need to be addressed:
- Overall methods to integrate the primary care team, including primary provider(s), nurse(s), and other staff to be described. Should include detailed staffing model.
- Strategies to promote patient engagement/uptake of primary care services in behavioral health settings
- Methods by which practice and culture integration will occur (for example, via shared meeting/case conferences)and by which behavioral health and physical health providers will communicate
- Strategies the practice will employ to ensure that age- and condition-specific screening and health intervention occur (for example, patient registries; tracking methods)
- Plan for primary care work flow, including such elements as: routine health exams (scheduling and follow-ups), follow-ups for abnormal labs, referrals for specialty and surgical care, referrals for medical hospitalizations, plans for after-hours on call/care.
- Knowledge of regulatory requirements in the delivery of integrated care and procedures for waiver application as needed
- Utilization of a fully integrated electronic medical record across provider specialties, including all visit documentation, prescription capabilities, electronic connection to pharmacy, integration of laboratory systems, ideally connected to a RHIO
- Detailed quality improvement methods and goals for performance of such an integrated care program, beyond basic data collection, and that demonstrates understanding of proven quality improvement process (e.g., PDCA cycles), preferably based on rapid cycle intervention to demonstrate impact on outcomes
- Demonstrate an understanding of integrated service delivery barriers and articulate strategies for overcoming these challenges.
- For integrated care housed in a primary care setting,
    - include ON-SITE delivery of a full range of behavioral health services from screening through patient-centered, team-based treatment
    - limit referrals to outside behavioral providers
    - and for pediatric primary care settings, screening for maternal depression
- For integrated care housed in a behavioral care setting, include
    - full integration of the primary care team,
    - strategies to promote engagement/uptake of primary care services in this behavioral setting and
    - evidence of practice and culture integration
- For applicants selecting the collaborative care model, demonstrate full understanding of the IMPACT model with specific strategies for implementation of all its required elements
  Include screening for tobacco use and targeted cessation treatment as appropriate for all individuals with behavioral health diagnoses
- IMPACT: This is an integration project based on the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model.

Successful applications will include the following:

- Demonstrate full understanding of the formal Collaborative Care Model and include its key components
- Care coordination and care management
- Regular, proactive monitoring and treatment to target of depression symptoms using validated clinical rating scales
- Systemic psychiatric caseload reviews and consultation for patients not showing clinical improvement
- Role of the behavioral care manager and consulting psychiatrist and the skill sets required for each position
- Importance of full team collaboration
- Application must fully demonstrate implementation of these core components of the collaborative care model including:
- Routine screening for behavioral health conditions and workflow for follow-up with behavioral care manager
- Frequent communication between the behavioral care manager and PCP, as well as other interdisciplinary team members
- Strategies for identifying and utilizing psychiatric consultant
- Understanding of "forced consultation" approach and the plan for tracking and identifying patients for follow up, as well as plans for warm handoffs to outside providers when referral is required
- Use of stepped care models for treatment of behavioral health conditions, including repeated monitoring of symptoms to inform treatment planning
- Plans for proactive follow up by behavioral care manager to ensure that patients do not fall through the cracks
- Utilization of behavioral care manager (usually RN and/or clinical SW or psychologist) and specification of skills necessary to deliver evidence-based behavioral health interventions including screening and symptom tracking, brief evidence based counseling treatment (behavioral activation, problem-solving therapy, and adherence coaching), motivational interviewing and trauma-informed care
- Strong applications will utilize peers to support and reinforce the work of the care manager
- Plans for documentation of behavioral health conditions in the medical record. Strong applications will utilize electronic health record and leverage its data for outcomes tracking and quality improvement
- Importance of psychoeducation of behavioral health conditions for patient and family members. Engagement of entire support system to improve patient engagement
- Contingency plans for behavioral health crisis management and relationship building with community crisis providers so warm handoffs can be accomplished
- Strategies for collaboration with the LGU to identify community behavioral health providers and resources for off-site referrals when more intensive behavioral health services are required
- Detailed quality improvement plan, beyond basic data collection, that demonstrates understanding of the quality improvement process (e.g., PDCA cycles), preferably based on rapid cycle intervention to demonstrate impact on outcomes
- ❖ Innovative approaches would apply or have a plan to develop adoption as well of evidence-based practices that enhance and extend the clinical scope of the model, such as addressing screening and treatment of anxiety disorders (CALM intervention), nicotine dependence/cessation and alcohol use (SBIRT)
- ❖ Similarly, innovative proposals will consider extending this model beyond adults with high priority public health needs as supported by the evidence such as to pediatric practices and adolescent care for common behavioral conditions, and to targeted capture as well of subgroups such as parents with depression.

3.a.ii

- Requirement 1: Suggest NYS consider additional models for this requirement, as the MAP has not been updated since 2010.
- Project Toolkit states application must, at minimum, include: outreach, mobile crisis and intensive crisis services.

1. CRISIS STABILIZATION
   Program has:
   - An observation unit within a hospital outpatient facility or at an off campus crisis residence for up to 48 hours of monitoring
   - ❖ Capacity to accommodate transitional age youth ("TAY": 18-24 years old)
   - ❖ Intention to adopt policies and procedures that invest *up front* in comprehensive and/or non-traditional services for individuals in crisis who may not necessarily have been through the mental health or substance use disorder treatment systems (i.e. "failed" at everything else)

2. SHORT AND LONGER-TERM RESPITE
   Program can:
   - ❖ Accommodate respite stays for up to (or more than) 14 days, per 1915i requirements
   - ❖ Include, train and support clinical, non-clinical, and peer staff (specifically trained in peer intervention models such as Open Dialogues and Intentional Peer Support)who are able to deliver or refer to traditional and non-traditional treatment models (including non-withdrawal substance use disorder stabilization services)
   - ❖ Support transitional age youth (TAY) and properly refer youth under 18 to like-services (e.g., form agreements with OMH-programs, such as NYC Children's Center,)
   - ❖ Form partnerships and linkage agreements with hospitals and other emergency services to facilitate diversion agreements and make proper referrals

3. MOBILE CRISIS TEAMS
   Program has:
   - ❖ Ability to recruit and support teams that are multi-disciplinary and multi-cultural to accommodate the diversity of New Yorkers and their crises and include peers
   - ❖ Ability to respond to a crisis within 2-4 hours
   - ❖ Preferred training in Needs Adapted Treatment Model and able to work with individuals and families on an ongoing basis as needed.
   - ❖ Staff capable of prescribing and administering in the field

4. EDUCATION, OUTREACH & COLLABORATION
   - ❖ Program has or can develop signed linkage agreements with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services (*that includes training ER staff in alternatives available and/or co-locating services to divert at hospital).
   - ❖ Ability to provide public education to key stakeholders to maximize buy-in of non-traditional services (hospital staff especially including inpatient AND outpatient staff, mental health professionals, peer advocacy groups, family support groups, etc.)

IMPORTANT TO ALL COMPONENTS DESCRIBED ABOVE:

- EHR and HIE connectivity to allow alerts and secure messaging and to obtain current medical records for the patient
- Agreements within and between each component on clinical protocols & risk management
- Immediate access to a hospital with specialty psychiatric services and crisis-oriented psychiatric services OR alternative (e.g., respite center)
- ❖ Availability of clinical consultation by mental health clinicians, including psychiatrists as a resource for primary care providers
- Agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project

- Involvement of a quality committee for oversight and surveillance of compliance with protocols and quality of care *that includes an Incident Review Committee and Consumer Advisory Board
- ❖ Program has or is willing to create a robust quality improvement strategy that tracks in real time the intended effects, subsequent service utilization, and outcomes of a multi-pronged crisis intervention and prevention approach
- ❖ Superior applications would incorporates these observations about efficacy into a regular process of program improvement to optimize the impact of this intervention on overall community independence, functioning and diminished acute care utilization.

- A strong application should:
  - Include elements of crisis stabilization, short- and longer-term respite care, mobile crisis teams and education, outreach and collaboration
  - Indicate capacity to accommodate children and Transitional Age Youth
  - Include non-traditional treatment models and use of peer-delivered services

3.a.iii

- A strong application should:
  - Discuss the specific existing MAP tool adaptations that are required for implementation for behavioral health consumers
  - Separately address the needs of children and youth when using behavioral health medications, and adherence to best practice guidelines

3.a.iv

- A strong application should demonstrate capacity for:
  - providing medication management for symptom relief of mild to moderate or persistent withdrawal from alcohol, opioids and sedatives, as differentiated from acute detoxification services
  - assessing acute inpatient detoxification needs and establishing linkages to inpatient detox services
  - buprenorphine prescribing by waivered physician staff
  - connections to outpatient treatment and recovery support services
  - Possess a certificate to offer “ancillary withdrawal” from OASAS

3.b.i

- Requirement 1: Applications should incorporate elements of the Chronic Care Model and reference existing evidence-based strategies in program development. Application will reflect planning for program development and implementation, including identifying where accountability for achievement will reside, identifying internal or consultant resource for program development, and plans to conduct planning and assessment to identify practice staff for program implementation.
- Requirement 4: Use of patient registries for identification of patients in need of additional care and use of recall strategies to outreach to patients as needed must be incorporated into a routine workflow and overall program strategy. Plans for identifying appropriate staff and providing training must be incorporated.
- Requirement 5: Best applications will include plans for comprehensive implementation of the 5 A’s of tobacco control, which should include: 1) utilizing an EHR that captures and prompts screening and treatment at every visit; 2) instituting routine tobacco use treatment training for all health care team members; 3) designing workflows (e.g., non-physician staff delivering counseling on-site) to optimize delivery of tobacco use treatment; 4) incorporating follow-up for on-going treatment support that minimizes lost to follow-up (e.g., Opt to Quit referral to the NYS Smokers Quit Line); 5) providing performance feedback reports using the EHR to increase screening and treatment rates.
- Requirement 6 and 9: PPS responses should document plans to conduct annual (or other pre-specified interval) training of all staff on current HTN and cholesterol treatment guidelines including accurate measurement techniques and approaches to improving medication adherence.
- Requirement 8: Providers have indicated that the provision of follow-up blood pressure checks without copayment is not permitted; further, providers have indicated that blood pressure checks provided by

non-physicians often 'turn into an appointment' when patients have additional questions or emergent conditions.

- Requirement 9: The response to this requirement should include description of plans to ensure all appropriate equipment, including chairs in exam rooms, will be available.
- Requirement 13: PPS responses must incorporate strategies to work with community based programs (CBP) to ensure bi-directional information sharing; CBPs will ideally share information back to providers to enable documentation of participation and health status changes in order to ensure effective communication. Implementation of such strategies may require dedication of resources (time and/or equipment) to CBPs.
- Requirement 14: PPS must document plan for obtaining and disseminating home blood pressure monitors and training strategies, as well as define how home monitors will be paid for.
- Requirement 18: edit 'Million Lives' to 'Million Hearts'

3.c.i

- Requirement 1: Applications should incorporate elements of the Chronic Care Model and reference existing evidence-based strategies in program development. Application will reflect planning for program development and implementation, including identifying where accountability for achievement will reside, identifying internal or consultant resource for program development, and plans to conduct planning and assessment to identify practice staff for program implementation.
- Requirement 4: Use of patient registries for identification of patients in need of additional care and use of recall strategies to outreach to patients as needed must be incorporated into a routine workflow and overall program strategy. Plans for identifying appropriate staff and providing training must be incorporated. Registry reports must be run on a frequent basis and regularly tailored to address target populations, which may shift as quality metrics are met and additional patient populations are identified for intervention.

3.c.ii

- Requirement 5: Strong applications will include a comprehensive plan and workflow to ensure consistent screening for tobacco use and provision of in-person support, e.g. by providing information about the individual's Medicaid tobacco cessation benefit which they can access via their provider and/or actively linking them to community or local resources such as in-person quit smoking clinics or the NYS Smokers' Quitline.

3.d.i

- Controller medication given in schools instead of the home is an evidence-based medication adherence program that is important to expand for pediatric asthma patients.

3.d.ii

- Requirement 2: Strong applications will include a comprehensive plan and workflow that screens for secondhand smoke exposure and provides treatment (counseling and/or quit smoking medications) for caregivers that smoke. Caregivers should also be provided information about the Medicaid tobacco cessation benefit and may be actively linked to community or local resources such as in-person quit smoking clinics or the NYS Smokers' Quitline.
- A strong application will include:
    - Use of evidence based intake and assessment protocol and service plan by in-home visiting staff (Consider examples used by East Harlem Asthma Center of Excellence and the Asthma Counselor Program and Air Harlem Community Health Worker Visiting Program)
    - Screening in primary care and asthma specialty care settings for behavioral health and other conditions that may be barriers to self-management of asthma and referral to appropriate care as needed
    - Efficient clinical follow-up with primary care physician (follow-up appointment within 2 weeks of Emergency Department visit)
    - Use of evidence-based patient-administered Asthma Control Test (trademark of Quality Metric Incorporated; used by New York State Department of Health Asthma Programs) to evaluate baseline knowledge by in-home visiting staff

- Basic asthma education, via home visiting staff and/or hospital-based, certified asthma educators, coupled with tailored assessment of knowledge and self-management skills to target education areas of greatest need
- Environmental assessment for indoor asthma triggers performed by primary care provider or asthma specialist
- Use of evidence-based in-home environmental assessment tools and remediation plans
  - To enhance effectiveness, remediation plans should incorporate integrated pest management (IPM) techniques, including
    - Inspection to identify pests and conditions conducive to pests like holes, leaks or foods sources
    - Non-chemical pest control measures including:
      - Allergen reduction through HEPA vacuuming and/or cleaning to remove pest debris
      - Sealing and caulking openings, fixing leaks
      - Containing garbage and other food sources
      - Educating families about things they can do to minimize pests
    - Where pesticides are required, the least toxic chemicals should be used in the safest manner in order to protect people and pests. Tenants should be notified at least 24 hours in advance of application.

- PPS provider coordination with pharmacies and managed care organizations to monitor and track prescription use
- PPS provider coordination with community-based organizations to provide social service needs
- Access to and/or referral to legal assistance to educate tenants of their rights, to aid clients in documenting health conditions impacted by housing issues and to facilitate legal proceedings as needed.
- Evaluation plan to measure health outcomes (ED visits, hospital utilization, cost) and effectiveness of interventions

3.e.i

- Requirement 6: Tobacco use should be an example of a health condition that can be addressed through coordination of care. For example, the requirement can be expanded to read: “Ensure coordination of care between all available services preferably through a single electronic health/medical/care management record so that critical health conditions (e.g., tobacco use) be addressed consistently.
- A strong application should:
  - Demonstrate established linkages with SDOH waivered Syringe Exchange Programs (SEP’s) in New York City.
  - Target injection drug users through SEP’s, ED’s and primary care for PEP and PREP

3.f.i

- If Model 1 in section 3.f.i is selected, all 4 components should be required in order to be successful.
- A strong application should:
  - Regardless of the intervention chosen for this project, include depression screening during pregnancy and postpartum, as well as protocols for treatment as clinically indicated.
  - Explore depression treatment models targeted to the special needs of pregnant and postpartum women, as well as family engagement and support
  - Identify evidenced based practices for pregnant woman with drug use issues, for example, medication assisted treatment with methadone for opioid use disorder.

Domain 4

4.a.i

- A strong application should demonstrate strategies that are informed, in setting and content, by the most recently available epidemiological and service data, with plans for longitudinal tracking of outcomes stratified by demographic and geographic variability.
- Implement programs that
    - prevent harmful use both of alcohol and other drugs, including opioid overdose prevention programs
    - support parents/caregivers to promote healthy early childhood development in young children, including parent coaching

4.a.ii

- Requirement 3: Strong applications for understanding and addressing tobacco use will include plans and workflow to screen for tobacco use among all individuals with behavioral health diagnoses and provide individualized cessation treatment (counseling and/or quit smoking medication) at every visit with adequate follow up.
- A strong application should implement:
    - Environmental strategies, including community coalition building with key stakeholders and innovative media campaigns that are data driven.
    - Strategies informed, in setting and content, by the most recently available epidemiological and service data, with plans for longitudinal tracking of outcomes stratified by demographic and geographic variability.
    - Programs that use risk reduction, i.e., preventing harmful use both of alcohol and other drugs, including opioid overdose prevention programs.
    - Programs and strategies that identify children and youth at risk of developing behavioral health conditions and proactively address risk factors to prevent development of behavioral health disorders

4.a.iii

- Strong applications will include screening for tobacco use among all individuals with behavioral health diagnoses and targeted cessation treatment.
- A strong application should also:
    - Demonstrate partnerships with a range of stakeholders, including families with children, and providers from various child-serving systems from affected communities, organized around advancing behavioral health prevention, and reference evidence-based methods in the creation and implementation of these partnerships.
    - Describe plan to ensure staff/leadership participation in proven implementation activities around collaborative care with state and/or LGU agencies, and demonstrate awareness of disparities in depression care access and outcomes in target population.
    - Reference strategies to
        - Reduce disparities in behavioral health outcomes,
        - Incorporate trainings in using data to inform program, and
        - Include a plan to evaluate the impact of cultural trainings on client-level program outcomes.
    - Collaborate with the LGU to identify at-risk populations and populations with MEB disorders, set targets for the number/proportion of the population who will receive evidence-based interventions tailored for the population and
    - Describe how they will share the data with communities and partner agencies/organizations.

- Demonstrate awareness of disparities (i.e., social, ethnic, economic) in depression care access and outcomes in the target population and strategies to close them and monitor and improve effectiveness in doing so
    - Reference, in particular, how the program evaluation and tracking will include race-ethnicity-specific outcomes data; and how the PPS will identify, track and execute strategies to reduce disparities in behavioral health outcomes.
    - Describes how the PPS will incorporate such training in collecting, disseminating, and using such data to inform program (whether in areas of promotion, prevention, or treatment).
    - For proposals that include cultural and linguistic training, include a plan to evaluate the impact of the training on client-level program outcomes.
- Conduct robust population needs assessments that capture need and track impact of PPS responses. The PPS would preferably rely on standard and accepted methods to describe those needs such as measuring the attributable fraction of different conditions to their population's health, such as DALYs, YPLL, etc.

- *Sector Project 1:* Participate in MEB health promotion and MEB disorder prevention partnerships.
    - A strong application would address partnerships with a range of community organizations, stakeholders, and key leaders from affected communities.
    - ❖ Strong applications would organize these partnerships around advancing preventive and promotion priorities in behavioral health with the potential to have high impact:
        - Reducing underage and excessive alcohol use in communities
        - Reducing the prevalence of tobacco use among populations with serious mental illness
        - Promoting successful early child development through policies/programs that promote parent coaching and interventions to identify and reduce maternal depression
    - ❖ A strong application will: reference evidence-based methods to create and implement partnership, preferably rely on accepted methods to measure attributable risk/disease burdens to specific populations (e.g. DALYs, YPLL), and will identify ways to identify the impact of these partnership on the health of their populations, and the priorities and targets they specify.
    - ❖ Measuring and tracking population need may be enhanced through innovative partnership with the LGU.

- ❖ *Sector Project 2*: Expand efforts with DOH and OMH to implement 'Collaborative Care' in primary care settings throughout NYS.
    - Describe plan to ensure staff and leadership effort(s) to participate in proven implementation activities around collaborative care with state agencies (DOH, OMH) and/or LGU agencies (DOHMH); these activities might include: learning collaboratives, data collection/sharing, best practices sharing, training
    - Demonstrate awareness of disparities (ie social, ethnic, economic) in depression care access and outcomes in the target population and strategies to close them and monitor and improve effectiveness in doing so.
- ❖ *Sector Project 3:* Provide cultural and linguistic training on MEB health promotion, prevention and treatment.
    - A strong application references in particular how their program evaluation and tracking will include race-ethnicity-specific outcomes data; and how the PPS will identify, track and execute strategies to reduce disparities in behavioral health outcomes.
    - The proposal describes how the PPS will incorporate such training in collecting, disseminating, and using such data to inform program (whether in areas of promotion, prevention, or treatment).
    - Proposals that include cultural and linguistic training need to include a plan to evaluate the impact of the training on client-level program outcomes.

- ❖ *Sector Project 4:* Share data and information on MEB health promotion and MEB disorder prevention and treatment.
    - Robust population needs assessments that capture need and track impact of responses by the PPS are described and PPS would preferably rely on standard and accepted methods to describe those needs such as measuring the attributable fraction of different conditions to their population's health, such as DALYs, YPLL.
    - Measuring and tracking population needs may be enhanced through innovative partnership with the LGU.
    - PPS's would therefore implement a plan to identify their at-risk populations, and their populations with these disorders.
    - PPS should set targets for the number/proportion of the population who will receive interventions (prevention/promotion; treatment), describe how they will track and report on these targets, and how they will respond if targets are not met.
    - Interventions should be evidence-based, and tailored for the populations.
    - PPS should describe how they will share these data with communities and partner agencies/organizations.
    - Data gathering and sharing would preferably advance preventive and promotion priorities in behavioral health with the potential to have high impact: such as: reducing underage and excessive alcohol use in communities; reducing the prevalence of tobacco use among populations with serious mental illness; promoting successful early child development through policies/programs that promote parent coaching and interventions to identify and reduce maternal depression

4.b.i

- The best applications will include plans for comprehensive implementation of the 5 A's of tobacco control, which should include: 1) utilizing an EHR that captures and prompts screening and treatment at every visit; 2) instituting routine tobacco use treatment training for all health care team members; 3) designing workflows (e.g., non-physician staff delivering counseling on-site) to optimize delivery of tobacco use treatment; 4) incorporating follow-up for on-going treatment support that minimizes lost to follow-up (e.g., Opt to Quit referral to the NYS Smokers Quit Line); 5) providing performance feedback reports using the EHR to increase screening and treatment rates.
- A strong application should:
    - Demonstrate an understanding of the unique needs of this population and use interventions tailored for behavioral health consumers, such as peer supported cessation models
    - Present strategies for tobacco cessation in behavioral health settings this context, such as ATTOC (Addressing Tobacco Through Organizational Change) that acknowledge systemic barriers

4.b.ii

- Suggest including language suggesting partnership with local jails to facilitate linkages to community preventive services for those being released to the community.
- Project Description and Justification b: Include language suggesting criminal-justice involved population as possible target population.

4.c.i

- Requirement 1: Add tobacco use as an example of disparities.
- Requirement 2: Add tobacco use as an example of other peer-led services.
- Requirement 9: Add tobacco use treatment as another example of an intervention directed at a high-risk individual patient
- A strong application should demonstrate established linkages with SDOH waivered Syringe Exchange Programs (SEP's) in New York City

4.c.ii

- Requirement 1: Add tobacco use as an example of disparities.
- Requirement 2: Add tobacco use as an example of other peer-led services.
- Requirement 9: Add tobacco use treatment as another example of an intervention directed at a high-risk individual patient
  - ❖ Successful applications will include the following somponents of the care coordination model:
    1. Patient Navigation to accompany clients to appointments, helping them navigate the health care system.
    2. Health Promotion to address risk reduction behaviors through a 16 module curriculum delivered in the client's home.
    3. Treatment Adherence to teach clients the importance of adherence to both medical appointments and medical regimens and help them do so by monitoring pill boxes and providing Directly Observed Therapy (DOT) if appropriate.
  - ❖ Care Coordination should target:
    1. Newly diagnosed
    2. Previously lost to care/never in care
    3. Irregularly in care
    4. With adherence issues (e.g., viral rebound, resistance)

Sector 1: Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.

- A strong application should demonstrate models of care:
  - To decrease HIV morbidity and disparities, **improve provider capacity to deliver PEP and PrEP**. There have been several studies evaluating the effectiveness of PrEP, as noted by the CDC[i].
  - To increase early access to care, decrease HIV morbidity and mortality by increasing the proportion of patients in the provider network who know their HIV status by participating in the **NY Knows** program.
  - To increase early access to care, implement Electronic Medical Record (EMR) changes throughout the network to **strengthen routine HIV testing**. PPS provider networks should incorporate the following documentation into the EMR:
    - # eligible clients receiving medical services in the month (eligible: Person age 13-64 years, without prior HIV diagnosis and not tested for HIV in last 12 months)
    - # eligible clients offered testing
    - # eligible accepting testing– if declined, reason for declination
    - # tested
    - # positive
    - # linked to care
  - To increase early access to care, use the CDC Anti-Retroviral Treatment and Access to Services (**ARTAS**) intervention. ARTAS is an individual-level, multi-session, time-limited intervention to link to medical care. It has demonstrated a higher proportion of successful linkage to medical care (78%) than the standard of care participants (60%) within 6 months.[ii]
  - To increase retention in care, use the **Care Coordination** model. Recent analyses have shown significant outcomes in engagement in care and viral load suppression for newly diagnosed and out of care individuals enrolled in these programs after 12 months.[iii] Care Coordination models should include:
    - Patient Navigation to accompany clients to appointments, helping them navigate the health care system.
    - Health Promotion to address risk reduction behaviors through a 16 module curriculum delivered in the client's home.

        - Treatment Adherence to teach clients the importance of adherence to both medical appointments and medical regimens and help them do so by monitoring pill boxes and providing Directly Observed Therapy (DOT) if appropriate.
    - To decrease HIV morbidity and disparities and to promote retention in HIV care, provide **financial incentives for Undetectable Viral Loads** for patients who continue to have chronically high viral loads after participation in interventions such as adherence counseling and care navigation. Individuals not responding to interventions such as ARTAS or Care Coordination may respond to financial incentives. Research has shown that financial reinforcement increases adherence.[iv]

Sector 3: Launch educational campaigns to improve health literacy and patient participation in healthcare.

- Social marketing for PLWHA to increase linkage, engagement in care, access to ART and adherence should include the following messages:
    - ART is available
    - Adherence leads to Viral Load Suppression (VLS)
    - VLS improves health outcomes
    - Early treatment improves morbidity and mortality
    - Treatment prevents HIV transmission
    - Making HIV care a priority

Sector 4: Design all interventions to address at least two co-factors.

- Studies have shown that housing provides a base from which people can access health care, reduce risk behaviors, adhere to treatment and link to social services, yet approximately half of all persons diagnosed with HIV in the US will face homelessness or an unstable housing situation at some point over the course of their illness.[v]
- Housing Placement Assistance for PLWHA is utilized to promote rapid rehousing of homeless and unstably housed individuals who frequently access emergency department and/or are hospitalized. Services may include:
    - Housing advocacy as immediate link to immediate emergency/transitional housing
    - Assessment of need for supportive housing due to comorbid conditions
    - Advocacy to assist in accessing benefits/entitlements
    - Housing advocacy to assist in obtaining supportive housing (e.g., NY/NY III, etc.)

Sector 5: Assure cultural competency training for providers.

- Between 35-40% of MSM in care do not report their same sex behaviors to medical providers.[vi] [vii] This lack of communication can lead to missed opportunities for preventive interventions such as Pre-Exposure Prophylaxis, HIV treatment, risk reduction counselling, and site-directed screening for sexually transmitted diseases.
- Provide cultural competency training for providers that includes training on:
    - Cultural competency
    - Cultural sensitivity
    - Sexuality
    - Gender identity
    - Completing a sexual history with patients

Sector 13: Promote delivery of HIV/STD Partner Services

- Partner Services (PS), the process of informing patients' sex or needle-sharing partners of their possible exposure to HIV, is an effective intervention for identifying previously undiagnosed cases of HIV infection and reducing HIV transmission.[viii] Persons aware that they are HIV-positive are more likely to protect their partners than those who are not aware of their status. PS by a medical provider or a health department public health staff is recommended over PS attempted by the patient.[ix]

- Facilitate connections with NYC DOHMH HIV and STD Partner Services Programs by:
    - Making Electronic Medical Record (EMR) adjustments that facilitate the timely and complete reporting of HIV and STD cases.
    - As appropriate, promoting the delivery of HIV/STD Partner Services to at risk individuals and their partners by providing designated space of NYC DOHMH Partner Services staff at sites with high volumes of at risk individual.

4.c.iii

- A strong application should demonstrate established linkages with SDOH waivered Syringe Exchange Programs (SEP's) in New York City.

4.d.i

- The best applications will include plans for comprehensive implementation of the 5 A's of tobacco control, which should include: 1) utilizing an EHR that captures and prompts screening and treatment at every visit; 2) instituting routine tobacco use treatment training for all health care team members; 3) designing workflows (e.g., non-physician staff delivering counseling on-site) to optimize delivery of tobacco use treatment ; 4) incorporating follow-up for on-going treatment support that minimizes lost to follow-up (e.g., Opt to Quit referral to the NYS Smokers Quit Line); 5) providing performance feedback reports using the EHR to increase screening and treatment rates. Specifically, tobacco use should be addressed at each prenatal visit, after delivery before discharge, and in the post-partum setting, including for those who quit during pregnancy since they are highly susceptible to relapse after delivery.

Section 5 - PPS Workforce Strategy

- This project notes that PPS are required to complete a more comprehensive assessment as part of Domain 1 process milestone. The current Domain 1 Milestones and Metrics document only includes metrics for domains 2 and 3. What is the timeframe for the provision of milestones and metrics for other sections?
- Strong responses in this section should incorporate results from analyses regarding the expected impact of workforce strategies on overall budget and business planning for the PPS.

Section 6: Data-Sharing, Confidentiality & Rapid Cycle Evaluation

- PPS plans for sharing "relevant patient information" should:
    - Address the need for seamless, highly-integrated information sharing protocols
    - Address the need to ensure confidentiality and maintain control over patient data.
    - Reflect strategies for managing information, including tiered access for different providers and strategies to segment or otherwise manage sensitive information.
    - Explicitly address the need to manage and share alcohol and other substance use disorder diagnosis and treatment information under 42 CFR Part 2.
- The application does not currently explicitly request information on the technical aspects of the data sharing plan. PPS should name the specific RHIO that participating providers will join, outline plans to achieve bidirectional data sharing, and address the specific data types that will be shared.

Section 7: PPS Cultural Competency/Health Literacy

- PPS responses should incorporate specific details regarding plans to monitor and track progress in this area, e.g. developing culturally and linguistically competent patient education materials, training health educators, developing templates in EHR or otherwise standardizing documentation practices.

Section 8: DSRIP Budget & Flow of Funds

- Strong applications will incorporate detailed budgeting analyses, including use of ratios (e.g. revenue to staff cost, revenue to COGS (cost of goods sold)) to demonstrate assessment of impact of changes in capacity as well as in workforce and evidence development of new business plans in response to revenue loss and changes in revenue streams due to implementation of DSRIP project plans.

- Strong responses in this section will include plans to engage community-based organizations and the community workforce
- Section 9: Financial Sustainability Plan

---

[i] http://www.cdc.gov/hiv/prevention/research/prep/

[ii] http://www.effectiveinterventions.org/Libraries/ARTAS_Materials/ARTAS_Fact_Sheetrev_12-0927.sflb.ashx

[iii] Irvine M, et al. (2014). Robust short-term effectiveness of a comprehensive HIV care coordination program in New York City (NYC). Oral presentation (Abstract 363), IAPAC, Miami, FL.

[iv] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3432682/

[v] http://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-operational-plan-hud.pdf

[vi] Bernstein KT, et al. Same-sex attraction disclosure to health care providers among New York City men who have sex with men: implications for HIV testing approaches. Arch Intern Med. 2008 Jul 14;168(13):1458-64.

[vii] Mehta SA et al. Awareness of post-exposure HIV prophylaxis in high-risk men who have sex with men in New York City. Sex Transm Infect. 2011 Jun;87(4):344-8.

[viii] Hogben, M, et al. The Effectiveness of HIV Partner Counseling and Referral Services in Increasing Identification of HIV Positive Individuals. Am J Prev Med 2007;33(2S)

[ix] Malave MC, et al. "Human Immunodeficiency Virus Partner Elicitation and Notification in New York City: Public Health Does It Better. Sex Transm Dis. 2008 Oct;35(10):869-76.

From: Samir D'Sa [mailto:sdsa@xghealth.com]
Sent: Friday, October 24, 2014 1:25 PM
To: us-albadvrcdsripsup@kpmg.com; doh.sm.delivery.system.reform.incentive.payment.program; doh.sm.DSRIPApp
Cc: Jamilkowski, Jennifer; Kristie.Golden@STONYBROOKMEDICINE.EDU; Charles Baumgart; Philip Wirtjes; Ladd, Ilene G.
Subject: DOH Q5) Details on budgets by project

DOH Application Support Team –

In context of the Suffolk PPS, the project teams have asked us if a detailed budgeted is needed for each individual project by 12/16. We understand that the project portion of the application requires a Y/N answer for the capital budget along with the rationale for requesting capital funding. We also understand that the organizational application pages 20 and 28 do reference some budgetary estimates.

Our approach is as follows:

- In the time available it may be very hard to develop a very detailed budget by 12/16
- So for 12/16,
    - For the project applications, we currently plan to submit a high level estimate of the capital budget needed
    - For table on Pg 28 of the Org. Application, we currently plan to submit just the percentage break down as requested
    - For table on Pg 20 of the Org. Application, we currently plan to submit the best estimates available (but not project by project budgetary details)

Q1) Can you confirm this approach above works?
Q2) We want to confirm with you if a precise figure is needed for capital budgets and if this can be changed later when the detailed implementation plan is being built for 4/1/15?

We would like the official DOH perspective on this.

Best,
Samir

Samir D'Sa
Sr. Director, Advisory Services
xG Health Solutions
m: (734) 546-2580
sdsa@xghealth.com

From: Maynor, Brenda [mailto:Brenda.Maynor@smha.org]
Sent: Sunday, October 26, 2014 12:33 PM
To: doh.sm.DSRIPApp
Subject: DSRIP Measure Specification and Reporting Manual available for public comment

Hi
Just a few comments re: Palliative Care integration into PCMH – metrics

1. All 5 metrics are designed and measured by NYS. OF all DSRIP domain 2 & 3 metric categories, Palliative Care is the only one where every metric is designed and measured by DOH. All the others are national standards….It is suggested that an agency like CAPC be used to determine palliative care metrics
2. Pain

    a. Risk Adjusted UAS Measure – It is unclear how risk adjustment applies to the measure or why below the performance goal for payment it is 'unadjusted". We need clarification
    b. For all 3 pain metrics – it is not clear on what the baseline is or when the measurement intervals are. With disease progression, in a substantial number of pts there will be pain and there will be onset of new and breakthrough pain related to disease progression.
    c. We do not see how the UAS assess "control" of pain. We should be measuring patient's satisfaction with their pain level, not the mere existence of pain.
3. Advance Directives – We do not see how the UAS captures conversations. It asks 2 questions on AD's, Is there a legal guardian?—odd language And is there an AD for certain interventions.
4. Depressive Feelings – the UAS is very simplistic relative to psychosocial distress related to advanced illness.

    a. Pt makes recurrent statements that something terrible is about to happen
    b. Patient expresses lack of any pleasure in life
    c. Pt has expressions of hopelessness

How does these questions relate or how a baseline and delta are arrived at? How are simple questions (ie: suffering a death of a loved one or learning they have a terminal prognosis) capturing our ability to support a patient successfully through these stresses and to assess more intensively care for a pt who is high risk for abuse or breakdown due to these circumstances?

We believe a more expert PC input into metric development.

Thank you for your time.
~Brenda

Brenda L. Maynor, MS, RN, LNC
Administrator of Care Coordination
St. Mary's Healthcare – Amsterdam
427 Guy Park Ave
Suite 304
Amsterdam, NY 12010
518-841-3896 (confidential VM)
518-770-7511 (confidential fax)

From: Kevin Holmes [mailto:kevinholmes943@gmail.com]
Sent: Monday, October 27, 2014 10:51 AM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.gov
Subject: RE: Comments on NYS DOH Draft Documents for Applying to DSRIP Funds

Dear Jason Helgerson, NYS
This letter is in response to the NYS DOH request for pulic comments which was released on September 29, 2014.

Comment #1: The DSRIP's goal is to reduce hospitalizations by 25% over a five year period. In order for this goal to be accomplished it will be very important for Community based Organizations and our peers to be able to go out into the community to reach our peers where they are most comfortable at in efforts to educate our community and keep them informed on preventive Health care.

Comment #2: Consumers and Non-clinical Community groups should be required to be included on local boards and DSRIP board.

Comment #3: we encourage the State to mandate that CBO's be included in PPS's contract to further cultural competency in our state medicaid system.

I thank the State for having this public comment period, however due to the amount of literature I would like to recommend the State to allocate enough time to effectively inform and communicate to the community how important the DSRIP is to the overall outcomes on their future health and wellness.

Thank You,
Kevin Holmes

From: Chevelle Wilson [mailto:chevellewilson50@yahoo.com]
Sent: Monday, October 27, 2014 11:04 AM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: Response for Public Comments on DSRIP PPA

This letter is in response to request by NYS DOH for comments which was released on Sept. 29, 2014.

My name is Chevelle Wilson, and I have been a peer educator at Health People, an award-winning community-based organization in the South Bronx, for over 3 years. I facilitate groups and conduct education in the community on health and wellness matters. As a peer educator, I know that peer education by community groups can work to prevent diseases and lower health costs. I should mention also that I am HIV+, on Medicaid with an assigned SNIPS plan, so I also know the importance of Medicaid to me and to my community.

My first comment is that I don't understand the materials you provided us to comment on. How am I supposed to understand about the DSRIP if I cannot even understand the whole process? I am more confused than ever about the Medicaid system and how it works. Does it really benefit me in the long run? What will these changes mean to me and to my community? What is a PPS and how will it involve community-based organizations and concerned citizens like me in the process? You need to let the people in the community have a voice and also provide for inclusion (in the process and distribution of DSRIP funds) to community-based organizations like ours.

Specifically, I recommend that you:

1. Release clear documents in easier language, more legible and using simpler terms. I'm not dumb -- this is just way too much absorb, particularly in such a short time.

2. Conduct outreach to the community which explains these changes to citizens who have Medicaid and are most affected by these changes, and finally

3. Extend the period for commenting, giving us a fair chance to voice our opinions.

Thank you.

Sincerely,
Chevelle Wilson

From: anisa greene [mailto:anisagreene60@gmail.com]
Sent: Monday, October 27, 2014 11:08 AM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Comments on the NYS DOH Draft Documents Applying to DSRIP Funds

Dear Jason Helgerson,

This letter is inresponse to the NYS DOH request for public comments which was released on September 29, 2014.

Comment #1: I would like the State to appoint a liaison that would be able to communicate the importance of DSRIP for Medicaid recipients.
Comment #2: I would like to see more consumer involvment on the PPS's and the DSRIP Govering body.
Comment #3:we wouldlike for the State to mandate that Community Based Organizations be included in the PPS's contract to durther cultural competency in our state.
Comment #4: the State need to conduct and advertise an outreach campaign for public comments, and that the public commenting period be extended so that citizens and Community based organizations have a fair chance to consider the very important subject at hand - and respond.

Thank You,
Robert Jones

From: anisa greene [mailto:anisagreene60@gmail.com]
Sent: Monday, October 27, 2014 11:34 AM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Comments on the NYS DOH Draft Documents Applying to DSRIP Funds

Dear Jason Helgerson,

This letter is in response to the NYS DOH request for public comments which was released on September 29, 2014.

Comment# 1 I would like to encourage the state to make provisions that insist on PPS's subcontracting with community agencies for Evidence Based community services.

Comment# 2 I recommend the State to provide DSRIP funding Strategies to include ways for non-clinical community based organizations to be paid for partnering with PPS's.

Comment #3 Training for non-clinical community health workers, peer educators, and outreach workers should count for points in how PPS's are evaluated. Health workers at community leve are valuable, culturally competent, well informed assets that increase the effectiveness of health care delivery and while the application calls for cultural competency it leaves out this point.
we recommend that the state include a procedure for consumer and community participation. Consumers seem to be left out the governance body, and their involvement in the process essential to establishing the Goals of DSRIP, which is to lower avoidable hospitalizations by 25% over a 5 year period. Consumers and non-clinical community groups should be required on local boards and DSRIP boards.

I would like to thank the State for providing me with this opportunity to express my concerns through this public comment, however I must mention that the time allocated for the public comments was far too short due to the amount of documents one had to view and process.

Thank You,
Vanetta Mc Fadden

From: Susan Guzman [mailto:SusanGuzman@healthpeople.org]
Sent: Monday, October 27, 2014 12:33 PM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Public comments on the PPS's Project Plan Application/Evaluation

To Jason Helgerson, state

My name is Susan Guzman and I am the minority women's health project assistant coordinator at Health People this letter is the request for public comments.
After listening to this valuable information about funding and Medicaid, I have an idea of what can be done to overall improve our community with funds that can be used towards Health education.
We health people are a non profit organization which is community based. We help people in our community with, HIV issues diabetes prevention amongst many. Our work is so important to the community, only because we help guide those who are in need to the proper services or those who lack vital information. I f many non profit organization would get funded including health people we can save much more lives. Our work is much more bigger than one thinks, we have saved and touched many lives. I just feel we deserve to be funded because our work speaks for itself. Please help be part of the bigger picture. The current draft application for DSRIP funding notes that PPS's should follow up with referrals to community based organizations (CBO's) to document participation and behavioral health status changes. However, it makes no real mention or definition of the contracting process with CBOs.
I would like for the State to establish a structure for the PPS's that contains a clearly defined contracting relationship with non-clinical community based organizations for their work. Consumers and non-clinical community groups should be required to be included on the local PPS's, and DSRIP advisory boards. The state draft proposal is written in very hard to understand language and was released for public, or advertised to the public, until a month before comments were due, I would like for the state to mandate that CBO's be included in PPS's contract to further cultural competency in our state Medicaid system. I would like to recommend the state to conduct and advertise an outreach campaign for public comments, and that the public commenting period be extended so that citizens and community-based organizations have a fair chance to consider the very important subject at hand- and to respond.

Thank you,

Susan Guzman
Assistant Coordiantor
Health People
552 Southern Boulevard
Bronx, NY 10455
718-585-8585 ext. 234
SusanGuzman@HealthPeople.org
www.healthpeople.org

From: Susan Guzman [mailto:SusanGuzman@healthpeople.org]
Sent: Monday, October 27, 2014 12:38 PM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Public Comments on DSRIP PPS's Project Plan Applications/Evaluation.

To Jason Helgerson,

This letter is in response to the NYS DOH request for comments which was released on Sept 29, 2014.

Comment# 1 I would like the State to establish a structure for the PPS's that contains a clearly spelled out contracting process for non-clinical CBO's, including payments to the CBO's for their work

Comment # 2 Consumers and non-clinical community groups should be required to be included on the local PPS and DSRIP boards.

Comment # 3 the state should mandate that CBO's be included in PPS's contract to further cultural competency in our state Medicaid system.

Comment # 4 I would like to recommend that the state conduct and advertise an outreach campaign for public comments, and that the public commenting period be extended so that citizens and community-based organizations have a fair chance to consider the very important subject at hand- and to respond.

I feel that non profit organizations should have the right to be funded only because we do show much for our own people and community. I would love to see more peer mentors going out helping educating and advocating for those who have no voices. Peer educators play a big part in prevention, We want to educate and help them understand health and how to take care of themselves or prevent getting a chronic disease. We are the pieces to the puzzle and its so much bigger than one thinks.

I would like to thank the State for providing me the opportunity to voice my concerns, however due to the amount of documents I had to read through I feel the state did not allow enough time for the public comment.

Thank You,
Ryziel Wylie
Program Coordinator Health People's Arches YMI
Health People
552 Southern Boulevard
Bronx, NY 10455
718-585-8585 ext. 229
347-355-7375 cell#
RyzielWylie@HealthPeople.org
www.healthpeople.org

From: gwendolyn kennely [mailto:gwenboggie@yahoo.com]
Sent: Monday, October 27, 2014 12:46 PM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Comments on NYS DOH Draft Documents for Applying to DSRIP Funds

Dear Jason Helgerson,

This letter is in response to the NYS DOH request for comments which was released on September 29, 2014.

Comment #1: I feel people should have a voice when considering which project plans will be funded

Comment#2: when distributing literature is be broken down to the lowest terms of what is being stated in the literature. I ask that the State remember that the average grade level of people in my community is the 5th grade reading level, also when considering language and terms remember the cultural barrier that is there.

Comment #3: there should bee more publicized announcements when important issues around the future of health care and wellness is involved.My suggestion would be to hold town hall meetings to keep the people informed on very important issues which can determine their future health care.

Comment #4: I would like to encourage the State DOH to include Consumers on the local DSRIP Govering Boards and PAC.

I hope my comments will be taken into consideration when making the final rule on the PPA.

Thank You,
Gwendolyn Kennely

From: anisa greene [mailto:anisagreene60@gmail.com]
Sent: Monday, October 27, 2014 12:56 PM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Comments on NYS DOH Draft Documents for Applying to DSRIP Funds

Dear Jason Helgerson,

This letter is in response to the NYS DOH request for public comments which was released on September 29, 2014.

Comment# 1 I would like to encourage the state to make provisions that insist on PPS's subcontracting with community agencies for Evidence Based community services.

Comment# 2 I recommend the State to provide DSRIP funding Strategies to include ways for non-clinical community based organizations to be paid for partnering with PPS's.

Comment #3 Training for non-clinical community health workers, peer educators, and outreach workers should count for points in how PPS's are evaluated. Health workers at community leve are valuable, culturally competent, well informed assets that increase the effectiveness of health care delivery and while the application calls for cultural competency it leaves out this point.
we recommend that the state include a procedure for consumer and community participation. Consumers seem to be left out the governance body, and their involvement in the process essential to establishing the Goals of DSRIP, which is to lower avoidable hospitalizations by 25% over a 5 year period. Consumers and non-clinical community groups should be required on local boards and DSRIP boards.

I would like to thank the State for providing me with this opportunity to express my concerns through this public comment, however I must mention that the time allocated for the public comments was far too short due to the amount of documents one had to view and process.

Thank you,

Selina Norwood,

Peer mentor

From: Rosa Perpinan [mailto:rossi19629@hotmail.com]
Sent: Monday, October 27, 2014 1:51 PM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: Dsrip and how affects your community

I consider that language its complicated it should be simplify for the community to understand right policies. A simple way to understand so the community knows the changes let voice be heard.

From: Cooke, Bernard [mailto:Bernard.Cooke@stonybrookmedicine.edu]
Sent: Monday, October 27, 2014 2:56 PM
To: doh.sm.DSRIPApp
Subject: Financial Stability Test

Hi:

I downloaded the file. I don't see a tab to enter the financial iformation.

Am I missing something?

Thanks,

Bernie

To Jason Helgerson,

This letter is in response to the NYS DOH request for public comments which was released on Sept 29, 2014

Comment # 1 I would like the State to establish a structure for the PPS that contains a clearly defined contracting relationship with non-clinical CBOs, including payments to the CBOs for their hard work

Comment # 2 Consumers and non-clinical community groups should be required to be included on local PPS's and DSRIP boards.

Thank You,
Juan Hilrado

From: Onaje Muid [mailto:omuid@realityhouseny.org]
Sent: Monday, October 27, 2014 1:14 PM
To: doh.sm.DSRIPApp
Cc: hdepass@realityhouseny.org
Subject: FW: DSRIP Application Conference Call

Greetings,
I would like attend this webinar, do I need to do anything else to be registered?
Onaje Muid

From: Dileivis gomez [mailto:dileivisg@gmail.com]
Sent: Monday, October 27, 2014 6:17 PM
To: doh.sm.DSRIPApp
Subject: NYS DOH requests comments

To: Jason Helgerson, NYS

Re: Comments to NYS DOH Draft Documents for Applying to DSRIP Funds

This Letter is in response to request the NYS DOH requests comments which was released on Sept.29 2014.

Comment 1: The current draft application for DSRIP funding notes that PP'S should follow up with referrals to community-based organizations (CBOs) to document participation and behavioral health status changes. However, it makes no real mention or definition of the contracting process with CBOs.

RECOMMENDATION #1: Establish a structure for the PPS that contains a clearly spelled out contracting relationship with non-clinical CBOs, including payments to these CBOs for their work.

COMMENT 2: The state's current draft application for DSRIP funding does not provide a procedure for consumer and community participation. Yet, the involvement of consumers in the process is essential to meeting the goals of DSRIP, which is to lower avoidable hospitalizations by 25% over 5 years.

RECOMMENDATION 2: Consumer and non-clinical community groups should be required to be included on local boards and the DSRIP board.

COMMENT 3: The state does not seem to be striving to achieve cultural competency, as it not demanding that PPS's contract with the most culturally competent organizations, namely CBOs.

COMMENT 3: We recommend that the state mandate that CBO's be included in PPS's contract to further cultural competency in our State Medicaid System.

COMMENT 4: The state draft proposal is written in very hard to understand language and was released for public, or advertise to the public, until a month before comments were due.

COMMENT 4: We recommend that the state conduct and advertise an outreach campaign for public comments, and that the public commenting period be extended so that citizens and community-based organizations have a fair chance to consider the very important subject at hand-and to respond.

From: Hailu Assefa [mailto:hailu.assefa@aol.com]
Sent: Tuesday, October 28, 2014 8:53 AM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: Comments on NYS DOH Draft Documents

To Jason Helgerson, NYS

This letter is in response to NYS DOH request for comments on DSRIP Project Plan Application/Evaluations which was released on September 29, 2014.

Current language: Follow up with referrals to community based programs to document participation and behavioral health status change.

· How does the state propose to accomplish this when there is no real mention of or definition of the contracting process with CBO's?

Partnering and subcontracting:

· The state need to set provisions that insist on PPS's subcontracting with community agencies for Evidence-based Community Services.

· DSRIP funding strategy does not include ways for non clinical community based organizations to be paid for partnering with PPS's.
· Training of non clinical community health workers, peer educators, and outreach workers ***should*** count for points in how PPS's are evaluated. Health workers at the community level are valuable, culturally competent, well informed assets that increase the effectiveness of health care delivery and while the application calls for cultural competency, it leaves out this point.
· The current proposal does not provide a procedure for consumer and community participation. Consumers seem to be left out of the governance body, and their involvement in the process is essential to the goals of DSRIP, which are to lower avoidable hospitalizations by 25% over a 5 year period. Consumers and non clinical community groups should be required on local PPS and the DSRIP boards.

Cultural Competency:

· If the state itself isn't demanding that PPS's contract with the most culturally competent organizations, namely community based groups, then the state is not even trying to achieve cultural competency.

Leadership is Critical:

· Much of the success of each PPS will rely on the lead organization. This organization will need to be open to a changed way of providing care and functioning within a coalition effort. Large institutions are not typically comfortable sharing power and decision-making with others. Yet if that is not what happens, carrying out the mandates of this project for the five years of the waiver will be very difficult. **The structure of the PPS must clearly spell out the relationships as well as the power relationship.**
I would like to thank the state for providing an opportunity to comment on the DSRIP Project Plan Application/Evaluation Draft Documents, however I must mention the time allocated for the public comment period was not suffice, due to the amount of documents one had to review and digest.

Thank you
Hailu Assefa

From: LATISHA.GIBBS [mailto:LATISHA.GIBBS@lc.cuny.edu]
Sent: Tuesday, October 28, 2014 8:39 AM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE: Comments on DSRIP Project Plan Application/Evaluation Draft documents

To Jason Helgerson, NYS

This letter is in response to NYS DOH request for comments on DSRIP Project Plan Application/Evaluations which was released on September 29, 2014.

Current language: Follow up with referrals to community based programs to document participation and behavioral health status change.

· How does the state propose to accomplish this when there is no real mention of or definition of the contracting process with CBO's?

Partnering and subcontracting:

· The state need to set provisions that insist on PPS's subcontracting with community agencies for Evidence-based Community Services.

· DSRIP funding strategy does not include ways for non clinical community based organizations to be paid for partnering with PPS's.

· Training of non clinical community health workers, peer educators, and outreach workers ***should*** count for points in how PPS's are evaluated. Health workers at the community level are valuable, culturally competent, well informed assets that increase the effectiveness of health care delivery and while the application calls for cultural competency, it leaves out this point.

· The current proposal does not provide a procedure for consumer and community participation. Consumers seem to be left out of the governance body, and their involvement in the process is essential to the goals of DSRIP, which are to lower avoidable hospitalizations by 25% over a 5 year period. Consumers and non clinical community groups should be required on local PPS and the DSRIP boards.

Cultural Competency:

· If the state itself isn't demanding that PPS's contract with the most culturally competent organizations, namely community based groups, then the state is not even trying to achieve cultural competency.

Leadership is Critical:

· Much of the success of each PPS will rely on the lead organization. This organization will need to be open to a changed way of providing care and functioning within a coalition effort. Large institutions are not typically comfortable sharing power and decision-making with others. Yet if that is not what happens, carrying out the mandates of this project for the five years of the waiver will be very difficult. **The structure of the PPS must clearly spell out the relationships as well as the power relationship.**

I would like to thank the state for providing an opportunity to comment on the DSRIP Project Plan Application/Evaluation Draft Documents, however I must mention the time allocated for the public comment period was not suffice, due to the amount of documents one had to review and digest.

Thank You,
Latisha Gibbs

From: S Jardine [mailto:shari.jardine@gmail.com]
Sent: Tuesday, October 28, 2014 1:08 PM
To: doh.sm.DSRIPApp
Subject: Public Comment Response DSRIP PPA

This letter is in response to the Request the NYS DOH request comments which was released on September 29th 2014.

My name is Peggy Lloyd. I am a peer educator at Health People, located in the Bronx. I have been a peer educator at Health People for 3 years. I am also a consumer on Medicaid with an assigned health plan from Health First.

My comment is that the language of the draft is written in a way that I find hard to understand.

I think that it is important for consumers to be involved in this process of Medicaid reform. The solution to this problem would be to write the draft in layman's terms, so that I can understand how this reform may effect me.

I also think that it is important that peer education be included as a way for community organizations to deliver health services to the community.

My suggestion is that the proposal include ways for community based organizations to be paid, so that they can pay peers to deliver classes, advocate, and help to improve wellness. These community measures at the local level will help to reduce hospitalizations over the five year period, and make the community able to care for itself, with the knowledge that they gain through classes that I deliver teaching people how to stay healthy.

Thank you for your time and consideration.

Peggy Lloyd.

--
Shari Jardine, MPH

From: Shari Jardine [mailto:sharijardine@healthpeople.org]
Sent: Tuesday, October 28, 2014 1:38 PM
To: doh.sm.DSRIPApp
Subject: Response, Public Comment, DSRIP PPA

This email is in response to the request for public comment which ends tomorrow, October 29th, 2014.

I work at Health People, a community based organization in the South Bronx.

It is my personal opinion that with reference to contracting, there is no language that describes if and how local community organizations will be involved in the process. There is no description of subcontracting to local community organizations, and no description of how funding may be allocated. Without detailed procedures and instructions, how are local hospitals expected to subcontract to local community organizations? Local community organizations offer a unique perspective, they are tied to the community in a way that a hospital is not. It is important for non clinical community organizations to be involved in the distribution of DSRIP's funding if New York State wants to achieve its goal of reducing hospitalizations by 25% over 5 years.

Additionally, peer based education is severely underfunded in the South Bronx. We are the only organization in our area recognized by the CDC to deliver the NDPP, which is an effective way for pre-diabetic and diabetic individuals to lower their A1C levels by teaching them how to manage their lifestyle and eating habits. However, we struggle to find funding streams that will support the dissemination of this program to a community in desperate need of it. This is the case with many of our peer delivered interventions. There are mountains of research which support the validity of peer based health education, but limited resources for non clinical organizations to financially sustain these operations. Peer education has been proven to effectively improve health outcomes in the United States. The capacity for non clinical organizations to deliver this education in the communities which have grown to trust them is an important and essential part of DSRIP's achieving its 5 year goals. Therefore, peer education models and non clinical organizations need to be explicitly mentioned in the vocabulary of the DSRIP PPA. Furthermore, the development and expansion of peer based education programs (through the training of peer educators) should be a criteria by which PPS's can gain points towards their evaluation numbers.

Thank you for your time and consideration.

Shari Jardine
Program Developer/Assistant Manager
Health People
552 Southern Boulevard
Bronx, NY 10455
718-585-8585 ext. 237
ShariJardine@HealthPeople.org
www.healthpeople.org

From: anisa greene [mailto:anisagreene60@gmail.com]
Sent: Tuesday, October 28, 2014 9:06 PM
To: doh.sm.DSRIPApp; Helgerson, Jason (HEALTH); michael.melendez@cms.hhs.gov
Subject: RE:Comments on the DSRIP Draft Application/Evaluation

as a Consumer and community advocate of the South Bronx my concern are that the Performing Provider System application and evaluation fully fails to integrate community resources in any constructive, coherent fashion.

1. There are no provisions that insist on PPS's subcontracting with community agencies for evidence-based services. This will make it impossible to

bring education, prevention and engagement services into the community which have enormous evidence behind them---even, for example, self-care education

as well proven to reduce hospitalizations and costs as the Stanford suite of self-care courses (which not incidentally must have peers at least as co facilitators) People are simply not going to travel to hospitals for such services and therefore the plan almost negates making very effective and proven self-care/cost-reducing protocols truly accessible.

This also leads to some bizarre self-contradictions within the plan: it mentions **"working with"** and **"partnering"** with community-based organizations in many domains.

For example, Domain 3.b.i Evidence Based Strategies for Disease Management in High risk/ affected populations. (adults only).

calls for Follow up with referrals to community based programs to document participation and behavioral health status change and Domain 3.c.ii. calls for Implementation of evidence based strategies in the community to address chronic disease primary and secondary prevention projects (adults only):

Yet, the evaluation of funds use only states "Describe on a high level how the PPS plans to distribute funds…along the care continuum, such as SNFs, LTACs, and Home Care."

Since community-based organizations aren't included in the evaluated funding continuum, evidently their roles---although mentioned as key in several domains---are supposed to be free!

2. ***Equally important, in staffing and other application subjects receiving points,, such as patient engagement, the use of community groups that train local staff, from CHW's to peer educators to outreach workers, etc.---should be a clear part of what's evaluated for POINTS.*** Using these local staff/peers representative of communities and, especially, representative of the targeted Medicaid patients, including those with chronic disease, disability, HIV, and other highly prevalent conditions leads to successful engagement

and in-built cultural confidence. It is just silly to have applicants writing about how they will create cultural competency when the application and evaluation itself ***HAVE NOT TAKEN THE***

FIRST STEP TO CULTURAL COMPETENCY---which is making sure that the evaluation scoring includes the integration of local groups that are already culturally competent into the funds flow of every PPS!

3. **The negation of real community participation IS ALSO SEEN IN GOVERNANCE WHERE THERE IS NO PROVISION FOR ASSURING REPRESENTATION OF CONSUMERS AND COMMUNITY GROUPS ON local governing boards or the overall DSRIP board.** ***These people must be integrated in real governance---not shuffled off to the usual "advisory board."***

I appreciate the opportunity the State has Provided me with to voice my opinion and hopefully be heard so that the overall goals of Dsrip is met.

Thank you,

sabirah Greene

From: Nancy Jaeckels [mailto:njaeckels@healthmanagement.com]
Sent: Tuesday, October 28, 2014 5:35 PM
To: doh.sm.DSRIPApp
Subject: 2 questions I could not get in on the Q&A session today

Hello,

I kept pushing *1 today but could not get in on the question line. I have two quick questions:

1. In regards to measurement – besides the outcome metrics set for each project, is there any place on the application that we need to list any process metrics or interim outcomes for each project or is that left for the implementation phase planning?
2. Could you please clarify how the state is defining "co-location" of primary care/PCMH practice in the ED for Project 2.b.ii? Are there specific guidelines regarding proximity of the primary care services?

Thanks you ahead of time for your response.

Nancy

Nancy Jaeckels
Principal
HEALTH MANAGEMENT ASSOCIATES
180 N. LaSalle, Suite 2305
Chicago, IL 60601
Phone: 312.641.5007
Cell: 952-250-6269
Fax: 312.641.6678
njaeckels@healthmanagement.com
www.healthmanagement.com

From: **Anthony Minervino** <anthony_minervino@dsripfingerlakes.org>
Date: Thu, Oct 23, 2014 at 2:59 PM
Subject: Requesting Clarification on Projects 2biii & 3ai
To: dsrip@health.ny.gov, dsripapp@health.ny.gov

Hello,

Question #1:

From Domain 2.b.iii ED care triage – page 32 Measure #3 – Can you please clarify how the state defines and will measure "immediate" and "timely"

For patients presenting with minor illnesses who do not have a primary care provider:

a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.

b. Patient navigator will assist the patient with identifying and accessing needed community support resources.

c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).

Question #2:

From Domain 3.a.i behavioral health/primary care integration - page 62 & 64 metric 1 - is the intent truly to have co-location of services 100% of the time regardless of need or instead to the extent necessary to respond to an evaluation of need?

"Behavioral health(/primary care) services are co-located within PCMH(/behavioral health) practices during all practice hours"

Thank you,

Anthony

From: Melnik, Tom (HEALTH)
Sent: Tuesday, October 28, 2014 3:40 PM
To: doh.sm.DSRIPApp
Subject: NY State Draft DSRIP PPS Plan Application Conference Call

Hi. I just wanted to let you know that Jason's voice is coming through loud and clear, but it's hard to hear the other voices on the conference call. It may be a matter of getting the microphone closer to each speaker. Hope this is helpful.
Tom

From: Samir D'Sa
Sent: Monday, October 20, 2014 12:18 PM
To: 'us-albadvrcdsripsup@kpmg.com'; 'dsrip@health.state.ny.us'
Cc: 'Jamilkowski, Jennifer'; 'Golden, Kristie L'; Charles Baumgart; Ladd, Ilene G.; Philip Wirtjes; george.choriatis@rivkin.com
Subject: DOH Q3) Clarification ref: Scale sections (Defn of Committed)

DOH Team –

We would like to understand the **official DOH perspective** on the SCALE section of the Project Application.

In context of the Suffolk PPS, under section 2 of most project applications (SCALE section), there is a requirement that we fill out a "Number Committed". The number related to the number of providers – PCPs, Hospitals, BH sites etc. Could you help us with the Qs below:

1. What is the definition of "Number Committed"? Are you requiring the PPS to have verbal commitment, written commitment or something else?
2. If written commitment, is there some template language around what this commitment entails e.g., should the commitment be for 5 years of DSRIP, can it be shorter, is it a legal document you are seeking or something informal, …
3. Each project has a Provider Name and NPI table listed before Q1 of the application. Is your expectation that only the providers that are "committed" (as defined above) make it to this list?

Your quick response will be greatly appreciated.

Best,
Samir

Samir D'Sa
Sr. Director, Advisory Services
xG Health Solutions
m: (734) 546-2580
sdsa@xghealth.com

From: Samir D'Sa [mailto:sdsa@xghealth.com]
Sent: Tuesday, October 28, 2014 3:13 PM
To: doh.sm.DSRIPApp
Subject: FW: DOH Q2) Clarification Ref: Project 4.B.2

From: Samir D'Sa
Sent: Monday, October 20, 2014 11:51 AM
To: 'us-albadvrcdsripsup@kpmg.com'; 'dsrip@health.state.ny.us'
Cc: Jamilkowski, Jennifer; 'Gomes, Carol'; Charles Baumgart; Ladd, Ilene G.; Philip Wirtjes
Subject: DOH Q2) Clarification Ref: Project 4.B.2

DOH Team –

In context of the Suffolk PPS, there has been some internal discussion ref: Project 4.B.2 and we were hoping you might be able to provide us the **official DOH perspective** on the Qs below.

1) For project 4.B.2 (Chronic Prevention), we reviewed Attachment J on metrics. The chronic prevention metrics (21-29, pg 18) include obesity, smoking, colorectal screening, asthma, heart attack, and diabetes. Our first Q is should the project be designed to address all of these metrics or **can we pick a subset**? Is the latter an option?

2) If we can pick a subset and only pick cancer, the only metric for cancer is colorectal screening in Appendix J. Does this imply that other cancer screenings e.g., breast, lung, prostate etc. should not be included in the project write-up? If the project were focused on cancer, is the project going to be evaluated solely on colorectal screening data – regardless of whether we moved the needle on other cancer screening metrics?

We would greatly appreciate the **official DOH perspective** on this.

Best,
Samir

Samir D'Sa
Sr. Director, Advisory Services
xG Health Solutions
m: (734) 546-2580
sdsa@xghealth.com

From: Samir D'Sa [mailto:sdsa@xghealth.com]
Sent: Tuesday, October 28, 2014 3:12 PM
To: doh.sm.DSRIPApp
Subject: FW: DOH Q1) Clarification Ref: Are footnotes counted in word count?

From: Samir D'Sa
Sent: Monday, October 20, 2014 12:00 PM
To: 'us-albadvrcdsripsup@kpmg.com'; 'dsrip@health.state.ny.us'
Cc: 'Jamilkowski, Jennifer'; 'Golden, Kristie L'; Charles Baumgart; 'Ladd, Ilene G.'; Philip Wirtjes
Subject: DOH Q1) Clarification Ref: Are footnotes counted in word count?

DOH Team --

We are planning on using the footnote to denote references to literature and to data points in the CAN/ Other sources. 2 Qs:

1. Can some data be placed in the footnotes to optimize the 1000 or 1500 word limit of the narrative?
2. Will the words in the footnote NOT count towards the 1000 or 1500 word limits prescribed by the application?

We would greatly appreciate the **official DOH perspective** on this.

Best,
Samir

Samir D'Sa
Sr. Director, Advisory Services
xG Health Solutions
m: (734) 546-2580
sdsa@xghealth.com

From: Samir D'Sa [mailto:sdsa@xghealth.com]
Sent: Tuesday, October 28, 2014 3:09 PM
To: us-albadvrcdsripsup@kpmg.com; doh.sm.delivery.system.reform.incentive.payment.program; doh.sm.DSRIPApp
Cc: Charles Baumgart; Kristie.Golden@STONYBROOKMEDICINE.EDU; Jamilkowski, Jennifer; Philip Wirtjes; Ladd, Ilene G.
Subject: DOH Q7) How to compute number of PCPs

DOH DSRIP Application Team –

On behalf of the Suffolk PPS, we would like to know the following in computing the number of PCPs.

1. Does PCP include physicians and nurse practitioners? For e.g., if there are 5 PCPs and 2 NPs in a practice, does that add 7 to the number of PCPs in the SCALE section table of the application?
2. If there is a NP-only clinic, should we count those towards PCP count in the SCALE table?
3. Finally, should the number of "PCPs" (depending on the definition above) match up with the count in the Provider Name and NPI table at the beginning of the application

We would appreciate the official DOH response to this question.

Best,
Samir

Samir D'Sa
Sr. Director, Advisory Services
xG Health Solutions
m: (734) 546-2580
sdsa@xghealth.com

From: Apurvi Mehta [mailto:amehta1@numc.edu]
Sent: Tuesday, October 28, 2014 3:50 PM
To: doh.sm.DSRIPApp
Subject: question regarding DSRIP Financial Stability Test

To Whom It May Concern,

I downloaded the Financial Stability Excel tool, and enabled macros in the workbook. However, I am unable to open the "Financial Information" tab – I get an error message saying that the cell or chart is protected and therefore read-only. Can this issue be fixed?

Thank you.

Apurvi Mehta, MPH
Project Manager, DSRIP
NuHealth/Nassau University Medical Center
2201 Hempstead Turnpike
East Meadow, NY 11554
P: (516) 572-5518
amehta1@numc.edu

From: David Alpern [mailto:dav_alp@msn.com]
Sent: Wednesday, October 29, 2014 1:51 PM
To: doh.sm.DSRIPApp
Subject: DSRIP Must Include Community Health Organizations

The state should require that the PPS's integrate community groups, such as Health People/Community Preventive Health Institute. In the age of chronic disease, bringing real self-care and preventive education to the community is key to reducing hospitalizations and ill-health generally. As Health People has noted, six session self-care courses for diabetes are very well evaluated to slash health care costs and hospitalizations from complications such as blindness and foot amputations that so often accompany uncontrolled diabetes.

To go beyond better controlled illness to a real chance for real health, integrating community-based wellness, prevention and self-care in DSRIP is essential.

David Alpern / 350 E. 62nd St.-4T, NYC 10065

From: du Pont, Lammot [LduPont@manatt.com]
Received: Sunday, 19 Oct 2014, 0:10
To: Donnaruma, Julia [JDonnaruma@manatt.com]
CC: du Pont, Lammot [LduPont@manatt.com]; Boozang, Patricia [PBoozang@manatt.com]
Subject: Measure Specification and Reporting Manual

Julia,

Below are five questions that have emerged as "urgent" from our team leads and clients regarding the Measure Specification and Reporting Manual.

I vetted the questions with Laura, and they are ready to transmit to the state. There are a few other questions in the cue (see attached), but the questions below appear to be the most urgent and deserving of a timely state response.

Thank for your very much for your continued coordination efforts.

- Lammot

=========

Measure Specification and Reporting Manual Questions

Question 1: In the discussion of Performance Goals on the top of page 5, the Manual states, "If the Performing provider system's performance on the 2012 and 2013 data for the majority of any chosen Domain 3 metric set is within 10 percentage points or 1.5 standard deviations to the performance goals, the project would not be approved." Please confirm that 10 percentage points refers to the arithmetic difference between the performance goal and a PPS's current state? For example, if the performance goal for comprehensive diabetes care is 24% and the PPS has a current state of 30% on this metric, that would be considered a difference of 6 percentage points.

Question 2: In the discussion of Performance Goals on the top of page 5, the Manual states, "If the Performing provider system's performance on the 2012 and 2013 data for the majority of any chosen Domain 3 metric set is within 10 percentage points or 1.5 standard deviations to the performance goals, the project would not be approved." Does the term "majority" mean more than half of the measures? For example, if a PPS is within 10 percentage points or 1.5 SD for five of the nine measures for Domain 3.E. HIV/AIDS listed on page 23, does this constitute a "majority" and therefore the State would disapprove the PPS's selection of a project in Domain 3.E. However if a PPS is within 10 percentage points or 1.5 SD for four of the nine measures for Domain 3.E. HIV/AIDS listed on page 23, this does not constitute a "majority" and therefore the State would approve the PPS's selection of a project in Domain 3.E.

Also, does the "majority" apply only to the metrics for which baselines have been published in the metrics guidelines to date? For metrics that are TBD (in some cases the majority of metrics for a given project), it would be extremely challenging to evaluate how close or far PPSs are from the baseline.

Question 3: When will a PPS know if a project has been disapproved by the State? Also, if the State disapproves a project, can the PPS propose an alternative project?

Question 4: In Appendix A beginning on page 21, a number of the State-set performance goals are listed as "0.00 (2012 Data)" (e.g., diabetes PQI #1, asthma PQI #15, asthma PDI #14). Does the PQI rate of 0 mean that the 90th percentile zip codes have no PQI discharges in that category or is there another interpretation?

Question 5: For Domain 3 projects in which the PPS's performance on the 2012 and 2013 data for the majority of any chosen Domain 3 metric set is within 10 percentage points or 1.5 standard deviations to the performance goals, can the PPS request State approval of the project based on evidence of a "hot spot" in the PPS's region in which the performance on the 2012 and 2013 data for the majority of any chosen Domain 3 metric set is not within 10 percentage points or 1.5 standard deviations to the performance goals?

From: Paula McCoy-Pinderhughes [mailto:pam9075@nyp.org]
Sent: Wednesday, October 29, 2014 3:36 PM
To: doh.sm.DSRIPApp
Subject: Draft DSRIP PPS Plan Application - Public Comments

Please see our submission of comments as they pertain to the Draft DSRIP PPS Plan Application.

1) Is the 2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions project intended to serve both pediatric and adult patients? Or is it dependent on how we define our target population?
2) Referencing the CGCAHPS survey (question # 1) **"How often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?"** Does this mean the expectation is for specialists within the hospital to send information to the primary care provider? Our medical patients with chronic conditions may see 2 or 3 specialists during the course of a visit but generally the attending responsible for their care is on the medicine service and this would be the provider documenting any information in the discharge summary which would be sent forward to the next level of care provider. Kindly clarify what the expectation is with respect to the selected measure?
3) Is there any discussion regarding pushing back the December 16, 2014 deadline given that we've just received new attribution parameters and this impacts the way we analyze the Community Needs Assessment data to identify our target population?
4) The Project Requirement for Domain 3.e.i (HIV) is: "Seek designation as a Center of Excellence from the NYS DOH." However, there is no HIV Center of Excellence currently defined by NYS DOH. How can a PPS meet this requirement in the absence of such a definition?

5) Attribution questions: The state gives attribution preference to PCPs. But if a patient gets most of their visits at a hospital NPI, will the state consider us specialists or primary care docs? Or something inferior to both? The answer would significantly affect attribution numbers.
There are three possibilities:
The state treats institutional NPIs just like PCPs
The state treats institutional NPIs just like Specialists
The state treats institutional NPIs with a lower priority than specialists

6) We are aware that the state is submitting rule changes and requesting statutory language changes to make integrated care possible. Will these changes be ready by April 1, 2015 to allow primary care providers (MD/NP) to bill under an Article 31 clinic license for in clinic, mobile, home and community based services?

7) Will the state provide financial incentives for smaller agencies to join RHIOs?

8) Please indicate the expected timeline for engagement of patients within the project (%).
Note: Actively Engaged = number of participating patients presented at the ED and appropriately referred for medical screening examination and successfully redirected to PCP." Is this cumulative? Do we double count the same person in two different quarters? Is it sequential?

Thank you,
Paula McCoy-Pinderhughes
Senior Grant Writer
NewYork-Presbyterian
212.342.1542 (office)
212.927.8447 (fax)

From: Brandi_Phelan@uhs.org [mailto:Brandi_Phelan@uhs.org]
Sent: Thursday, October 30, 2014 2:31 PM
To: doh.sm.DSRIPApp
Subject: Financial Stability Test

Good afternoon. I went in to open the Financial Stability Test Application that was online and see that the document is only available as a PDF. Is there an editable document that can be emailed to us to complete?

Thank you.

Brandi Phelan
Office of the President
UHS Binghamton General Hospital
607-762-2260

From: Cheryl Perry [mailto:cperry@mvnhealth.com]
Sent: Wednesday, October 29, 2014 3:58 PM
To: doh.sm.mrtupdates
Subject: Faxton St. Luke's Re: DSRIP Financial Stability Test now available
Importance: High

** High Priority **

I have been told by Stephanie Lawrance of the DSRIP Support Team that Faxton St. Luke's does not have to complete the Financial Stability Stress Test. Although we, with 3 other PPSs, have submitted our letter to Jason Helgerson notifying him of our decision to become a single PPS were are not sure the impact if we do not submit these documents. Please expedite your response. We are working on the document at this time. Thank you:-)

I expect to pass through this world but once...any kindness I can show...let me do it now; let me not defer...for I shall not pass this way again. Stephen Grellet

Cheryl Perry, BS, BSN, MA, RN
Faxton-St. Luke's Healthcare
DSRIP Project Coordinator
Phone: 315-624-6153
FAX: 315-624-6456 (Temporary)
e-mail: cperry@mvnhealth.com

From: Donnaruma, Julia [mailto:JDonnaruma@manatt.com]
Sent: Friday, October 31, 2014 4:52 PM
To: doh.sm.DSRIPApp
Cc: Donnaruma, Julia
Subject: Question on DSRIP Scoring

Happy Halloween DSRIP Team –

We would appreciate your response to this.

In the scoring example provided in the DSRIP PPS Application Scoring Guide on page 9 and illustrated below, please provide a definition of Medicaid Beneficiaries in Column E.

More specifically is the value:

(1) the total attributed population in the PPS;

(2) the "Target Population"; or

(3) the "Actively Engaged Patients"?

From: Fargnoli, Stephanie [mailto:Stephanie.Fargnoli@suny.edu]
Sent: Tuesday, November 04, 2014 11:49 AM
To: doh.sm.DSRIPApp
Cc: Cuevas, Carlos (HEALTH); Matthews, Fred; McCabe, John; Wright, Stuart
Subject: Request Re: Upstate University Hospital Financial Stability Test
Importance: High

SUNY Upstate University Hospital (UUH) is the public hospital in Central New York that is leading the PPS development in the region.

Upstate fails the Phase I and Phase II of the financial stability test (FST) for technical reasons that do not accurately reflect its underlying financial stability. We request permission to submit "adjusted financials" for UUH, as described below.

UUH has received direct state support annually and has done so since 1986. State support is linked to fringe benefit costs, which are not covered for state employees of the hospital as they are for state employees of the university. The form and amount of hospital state support has changed from time to time, but it is linked to fringe benefit expense and has been available for 28 consecutive years. There is no reason to expect an interruption in direct state support for UUH.

Using GAAP, UUH reports state support as non operating revenue. In other words, it is not included in revenue that is offset by operating expenses, even though the state support is associated with UUH's fringe benefit expenses. Because of GAAP presentation, Upstate fails Phase I (and therefore, Phase II) of the FST.

When Upstate adjusts its financial statements, however, to present state support as operating revenue, Upstate passes both Phase I and Phase II. Upstate believes the adjusted financial information more accurately reflects its underlying financial position as a public hospital and as a lead entity for the PPS in Central New York.

We request permission to present UUH adjusted financials on the FST form, i.e., with state support shown as operating revenue, not as non operating revenue, accurately reflecting UUH's financial stability.

We look forward to hearing from you and would be happy to have a brief call to discuss more fully, if preferred. Thank you.

Kind regards,

Stephanie Fargnoli
Senior Director of Academic Health and Hospital Affairs
The State University of New York
State University Plaza - Albany, New York 12246
Tel: 518.320.1660
Be a part of Generation SUNY: ***Facebook*** **-** ***Twitter*** **-** ***YouTube***

From: Samir D'Sa [mailto:sdsa@xghealth.com]
Sent: Monday, November 03, 2014 11:55 AM
To: us-albadvrcdsripsup@kpmg.com; doh.sm.delivery.system.reform.incentive.payment.program; doh.sm.DSRIPApp
Cc: Charles Baumgart; Kristie.Golden@STONYBROOKMEDICINE.EDU; Jamilkowski, Jennifer; Philip Wirtjes; Ladd, Ilene G.; Niegelberg, Eric
Subject: DOH Q8) List of Providers in the 2.B.4 and 2.B.9 projects

DOH DSRIP Application Team –

On behalf of the Suffolk PPS, we would like to know if the table that lists "Partners participating in the project" for projects 2.B.4 (Care Transitions) and 2.B.9 (Observation Units) should only list hospitals or if it should also contain other community resources.

The reason we ask is that the SCALE section of both projects only lists "Hospitals participating in the project", so we wanted to confirm if the count in the SCALE section (for hospitals) should match the list for which Names/ NPIs are requested in the participating partners table.

We would appreciate the official DOH response to this question.

Best,
Samir

Samir D'Sa
Sr. Director, Advisory Services
xG Health Solutions
m: (734) 546-2580
sdsa@xghealth.com

Attention: DSRIP Application Team October 28, 2014
Subject: DSRIP Application Public Comment

Thank you for the opportunity to provide comment on the DSRIP application on behalf of the many PPS partners across the North Country Initiative's Tug Hill Seaway region. The DSRIP will build the base for comprehensive change to healthcare delivery in our region; moving from a healthcare system to a system for health. This is the right thing to do and we appreciate the effort that has been put in by all.

In light of this, it is critical that the scoring and technical areas of the application support sustainable system transformation across all of NYS, both rural and urban. Thank you for the opportunity to speak to the application on behalf of the rural providers and rural residents we serve.

General Comments

Scoring: Scoring applications based on the raw number of providers participating not in relation to the number of providers in the PPS service region disproportionately disadvantages rural PPSs. A PPS serving a large geographic rural region with every provider participating, with strong governance and well-formed clear measurable objectives based on population need will score lower across every project simply based on rurality. DSRIP project funding is per-member-per-month (PMPM) thus larger urban PPSs will, and should, receive more funding because they have more concentrated populations and more attribution, they do not need a secondary advantage by scoring rural PPS's lower automatically reducing the PMPM potential of the rural project initiatives.

The concept that large urban providers will need a greater PMPM to serve their attributed patient population does not conform to the logic used to reduce PMPM as the greater number of projects are undertaken due to economy of scale. It will take all of the PMPM to consistently and measurably achieve the outcomes of the projects for both the largest and the smallest PPSs. Significant reductions in this based on scoring will put projects at risk.

Application scoring should be based on the ability of the PPS to effectively carry out the proposed activities to transform the health system and improve the health outcomes of the total attributed population served.

Funding Distribution – Application Scoring Impact: Section 8 budgeting and funding distribution percentages will be based on PMPM project expectations. Project implementation costs and revenue losses are fixed costs to achieve DSRIP outcomes. If application scoring causes a significant reduction in PMPM, the percentage of payment required to cover fixed costs will increase which will decrease the

120 Washington Street, Suite 230
Watertown, New York 13601
www.fdrhpo.org
(315) 755-2020 office
(315) 755-2022 fax

remaining percentage available for incentive payments to internal PPS providers. It is clearly understood by the NYSDOH DSRIP team that realigning provider incentives is the key to Delivery System Reform success. This unintended consequence of the scoring mechanism and its impact on valuation must be thought through if the DSRIP is to be successful.

Specific Comments

2.b.iv. Care transitions intervention to reduce 30 day readmissions for chronic health conditions.
Domain 1 DSRIP Project Requirements Milestones and Metrics:

Page 31 – Project Requirement 1 – Develop standardized protocols for Care Transitions Intervention Model with all participating hospitals, partnering with home care service or other appropriate community agency. **The data source does not match the project this appears to be a copy and paste error from PCMH requirement areas (i.e. page 6 project 1, page 15 project 3 etc).** If PCMH achievement at Primary Care practices is a requirement to develop Care Transition Intervention Models at Hospitals this will significantly impact the speed of implementation for Care Transitions Models which can be rapidly developed and deployed. PCMH Level 3 certification may take practices 1-3 years depending on current status.

3.a.i. Integration of Primary Care and Behavioral Health Services
Domain 1 DSRIP Project Requirements Milestones and Metrics:

Pages 62 (Model 1) and 64 (Model 2) Project Requirement 1 – The Metric/deliverable is defined as "**co-located services during all practice hours**". **When asked during Q&A, both Jason Helgerson and the NYSDOH OPCHSM, indicated this is not intended to be the requirement, thus it is our understanding this is an error on the application that requires a simple modification.** If not, a requirement for co-location of primary care and behavioral health during all practice hours will preclude the integration of primary care and behavioral health in all but the most urban settings. It would be an inefficient use of resources to place a primary care provider at a BH clinic during all hours of operation as there would not be sustainable volume to utilize the capacity or vice versa.

Pages 62 (Model 1) and 65 (Model 2) Project Requirement 3, and Page 67 (Model 3) Project Requirement 5 – The metric/deliverable of **"100% of individuals receive screenings (SBIRT, PHQ(etc) at project sites" is unattainable**. There is no certifying or quality agency that requires 100% screening as a metric – this requirement would preclude any PPS from meeting the deliverable. The NCQA 2014 requirement for documentation of PHQ-9 (or other depression screening) is a practice generated report (or medical record review if EMR cannot generate the report) with a

numerator and denominator based on unique patients in a 3 month period, that indicates that more than 50% were screened. Since each of these screenings are meant to be periodic preventive screening tools it would be unnecessarily burdensome on both patients and providers to expect screening at every visit without evidence of improved outcomes over periodic screening. The **NCI medical director and medical management committee recommend that the NCQA 2014 requirement of more than 50% of unique patients seen in a 3 month period be adopted as the appropriate metric/deliverable for this project**.

3.a.i. Integration of Primary Care and Behavioral Health Services

Program application page 87 section C. IMPACT Model 4. Designate a "Psychiatrist" and Domain 1 DSRIP Project Requirements Milestones and Metrics:
Page 67 (Model 3) Project Requirement 4

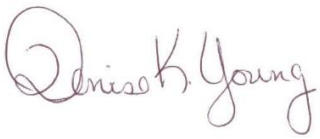
Based on the new scope of practice under the Nurse Practitioner Modernization Act which takes effect January 1. 2015 which allows Nurse Practitioners with > 3600 hours of practice to operate without a Written Practice Agreement and the shortages of Psychiatrist across NYS, we would request that this section be modified to read a "Psychiatrist or Psychiatric Nurse Practitioner".

3.b.i. & 3.c.i. Evidenced-Based Strategies for Disease Management in High-Risk/Affected Populations

This is a more generalized concern expressed by the physician leadership and the medical management committee that the NYSDOH DSRIP team be cognizant of the fact that the strategies of the Millions Heart Campaign are good today but that medicine is a growing and changing field and the PPS's physician medical management/quality committees must be able to adopt the best clinical guidelines and disease management protocols as they evolve and should not be tied to implementing what may become outdated and no longer best-practice guidelines for 5 years.

Again, thank you to all on the NYS DSRIP team who are leading the way along a very difficult process. We look forward to assisting the people of our region to engage with a transformed system for health and to assisting our providers and community organizations to successfully achieve that transformation. Please contact us at (315) 755-2020 if further clarification on any of the above is required. Thank you for your time and consideration.

Respectfully submitted,



Denise K. Young

Family Planning Advocates
of New York State

Comments on the Draft Plan Application for the Delivery System Reform Incentive Payment Program
October 29, 2014

Family Planning Advocates of New York State (FPA) appreciates the opportunity to provide the following comments on the Delivery System Reform Incentive Payment Program (DSRIP) Draft Plan Application.

Seizing Every Opportunity to Expand Access to High Quality Primary Care

Enhanced access to high quality primary care services can have profound and far reaching effects for patients, providers and the health care delivery system as a whole. It is therefore not surprising that this is a central component of DSRIP, an emphasis that will drive systemic change in the health care delivery system in New York. Successful implementation however, will require a system that is not only transformative but also reflective of diverse access points, and responsive to the primary care needs of all. FPA maintains great concern that the current construct of primary care within DSRIP fails to acknowledge how women of reproductive age access primary and preventive care. Such failure could have a devastating impact on access to needed health care services from a network of safety-net providers the state has relied upon for decades.

For millions of women of reproductive age, reproductive health focused providers like family planning providers or OB/GYNs, play a critical role in providing primary and preventive care. According to the Guttmacher Institute, six in 10 women who obtain care at a family planning center consider it their usual source of medical care, and for four in 10, that center is their only source of care.[1] Contained within this data point is an important fact, women often choose to receive their reproductive care from a family planning or OB/GYN provider, over a more "traditional" comprehensive primary care setting. Furthermore, recent research conducted by Planned Parenthood Federation of America underscores the importance of developing policies that increase access to OB/GYN providers – including family planning providers – as a way of safe-guarding the important relationship many women have with their OB/GYNs.[2] When it comes to the health care women needed most over the last two years, women said they needed the type of care that OB/GYNs provide; 56% stated they needed an annual exam, nearly half said they needed a Pap test, and one-third said they needed birth control. Furthermore, by a 16-point margin, women say they are more likely to be open and honest with their OB/GYN provider than other providers. Comprehensive providers may not always be the most comfortable in counseling on contraceptive methods compared to reproductive health focused providers and may lack immediate access to a broad range of contraceptive methods and/or the expertise to

[1] Guttmacher Institute, Moving Forward: Family Planning in the Era of Health Reform, 2014, http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf, accessed May 14, 2014.
[2] Planned Parenthood Federation of America. *Ob-Gyn Providers and Their Role in the Health Care Delivery System*, Summary of Research

insert highly effective devices to facilitate timely initiation.[3] In light of these facts, it is clear that reproductive-focused providers play an important role in the primary and preventive health care delivery system when it comes to influencing key behaviors that can have a lasting impact on population health outcomes, such as prevention of unintended pregnancy and the corollary reduction of preterm birth.

Policy, payment and practice in the state of New York reinforce this role. In Medicaid and commercial insurance alike, women are granted two primary care providers, a comprehensive or more "traditional" primary care provider, and a reproductive health focused provider. Direct access to reproductive health focused providers, and the free access policy within Medicaid point to the value placed on the services rendered by these providers and the importance of broad access points that allow for timely entry into the health care delivery system. In the effort to appropriately emphasize primary and preventative care to improve population health and achieve the Triple Aim, we cannot lose sight of the inherent value reproductive health focused providers bring to this effort. However, within the DSRIP there are notable places where this occurs, specifically the emphasis on enhanced access to high quality primary care from providers who meet NCQA 2014 Level Three Patient Centered Medical Home (PCMH) Accreditation and/or state-determined criteria for Advanced Primary Care Models (APCM).

For a variety of reasons, reproductive health focused providers are unable and unlikely to achieve these models that are clearly developed for "traditional" primary care delivery. With 55% of New York's Medicaid population being women,[4] and 70% of those being of reproductive age[5], ensuring these critical primary and preventive health care providers are substantively included in significant DSRIP projects is critical to maintaining direct access points to needed health care services and the overall success of the program. To that end we recommend that the state implement the following:

- Alteration of project requirements and metrics to be inclusive of women's health care providers who meet the NCQA Patient-Centered Specialty Designation.

- Flexibility within project requirements and metrics to enable a discrete segment of primary and preventive care providers to demonstrate reasonable levels of care coordination, health information exchange, implementation of preventive screening protocols, open access scheduling and adherence to evidence based practices without needing to meet the requirement to achieve Level 3 PCMH or APCM accreditation. This will facilitate the engagement of a segment of key providers thereby preserving critical access points. This limited flexibility will also result in a more realistic goal for PPS while conserving the overall intent to achieve higher quality primary care.
    - *Example: Project 2.a.i: Create an Integrated Delivery System focused on Evidence Based Medicine and Population Health Management*
      It is an unfortunate but true fact that health care coverage does not equate access to, or utilization of, health care services. The same logic can be applied to integration. While there

---

[3] Frost JJ, Gold RB and Bucek A, *Specialized family planning clinics in the United States: Why women choose them and their role in meeting women's health care needs*, Women's Health Issues, 2012, 22(6): e519-e525

[4] The Henry J. Kaiser Family Foundation. Medicaid Enrollment by Gender, FY2010, http://kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender/?state=NY, accessed October 27, 2014.

[5] The Henry J. Kaiser Family Foundation. Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act, December 2012, http://files.kff.org/attachment/medicaid-role-for-women-across-the-lifespan-issue-brief, accessed October 27 2014.

are inherit benefits to more formally integrated systems, integrated systems that do not reflect the health care needs of all, will fail to fully actualize these benefits. These integrated systems should be informed by the utilization practices and preferences of those it seeks to serve. A typical woman spends three decades avoiding pregnancy.[6] A key concern during reproductive years that as stated previously, is often purposely addressed with a reproductive health-focused provider over a "traditional" primary care setting. A reproductive health focused provider's ability to successfully participate within an integrated system and deliver the goal of "high quality care in the right setting at the right time and at an appropriate cost" is not intrinsically linked to achievement of PCMH Level 3 accreditation. A reproductive health focused provider is capable of delivering evidence-based services addressing the patient's reproductive health care needs and appropriately connecting the patient to other providers in the integrated delivery system (IDS) should the health assessment and preventive screenings indicate. An IDS that has limited flexibility to allow for the substantive involvement of a segment of reproductive health-focused providers who are not PCMH or APCM could better meet the needs of women of reproductive age, supporting not compromising the intent of the project.

- *Example: Project 3.a.i: Integration of Primary Care and Behavioral Health Services*
  As a source for primary and preventive health care for women, reproductive health focused providers can play an important role in the integration of primary care and behavioral health services. By nature of the services provided, family planning providers often care for patients that are taking part in risky behaviors. Their staff, who are trained to discuss sensitive subjects compassionately with patients, have a solid foundation for delivering screening and, when appropriate, referral information for individuals in need of substance abuse services. This model can be further advanced by support for bi-directional colocation. As stated previously, sufficient demonstration of appropriate care coordination, sharing of clinical information and adherence to evidence based practices without the requirement to be an accredited Level 3 PCMH or APCM, would facilitate further integration of these services while maintaining the broader goal of the project.

- Clearly articulate the importance of PPS including reproductive health focused providers in the assessment of health care resources that are available within the service area during the conduction of the Community Needs Assessment (CNA). Furthermore, given the corollary relationship between unintended pregnancy and adverse maternal and infant health outcomes, the state should require PPS to explore the impact of unintended pregnancy as a component of maternal health outcomes in their CNA. This focus will help ensure reproductive health care issues are appropriately assessed in CNA across PPS and highlight the role these providers can play in meeting key population health outcomes within various DSRIP projects.

- Emphasis on the inclusion of reproductive health-focused providers and insurance coverage options (i.e. Family Planning Benefit Program and Family Planning Extension Program) in the development of resource guides and supportive training materials in projects that reflect care coordination or navigation.

- Require in 2.d.i that PPS reconnect female beneficiaries to both their "traditional" PCP, as well as any designated reproductive health-focused provider. This dual reconnection will most appropriately reflect the way in which women of reproductive age access primary and preventive health services and

[6] Ibid.

reinforces the policy, practice and payment system that has been a cornerstone to timely access to reproductive health care services in the state of New York.

Sharing Health Information Raises Concerns about Patient Confidentiality

Family planning providers have some concerns about the requirement for sharing health information between participants in DSRIP projects. While the benefits of sharing health information can be enormous, we cannot lose sight of the importance that many patients place on confidentiality. This is a particular concern for minor patients, many of whom will not seek care if they cannot be guaranteed confidentiality[7], but is also a concern for adult patients, particularly patients who have had an abortion.[8] Many of these patients seek care from family planning centers because of the guarantee of confidentiality. While family planning providers recognize the importance of sharing most clinical information, the current inability to tag and segregate data causes trepidation about the impacts on patients who will have this data revealed to other providers in situations where it may not be relevant to the care being provided.

We are aware that the state is working on technical solutions that would allow for tagging and segregating data, and fully support this effort. FPA also supports educating health care providers, particularly providers who are not generally involved in the provision of reproductive health services, about the laws regarding the confidentiality of minor consent services, prohibitions on revealing such information to parents or guardians and the importance of being sensitive to patient concerns about their ability to receive reproductive health services in confidence. FPA would welcome the opportunity to work with the state to find solutions that will meet the goals of DSRIP while also ensuring patients are not deterred from seeking reproductive health services because of a fear of a loss of confidentiality. The State already has recognized these concerns in the proposed SHIN-NY regulation by including an exemption from the requirement that all licensed health care providers connect to the SHIN-NY within two years of the adoption of a final rule. We feel including a partial exemption from sharing all health information until the ability to tag and segregate data is accomplished in DSRIP is also appropriate.

***

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

---

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

[8] Frost J, Gold R, Bucek A, Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs, *Women's Health Issues,* Vol 22, Issue 6:e519-e525, 2012; Weitz TA, Cockrill K, Abortion clinic patients' opinions about obtaining abortions from general women's health care providers, *Patient Educ Couns,* 2010 Dec, 81(3):409-414.

Family Planning Advocates of New York State represents the state's family planning provider network in New York. Our provider members include the state's Planned Parenthood affiliates, hospital and county based health systems and community health centers that collectively represent an integral part of New York's health care safety net for uninsured and underinsured women and men. Often the entry-point into the health care system for primary and preventive care, family planning centers provide critical health services such as well-woman exams, contraception, pregnancy testing, prenatal and postpartum care, health education, abortion, treatment and counseling for sexually transmitted infections, HIV testing and prevention counseling, as well as breast and cervical cancer screenings.

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

October
Twenty-Nine
2014

Jason Helgerson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgerson:

Thank you for the opportunity to provide comments on the Delivery System Reform Incentive Payment (DSRIP) Draft Application and Scoring Guide. The Department of Health (DOH) and the Public Consulting Group (PCG) did an outstanding job putting these materials together in a very short timeframe. Our comments are organized in accordance with the four separate documents that form the draft application materials:

Part 1 - PPS Organizational Application
Part 2 - Project Plan Applications
Part 3 - Domain 1 Project Requirements Milestones and Metrics
Part 4 - PPS Application Scoring Guide

We are available for further discussion on any of our comments, particularly those that are technical in nature.

We look forward to continuing to work with you on DSRIP implementation. Please contact Kathleen Shure at 212-506-5407 or kshure@gnyha.org with any questions.

Sincerely,

Kenneth E. Raske
President

PART 1 – PPS ORGANIZATIONAL APPLICATION

Section 1 – Executive Summary

The Executive Summary is a pass/fail section with no point scoring. Applicants are required to address several areas, including a vision of what the delivery system will look like after five years and "how the full PPS system will be sustainable into the future." ***We believe this should be modified to eliminate the word "full" before "PPS system."*** The PPS is likely to change over time, a fact the New York State Department of Health (DOH) appears to acknowledge by requesting a description of what the delivery system will look like in the future. Providers may be added, others may change affiliation, and some may even cease operation. The word "full" could be misinterpreted to mean all providers in the original PPS must be sustained in perpetuity. It is *services*, not necessarily all providers, that must be sustained.

This section also requests the PPS to indicate if it is applying for a Certificate of Public Advantage (COPA) or to become an Accountable Care Organization (ACO), and to provide details on regulations for which a waiver is sought. We believe it is likely premature for many PPSs to be able to respond fully on these issues. ***If this is simply information gathering on the part of the State, it should not be part of a section to be scored, even on a pass/fail basis.*** PPSs will need to have the ability to request a COPA, become an ACO, and seek regulatory relief at any time during the five-year demonstration.

Section 2 – Governance

This section requires the applicant to describe the organizational structure of the PPS and references the three models outlined in the "Governance How to Guide." ***We recommend clarification that alternate models are permissible as long as they can support a well-integrated and high-functioning DSRIP PPS network.***

The PPS is also required to explain how the members of the governing body sufficiently represent all the providers and community organizations within the PPS network. We do not think it possible for the governing body to represent "all" providers and community organizations within the PPS network. Providers and organizations will participate in the PPS in different ways. ***Certainly key groups should have representation on the governing body, but other PPS participants may have relatively minor roles and not require or desire representation.***

This section's financial and organizational structure component references establishment of a compliance program in accordance with New York State law (note the reference should be to Social Services Law, not Social Security Law). That law requires Medicaid providers to establish compliance programs to ensure appropriate billing and payment. A PPS is actually a group of providers, and the individual providers are the entities that bill and receive payment from

Medicaid and Medicaid managed care plans. Those individual providers are required to have compliance programs that are sufficient to ensure compliance with the law. The PPSs are expected to eventually form joint contracting entities for payment purposes, but until the PPS itself bills and receives Medicaid payments, it is not clear why the PPS would need a separate compliance program layered on top on the individual provider's programs. Since that will likely occur sometime in the future, ***we believe that the application should simply require the PPS to indicate that it will develop a compliance program that meets the requirements of State Social Service law as part of its managed care contracting strategy.***

Section 3 – Community Needs Assessment (CNA)

As the applications are reviewed by DOH and its contractors, reviewers should recognize that the DSRIP application was released in the fall after many PPSs had already completed their Community Needs Assessment (CNA) based on guidance released in June 2014. While the State's thinking about the contents clearly evolved as the application was being drafted, an earlier release of the application would have afforded PPSs the opportunity to target their CNA analysis to respond to the level of specificity in the application's questions, which were not part of the original CNA guidance.

One application question, which requested information on the number of hospital and nursing home bed reductions found through the CNA, provides the best example of this issue. The original guidance, in Section A under *Description of Health Care Resources*, describes the need to identify service gaps and excess services that need to be addressed to meet the goal of a 25% reduction in avoidable hospitalizations, without reference to bed reductions. Although reference was made to bed reduction as part of a subsequent DOH CNA webinar, PPSs that relied on the original guidance's wording to conduct their CNA—which was already underway—would not have captured the information necessary to make detailed estimates of bed reduction in the way the DSRIP application subsequently requested. More importantly, it can be argued that it is simply not possible to provide bed capacity reduction information in the way the application requests prior to project design and implementation.

Reviewers should keep these factors in mind as applications are reviewed and scored. ***PPSs should not be penalized for being unable to provide detailed bed reduction information that may not be possible to estimate at this time and that was not requested as part of the original guidance that the PPS used to complete its CNA.***

Section 5 – PPS Workforce Strategy

GNYHA recognizes that the key to successfully achieving DSRIP's goals, both at the organizational and project-specific level, is utilizing existing and new workforce in the most effective manner possible. In discussions with GNYHA member hospitals and their partner organizations, they have indicated they are actively working to develop models of care

coordination, patient navigation, case management, and community health support. These models are, however, in the nascent stages of testing and evaluation, including what portion of these new functions can be effectuated by existing staff and which functions require the hiring of new staff.

Thus, while GNYHA agrees that DOH should include and expect a significant workforce strategy component within the organizational application, we are extremely concerned that the information DOH requested is much more specific than any PPS could credibly supply. The PPS leads are actively working to define an overall approach to workforce retraining, redeployment, and hiring that would include an assessment strategy, a training approach, and remediation for talented workers who need additional training and support. They are also considering the need for additional staff to meet project-specific goals and the overall PPS goals, what these job titles would be, and what educational or experience background would most likely function well in those new jobs. However, the PPSs, have indicated to GNYHA that they are not able to specify exact numbers of incumbent staff that would need to be retrained or redeployed (by title or overall), and they are not able to specify the number of new staff they will need to hire. The PPSs are also not able to specify (or even approximate) the planned spending by project as the projects are interrelated in terms of workforce strategy. Without a full evaluation of the models, it is impossible to specify an exact budget needed for the workforce component. The PPSs are also not able to indicate at this time which retrained incumbent workers will be able to be re-deployed to a job title that has a specific wage level. Finally, the PPSs are not able to specify or approximate the amount of workforce development spending that would be needed in each of the demonstration years.

GNYHA therefore recommends that DOH eliminate all requests for specific numbers of staff and budget information in the application's PPS Workforce Strategy section. We believe Section 5 should instead be evaluated solely on the basis of the comprehensiveness and completeness of the workforce strategy approach and process developed by the PPS. Within this description, DOH could also request information on new job titles (if any) that are expected to be developed. DOH has experience evaluating workforce development programs such as the Health Workforce Retraining Initiative on the basis of these and other indicators (e.g., assessment and evaluation of workers, training delivery approach, measures of success), and GNYHA encourages DOH to evaluate Section 5 based on a similar review and evaluation methodology.

GNYHA understands that DOH may need to develop a more specific methodology for awarding the overall DSRIP workforce development funding to individual PPSs. If so, ***GNYHA recommends that each PPS's workforce development strategy section be scored for comprehensiveness and completeness of approach as described above, and DOH then multiply the PPS workforce development strategy score by a funding amount per attributed life to determine a PPS-specific workforce development funding award.***

GNYHA understands that questions have been raised on whether the expenditures for the PPS workforce strategy could count toward the 5% cap on funding provided to non-safety net providers. For example, a PPS might elect to contract with one workforce training organization on behalf of the entire PPS to organize and manage its DSRIP workforce development component instead of providing the workforce funding directly to individual provider partner organizations to individually subcontract. GNYHA assumes that in the former situation, this strategy would not count against the 5% cap as it is merely a means to efficiently organize the workforce strategy component and is separate from concerns regarding allocating DSRIP funding to non-safety net providers. ***We recommend that DOH clarify that workforce strategy funding is outside of and does not count against the 5% cap regardless of the administrative structure by which the PPS organizes this function.***

Section 6 – Data-Sharing, Confidentiality and Rapid Cycle Evaluation

This section requires the PPS to describe data-sharing arrangements, ensure privacy and HIPAA compliance, and describe the plan to share relevant patient information in real time. In responding to this, it would be useful to know if the State contemplates any regulatory flexibility with respect to data sharing. As you know, the consent requirements imposed for the Health Home initiative have proven cumbersome and we are hopeful that under DSRIP, providers will be able to obtain consents that more broadly allow for the sharing of data. Providers also continue to ask that DOH share patient identifiable claims history on patients attributed to the PPS to assist in care coordination and patient engagement.

Section 8 – DSRIP Budget & Flow of Funds (Pass/Fail)

The application requests that the PPS generally describe how it plans to distribute DSRIP funds and how that methodology will allow the PPS to best achieve its goals. The application also requests that the PPS identify the *percentage* of payments that it intends to distribute among certain funding categories, including 1) cost of project implementation, 2) revenue loss, 3) internal PPS provider bonus payments, and 4) other. We believe it is unreasonable to expect PPSs to provide this level of detail/information during the application phase, and we request that it be removed from the application. We note that this section is Pass/Fail, so its removal would have no impact on the application scoring. If DOH continues to keep this section, we request that it add a funding category for administration.

Our specific comments on the difficulty of providing the requested information are provided below.

- **Cost of implementation**. The determination of the amount of funding required for project implementation won't be determined until the PPS finalizes its project implementation plans and approach (April 1, 2015), and will be partially contingent on the total amount of funding available to the PPS, which is not yet known.

- **Revenue loss.** PPSs have not developed their formal restructuring plans yet, so determination of anticipated revenue losses across provider types at this point would be very difficult.
- **Percentage of payments.** There are certain fixed costs (such as the cost of project implementation) that must be covered. Depending on the total amount of funding available to the PPS—which is not yet known—the percentages by category would change to ensure coverage of these fixed costs.

As an alternative, the application should ask for the PPS's approach to determining its distributions in each of the funding categories. PPSs would still be required to report on actual distributions and the basis of funding in their quarterly reports.

Section 9 – Financial Sustainability Plan

Generally, we are concerned that the application appears to place the burden of financial sustainability of each PPS partner on the PPS. ***We think a more reasonable approach would be for the PPS to discuss how it will monitor the financial sustainability of its partners and, most important, ensure continued access to care for its attributed members throughout the five-year DSRIP demonstration period.*** To be meaningful, the issue of continued access may be most appropriately addressed at the project level.

Our specific comments on each section of the Financial Sustainability Plan are provided below.

- **Assessment of Financial Landscape**. The application assumes that a financial assessment of each PPS partner will have been performed prior to submission of the application. Given the timeframes, ***a more appropriate application request would be for the PPS to describe how it will conduct a financial assessment of its PPS partners.***
- **Path to PPS Financial Sustainability**. It is too early for facilities to report on the financial restructuring efforts that will be required. This issue would be best addressed in the detailed implementation plan on the PPS's financial sustainability strategy, which is due April 1, 2015. Again, we are also concerned that this section places the responsibility for financial sustainability for each of the partners on the PPS. ***Instead, the application should ask how the PPS will support the PPS partners in addressing financial sustainability concerns.***
- **Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability**. While it is appropriate to request information on how the PPS will engage in payment reform over the course of the five-year demonstration period, ***the emphasis should be on continued access for Medicaid beneficiaries, not the financial sustainability of every PPS partner.***

PART 2 – PROJECT PLAN APPLICATIONS

Domain 2 Project Requirements: General

PCMH Certification. GNYHA is concerned that many sets of project requirements specify that patient-centered medical home (PCMH) practices must meet 2014 Level 3 PCMH standards of the National Committee for Quality Assurance (NCQA) or Advanced Primary Care Model (APCM) standards by Demonstration Year 3 or a similar timeframe (e.g., "within 2 years after relocation"). While GNYHA believes this is a reasonable expectation for primary care practices that have previously been recognized as PCMHs by the NCQA under the 2011 standards, this is an extremely ambitious, potentially unattainable timeframe for primary care practices that have not been recognized previously. Many PPSs are appropriately bringing large numbers of community physicians and small group practices into their networks. Imposing this requirement on these practices may discourage them from continuing to be included in the network.

GNYHA recommends that DOH modify this requirement to specify that practices that are not NCQA-recognized as Level 2 or 3 PCMHs under the 2011 standards at the time of the submission of the DSRIP application be required to meet 2014 Level 2 PCMH standards of the NCQA by Demonstration Year 3 or a similar timeframe. Also, please clarify throughout the document that PCMH certification applies to primary care practices, not the PPS.

SHIN-NY Availability to Facilitate PPS activities. Most project specifications reference active PPS participation in local health information exchange/RHIO/SHIN-NY. The specifications also include a requirement for all PPS participants to connect and actively exchange information through the SHIN-NY. GNYHA is concerned that this requirement precedes RHIO and SHIN-NY capability to support the necessary data sharing and information exchange to comply with DSRIP's specifications and meet its goals. While there is some capability to exchange information within RHIOs, it is limited to a small number of mostly acute care providers, a limited data set, and is not available across regions. Further, while the State's funding for the SHIN-NY's development and implementation will help facilitate increased capability, there are questions about an individual RHIO's capacity to support a stark, sudden increase in the number of new RHIO participants. ***PPS participants' capability to use secure messaging technologies, as required under current Federal health information exchange requirements, would be a more reasonable initial requirement as Federal standards evolve. Moving forward, we urge DOH to remain aligned with Federal standards and requirements for health information exchange.***

Project Description/Justification. The project description/narrative appears somewhat disconnected from the project requirements. ***Please provide additional guidance on the narrative response requirements for project description/justification.*** Should the PPS integrate

how it intends to meet the project requirements and Domain 1 milestones in the narrative response for each project? Given the word limitations, this may be difficult.

Project 2.a.i: Create an Integrated Delivery System (IDS)

The project requirements specify that PPSs should establish monthly meetings with managed care plans to evaluate utilization trends, performance issues, and payment reforms. Given the number of plans and PPSs, we believe this frequency is excessive and unrealistic. ***While regular meetings are important, the plans and the PPSs should determine the appropriate frequency.***

The application requires the PPS to provide the number of patients that will benefit from the IDS. Theoretically, all attributed patients should benefit from a more integrated delivery system. Should the PPS respond with its projected attribution?

Project 2.b.ii: Development of Co-Located Primary Care Services in the Emergency Department

GNYHA recommends that the project requirements be modified to allow the practices to achieve open access scheduling extended hours and have Electronic Health Record (EHR) capability that is interoperable at start up *or by the end of Demonstration Year 3, whichever is later*. While we recognize that the components of the co-located primary care services (PCSs) are important, we are concerned that having them perfectly in place should not delay the establishment of the service.

Project 2.b.iii: ED Care Triage

GNYHA recommends the following changes to this project's requirements:

- ***Project requirement 2 should be revised to indicate that partnerships will be developed "with" community PCPs, not "to" them.***
- Requirement 3 specifies that patients without a PCP must receive "immediate" appointments with a community PCP. ***Because it is unclear how "immediate" would be defined, we suggest this be replaced with "timely."***

Also, it is not clear how managed care plan policies will be applied under this project. If the goal is to divert inappropriate ED utilization to appropriate primary care, ***DOH should require that managed care plans reimburse for that primary care, regardless of network participation.***

Project 2.b.iv: Care Transitions Intervention Model

The project description uses the term "case manager" to perform certain functions enumerated in the same section. ***GNYHA recommends that the PPS determine the staff or team members who will deliver the required functions to meet the project's goals and objectives***.

Project 2.b.v: Care Transitions Intervention for SNF Residents

Project requirement 3 calls for the development of care protocols that include, among other things, skilled nursing facility (SNF) staff visits with the patient and hospital staff to develop the transition of care services. This will not be possible in all cases and may have the unintended consequence of delaying an appropriate discharge. ***We recommend modifying the language as follows: "Develop transition of care protocols that include timely notification of planned discharges and, when deemed necessary, SNF staff visits to the hospital to meet with the patient and hospital staff."***

Project 2.b.vii: Implementing the INTERACT Project

GNYHA recommends that the project requirements be modified to specify that the INTERACT 3.0 or 4.0 toolkit (the latter is scheduled to be introduced soon) can be used. We also recommend that the language within requirements #3 and #5 be modified to state, "Implement care pathways…" and "Implement Advance Care Planning Tools…" The INTERACT toolkit includes both care pathways and advance care planning tools, so we believe it is unnecessary to develop new versions of these tools when using INTERACT.

Project 3.a.i: Integration of Primary Care and Behavioral Health

One option for integrating primary care at behavioral health sites is to embed nurse practitioners at those sites. To do so, the provider must be able to bill for the medical services they provide. Although the State is submitting rule changes and requesting statutory language changes to make integrated care possible, currently licenses apply to brick and mortar and staff is assigned to individual clinic spaces. In an integrated model, the licensed staff of one clinic needs to be able to provide services in various locations and bill for those services to create a sustainable model. Will the State have revised polices and rules in place by April 1, 2015 to support integrated care?

Project 3.a.iii: Implementation of Medication Adherence Program

This project requires the PPS to engage with managed care plans to develop protocols to improve medication adherence. While this is important to successfully implementing this project, ***we believe success will be greatly improved if the State requires plans to cooperate with PPSs by sharing data***. Plans have real-time data on prescription claims that is critically important to care managers in determining medication adherence.

Project 3.b.i: Evidence-Based Strategies for Disease Management in High-Risk Populations

This project requires implementation of a variety of initiatives targeted to cardiovascular disease, hypertension, high cholesterol, and tobacco cessation. Treating these conditions will involve primary care physicians and other providers, including specialist such as cardiologists. However, the project requirements specify that all participating providers have PCMH Level 3 certification by Demonstration Year 3. ***Since only primary care practices can attain PCMH certification, this requirement should be modified accordingly.***

The project also requires the engagement of a "majority" (80%) of primary care practices. We believe 80% is an unrealistic number and ***should be reduced to 60%. Further, it should be made clear that pediatric primary care practices are excluded from the calculation. We would also recommend that the requirement to refer to the NYS Smokers Quitline be modified to add "or equivalent program."***

Project 3.e.i: Comprehensive Strategy to Reduce HIV/AIDS Transmission

One of the project requirements is to seek DOH designation as a Center of Excellence. We are unaware of this designation and have been unable to identify its requirements. ***Please clarify if this designation is under development or is an existing program. If the latter, please share the designation requirements so a PPS choosing this project can appropriately develop budgets and work plans.***

Project 3.g.i: Integration of Palliative Care into the PCMH Model

GNYHA recommends that the first project requirement be modified to recognize incorporating palliative care into those primary care practices that do not achieve NCQA PCMH recognition. We understand that DOH's goal is to have as many primary care practices as possible receive NCQA recognition. However, in this particular project, the PPS should be given appropriate credit for incorporating palliative care into any primary care practice participating in its PPS. This would benefit the patients utilizing those practices and support the overall goal of the project.

Project 3.g.ii: Integration of Palliative Care into Nursing Homes

GNYHA recognizes that there is a critical need for palliative care programs and services to be further developed in nursing homes. We are concerned, however, that focusing this particular project solely on the nursing home sites will further complicate efforts to create a well-functioning continuum of care. In our experience working with nursing homes, there has been frustration expressed regarding the implicit suggestion that the complex issues presented by palliative care should be addressed solely in the nursing home setting. GNYHA recognizes that project 3.g.i specifically targets primary care practices for development of palliative care services also, but these two projects together still ignore the roles of hospitals and other types of providers (e.g., home health agencies) in contributing to a well-functioning palliative care system. ***We recommend that project 3.g.ii be modified to provide appropriate recognition and credit for multiple types of provider efforts – across the continuum – to achieve the overall goal of improving palliative care services.***

PART 3 – DOMAIN 1 PROJECT REQUIREMENTS MILESTONES AND METRICS

General

As referenced in Part 2 above, GNYHA is concerned that many project requirements specify that PCMH practices must meet 2014 Level 3 PCMH standards of the NCQA and/or APMC standards by Demonstration Year 3 or a similar timeframe (e.g., "within 2 years after relocation"). We have recommended that this requirement be modified to specify that practices that are not NCQA-recognized as Level 2 or 3 PCMHs under the 2011 standards, at the time of the DSRIP application submission, be required to meet NCQA's 2014 Level 2 PCMH standards by Demonstration Year 3 or a similar timeframe. ***We therefore also request that this modification be incorporated into the project milestones and metrics.***

Likewise, for metrics related to SHIN-NY/RHIO connectivity, we recommend that they be modified to conform to our suggestions on modifying the SHIN-NY/RHIO requirements.

In addition, there are a number of Metric/Deliverables that specify that the PPS has achieved NCQA Level 3 PCMH standards. The NCQA certification/standards are applicable to primary care practices. We are not aware of any process under which a PPS, as an entity with many different types of providers, could achieve such certification. Even with respect to EHRs, inpatient and nursing home EHRs may not be consistent with NCQA standards. ***We therefore recommend that the metrics be clarified to specify they apply to primary care practices.***

Finally, a number of the Metric/Deliverables require PPSs to negotiate with managed care plans on coverage for particular services required under their projects. Coverage of services under Medicaid is generally determined by DOH, not by individual managed care plans. ***If there are services to be provided under a project that are currently not "covered" by Medicaid, it must be addressed at the State level for both fee-for-service enrollees and managed care.*** Negotiations with payers may be necessary around coordination and reimbursement, but not coverage.

Project 2.a.ii: Increase Certification of PCPs with PCMH and/or APCM Certification

One of this project's deliverables is to reduce no-show rates by 15%. This appears to be an arbitrary target. ***We believe the PPS should its target after analysis of the extent of no-shows within each practice and taking into account procedures already in place to reduce no-shows.***

Project 2.b.i: Ambulatory ICUs

The first project requirement is to ensure that the intensive care unit (ICU) is staffed or has access to a network of appropriate providers of various types (e.g., medical specialties, behavioral health, nutrition). The data source listed for this is NCQA-certified

physicians/practitioners. ***NCQA certification would appear to apply only to PCMH practices, and thus does not appear to be an adequate source for this information.***

Project 2.b.vii: Implement INTERACT

We recommended modification of the project requirements to specify "implementation" of care pathways rather than "development." ***The Domain Metric/Deliverable should be modified accordingly.***

Project 3.a.i: Integration of Primary Care and Behavioral Health

One of the Metric/Deliverables for this project is that 100% of individuals receive screenings at the established project sites. We believe a target of 100% is unreasonable, as patients may refuse or not cooperate with screening. ***Perhaps the requirement should be that 100% are* offered *screening. Alternatively, the target threshold could be reduced, but we are unaware of data to support an appropriate standard.***

A key Model 2 metric is achievement of 2014 NCQA Level 3 PCMH or APMC certification by Demonstration Year 3. This model involves co-location of primary care in behavioral health practices. We do not believe that NCQA certifies behavioral health practices. If the intent of this project is to establish a full PCMH primary care practice within a behavioral health site, that would appear to go far beyond the project's screening and warm transfer requirements.

PART 4 – PPS APPLICATION AND SCORING GUIDE

PPS Application Score

Three documents provide information about how each PPS's application will be scored:

- DSRIP PPS Organizational Application
- DSRIP Project Plan Application
- DSRIP PPS Application Scoring Guide

After carefully reviewing these documents, we believe the overall application score can be described as the sum of three components:

- PPS Organizational Score × 0.3%
- *Average* PPS Project Score × 0.7%
- Bonus points, if any (capped so that the overall application score does not exceed 100%)

GNYHA is comfortable with this overall approach.

PPS Organizational Score

The DSRIP PPS Organizational Application has 11 sections, of which six are components of the PPS Organizational Score. Among the six sections are 28 essay questions, some with data required. The Organizational Application distributes 100 points among the 28 essay questions, which roll up to maximum points for each of the six sections. Section 2 of the Scoring Guide describes a rigorous process that the Independent Assessor will use to award points to each section. Once this process is complete, the points awarded to each section are summed and divided by 100 to derive the PPS Organizational Score. ***We reviewed and successfully replicated the scoring example in the Scoring Guide and believe it is reasonable and equitable.***

The only statement in the description of the scoring approach that we believe requires clarification was the following: "The training will include meetings with NY state agencies such as OMH, OASAS, OPH, and other stakeholders to develop program specific scoring methods." Since we don't believe that program-specific (e.g., OMH, OASAS) scoring is applicable in this context, we interpreted the statement to mean that the Independent Assessor and evaluators will meet with those agencies and other stakeholders to learn about the criteria they use to evaluate qualitative applications in order to inform the criteria they select to evaluate the DSRIP application essays, which will be uniformly applied. Whether or not our interpretation is correct, ***we recommend that DOH revise this statement in the final Scoring Guide to clarify its meaning.***

Average PPS Project Score

Section 3 of the Scoring Guide begins the description of individual project scoring as follows: "The PPS applicants for Domain 2, 3, and 4 projects will be scored based on the quality of the *Project Description and Justification* response, the scale of implementation, and the speed of

implementation." ***Since Domain 4 projects will be scored solely on the quality of the Project Description and Justification response, this opening sentence needs to be revised.***

Moreover, while the Scoring Guide acknowledges that all projects require a *Project Description and Justification* (and Project 2.a.1 also requires a description of the PPS's *System Transformation Vision and Governance*), it does not describe how these essays will be scored. ***If no process has yet been determined, we recommend using the same approach that will be used for the individual sections of the PPS Organizational Score.***

After the opening sentence, the Scoring Guide says: "The project-specific scoring will be based on a number of variables for each PPS. These metrics include:

1. Total number of providers, programs, facilities, or sites that the PPS intends to include for implementation of the project.
2. Percentage of safety net providers that the PPS intends to include for implementation of the project.
3. Total expected percentage of targeted patients the PPS intends to actively engage for the project.
4. Expected timeline for achieving all project requirements.
5. Expected timeline for engagement of targeting patients."

Because this list does not include a patient scale metric, which we think is a material oversight, and because the metrics used in the project scoring example align with either the Scoring Guide metric list or the data collected in the Project Plan Application, ***more clarity is needed as to which metrics will apply to each project, unless we are to assume that all data requested will be evaluated. In addition, somewhere in the application documents, DOH should better specify the evaluation metrics.*** Our specific comments and recommendations concerning evaluation metric selection, specification, and scoring are provided below.

Metric Selection

Except where indicated, the Project Plan Applications collect the following data:

- Scale of Implementation
  - Project scale
    - Number of committed providers, programs, facilities, or sites (varies by project)
    - Number of safety net providers (not applicable to all projects)
    - Percent of safety net providers by county (not applicable to all projects)
  - Patient scale (same for all projects except 2.d.i)
    - Targeted population to benefit from project
    - Total attributed population
    - % of total attributed to benefit from project

- Speed of Implementation/Patient Engagement (same for all projects)
  - Project implementation speed
  - Patient engagement speed
    - Expected number of actively engaged patients
    - Targeted population

However, the applications do not specify which metrics will be derived from those data for the purpose of evaluating each project. ***For administrative simplicity, we recommend evaluating all projects based on the following metrics, except where indicated:***

1. ***Number of committed providers, programs, facilities, or sites***
2. ***Committed safety net providers as a percent of all safety net providers in the PPS's service area (where applicable)***
3. ***Number of targeted patients***
4. ***Expected actively engaged patients as a percent of targeted patients***
5. ***Number of years to complete all project requirements, rounded upward to the half year***
6. ***Number of years to actively engage all patients, rounded upward to the half year***

In addition, to achieve a more balanced distribution of points among these evaluation metrics, ***we recommend weighting each metric as follows:***

	Project 2.1.a	Others *with* Safety Net Data	Others *without* Safety Net Data
Scale Metrics	**30**	**40**	**40**
Number of committed providers, etc.	**10**	**10**	**20**
Percent of safety net providers	**5**	**10**	
Number of targeted patients	**10**	**10**	**10**
Expected actively engaged percent of targeted patients	**5**	**10**	**10**
Speed Metrics	**30**	**40**	**40**
Years to project completion	**15**	**20**	**20**
Years to full patient engagement	**15**	**20**	**20**

Metric Specification

Number of providers, programs, facilities, or sites (Metric 1)

- The project scale table requests the number of committed providers by provider type. Since there are many ways to count providers, especially hospitals, in order to ensure that all applicants count providers in the same way, ***we recommend that they be instructed to count the number of campuses and not the number of operating certificate numbers.***

- Projects 2.a.i, 3.a.i, 3.a.iii, and 3.a.iv have a project scale table that includes an expected number of *all other* providers. Since there might be some provider types in the *all other* group that do not have a safety net list, ***we recommend that applicants be instructed to separately list each provider type that has a safety net list and only aggregate the count of providers without a safety net list.***

- The scoring guide's illustration of how to score this metric pertained to a project with only one type, ambulatory ICUs. There was no discussion of how to score projects with multiple types, such as Projects 2.a.i, 2.c.ii, 3.a.i, 3.a.iii, and 3.a.iv. ***We recommend scoring each type separately and then averaging the results.***

Percentage of safety net providers (Metric 2)

- We infer from context that the denominator of this metric is *not* the total number of PPS providers, but rather the total number of safety net providers (in the county). ***We recommend that the project plan applications explicitly state this.***

- Of the 17 provider types with safety net lists on the DSRIP web site, only four include the county—hospitals, nursing homes, OASAS providers, and pharmacies—and the files are PDF documents. To reduce the burden of obtaining the number of safety net providers of each type in each county, ***we recommend that DOH post an Excel file on the DSRIP web site with a separate tab for each provider type. Each tab should list all the safety net providers by campus and county, which is how they are listed on the provider profile sites. Each tab should also summarize the number of safety net providers by county.***

- If the denominator of the metric remains the total number of safety net providers *in the county*, then PPS applicants serving multiple counties will have to submit separate data tables for each county. ***To reduce the administrative burden on the evaluators, we recommend that applicants aggregate information for the collection of counties they will serve. For the number of PPS providers and safety net providers, they can simply sum the counts across the counties, but for the PPS safety net share of total safety net providers, they should derive a weighted average as follows: Sum of PPS safety net providers ÷ sum of all safety net providers in PPS service counties.***

- For aggregated *all other* providers without a safety net list, ***we recommend that the data table block out the number of safety net providers and the percent of safety net providers to make it clear that those fields are not applicable.***

Expected actively engaged percent of targeted patients (Metric 4)

- Since we consider the actively engaged percent of targeted patients to be a scale metric rather than a speed metric, ***we recommend expanding the patient scale table in the Project Plan Applications as follows.***

Patient Scale	Commitment/Expectation
Targeted Population to Benefit from Project	
Total Attributed Population	
% of Total Attributed to Benefit from Project	
Expected Fully Phased-In Actively Engaged Population	
% of Targeted Patients Actively Engaged	

The expected fully phased-in actively engaged population in this table should match the highest number reported in the patient engagement speed table.

Metric Scoring

The Scoring Guide provides an example of how relative scores would be derived for different PPSs applying to undertake a particular project. The example pertains to Project 2.b.i, creating ambulatory ICUs, and includes four metrics. Based on our review of that example, we believe it was inadequately explained and that the table showing the awarded points contains many mistakes. Therefore, ***we recommend revising the description of the scoring methodology as described below.***

1. For each project:

a. Start with a table that provides the raw data submitted by each PPS for each metric (i.e., the table on page 7 of the Scoring Guide).

b. Add a second set of metric columns and in each column derive:
i. The percentile rank for the *scale* metrics, since *higher* values are more favorable.
ii. 1 – the percentile rank for *speed* metrics, since *lower* values are more favorable.

c. Add a third set of metric columns and include in each column heading the maximum points assigned to each metric, which can vary by metric. Then for each metric, derive points for each PPS based on the following formula:

$$0.5 \times \textit{the metric's maximum points} \times (1 + \textit{the PPS's percentile})$$

The purpose of this formula is to give each PPS 100% of half the maximum points plus a (usually) lower proportion of the other half of the maximum points, with that proportion representing either the percentile rank or 1 – the percentile rank,

whichever is applicable. ***We recommend applying the applicable percentile rather than a derived quartile proportion because it simplifies the formula and is empirically valid.***

d. Then for each PPS, sum the points awarded for all metrics and add the points awarded for the essay(s). The result is each PPS's final project score.

2. For each PPS, average the final scores awarded to each project and divide by 100 to derive the Average PPS Project Score used in the total application score.

Although we recommend a revised description of the scoring approach, we believe the approach itself is reasonable and equitable.

Derivation of the Maximum Award

The application documents describe a methodology for determining the maximum award each PPS can obtain over a five-year period ("maximum award"). Then each PPS's *performance* will determine the portion of the maximum award it will actually earn. The method to determine the maximum award contains hundreds of computations and is difficult for some stakeholders to grasp. ***Therefore, we suggest simplifying the presentation of the maximum award methodology by using the mathematical distributive property, as outlined below.***

I. Maximum Annual Award Per Member
- **a. Number of projects (given by the applicant)**
- **b. Payment per member per project per month (given for the number of projects)**
- **c. Annual payment per member: $a \times b \times 12$**

II. Discounted Maximum Annual Award Per Member
- **d. Average project value: $Sum\ of\ selected\ project\ index\ scores \div number\ of\ selected\ projects$**
- **e. Weighted PPS Organizational Score: $PPS\ Organizational\ Score \times 0.3$**
- **f. Weighted Average PPS Project Score: $Average\ PPS\ Project\ Score \times 0.7$**
- **g. Bonus points ÷ 100**
- **h. Total application score: $lower\ of\ (e + f + g)\ or\ 1$**
- **i. Discount factor: $d \times h$**
- **j. Discounted maximum annual payment per member: $c \times i$**

III. Total Maximum Award
- **k. Attributed population (given by the State)**
- **l. Total annual award: $j \times k$**
- **m. Total award: $l \times 5\ years$**

Section 4 of the Scoring Guide includes a table that shows the derivation of the maximum award *for a single project.* But nowhere in the application documents is a summary of the derivation of

the entire maximum award. ***We believe this is an essential part of the application and therefore recommend that DOH consider using something akin to our summary either in place of the table in Section 4 or in the Executive Summary of the PPS Organizational Application.***

HANYS Healthcare Association of New York State

Proud to serve New York State's Not-For-Profit Hospitals, Health Systems, and Continuing Care Providers

Dennis Whalen, President

October 29, 2014

Jason Helgerson
Deputy Commissioner
Office of Health Insurance Programs/Medicaid Director
New York State Department of Health
Empire State Plaza Corning Tower Building, 14th Floor
Albany, NY 12237

Dear Mr. Helgerson:

On behalf of the Healthcare Association of New York State's (HANYS) statewide membership of 500 not-for-profit and public hospitals, health systems, nursing homes, and home care agencies, thank you for the opportunity to comment and provide input on the Delivery System Reform Incentive Payment (DSRIP) Draft Application materials posted on September 29, which consist of the following documents:

- DSRIP Performing Provider System (PPS) Organizational Application;
- DSRIP Project Plan Applications: Domains 2, 3, and 4;
- Domain 1 DSRIP Project Requirements Milestones and Metrics for Domains 2 and 3; and
- DSRIP PPS Application Scoring Guide.

These materials enumerate many critical details of DSRIP, including the scoring methodology that will directly affect each PPS' total potential amount of incentive payments for the entire five-year duration of the program. HANYS strongly believes that the application scoring methodology must ensure fairness and transparency.

The following are highlights of our general comments and recommendations on the application materials:

- Provide additional guidance regarding the release of protected health information (PHI)-level data within a PPS and to the Independent Assessor to assist PPSs in achieving DSRIP goals and outcomes while protecting providers and patients.
- In many cases, the details for a workforce strategy budget, fragile safety net provider path to financial sustainability, and payment reform plan are unlikely to be worked out in the next several weeks, and the scoring tool should be adjusted to allow more general descriptions of approach, strategy, and goals, with workplans and budget that follow later.

- Consistent with the *Governance How-To Guide*, there are a number of different permissible governance models and the scoring of the governance section should be without bias or higher scores for particular favored models, since what will work effectively for each PPS will be dependent on the composition of the PPS and regional markets and preferences.
- Specifics on the ability of the healthcare system to undertake bed reductions will evolve and are difficult to estimate with precision, and, in addition, a number of applicants are currently maintaining required capacity for disaster preparedness and outbreaks such as Ebola.
- If a PPS is initially determined to have failed on pass/fail sections, it should be provided with an explanation of where its response falls short and given an opportunity to provide additional information before a final determination on the application is made.
- Project requirements should acknowledge service area variation and the associated unique challenges, such as workforce recruitment challenges in rural areas (e.g., Project 3.a.i Integration of Primary Care and Behavioral Health Services).
- Protect the work of the PPS Clinical Governance Committee and the various quality sub-committees, with protections as are currently afforded to individual hospitals under Sections 2805-j and 2805-m of the Public Health Law (PHL).
- Provide additional clarity and detail regarding the scoring methodology.

Our detailed comments are attached.

In addition, we are increasingly concerned that it will be difficult for many PPSs to prepare quality DSRIP applications by December 16, given the magnitude of change and program complexity and request that you once again review the timeframes. As we have discussed, we continue to have concerns about the adequacy and uncertainty of anti-trust protection, the need for additional transitional funding, the timing of incentive payments, and the intersection of multiple overlapping initiatives. We look forward to our ongoing work on regulatory reform via DSRIP waivers and the development of the Medicaid Managed Care DSRIP Contracting Plan.

We continue to believe that DSRIP can hold great promise for achieving the triple aim in the Medicaid program. It is a tremendous undertaking and we thank you for your strong leadership. HANYS and our members look forward to continuing our dialogue with DOH on the DSRIP program.

Sincerely,

Dennis P. Whalen
President

DPW:nd

Enclosure

HANYS Healthcare Association of New York State

Comments on Delivery System Reform Incentive Payment (DSRIP) Draft Application Materials

(Posted on September 29)

October 29, 2014

Following are highlights of our general comments and recommendations on draft DSRIP Application materials. This multi-year waiver effort will require continuous and ongoing dialogue with the Department of Health (DOH) to address myriad policy issues that exist today and will arise in the future. The operational issues associated with a new performance-based program of this magnitude and transformational goals will require tremendous time, energy, and focus. HANYS looks forward to our continued partnership.

Note: In our comments, text from the DSRIP Draft Application materials appears in *italic*.

General Observations

HANYS has identified important threshold issues that span several individual project requirements across domains. These issues generally relate to the release of information to the Independent Assessor and others.

Several projects that include quality assessment features provide that quality assurance (QA) minutes and other related documents be provided to the Independent Assessor and, in some instances, to patients and their families.

Quality assurance materials are subject to statutory protections that may not apply in the DSRIP program context. Section 2805-j of PHL requires that general hospitals implement medical malpractice prevention/quality assurance programs. Among other things, these programs must continuously collect and analyze relevant data and apply findings to improve patient care quality.

Section 2805-m of PHL provides that the information collected pursuant to Section 2805-j "may not be released except to the Department." It further provides that none of the information is subject to disclosure under the Freedom of Information Law or to discovery in the course of civil litigation.

However, these laws only apply to general hospitals, not PPSs or any other provider type. This raises several concerns. First, the limit on disclosure to only the Department of Health (DOH) would not apply. Second, the crucial disclosure and discovery protections would not apply to PPS submissions. Third, the broad release of QA information as contemplated by the Application is clearly contrary to the public policy underlying the provisions of Section 2805.

A second broad category relates to proposed requirements for the release patient names, health information, and records to the Independent Assessor. These disclosures would be sufficiently detailed to constitute PHI under the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) Act.

Since all providers in PPSs are covered entities under HIPAA, it is not clear that release of this information, as currently proposed, is allowed. This is a significant threshold issue, since covered entities face severe sanctions for improper disclosure of PHI.

Even if disclosure is allowable, other concerns remain. Patient-specific information in the possession of individual providers would, in order to be released, be shared with other PPS providers. Eventually, that information would be disclosed to the Independent Assessor. The HIPAA privacy and security rules apply throughout the chain of custody and a covered entity remains ultimately responsible for any improper disclosure along the custody chain.

Rather than discussing the many other pertinent HIPAA-related issues in this comment letter, HANYS recommends that DOH provide additional guidance regarding the release of PHI-level data. Further, DOH should receive assurances from the Centers for Medicare and Medicaid Services that PPSs may receive Medicaid PHI-level data because this information will be critical for PPSs to operate as integrated delivery systems.

A third broad category relates to the release of contracts, agreements, and other business-related documents to the Independent Assessor. Many managed care plan documents include confidentiality provisions that forbid the release of the contents. In addition, it is not clear that information may be released by or regarding self-insured plans due to the potential that a mandate to do so may be pre-empted by the Employee Retirement Income Security Act (ERISA).

Information Security

Domain 1 DSRIP Project Requirements Milestones and Metrics for Domains 2 and 3 contains requests for information with legal protections of privacy and security, especially as it pertains to HIPAA. Ninety-two percent of the projects refer to identified/targeted patients or patient registries as a metric/deliverable or data source. References are found in the following projects:

- Domain 2: a.i, a.ii, a.iii, a.iv, a.v, b.i, b.ii, b.iii, b.iv, b.v, b.vi, b.vii, b.ix, c.i, c.ii, and d.i;
- Domain 3: a.i (Models 1 and 3); a.ii, a.iii, a.iv, b.i, b.ii, c.i, c.ii, c.ii. d.i, d.ii, d.iii, e.i (Models 1 and 2); f.i (Models 1, 2, and 3); g.i., g.ii, and h.i.

HANYS' Comment: DOH should provide additional guidance regarding the release of PHI-level data and amend these metric/deliverables and data sources to aggregated levels such as percentages and/or summary results with small cell size provisions, to protect PHI-level data.

Clinical Governance

Section 2—Governance requires the PPS to specify how the selected governance structure will "ensure adequate clinical governance at the PPS level, including establishing quality standards and measurements, clinical care management processes, and the ability to be held accountable for realizing clinical outcomes."

Similarly, the *Governance How-To Guide* prepared by KPMG notes that PPSs should form a "Clinical Governance Committee that will establish and oversee the clinical leadership of the enterprise within each PPS." Among the functions outlined for the Committee is "oversight and continuous improvement."

Finally, in the Domain 1 DSRIP Project Requirements Milestones and Metrics, DOH indicates that quality improvement plans, root cause analysis, and meeting minutes should be the source of data for specific milestones within 2.b.vii. Similar sources are noted for 3.a.ii, 3.d.ii, 3.e.i, and 3.f.i.

As outlined above, the Clinical Governance Committee and the quality sub-committees required for specified projects will perform many of the same functions as hospital quality committees, yet their work product will be shared with an outside contractor to determine PPS compliance and effectiveness.

HANYS is very concerned that this compromises protections provided under Sections 2805-j and 2805-m of PHL, which protects hospital medical malpractice/quality assurance committee work product from being released in the course of civil litigation and from discoverability under the Freedom of Information Law. Loss of these protections and concerns about the confidentiality of their proceedings will negatively impact providers' ability to engage in meaningful conversations about quality issues and take action to improve the quality of care.

HANYS' Comment: HANYS recommends that DOH explore how to protect the work of the PPS Clinical Governance Committee and the various quality sub-committees, with protections as are currently afforded to individual hospitals under Sections 2805-j and 2805-m of PHL.

DSRIP Organization Application

Section 1—Executive Summary

The application specifies that response in this section will be reviewed for completeness and a pass/fail determination will be made.

HANYS' Comment: If a PPS is initially determined to have failed on this, or other pass/fail sections, it should be provided with an explanation of where its response falls short and given an opportunity to provide additional information before a final determination on the application is made.

Section 2—Governance
Description
The PPS must include a detailed description of how the PPS will be governed and how the PPS system will progressively advance from a group of affiliated providers to a high performing integrated delivery system. A successful PPS should be able to articulate the concrete steps the organization will implement to formulate a strong and effective governing infrastructure.

Governance Organizational Structure
When applicable, outline how the organizational structure will evolve throughout the years of the DSRIP program period to enable the PPS to become a highly performing organization.

HANYS' Comment: Consistent with the Governance How-To Guide, there are a number of different permissible governance models and the scoring of the governance section should be without bias or higher scores for particular favored models since what will work effectively for each PPS will be dependent on the composition of the PPS and regional market and preferences. We further expect that the governance of PPSs will evolve over the years in response to successes, weaknesses, and the transformation of the system. At this point, it would be very difficult for an applicant to foresee with confidence what the ultimate governance structure might be.

PPS Financial Organizational Structure—*the requirements include:*

- *Description of the PPS' plan to establish a compliance program in accordance with New York State Social Security Law 363-d.*

HANYS' Comment: Social Services Law § 363-d requires that Medicaid providers develop, adopt, and implement effective compliance programs and specifies core elements that must be included in all compliance programs. This description would be more appropriately included in the scoring for the compliance requirements and **not** the Financial Organizational Structure. In addition, each individual provider that joins the PPS will have a pre-existing compliance plan. While PPSs with some governance structures, such as the Incorporated Model, may develop a comprehensive compliance plan that covers all members, PPSs with other structures, such as the Collaborative Contracting Model, may continue to operate with individual compliance plans for each provider. The application instructions should allow for this possibility and instruct the PPS that instead of describing a plan to establish a compliance program, the PPS may describe the process that will be used to review and coordinate the pre-existing individual plans.

Section 3—Community Needs Assessment

Healthcare Provider and Community Resources Identified Gaps—*the requirements include:*

- *Identify the health and behavioral health service gaps and/or excess capacity that exists in the community,* ***specifically outlining excess hospital and nursing home beds****.*

HANYS' Comment: Specifics on the ability of the healthcare system to undertake bed reductions will evolve and is difficult to estimate with precision especially given the need to maintain required capacity for disaster preparedness and outbreaks such as Ebola.

Community Resources Supporting PPS Approach
Community based resources take many forms. This wide spectrum will include those that provide basic life needs to fragile populations as well as those specialty services such as educational services for high risk children. There is literature that supports the role of these agencies is stabilizing and improving the health of fragile populations. These resources should include but not limited to the following:

- *Housing services for the homeless population including advocacy groups as well as housing providers;*
- *Food banks, community gardens, farmer's markets;*
- *Clothing, furniture banks;*
- *Specialty educational programs for special needs children (children with intellectual or developmental disabilities or behavioral challenges);*
- *Community outreach agencies;*
- *Transportation services;*
- *Religious service organizations;*
- *Not for profit health and welfare agencies;*
- *Specialty community-based and clinical services for individuals with intellectual or developmental disabilities;*
- *Peer and Family Mental Health*
- *Advocacy Organizations;*
- *Self-advocacy and family support organizations and programs for individuals with disabilities;*
- *Youth development programs;*
- *Libraries with open access computers;*
- *Community service organizations;*
- *Education;*
- *Local public health programs;*
- *Local governmental social service programs;*
- *Community based health education programs including for health professions/students;*
- *Family Support and training;*
- *NAMI;*
- *Individual Employment Support Services;*
- *Peer Supports (Recovery Coaches);*
- *Alternatives to Incarceration;*
- *Ryan White Programs; and*
- *HIV Prevention/Outreach and Social Service Programs.*

Please address the following in the response:

- *Describe in an aggregate level the existing community resources, including the number and types of resources available to the PPS to serve the needs of the community.*
- *Outline how the composition of the community resources needs to be modified to meet the needs of the community.*

HANYS' Comment: To ensure that PPSs are aware of all possible resources, HANYS encourages DOH, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and other state agencies to provide a directory of these resources, because these agencies should have access to more comprehensive information than PPSs. While hospitals have historically collaborated with community organizations and the *Prevention Agenda* has begun to expand those collaborations, collecting a comprehensive listing is overly burdensome given the significant number of organizations that exist and the variation across communities. HANYS recommends that a list of resources that is relevant to the projects selected by the PPS is more appropriate.

Section 5—PPS Workforce Strategy

Workforce Strategy Budget—*the requirements include:*

In the table below, identify by DSRIP project number the planned spending the PPS is committing to in its workforce strategy over the term of the waiver. The PPS must outline the total funding the PPS is committing to spend over the life of the waiver. The larger the financial commitment to the workforce strategy, relative to the size of the PPS, will have a direct impact on the scoring of this section.

HANYS' Comment: We object to the undue weight given to the proportion of total funds committed to workforce spending. Currently, the total amount of potential DSRIP funds for each PPS is unknown and depends upon a number of factors, including the funds awarded to all other PPSs across New York State, so it is extremely difficult to project spending with any confidence at this juncture. Workforce spending will also be highly contingent upon the specific circumstances of each PPS plan such as the mix of DSRIP projects, current staff vacancies for PPS members, local labor conditions, and health professional shortages in the local market. Other questions in the Section 3 request detailed information on the PPS' overall workforce strategy, impacts on specific categories of existing staff, retraining and redeployment of existing staff, and new hires. The responses to these questions provide the data and context necessary to evaluate the PPS workforce plans and are a better gauge of the PPS workforce strategy than a spending budget. We request that the requirement for a workforce strategy budget be eliminated.

State Program Collaboration Efforts

Describe the PPS workforce strategy and how it may intersect with existing State program efforts, please include the following in the response below:

- *As applicable, describe any plans to utilize existing state programs (i.e., Doctors Across New York, Physician Loan Repayment, Physician Practice Support, Ambulatory Care Training, Diversity in Medicine, Support of Area Health Education Centers, Primary Care Service Corp, Health Workforce Retraining Initiative, etc.) in the implementation of the Workforce Strategy—specifically in the recruiting, retention or retraining plans.*

HANYS' Comment: While HANYS was pleased to see that the application acknowledges Doctors Across New York (DANY) and other state-funded programs by asking applicants to indicate their intent to utilize these funding sources, it is problematic given that funding for the DANY program in particular has been limited and very erratic. While the statutory authority that created DANY was passed in 2008, there have only been three cycles of funding for this program in six years. For this program to be a useful resource to all DSRIP PPS applicants, there must be a consistent and sufficient funding stream and annual solicitation that is released on a certain date each year. Workforce comments made by emerging PPSs in initial project plans indicate a significant need for primary care and behavioral health practitioners. DANY funding is currently being extended through small legislative add-ons to the state budget each year after sustained advocacy, and this funding could only satisfy a small fraction of the needs of emerging PPSs throughout New York State.

Section 8—DSRIP Budget and Flow of Funds

The application specifies that response in this section will be reviewed for completeness and a pass/fail determination will be made.

HANYS' Comment: If a PPS is initially determined to have failed on this, or other pass/fail sections, it should be provided with an explanation of where its response falls short and given an opportunity to provide additional information before a final determination on the application is made.

Budget and Flow of Funds Description*—the application includes the following requirement:*

To summarize the methodology, please identify the percentage of payments PPSs intend to distribute amongst defined funding distribution categories. Funding distribution categories must include (but are not limited to):

1. ***Cost of Project Implementation:*** *the PPS should consider all costs to be incurred by the PPS, such as salary and benefits, contractor costs, materials and supplies, and its participating providers in implementing the DSRIP Project Plan.*

2. ***Revenue Loss:*** *the PPS should consider the revenue lost by participating providers in implementing the DSRIP Project Plan through changes such as a reduction in bed capacity, closure of a clinic site, or other significant changes in existing business models. In addition, funding can be distributed based upon providing the necessary funding to sustain the safety net.*

3. ***Internal PPS Provider Bonus Payments:*** *the PPS should consider the impact of individual providers in the PPS meeting and exceeding the goal of the PPS' DSRIP Project Plan.*

HANYS' Comment: While HANYS agrees that these categories are important considerations, currently the total amount of potential funds for each PPS is unknown and depends upon myriad factors, including the other PPSs across New York State—and that information is required to reasonably estimate percentages. The application instructions should acknowledge this difficulty and instruct the PPS that instead of estimating percentages, the PPS should describe how each of these categories will specifically factor into allocating performance payments.

Domain 1—Project Budget & DSRIP Flow of Funds Milestones*—milestones include:*

Quarterly or more frequent reports on the distribution of DSRIP payments by provider and project and the basis for the funding distribution ***to be determined by the Independent Assessor.***

HANYS' Comment: It is unclear what the Independent Assessor will determine and we request clarification.

Section 9—Financial Sustainability Plan

Path to PPS Financial Sustainability*—In the narrative, please address the following:*

- *Describe how the PPS will ensure fragile safety net providers will achieve a path of financial sustainability.*

HANYS' Comment: We expect that the PPS partnerships with fragile safety net providers will continue to develop and ultimately facilitate their appropriate path to financial sustainability. At this point, many PPS applicants may not be able to provide a plan or vision to financial sustainability for their partners in any but the most general terms, because these partnerships are in the early formation stages. We believe that scoring the PPS on the quality of their response to this question will be highly problematic and it should be eliminated.

Strategy to Pursue and Implement Payment Transformation to Support Financial Sustainability*—the requirements include:*

Please describe the PPS' plan for engaging in payment reform over the course of the five year demonstration period. This narrative should include:

- *Articulate the PPS' vision for transforming to value based reimbursement methodologies and how the PPS plans to engage Medicaid managed care organizations in this process.*
- *Outline how payment transformation will assist the PPS to achieve a path of financial stability, particularly for financially fragile safety net providers.*

HANYS' Comment: The transformation to value-based reimbursement will be a gradual process that will evolve over time as the PPS develops. At this point, many PPS applicants may not be able to provide a plan or vision for this transformation in any but the most general terms. In addition, cooperation of Medicaid managed care organizations in this transformation is necessary but it is largely outside the ability of the PPS to plan or control. We believe that scoring the PPS on the quality of its response to this question will be highly problematic and it should be eliminated.

Section 10—Bonus Points

Proven Workforce Strategy Vendor*—specifies:*

If the response can effectively demonstrate the PPS Lead contracted with a proven and independent organization to assist the workforce strategy the PPS will be awarded 3 additional bonus points to each project application score.

HANYS Comment: DOH should provide a list of vendors that meet this criterion as examples of the type of organization that is contemplated. The list should not be a comprehensive list of all qualified vendors but should include a number of organizations to serve as examples.

DSRIP PPS Project Plan Applications

Domain 2

2.b.iii ED Care Triage for At-Risk Populations

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. In order to assess scale, please complete the following information below.

a. Please indicate the total number of Emergency Department sites where Care Triage will be established by the Demonstration Year 4, or sooner as applicable.

HANYS' Comment: The application should also request the number of individuals served by the Emergency Departments, because that information will also be needed to evaluate the scale of implementation.

2.a.i Create an Integrated Delivery System

System Transformation Vision and Governance—*The subjective metrics for Project 2.a.i. include:*

b. Please describe how this project's governance strategy will evolve participants into an integrated healthcare delivery system. The response must include specific governance strategy milestones indicating the commitment to achieving true system integration (e.g., metrics to exhibit changes in aligning provider compensation and performance systems, increasing clinical interoperability, etc.).

HANYS' Comment: We expect that the governance of PPSs will evolve over the years in response to successes, weaknesses, and the transformation of the system. While the applicant might supply information on the ultimate goal and the strategy that will be followed to move toward that goal, the formulation of specific milestones and metrics may not be possible at this time.

Scale of Implementation—*the application requests:*

a. Please indicate the total number of providers by county that the PPS intends to include in the IDS by the end of Demonstration Year 4, or sooner as applicable.

HANYS' Comment: The application requests the total number of committed providers and number of safety net providers for multiple provider types by county. There is no apparent need for this information at a county level. Providers serve patients from multiple counties and the provider location has little value in evaluating the scale of the PPS. The application should be revised to eliminate the request for information by county and instead request the information for the total PPS.

Scale of Implementation—*the application requests:*

a. Please indicate the total number of providers by county that the PPS intends to include in the IDS by the end of Demonstration Year 4, or sooner as applicable.

Speed of Implementation/Patient Engagement—*the application requests:*

Please indicate the expected timeline for engagement of patients within the project. It specifies that: "For this project, Actively Engaged is defined as patients residing in counties served by the PPS having completed a RHIO Consent Form."

HANYS' Comment: While we recognize the importance of establishing systems to exchange data and the need to involve patients in this process, accurate projection of the number of patients that will complete a RHIO Consent Form will be difficult. One alternative measure of patient engagement would be the number of patients served by PPS Patient-Centered Medical Homes (PCMHs). This information could be more accurately projected by the PPS.

2.a.ii Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan [SHIP])

Project Objective: *This project will transform all safety net providers in primary care practices into NCQA 2014 Level 3 Patient Centered Medical Homes (PCMHs) or Advanced Primary Care Models by the end of DSRIP Year 3.*

Project Requirements:

1. Ensure that all primary care providers within the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.

HANYS' Comment: The project requirement (including in DSRIP Domain 1 Requirements Metrics and Milestones) should be made consistent with the project's objective that all safety net primary care providers need to meet the threshold, as opposed to all primary care providers. This consistency avoids discouraging PPSs to include non-safety net providers, which increases access to Medicaid beneficiaries.

2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

HANYS is pleased to see that DOH has added an 11th Project (2.d.i), which will enable the uninsured and low-utilizers of Medicaid to benefit from a transformed healthcare delivery system. According to the revised DSRIP Project Toolkit, the outcome metrics for this project will differ by population, with non- and low-utilizer Medicaid Members to be measured at Level 3 or Level 4 on the Patient Activation Measure (PAM), and the uninsured population to be measured at Level 4 on PAM.

HANYS' Comment: It is not clear why activation goals differ for these two patient populations. HANYS recommends that DOH adjust the PAM measurement expectations to be consistent to reach a Level 3 or 4. The uninsured population may not yet be receiving healthcare services and/or is receiving services that are not being delivered in the most coordinated, efficient setting. It will be much more difficult for this patient population to even reach Level 3, much less 4, on PAM.

Project 2.b.viii—Hospital-Home Care Collaboration Solutions
This project requires implementation of an INTERACT-like program in the home care setting to reduce risk of hospitalizations for high risk patients. Interventions to Reduce Acute Care Transfers (INTERACT) is a quality improvement program that focuses on the management of acute change in skilled nursing facility (SNF) resident condition. The tool has been adapted for other settings, including home health care.

HANYS' Comment: HANYS urges DOH to describe the principles of the INTERACT Home Health Tools that it believes are most relevant. Many providers are not experienced with this strategy and will not understand the meaning of an "INTERACT-like" project without reviewing the reference material.

Domain 3

Inconsistencies with the DSRIP Project Toolkit

HANYS appreciates that DOH incorporated suggestions submitted in our comments on the Draft DSRIP Project Toolkit, particularly as it relates to flexibility in selecting evidence-based models for several Domain 3 projects. In general, HANYS recommends that DOH provide flexibility for PPSs to adopt alternative methodologies and incorporate new proven and effective approaches over time, as the science evolves.

In reviewing the Project Plan Application, however, that much-needed flexibility seems to have been overlooked. As an example, Project 3.f.i lists the Nurse-Family Partnership as the only model for home visiting (page 150), but the DSRIP Project Toolkit listed the Nurse-Family Partnership as just one example of home visiting programs, and noted that "potential programs include Nurse-Family Partnership . . . and Healthy Families New York" (page 64).

Similarly, in the Project Plan Application, Projects 3.a.iii and 3.d.i require use of the New York City Department of Health and Mental Hygiene's and the Fund for Public Health NY's Medication Adherence Project, while the Toolkit notes that "Other evidence-based training and tools may also be used" (pages 50, 59).

HANYS' Comment: HANYS recommends that DOH resolve inconsistencies between the DSRIP Application and the Final Version of the DSRIP Project Toolkit.

> ***Project 3.f.i Increase Support Programs for Maternal and Child Health (Including High Risk Pregnancies)***
>
> *The DSRIP Application outlines three models for intervention that may be utilized for Project 3.f.i. Model two includes engagement of Regional Perinatal Centers (RPCs) in efforts to establish a care/referral community network based on a regional center of excellence for high risk pregnancies and infants. Many hospitals already have established relationships with a RPC; however, the new collaborations and partnerships that will be formed as part of DSRIP may require changes to the existing relationships as part of the DSRIP Application Process, or later in the PPS lifecycle.*

HANYS' Comment: HANYS recommends that DOH provide flexibility for PPSs to change current and future relationships with RPCs as PPSs work to provide the best care for high risk pregnant women and their infants.

Project Requirements Milestones and Metrics

Domain 1

Typographical Errors
The Domain 1: Milestones and Metrics document includes typographical errors that fundamentally change the meaning of the sentences.

Project 2.b.viii Hospital-Home Care Collaboration Solutions
Under Metric/Deliverable, Project Requirement 3 should read: "PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor *chronically* ill patients and avoid hospital readmission."

Similarly, the associated Data Source(s) should read: "Documented strategic plan for monitoring of *chronically* ill patients and hospital avoidance; implementation plan; Written training materials; List of training dates along with number of staff trained."

Project 3.a.v Behavioral Intervention Paradigm (BIP) in Nursing Homes
Under Metric/Deliverable, Project Requirement 6 should read: "PPS monitors medication administration to identify opportunities for *medication* reduction, especially where early behavioral interventions can be used to prevent use of medication."

HANYS' Comment: HANYS urges DOH to correct these errors.

Domain 3

Project 3.a.i (Models 1 & 2) Integration of primary care and behavioral health services
Metric/Deliverable, Project Requirement 1 states-

Primary care services are co-located within behavioral health practices during all practice hours.

HANYS' Comment: The stipulation for all practice hours should be eliminated because certain markets have unique challenges, such as rural settings with workforce recruitment, particularly as it relates to behavioral health services. Further, some hospital off site extension clinic facilities, especially in rural areas, are small in size and could not accommodate offering both primary care and BH services at the same time.

DSRIP PPS Application Scoring Guide

Example Scoring of Objective Areas
The Scoring Guide provides an example to demonstrate how the Independent Assessor will review a group of PPS(s) that complete an application for Project

> *2.b.i (Ambulatory ICU). The example methodology for 2.b.i calculates scores for four metrics: 1) Number of Ambulatory ICUs, 2) Percentage (%) of Safety Net Providers, 3) Percentage (%) of Targeted Patients Actively Engaged, and 4) Number of Years to Project Implementation. Once the data is grouped the Independent Assessor will divide the dataset for each scored section into four tiers based on the highest response submitted of the 13 PPSs. Then, a score is assigned "based on the individual rank within the 4 quadrants."*

HANYS' Comment: How would the scoring for Percentage (%) of Safety Net Providers be calculated where multiple provider types are involved in the project? For example, Project 2.a.i Create an Integrated Delivery System requires the PPS to separately report safety net information for hospitals, primary care providers (PCPs), nursing facilities, behavioral health providers, and all other providers. Would the Percentage (%) of Safety Net Providers be ranked and scored separately for each of these? If a single overall Percentage (%) of Safety Net Providers would be calculated, it should be done as an average of the percentages for each type of provider **not** as a percentage calculated by summing the data for all provider types (which would give extremely high weight to the PCP category and slight weight to the hospital category).

HANYS' Comment: One of the example metrics is the Number of Ambulatory Intensive Care Units (ICUs). In the example, each PPS is ranked on the expected number of ambulatory ICUs it will implement and higher scores are given to those with higher counts. The scoring should take into account the size of the PPS service area and the population it will serve. Instead of a simple count of units, the metric should be the ratio of Ambulatory ICUs to the total attributed population. This should be true for scoring all projects—scoring should not be based on counts and should instead be based on counts divided by an appropriate population.

HANYS' Comment: The scoring guide should indicate how the tier classification will be determined. This will likely require adjustments to account for variation explained by circumstances outside the scope of PPS control such as markets and populations. Minimally, there should be no requirement for tiers with equal number of PPSs, because in many cases, that will inappropriately delineate variation. Calculating a z-score is a common methodology to standardize while preserving variation.

HANYS' Comment: How would the scoring methodology be applied in the case of projects that only a small number of PPSs elect to implement? For example, only two PPSs listed Project 3.H.i. Specialized Medical Home for Chronic Renal Failure in their grant applications. The project used in the scoring example, Ambulatory ICUs, was selected by only three PPSs. In the grant applications, there are several projects in Domains 2 and 4 that were selected by a small number of PPSs—two of the projects were selected by only two PPSs, five of the projects were selected by only three PPSs, three of the projects were selected by only four PPSs. The proposed scoring methodology could lead to extreme and inequitable results when applied to such small numbers of PPSs.

October 29, 2014

To Whom it May Concern:

Montefiore Health System, lead applicant for the Hudson Valley DSRIP Collaborative (HVDC), provides the following comments on the draft DSRIP plan application materials:

Level of Detail Solicited

We appreciate DOH's intention to ensure that project valuation is based upon discrete and scoreable elements. And while the HVDC is hard at work to develop specific implementation plans in line with the types of information solicited in the organizational and project plan application, it is simply too early to provide that level of information. Areas of challenge include:

- **Workforce:** Identifying percentages of workers who will be retrained or redeployed; specification of impacts to current wages and benefits to existing employees; and number of new jobs by category
- **Budget and Funds Flow:** Outlining percentage of funds that will be allocated to project implementation costs, revenue loss, and bonus payments when the actual PPS performance in a given year may influence this apportionment
- **Project Plan Applications:** Identifying participating providers and setting the scale of implementation
- **Community Health Needs Assessment:** Defining excess hospital and nursing home beds; assessing the availability, affordability, acceptability, and quality of all health services in a region; and identifying solutions to all identified gaps

Instead of seeking the specific items above, we recommend that DOH request narrative information on the overarching approach and process the PPS intends to undertake to determine workforce allocation, budget and funds flow processes, and approach for project scale-up, as well as more general findings from the community needs assessment. Our concern is that responses to the queries above will be overly speculative and that seeking written commitment to particular approaches will lock PPSs into strategies that should rightly be adjusted with the benefit of further experience. We believe it is more reasonable to solicit this information after implementation planning, as well as offer pathways for PPSs to dynamically update project plans once implementation is underway.

Provider Certification Requirements

The project plan application for Domain 2 indicates that all providers must have EHRs that meet meaningful use requirements and PCMH level 3 by DSRIP Year Three. The HVDC will strive to meet that objective to the maximum extent possible, but

recommends that there be some flexibility for organizations that have limited or no EHR capacity at the start of DSRIP or are not yet PCMH certified.

Regulatory Relief

In the regulatory relief section, we believe it would be valuable for DOH to also seek information on non-regulatory barriers, such as operational hurdles or other legal/statutory barriers to implementation. Of particular note, we strongly urge support for a single, simplified patient consent form to enable information exchange and care coordination among PPS providers connected to a qualified entity/regional health information organization; this area is not discussed in the state's regulatory flexibility guide, but we believe it is critical to the success and population health aims of DSRIP. We have attached comments Montefiore submitted to the Department of Health on the proposed Statewide Health Information Network for New York (SHIN-NY) regulations as further context on this issue.

Additionally, we request further guidance on the process for updating or applying for further waivers once implementation is underway and other needs become evident.

Stakeholder and Community Exhibit

The stakeholder and community exhibit section seems to solicit information on stakeholders within and outside of our PPS that contributed to the project design development. We have worked with our entire PPS through electronic communication and in-person meetings to design projects. To avoid simply repeating the entirety of our PPS network, we recommend that this section focus only on partnerships with organizations outside of the PPS.

Proven Workforce Strategy Vendor

We request that this section not be restricted to vendors, but also open up the opportunity for PPSs to supply information on whether the lead applicant or particular partners have internal workforce resources that can be brought to bear in DSRIP.

BRAVE NEW WORLD – CREATING A COMPLICATED SYSTEM TO IMPROVE THE HEALTH CARE DELIVERY SYSTEM IN NEW YORK STATE

A review of the DSRIP part of the New York State Medicaid Waiver from a community/consumer perspective

This review is in three parts:

- Introduction and Recommendations
- Critical Issues of Concern for Communities and Consumers
- Specific Issues in Documents

Introduction

DSRIP – the Delivery System Reform Incentive Program – is developed as an extraordinarily intricate, complicated, and perhaps beneficial proposal to transform the health system (really hospital system) in New York State. This complex system is spawning an expanded policy, program, and legal consultant business. Commenting on the draft implementation documents prepared by the State Health Department, and its contractors, is a major endeavor, not only because of the numbers of pages to review, but also because of the detailed strategies.

It is critical to note, admiringly, that the Special Terms and Conditions negotiated between the State and CMS, governing the state Medicaid waiver, require official oversight along with many points of public involvement on proposals, draft documents (such as these documents), and more. This is a critically important opportunity which has not been available during other state-approved waivers.

There has already been one effort to influence the waiver which has been successful – uninsured residents should be counted in attributing patients to the Performing Provider Systems (PPS). Community arguments in favor focused on the uninsured living in same communities as Medicaid beneficiaries and using the same safety net providers. Based on this advocacy argument, a new Project 11 was devised which includes focus on the uninsured. Unfortunately, the advocacy efforts to limit the definition of safety net providers, was not successful. The State chose to support the hospital associations advocacy to broaden the definition and therefore which providers would be eligible for funding under DSRIP.

A major issue that must be addressed is the unequal delivery of health care services. If care is not delivered in a culturally competent way in the patient's primary language; if hours of service do not work for many residents, if attitudes of those providing service is not improved, if there is no consistency in a patient's health care provider, and more; no

amount of money will improve access to services and thus the transformation of a system.

This review will focus on community/consumer-related provisions of the waiver. Other issues are outside the expertise of these reviewers, but that does not mean that they are unimportant. We hope that others will review these areas and share their concerns. It is also difficult to review and comment on the massive number of pages during the short review time allowed.

Overall Recommendations

1. **The structure of the PPS must clearly spell out the relationships as well as the power relationship who is in charge and how are decisions made.**
2. **There is a strong need to add evaluators from New York to the evaluation team who are more than professionals. A process of choosing residents/organizations with no conflicts of interest should be begun immediately so that they could be available on time for the early next year process of evaluating the PPS applications.**
3. **The application needs to require outreach in culturally competent manner and adjustments to the system that make services more accessible. It also needs to require involving the trusted community organizations and institutions so that harder-to-reach residents feel comfortable.**
4. **There is a need to focus on health care disparities in access and outcomes of care, otherwise a system could be transformed for some without ever getting to people who face the most difficulty.**
5. **Concern Is raised that if involved early, stakeholders could have informed how the CNA was done and how to target critically. Performing a CNA over a large geographic area is likely to mask some critical problems that affect some part of the population, and therefore not be chosen as one of the projects to pursue. .**
6. **It is important to include a requirement that the PPS's contract with community-based organizations, just talking about partnering is not adequate. The CBO's need appropriate financing to ensure that they are partners and doing a thorough job.**

Critical Issues of Concern for Communities and Consumers

Leadership is Critical

Much of the success of each PPS will rely on the lead organization. This organization will need to be open to a changed way of providing care and functioning within a coalition effort. Large institutions are not typically comfortable sharing power and decision-making with others. Yet if that is not what happens, carrying out the mandates

of this project for the five years of the waiver will be very difficult. The structure of the PPS must clearly spell out the relationships as well as the power relationship.

Assessor/Evaluator

The Organizational application, Project Plan applications, and Application scoring guide documents are comprehensive and overwhelming. The PPS application submitted is to be evaluated and scored based on objective **criteria** and subjective **opinions**. This may be the most complicated (although short) of the four to five documents regarding the application. **The Assessor is an international corporation chosen by the State Health Department, the Public Consulting Group (PCG). The description of health activities on PCG web site include*: PCG Health helps state and local health agencies achieve their performance goals. Our seasoned professionals and proven solutions help agencies to increase program revenue, cut costs, and improve compliance with state and federal regulations. From behavioral health cost reporting to public hospital rate setting, PCG Health offers a wide array of consulting services to help state and local health agencies operate more efficiently and improve service to the populations they serve.*** Based on this description, it does not appear that PCG has focused on evaluation services, so it is not clear their level of skill and experience in this arena. Even if approved for funding, the amount of dollars allocated to PPS will be based on Medicaid residents attributed to the system and based on the scoring system set up. The evaluators involved are critical to the scoring system working. In particular, the subjective scoring must not be left in the hands of a corporation, no matter how good it is. There is a strong need to add evaluators from New York who are more than professionals. A process of choosing residents/organizations with no conflicts of interest should be begun immediately so that they could be available on time for the early next year process.

Health Care vs. Medical Care

The New York State approved 1115 Medicaid waiver is complicated, sweeping, and potentially transformative. Practicing business as usual in the medical care system in the city will not accomplish the major goal of this waiver – reducing unneeded hospitalizations by 25% over the five years of the waiver. There are superficial changes that could make a bit of a difference by influencing the "top of the heap" or reaching people amenable to being reached. But for those who are not engaged in the system and/or are not easily reached by health message, more needs to happen. The more that needs to happen is known as the social determinants of health, which are everything including medical care, e.g., housing, environment, food, and more. A broader health care planning effort is needed to truly transform the system. This broader effort requires involving other than medical personnel**.** It requires outreach in culturally competent manner and adjustments to the system that make services more accessible. It also requires involving the trusted community organizations and institutions so that harder-to-reach residents feel comfortable.

Health Care Disparities vs. Population Health

This waiver focuses on population health, or addressing the health of an entire community. Action addressing health care disparities is targeted to the differential in access to care and outcomes in care provided based on race and ethnicity. The population health focus negates the breadth of studies showing that changing the numbers will be near impossible, or at least very difficult, if one does not address individuals with the most difficulty. A system could be transformed for some without ever getting to people who face the most difficulty.

Community Health Needs Assessment

Each of the emerging Performing Provider Systems that received a planning grant within this waiver, are required to perform a community health needs assessment (CNA) and to determine which projects to pursue based on results of the assessment. In New York City, many of the PPS's contracted with the same consultant organization to perform the assessment. Since important decisions will be based on this project, the outcomes are clearly critical to many communities. A requirement is the involvement of stakeholders in the development of the CNA, including labor, Medicaid beneficiaries and community based organizations. Yet, it is unclear how many, if any, of the PPS's actually involved these stakeholders, other than being involved in being interviewed and/or focus groups. But if they had been involved, stakeholders could inform how the CNA was done and how to target critically. Performing a CNA over a large geographic area is likely to mask some critical problems that affect some part of the population, and therefore not be chosen as one of the projects to pursue. .

Partnering vs. Contracting

It is appropriate to see that working with community-based organizations is mentioned within many of the domains and projects. The recognition of the important role played by local, trusted groups is welcomed. As noted above, working with community organizations will be an important determinant of success in achieving the goals set in the projects selected for implementation. Reaching populations that might otherwise be left out, is a critical part of the overall success of the waiver. A problem exists however in that the word partnering is used but, except for rare instances, there is no mention of contracting with community organizations. The type and quality of work, with important outcomes, anticipated for community organizations must be remunerated at an appropriate rate. It is important to include a requirement that the PPS's contract with community-based organizations. The Organizational Application document, Section 8, details the budget and flow of funds, and contains the following language: "Describe on a high level on how the PPS plans to distribute funds among the clinical specialties, such as primary care vs. specialties, and, among organizations along the care continuum, such as SNFs, LTACs, and Home Care." The focus for funding is on clinical

services and does not address the important non-clinical services that must be provided.

The importance of Project 11

Project 11 (2.d.i), is a special new project developed to address care for the uninsured, as well as Medicaid non-utilizers and low-utilizers of service. This project was added as a result of advocacy efforts by advocates and community organizations. This project, in particular, will need strong involvement from community organizations to ensure that connection is made with this population. The parameters of this project are just available in the DSRIP Project Tool Kit (pages 41-45). A potential problem exists in that the methodology for this outreach is limited to an evidence-based methodology, the Patient Activation Measures (PAM). Although this is a tested method, it may not be the only or the best way of reaching this population. In spite of this concern, the detailed description of activities and outcomes in this section are an important guide to reaching hard-to-reach residents.

Some Specific Issues In The Documents

This section will discuss some of the specific issues in each of the four main documents released by the State Health Department to use as guide for implementing the DSRIP PPS'. Review of the documents, with comments, are due by October 29th, 2014.

DSRIP PPS Organizational Application, dated September 29, 2014

Section 1 – Executive Summary, page 3. One of the few places where it says "and address identified health care disparities"

Section 2 – page 6 – The Project Advisory Committee scoring process (PAC). There is no membership requirement detailed, including how representative the membership is. Details of expectations of representation should be included, by type of CBO, race, ethnicity, disability and more.

Section 3 – page 9. The description of the Community Needs Assessment should be required the differences among and between neighborhoods in the geographic area, and how determination was made on how to focus and choose projects based on targeted need.

Pages 11 and 12 – The listing of community resources is excellent, but is missing some important organizations, e.,g., immigrant serving organizations, organizations based on race and ethnicity, faith-based organizations. There is no requirement to describe the nature of the involvement with these organizations, e.g., contracting for services.

Page 13 – Healthcare Provider and Community Resources identified Gaps – There are other important barriers that are not listed, e.g. language access, and wait to get an appointment.

Page 14 – Stakeholder and Community Engagement. This section is allocated a very small percentage of the overall scoring, and yet is critical if done right, to develop a meaningful product. There should be a spelling out of requirement for consumer/CBO direct involvement in the planning activities.

Section 7 – PPS Cultural Competency/Health Literacy There two are lumped together as if they were one and the same – but they are not.

Section 8 – DSRIP Budget and Flow of Funds – page 27 – When listing services to contract with and dollar flow, community-based services and community-based organizations are not listed. It is critical to require contracting, as some PPS' may not understand the benefits of such arrangements.

Section 10 – Bonus Points – page 31. Unclear.

DSRIP Project Plan Applications

2.a.iv – Create a Medical Village Using Existing Hospital Structure – page 16. This requirement proves that this is all about setting up "mini Bergers" or little hospital closing commissions. There will undoubtedly be recognition of excess hospital beds after the PPS' and the new services are developed. There should be a process after services are developed and new patterns of care are identified, to review where excess is located. It will be too easy under this provision to target safety-net providers in medically underserved immigrant and communities of color, as has been done in the past. This pattern **must** not be allowed to continue.

Transitional Housing – page 5` -- This is perhaps the only project where there is a recognition of the need to contract with community organizations to provide the housing.

Create a Community Based Health Navigation Service to Assist Patients – Page 70 – This clearly should be a project in which contracts are drawn with community based organizations, but it does not specify the contracting. There should be a mechanism for reporting problems faced by patients (unlike the State funded navigators) with the ability to do advocacy for changes.

Implementation of Patient Activation Activities to Engage, Educate and Integrate the Uninsured low/non-utilizing Medicaid Populations into Community Based Care – page 80. This is now the description of the 11th Project that was long-sought. The reliance on Patient Activation Measures (PAM) as the sole methodology is troubling and should

be reviewed. There is again a recommendation for development of navigators but no absolute requirement.

DSRIP PPS Application Scoring Guide. The complexity of the scoring system should be thoroughly explained. As is, it is near impossible to understand this guide, so that a webinar or some other means to walk people through this document would be important. See notes above about recommendations to include other than the consultant Assessors and professionals in the review and evaluation of projects.

Paper prepared by Judy Wessler, with Commission on the Public's Health System and Health People.

October 16, 2014

October 29, 2014

Jason Helgerson
New York State Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: DSRIP Application Comments

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our comments on the Delivery System Reform Incentive Payment (DSRIP) Application documents. We appreciate the opportunity to provide input into this process. Below are some overarching themes, followed by specific comments on the application documents.

1. ***The Role of LTPAC Providers in DSRIP:*** As we have previously indicated, we remain concerned about the significance of the role that Long Term and Post-Acute Care (LTPAC) services will play in DSRIP. We see the involvement of LTPAC providers as being essential to achieving DSRIP objectives, and ask the Department of Health to reinforce this reality in the application documents and elsewhere. This complex initiative is evolving at a rapid pace, and without this guidance, Performing Provider Systems (PPSs) may fail to form networks with sufficiently robust LTPAC services. One way in which these opportunities could be highlighted is by naming them in the application documents, particularly in the "Scale of Implementation Sections".

2. ***Need for Investment in Health Information Technology (HIT) and Exchange:*** A consistent theme throughout our comments is the need for strategic investments in technology for LTPAC providers. The electronic health record (EHR) and Health Information Exchange (HIE) requirements in the Domain 2 projects are concerning as these providers have not had access to capital opportunities to establish the necessary platform. We anticipate that there will be multiple other needs for the Capital Restructuring Financing Program dollars available, and we can't presume or rely on that funding as the way in which all providers in the project achieve that level of connectivity. We wholeheartedly believe that this level of connectivity will be essential, but fear it is not possible without further state investment.

3. ***Skilled Nursing Facility (SNF) Bed Reduction:*** There are multiple references in the application to reducing SNF bed capacity, including the opportunity to increase the application score as a result. We note that SNF bed reduction is not necessarily the only mechanism to achieve DSRIP objectives, and in some cases, may be short-sighted. As we seek to keep people out of the hospital, nursing homes will play a key role in providing an alternative to subacute placements

13 British American Blvd. | Suite 2 | Latham, NY 12110
P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

in hospitals. In addition existing SNF beds/infrastructure can be transformed to a more acute-care (and in some cases less acute) setting without forgoing valuable and much needed residential infrastructure.

4. ***Managed Care and Managed Long Term Care:*** While the application acknowledges a role for managed care (and presumably, managed long term care (MLTC) plans), it remains unclear exactly how managed care/MLTC would be integrated into PPSs and Integrated Delivery Systems. Given the significant efforts underway to enroll Medicaid recipients into managed care and MLTC, it is important that providers and managed care plans obtain clarity on this role to ensure the efforts are complimentary and not duplicative or at odds with one another in any way.

Below we provide comments first on the Organizational Application, and then on the Project Application.

Part 1: Organizational Application

Section 1: Waivers

The application, as drafted, requires waivers to be project-specific, and requires a high level of detail. To increase process efficiency, perhaps there could be some agreed-upon blanket waivers that would be useful industry-wide in order to achieve DSRIP objectives. In addition, we recommend that PPSs have an additional opportunity in the development of the work plan process in the spring and beyond, as the needs and barriers become clearer. There are likely several factors that haven't been considered or may not be encountered until work plan implementation is underway.

Section 2: Governance

The Project Advisory Committee (PAC): There should be some bolstering of this structure to ensure LTPAC providers have a voice. For example, the application should require the PPS to explain the role/mechanism of providers with the PPS and identify a process for ensuring partnering provider roles.

Oversight and Member Removal: It is important to build in some protections for LTPAC providers in the "progressive sanctions" and procedures for member removal from a PPS.

Section 3: Community Needs Assessment

While we understand that Community Needs Assessments are under way and the timeframe is short, we urge that PPSs consider the entirety of healthcare and supportive services in a community that can help individuals remain healthy in the community.

Healthcare Provider Infrastructure: The Community Needs Assessment requires an assessment of health care and community resources capacity. The health care category should explicitly include adult day health care (ADHC) programs, hospices, and End-Stage Renal Disease (ESRD) services.

Community Resources Supporting PPS Approach: Additionally, the community resources category should explicitly include senior housing, senior centers, Naturally Occurring Retirement Communities (NORCs), home-delivered meals, and independent living centers.

Community Population Health & Identified Health Challenges: We suggest that this include "Leading Causes of Disability" in assessing the health of the population.

Section 5: PPS Workforce Strategy

This section focuses on how the existing workers will be impacted in terms of the need for redeployment, retraining, as well as potential reductions to workforce as a result of transformation of the delivery system. Unfortunately, it ignores workforce shortages, particularly the unique challenges faced in rural and other underserved areas. The section also fails to address how to meet the needs of an aging population as the ratio of potential caregivers to frail elderly individuals shrinks, including the paraprofessional aide workforce. These issues should be incorporated in the strategy.

Section 6: Data Sharing, Confidentiality and Rapid Cycle Improvement

LTPAC providers have not been able to access funding for EHR adoption, are not eligible for meaningful use incentives, and have not been actively engaged in all RHIOs. Building the software connections to connect to RHIOs costs money and will require upfront investment. These providers will need financial assistance to accomplish the objectives of data sharing and connectivity.

Section 8: DSRIP Budget and Flow of Funds

Other Safety-Net providers should be added to second bullet describing the flow of funds to PPS partners, including adult care facilities (ACFs), assisted living programs (ALPs), licensed home care services agencies (LHCSAs), and ADHC programs. It is crucial that these services are considered in this planning process.

As drafted, this gives significant power to the PPS leads, with no protections to ensure downstream providers receive any incentive funds. This section should include an explanation of how the funding distribution plan was developed to ensure all partnering providers within the PPS will be receiving necessary funding to facilitate and recognize achievement of collective goals. Providers that help PPSs achieve incentive funds should share in the benefits.

Lastly, it should be noted that details may become clearer after the PPS develops its implementation plan. Is there any opportunity to make adjustments at that time?

Section 9: Financial Sustainability Plan

We raise concern about financially fragile or tenuously stable providers taking on risk. Assumption of risk by these providers could have significant implications for other PPS providers.

Section 10: Bonus Points

We recommend that bonus points be offered to incentivize PPS leads to ensure capital funds flow to downstream providers. This would help ensure that all safety-net providers can meet Domain 2 HIT and exchange requirements. Many ACFs, ALPs, home care providers and nursing homes do not currently have EHRs and will need significant access to capital funding to make this successful. Bonus points would help the PPS achieve the objectives of the Domain 2 projects and create a truly integrated delivery system.

Further, the application process could build in more incentives to engage diverse LTPAC providers. The initial round of attribution highlighted gaps in that so many people were not attributed to any PPS.

This, and discussions with providers, suggest that this reflects a need to further engage SNFs and other LTPAC providers. Incentives to involve LTPAC providers could improve attribution results and support transitions to more integrated service delivery systems.

Part 2: Project Application, Domains 2, 3, and 4

Below are our comments on specific projects:

2.a.i: Integrated Delivery System:

The PPS is expected to use existing Health Home or ACO infrastructure to develop a comprehensive health management strategy. While Health Homes serve all regions of state, they were designed to focus on individuals with behavioral health needs and typically do not incorporate LTPAC providers. In addition, ACOs do not serve all regions of the state and, as a Medicare-driven model to date, do not incorporate long-term care. Medicaid managed care, MLTC, and the Program for All-inclusive Care for the Elderly (PACE) population health management infrastructure can and should also be deployed to support the development of these systems in order to achieve the objective to "…create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services."

The EHR and HIE requirements relative to this and other Domain 2 projects do not recognize unique challenges for LTPAC providers. As noted above, these providers have not had access to capital opportunities and meaningful use incentives. The few providers that already have systems in place may also have struggles in connecting with other providers in the region. For these reasons, we believe an additional targeted investment in HIT for LTPAC providers is needed.

For a PPS to evolve into a truly integrated delivery system that is capable of providing the full scope of Medicaid services for its attributed population, it should include residential providers serving as an alternative to premature nursing home placement (ALPs and ACFs), and providers capable of providing skilled home care services (certified home health agencies (CHHAs) and ADHC) and less skilled personal care services on a cost efficient basis (licensed home care services agencies (LHCSAs)). The current scoring construct does not account for this at all and ignores the need for community-based long term care providers in an integrated delivery system. These Medicaid LTPAC providers are designated safety net providers and play a specific role in the long term care continuum that is integral to the ability of the PPS to become an integrated service delivery system and reduce avoidable hospital use.

The "scale of implementation (3)" section should include individual lines for the expected numbers of ACFs, ALPs, LHCSAs, ADHCs, and CHHAs so as to encourage PPS leads to ensure these providers are in their network. The current scoring construct puts these providers together, along with any "other" provider type, into a single category. As drafted, it fails to recognize the unique role each of these providers plays and the need for each to be present in the continuum. The construct dis-incentivizes PPSs to have broad networks of each provider type, and perversely, creates an incentive to simply accumulate as many safety net providers as possible.

2a.iii Health Home At-Risk Intervention Program:

As above, we are concerned about the ability of LTPAC providers to achieve the HIT and HIE requirements by year 3, for the reasons noted above. Additionally, we see other home and community-based providers being critical to the success of this program, and yet the "scale of

implementation section" seems to focus solely on primary care providers. The scoring may result in a lack of focus on getting the necessary community based providers involved in the project.

2.a.iv Create a Medical Village Using Existing Hospital Infrastructure:

While not directly related to the application process, we want to identify an opportunity for DOH, the state, and communities. Hospitals will often have excess land adjacent to their property as a result of decertification. Land acquisition and cost is a major barrier to developing senior housing especially in the downstate market. Senior housing could be co-located next to the Medical Village so that residents could take advantage of the medical and support services. Such an effort could support project 2.a.v, but also provide an avenue to support much needed development of affordable senior housing.

2.a.v Create a Medical Village/Alternative Housing Using Existing Nursing Home Infrastructure:

We note that the project description on page 21 erroneously refers to "skilled nursing hospital capacity." The description goes on to say: "This project will convert outdated/unneeded hospital capacity into a stand-alone emergency department/urgent care center and/or spaces occupied by local service organizations and primary care/specialized/behavioral health clinics with extended hours and staffing." We want to clarify whether the Department is suggesting that unneeded nursing home capacity can be converted to these uses. Additionally, there is no mention of ADHC services as an option for this model; it should be explicitly included.

Under project requirements, there is a vague reference to any NORC within the PPS. It is unclear what the nexus should be between the medical village and a NORC; which we believe could be located on-site or off-site.

Project requirement #4 references consistency of any housing options with *Olmstead*. Given that all of these services would be on a campus with a nursing home and could even be in the same building or attached, we question whether this creates a compliance issue in light of the federal home and community based settings requirements. We recommend that the state provide clear guidance to those PPSs that select this project so that they develop a Medical Village that is viable when the state implements these federal requirements.

Project requirement #6 requires patient tracking using EHRs and other technical platforms. Could this requirement be a problem if housing is part of the campus? Housing operators generally do not collect such information. If the housing operator is put in the position of health care provider, they are likely going to need to meet the criteria for becoming licensed as an assisted living provider, per the Assisted Living Reform Act (Public Health Law Article 46-B).

Project requirement #8 would impose SHIN-NY requirements, including interoperability, on LTPAC providers which, as discussed above, have received no funding for HIT.

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions:

The success of this project will rely heavily on the community-based partners such as home care and ADHC that provide post-acute services. We recommend that the scale of implementation should consider those providers, and not solely hospital providers. Again, investment in HIT and HIE for post-acute providers is needed.

2 b.v Care Transitions Intervention for Skilled Nursing Facility Residents:

As above, we are concerned about the ability of SNFs to achieve the HIT and HIE requirements by year 3, for the reasons noted above. Many SNFs have not deployed EMRs, and those that have will likely also have to invest in or modify systems to ensure the appropriate level of connectivity.

2.b.vi Transitional Supportive Housing Services:

We see how this project could be particularly useful in certain communities. We are concerned, however, about how this housing is regarded in light of the state Assisted Living Reform Act (Public Health Law Article 46-B). Ironically, this project appears to have a more medical focus than the services provided by traditional assisted living facilities, and would also appear to have to be licensed as assisted living if the project is executed as outlined. It may make sense to explicitly include assisted living as a "housing provider', but also to provide clarity regarding this licensure question to those interested in this project.

2b.viii Hospital-Home Care Collaborative Solutions:

Project requirement #1 references a Rapid Response Team which includes hospice, if appropriate. We recommend adding palliative care, as well.

Project requirement # 9 mentions utilizing telehealth, but there are some reimbursement issues that pose a barrier and ideally should be worked out before the project is implemented.

As above, this project also requires considerable HIT and HIE requirements, for which LTPAC providers have not received funding.

2.c.i Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently:

We note that the application description and requirements fail to acknowledge the importance of culture as a factor in how someone accesses services. It may make sense to explicitly state this.

3.a.iii Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance:

ADHC conducts effective medication management for many registrants, including those with behavioral health issues. In addition, home care providers can be effective in supporting medication adherence. It may make sense to explicitly name these providers in the scale of implementation section, as opposed to the "other".

3.b.i Cardiovascular Health - Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only):

ADHC programs do this kind of work with this population daily, and should be considered as a resource.

3.c.i Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease—Primary and Secondary Prevention Projects (Adults Only):

Numerous ADHC programs have diabetes management programs in place and the Adult Day Health Care Council conducted an evidence based practice collaborative for diabetes management involving

ADHC programs that showed statistical, positive value for registrants involved in these diabetes management programs.

3.c.ii Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease—Primary and Secondary Prevention Projects (Adults Only):

ADHC programs would be effective partners in this project for the reasons stated under Project 3.c.i above.

3.d.i Development of Evidence Based Medication Adherence Programs (MAP) in Community Settings – Asthma Medication:

Again, ADHC programs would be effective partners in this project.

3.e.i Comprehensive Strategy to Decrease HIV/AIDS Transmission to Reduce Avoidable Hospitalizations—Development of Center of Excellence for Management of HIV/AIDS:

AIDS ADHC programs would be effective providers in this project.

Thank you for your consideration of our concerns and recommendations. If you have any questions regarding our comments, please do not hesitate to contact us at (518) 867-8383.

Sincerely,

Daniel J. Heim
Executive Vice President

cc: Greg Allen
Mark Kissinger

Medicaid Matters New York

Delivery System Reform Incentive Payment Program
Comments on the Draft Project Plan Application and Scoring Guide
October 29th, 2014

Medicaid Matters New York (MMNY) is the statewide coalition of over 140 organizations representing the interests of New York's Medicaid beneficiaries. The role of MMNY in the Delivery System Reform Incentive Payment (DSRIP) program, and all other discussions on Medicaid, is to engage in advocacy from the perspective of consumer experience and community impact. In this role, MMNY has reviewed the Draft DSRIP Project Plan Application and Scoring Guide and submits the following comments. MMNY is grateful for this opportunity and applauds the state for building transparency and public input into the development and implementation of DSRIP.

MMNY has previously communicated concerns related to DSRIP, grounded in the premise that transformation of New York's delivery system must promote accessibility, consumer protections, culturally appropriate and competent care, and elimination of health disparities. There are many factors that will contribute to the success of the DSRIP program, including but not limited to:

- Performing Provider System (PPS) governance structure and the degree to which consumers and community interests are represented;
- How applications and projects will be evaluated, and by whom;
- The degree to which non-clinical measures (like social determinants) are included in project outcomes;
- Whether appropriate consumer protections are built in and preserved (like education, notification, choice and rights);
- The degree to which health disparities are reduced, including disparities experienced in addition to race and ethnicity, such as disability, sexual orientation, housing status, and more; and,
- How community-based organizations are supported for the work they will continue to do to reach people where they are, to provide services which will greatly contribute to the overall goals of DSRIP.

The health delivery system must work for everyone, no matter who they are and what their circumstances, and the development and implementation of DSRIP will determine how successful New York State is in making that happen.

Organizational Application/PPS Structure Score

The elements of the organizational structure included in the PPS Organizational Application are integral to the success of DSRIP. Leadership structure, governance, the community needs assessment, cultural competency, health literacy, and other factors are critical in assessing the degree to which PPSs and their DSRIP projects will recognize the importance of addressing true community

need, engaging Medicaid consumers where they are, and involving community partners in a meaningful way.

Section 2. Governance

- **Governance Organizational Structure, p. 5**
    - Applicants are asked to "Specify how the selected governance structure and processes will ensure adequate clinical governance at the PPS level, including establishing quality standards and measurements, clinical care management processes, and the ability to be held accountable for realizing clinical outcomes."
    - We recommend that PPSs additionally be asked to describe their intentions for soliciting consumer feedback when establishing clinical accountability, and explain plans for integrating consumer feedback throughout the life of the PPS project.
- **Governance Members and Governance Processes, p. 6**
    - We strongly support the inclusion of the instruction asking the PPS how it will engage stakeholders, including Medicaid members, on important decisions.
    - We recommend further expanding this instruction to ask a PPS to formally engage community members and Medicaid members in the official governance process.
    - We additionally suggest engaging uninsured community members around the governance process.
    - A proposed PPS that formally includes consumers and community members in its governance structure or creates a formal, accountable input mechanism through which consumers can direct concerns and needs to the governance structure should receive a higher score.

      The PPS should be required to specify how it will distribute outcomes of meetings to various stakeholders, including PPS members, the community, and patients of the PPS. For example, the following instruction should be amended to read, "*Describe how the PPS governing body will ensure a transparent governing process, such as methodology in which the governing body will transmit the outcomes of meetings*, <u>to PPS members, the community and patients of the PPS</u>*."*
- **Project Advisory Committee, p. 6**
    - As with the PPS governance structure, the Project Advisory Committee (PAC) should incorporate direct consumer input into the project development process. The application should ask the PPS to describe its strategies for recruiting and retaining consumers and community members.
    - Applications that emphasize inclusion of consumer input into project development should be rewarded with a higher score.
- **Compliance, p. 7**
    - The application should ask the PPS to describe how it will facilitate opportunities for community members, including Medicaid beneficiaries and people who and uninsured, to file compliance complaints when necessary.
- **Oversight and Member Removal, p. 8**
    - The application should ask the PPS to describe the mechanism through which the PPS will solicit feedback from community members, including Medicaid beneficiaries and people who are uninsured, regarding a provider potentially subject to removal.

- The application should ask the PPS to describe how it will communicate member removal decisions to consumers and community members.

- **Domain 1 – Governance Milestones, p. 8**
  - The application should ask the PPS to describe how it will disseminate to community members the periodic progress reports on the PPS and DSRIP governance structure.

Section 3- Community Needs Assessment

- **Description, p. 9**
  - We strongly support the Department of Health's emphasis on understanding the particular health needs of a community through a thorough community needs assessment (CNA). In the *Description* section, the application notes that, "The CNA will be evaluated based upon the PPS' comprehensive and data-driven understanding of its service delivery system and the community it intends to serve." While adequate data are critical to a successful understanding of community needs, the application should emphasize a need for both qualitative and quantitative data. The hard numbers detailing clinical measures of the community must be verified with qualitative information solicited from community members.
- **Community Population Health & Identified Health Challenges, p. 13**
  - As PPS applicants seek to describe the community population health and Identified health challenges in their services areas, it remains crucial to carefully examine the particular demographic subgroups in each community. A community needs assessment that too broadly defines the community a PPS seeks to serve, risks losing sight of health care challenges that may be critical despite affecting a smaller portion of the community. Certain morbidities may fail to surface in a purely quantitative examination of the community at large. Rather, these morbidities may be clustered in "hotspots." Subgroup analysis will be key to detecting these "hotspots."
- **Stakeholder & Community Engagement, p. 14**
  - We strongly support the inclusion of Stakeholder and Community Engagement in the scoring of the Organizational Application. Broad stakeholder and community engagement is critical to ensuring a comprehensive and accurate CNA.
  - The application should additionally ask the PPS to, identify languages in which materials were distributed and meetings, events and focus groups were advertised and conducted; describe how meetings were advertised; describe how and why particular groups and participants were targeted for inclusion in the CNA and recruited; and describe what information regarding the proposed projects was shared with community members.
  - The PPS should be asked to include in its summary of *"key findings, insight, and conclusions that were identified through the stakeholder and community engagement process"* details on the community's experience of healthcare within the existing health care infrastructure. Additionally, the PPS should describe how the community's perception of its needs compared with those identified by data.
  - We recommend additional language asking the PPS to describe how it will continue to assess the needs of the community and facilitate community and consumer feedback throughout the life of the PPS project. As the PPS takes shape and begins to realize

improved health outcomes, it will be important for the PPS to be aware of the changing needs of its community.
    - Considering the importance of consumer and community input and buy-in to the success of any proposed PPS project, we recommend increasing the value of the Stakeholder and Community Engagement score. At just 5% of the Section 3 score, the point value does not reflect the importance of the stakeholder and community engagement, nor does it reflect DOH's commitment to active community engagement.
- **Summary of CNA Findings, p. 14**
    - The application should ask the PPS to describe how it will disseminate the CNA findings to community members and local health and social service organizations.

Section 5 – PPS Workforce Strategy

- **Description, p. 17**
    - We support the goal of reducing avoidable hospitalizations and accept the workforce changes that will naturally result from a shift towards quality, rather than quantity care. PPS applicants should be careful to consider the potential effects of workforce changes on a patient's provider choice. As necessary workforce changes take effect, a PPS should work to preserve an adequate range and choice of providers and service intensity levels, especially for communities already facing health care resource shortages.
- **Analysis of Workforce Impact: *New Hires*, p. 19**
    - As PPS applicants consider the new roles and responsibilities that will be needed to successfully carry out their projects, incorporation of Community Health Workers and Peer Support Specialists in PPS projects should be encouraged. Community Health Workers come from the communities served by PPSs and act as a liaison between communities and providers. Community Health Workers have a history of successfully engaging community members in integrated care models.[1] They have been shown to promote improved access to care and reduce health disparities. Additionally, Community Health Workers can be a cost-effective support in the effort to improve population health outcomes.[2]
- **Stakeholder & Worker Engagement, p. 20**
    - We strongly support efforts to engage stakeholders and workers in the process of assessing workforce implications. We believe that comprehensive stakeholder and worker engagement will result in workforce processes with greater "buy-in" and a better chance of success.

Section 6 – Data-Sharing, Confidentiality & Rapid Cycle Evaluation

- **Data-Sharing & Confidentiality, p. 22**
    - The application should ask the PPS to describe the process by which it will explain to patients PPS patient information data-sharing and confidentiality.

[1] Valesky K. Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council. June 2011.

[2] Beckham S, Kaahaaina D, Voloch K, and Washburn A. A community-based asthma management program: effects on resource utilization and quality of life. Hawaii Med J 63(4):121-6 (2004).

- *Describe how the PPS will have/develop an ability to share relevant patient information in real time so as to ensure that patient needs are met and care is provided efficiently and effectively while maintaining patient privacy.*

Section 7 – PPS Cultural Competency/Health Literacy

- **Description, p. 24**
  - We strongly support the Organizational Application's emphasis on the need for cultural competency and health literacy. Only with culturally and linguistically competent providers, and education and outreach materials will a PPS be able to fully engage the community it seeks to serve and achieve positive population health outcomes.
- **Approach to Achieving Cultural Competency, p. 24**
  - Again, we would like to highlight the importance of Community Health Workers in achieving cultural competency. Community Health Workers can be particularly beneficial in circumstances where culturally and linguistically competent doctors, nurses and other providers are in short supply.
  - The PPS response in this section should be expanded to 500 words, rather than 250 words.
- **Approach to Improving Health Literacy, p. 25**
  - The application should ask the PPS to describe how consumer feedback informed the creation of health literacy materials. Additionally, the PPS should describe in which languages materials were made available during its Community Needs Assessment.
  - The PPS response in this section should be expanded to 500 words, rather than 250 words.

Section 10 – Bonus Points

- A PPS that can successfully demonstrate a capacity to provide culturally competent services and improve health literacy should receive bonus points in the scoring of its application.

Project Plan Application

Accessible, high quality health services should be the foundation of all DSRIP projects in order to meet the goals of the program. Delivery of health care services should be performed in a culturally competent way, in the person's primary language, recognizing a person's level of health literacy.

Greater attention should be placed on social determinants of health (e.g., employment, housing, etc.) to increase population health and eliminate disparities. Project Requirements and Milestones and Metrics should focus on addressing health disparities to drive project success.

In addition, projects, particularly those aimed at nursing home populations, should include requirements to transition people from institutional settings to community settings. For example, Project 3.a.v, Behavioral Interventions Paradigm (BIP) in Nursing Homes, acknowledges that many nursing home residents have a primary behavioral health diagnosis, which nursing homes have not been equipped to handle. Rather than focus exclusively on increasing behavioral health services in nursing homes, this project should include requirements that people with behavioral health

diagnoses be transitioned to community settings where they will be able to obtain services form experienced community mental health providers.

Project 2.a.i Create an Integrated Delivery System focused on Evidenced-Based Medicine and Population Health Management:

- This project defines "actively engaged" as "patients residing in counties served by the PPS having completed a RHIO content form." If the goal is to get 100% regional health information organization (RHIO) consent forms throughout the network (as stated by a PCG representative on the DSRIP Draft Project Plan Application Review October 2nd webinar), all providers in a PPS must be equipped to do so and must have patient consent. PPS payments should not be impacted if patients opt out of the RHIO.
- A better measure of "actively engaged" would be documentation of the number of attempts to get patient consent to join the RHIO.
- Additionally not all providers have the funding to set up an interface to contribute to a RHIO and they may not be eligible for incentive payments to do so. Therefore their contribution in the RHIO is limited beyond the free "public good" baseline services (e.g., patient look-up).

Project 2.b.iv Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions:

- Mobile Crisis and Support Teams should be incorporated into this project to drive project success.
- If the expectation is to use electronic health records and other technical platforms to track all patients engaged in the project then patient consent must be obtained. However, not every patient may be willing to give consent. This concern pertains to other projects (e.g., Project 2.c.i) as well. There is no regulatory waiver for information sharing in the "Regulatory Flexibility Guidance for Performing Provider Systems" dated September 18, 2014. This document states, "Because patient consent issues are governed by HIPAA and state confidentiality statutes, there is no ability to waive regulations under Public Health Law § 2807(20)(e) and (21)(e). However, DOH, OMH and OASAS will coordinate on the development of a model consent form for use by PPS providers that would cover all forms of patient information exchanged by providers." Patients will still have to give consent for information sharing. If patients do not give that consent DSRIP project success will be impacted as communication within the PPS is key to DSRIP project success. Success will be limited without patient consent for information sharing. Project Requirements and Metrics and Milestones should be amended to recognize this. Another concern is that regulatory waivers may not exceed the life of the DSRIP program.

Project 2.c.i Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently:

- The Project Requirements mention establishing caseloads, but do not give any guidance on the patient to navigator ratio. DOH should provide guidelines on this.
- If navigators will be paid with DSRIP funds, the PPS must describe a sustainability plan for the continued employment of navigators at the conclusion of the DSRIP five year term.

Project 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care:

- A potential problem exists with this project because outreach is limited to an evidence-based methodology, the Patient Activation Measures (PAM). While this is a tested method, it may not be the only way of effectively reaching this population.

Project 3.b.i Evidence Based Strategies for Disease Management in High Risk/ Affected Populations. (Adults Only)

- To achieve the requirement of "follow-up with referrals to community based programs to document participation and behavioral health status change," processes to develop contracts with community-based organizations must be developed.

Project 3.c.ii. Implementation of evidence based strategies in the community to address chronic disease primary and secondary prevention projects (adults only)

- We applaud recognition of the CDC National Diabetes Prevention Program (NDPP), but PPSs will have to develop partnerships to refer patients to the CDC-recognized programs.

PPS Application Scoring Guide

Independent Assessor

- We are pleased that the "Independent Assessor will go through a comprehensive training program prior to the evaluation period" and that "the training will include meetings with NY state agencies such as OMH, OASAS, OPH, and other stakeholders to develop program specific scoring methods." In the interests of transparency and community engagement, it would be beneficial for the training materials to be made public.
- The Independent Assessor should be required to collaborate with and include in the assessment process community residents, professionals representing community-based organizations, and health care practitioners with no conflicts of interest.

Minimum Standard for PPS Application (60%), p. 9

- Additional information is needed on the process by which an application will be failed and sent back for remediation if the PPS scores less than an average score of 60% across all of its proposed projects. A PCG representative on the NY DSRIP Draft Project Plan Application Review October 2, 2014 webinar noted that there will be more to come on this process. Stakeholders, including consumers, and community members, must be provided with full information on this aspect of the scoring process as soon as possible so that it may be evaluated.

Bonus Points, p. 9

- A PPS that includes in its projects a proposal to train and hire people with disabilities or chronic conditions as Community Health Workers or Peer Support Specialist should receive bonus points.

Comments prepared by Lara Kassel, MMNY Coordinator, with Elizabeth Berka, Southern Tier Independence Center; Latisha Gibbs, Health People; Andrew Leonard, Children's Defense Fund-NY; Amy Lowenstein, Empire Justice Center; and Susan Mitnick, New York State Nurses Association.
For more information, please contact Lara Kassel at 518-320-7100 or lkassel@cdrnys.org.

manatt
manatt | phelps | phillips

To:	Jason Helgerson, Deputy Commissioner New York State Department of Health
From:	Manatt, Phelps & Phillips, LLP
Date:	October 29, 2014
Subject:	NY Draft DSRIP Project Plan Application Request for Comments

Submitted Via Email:
dsripapp@health.ny.gov

On behalf of five emerging Performing Provider Systems (PPSs) – Bronx Partners for Healthy Communities (SBH Health System, lead applicant), Community Care of Brooklyn (Maimonides Medical Center, lead applicant), Health and Hospitals Corporation (HHC), Lutheran Medical Center, and the Center for Regional Healthcare Innovation at Westchester Medical Center – Manatt, Phelps and Phillips, LLP (Manatt) appreciates the opportunity to comment on the New York State Department of Health (DOH) Delivery System Reform Incentive Payment (DSRIP) Plan Application and Scoring Guide, (together, the "Application") released September 29, 2014.

DSRIP represents an unprecedented transformation opportunity not only for our State's safety net hospitals but for all who are engaged in the State's health care system. The program has the potential not only to result in substantial improvements in the quality of care for those most in need, but also to achieve efficiencies that will make the health care system sustainable for years to come. We, and the PPSs we represent, look forward to helping to make this vision a reality.

As DOH is aware, implementing DSRIP will be a monumental task for all of the PPSs and their participating partners and partner organizations. These groups are up to the challenge and committed to success – as evidenced by the intensive planning efforts already underway. Through these planning efforts it has become clear that the size, scope and complexity of the undertaking require an incremental approach to implementation, and intensive collaboration and dialogue between the State and the PPSs as the State and PPSs chart the path to transformation together.

Manatt and the PPSs we represent recognize that attestations made in the DSRIP application are binding and carry significant implications for the next five years and beyond. The suggestions that follow are aimed at ensuring a foundation of success: making the DSRIP application and implementation process as streamlined and efficient as possible, focusing on the questions that are answerable today and provide the best measures of success for the future, and balancing the need for appropriate regional flexibility with standardized metrics. At

October 29, 2014

the end of the day, success will be measured by the health of our communities and the sustainability of our healthcare system. We offer our comments with these central goals in mind.

Enclosed please find **detailed comments** on each section of the application:

I. DSRIP PPS Organizational Application
II. DSRIP Project Plan Applications (Domain 2, 3, & 4)
III. Domain 1 DSRIP Project Requirements Milestones and Metrics
IV. DSRIP PPS Application Scoring Guide

Comments in the narrative and Appendices also include a discussion of issues related to health information technology implementation, DOH's definitions for "Actively Engaged Patients", metrics related to project scale, and DOH's requirements referencing Health Information Exchange, RHIO and SHIN-NY.

We applaud the efforts of DOH to take the time to solicit input from healthcare providers and stakeholders as you prepare the final application for the DSRIP program.

We are collectively committed to helping DOH and CMS structure the DSRIP program so that it is successful in improving care for the most vulnerable New Yorkers. Please let us know if we can offer any additional assistance. We and each of our PPS clients would welcome the opportunity to meet with you to further discuss our comments.

Sincerely,

William Bernstein
Partner
Chair, Healthcare Division
Manatt, Phelps & Phillips, LLP

Office: 212.830.7282
Email: wbernstein@manatt.com

CC: Len Walsh, SBH Health System
David Cohen, Maimonides Medical Center
Claudia Caine, Lutheran Medical Center
Christina Jenkins, New York City Health and Hospitals Corporation
June Keenan, Westchester Medical Center

October 29, 2014

DETAILED COMMENTS

The DSRIP Project Plan Application is comprised of four separate but interrelated artifacts, the DSRIP PPS Organizational Application; DSRIP Project Plan Applications (Domain 2, 3, & 4); Domain 1 DSRIP Project Requirements Milestones and Metrics; and DSRIP PPS Application Scoring Guide. The comments provided below are organized by artifact and contain overarching comments and recommendations followed by detailed comments and recommendations by section, as noted by section title and page number, of the artifact.

I. DSRIP PPS Organizational Application

A. Executive Summary

- **Certificate of Public Advantage (COPA) and Accountable Care Organization (ACO) (p. 3)**

  Recommendation I.A.1:
  DOH should remove the COPA and ACO boxes from the Application.

  Comment:
  The request that applicants consider applying for a COPA or an ACO certification is premature. PPSs are not in a position to make decisions regarding the need for a COPA or ACO status at this juncture. Moreover, the final COPA and ACO state regulations have not yet been issued, so PPSs cannot yet make an assessment of the benefits of a COPA or ACO status; PPSs instead should have the ability to make these decisions at a later stage of DSRIP.

- **Regulatory Relief (p. 4)**

  Recommendation I.A.2:
  The Application should allow applicants to identify the types of waivers they believe they will need, and DOH should indicate its willingness to grant regulatory waivers once PPSs have determined all implementation details.

  Comment:
  The details of project implementation will not be determined until April 2015 (according to the current draft DSRIP timeline). Many of these details—such as the design of new project space in regulated facilities—will have an impact on the regulatory waiver requests. DOH should issue guidance on the process for obtaining DSRIP-related regulatory relief outside the DSRIP Application itself, and DOH should allow for

expedited requests for regulatory relief as part of that process. We also note the final COPA and ACO guidance, when released, may further inform waiver requests.

B. Governance

- **Oversight and Member Removal (p. 7)**

Recommendation I.B.2:
DOH should clarify that the PPS may remove providers for non-compliance.

Comment:
As discussed in the Special Terms and Conditions (STCs), PPSs need a robust PPS partner evaluation capability, a strong governance structure, and the capacity to identify and work intensely with underperforming providers such as through corrective action programs, and technical assistance, and similar activities. However, DOH has issued conflicting guidance to date on the permissibility of removing PPS partners. The PPSs must have mechanisms and the flexibility to mitigate the effects of chronically underperforming providers, and needs the power to remove providers for non-compliance, bankruptcy or bad-faith.

C. Community Needs Assessment (CNA) (p. 9)

- **Overarching Comments Structure of Section**

Recommendation I.C.1:
The Application should allow PPSs to submit attachment exhibits and upload PDF documents that detail the CNA process, the participants, and community and stakeholder engagement efforts. The Application should not require applicants to fill in tables in an online format that requires field-by-field hand-keying; instead, applicants should be allowed to upload tables that contain the information that DOH seeks.

Comment:
Allowing PPSs to upload additional documents in this section would make it easier for PPSs to convey necessary information while reducing an unnecessary paperwork burden. For some questions in this section, information could be better presented by graphs, charts and/or maps. PPSs should have the ability to upload information in this form. In addition, DOH should eliminate the requirement that applicants fill in the tables described at Pages 14 and 15 in the current Application. While PPSs are happy to provide this information, PPSs should be able to provide this information through

attachments. It is significantly less burdensome for applicants, as well as less prone to human error, if the required tables can be uploaded, instead of having to hand key information directly into the Application.

- **Healthcare Provider Infrastructure and Community Resources (p. 10-12)**

  Recommendation I.C.2:
  DOH should strike the language asking for an "assessment of capacity, service area, Medicaid status, as well as any particular area of expertise" for each health care provider and community resource.

  Comment:
  The Application asks for "an assessment of capacity, service area, Medicaid status, as well as any particular area of expertise" for each health care provider and community resource. Completed CNAs include robust analysis of health care providers and community resources including aggregate level, types of services provided, and location of providers in the geographic area. This analysis is supplemented by primary data that identifies capacity issues. We believe this level of analysis should be sufficient for the planning phase. As PPSs move towards implementation, additional capacity information will be gathered through surveys and information gathering from PPS partners to supplement the initial CNA analysis.

- **Summary of CNA Findings (p. 14)**

  Recommendation 1.C.3:
  We recommend this section be restructured. Rather than restate the findings of the CNA (which is summarized in previous text entries in this section and included in the full report as an attachment), the table on page 14 should outline the CNA-based justification for each of the projects the PPS has selected. The entries in this section should match the justification required in each individual project justification in the Project Plan section of the Application.

  Comment:
  The Summary of CNA Findings section requires data entry related to the CNA findings report and requires that each community need be given a unique community need number that is then mapped directly to a PPS project plan selection. However, community health needs have been identified through the CNA that extend beyond the number of projects each PPS can undertake. Also, the CNA may define a need (such as asthma management) that a PPS is precluded from pursuing (for example, because the region is determined to have higher performance against project metrics than the

established goals). Mapping every finding does not convey the rationale behind project choice. Asking for the CNA-based project justification will give a richer explanation of the PPSs' choices. We believe a more helpful and focused query would be to ask PPSs to link to CNA findings to the selected projects.

D. DSRIP Projects

See Section II

E. PPS Workforce Strategy

- **Structure of Section (p. 17-21)**

Recommendation I.E.1:

Workforce strategy is an important aspect of DSRIP implementation and must be a core area of focus for PPSs. However, this work will only be meaningful if it is developed through a thoughtful, collaborative stakeholder process that informs a valid, actionable strategy.

We strongly urge DOH to revise this section of the application to better align with the current stage of planning, both as experienced by PPSs and as contemplated in the rest of the Application. As a condition of DSRIP funding, each PPS should be required to develop and submit to DOH by the end of DY1 a written DSRIP workforce strategy that describes the impact of the PPS's DSRIP project selection on job creation, job restructuring and possible job redundancies; a workforce training plan; the process for identifying candidates for new jobs and for training; and the stakeholder engagement process, including collaboration with organized labor.

In the Application due December 16, 2014, each PPS should be required to attest that it will develop the above reference detailed workforce plan in DY1, narratively outline in the Application its strategic approach to developing the strategy in collaboration with its partners, and attest that it will commit DSRIP funds to training.

Comment:

In the Draft Application, DOH requires an exceptionally detailed workforce strategy discussion that identifies "all impacts on [PPS] workforce that are anticipated as a result of the implementation of their chosen projects." The section as currently proposed is incongruous with the level of detail requested in the rest of the application, and the current stage of project planning for PPSs. The granular level of detail requested -- on issues such as line item budget numbers, numbers of employees that will be redeployed, and individual job functions that will be revised -- is premature given the

stage of implementation planning for most if not all PPSs. The qualitative approach to workforce strategy as outlined in the draft application's text fields seems appropriate for this stage in PPS planning. The detailed quantitative data requested in the table fields will require either very rough estimates that lack any basis in collaborative planning, or detailed estimates that seem to pre-suppose robust operational planning with our PPS partners – when these detailed plans are not due until next year.

At this stage of DSRIP, it is unreasonable for PPSs to be required to provide numbers of new, retrained and redeployed staff without detailed implementation plans for each project, and for each clinical intervention necessary to implement each project and the DSRIP effort as a whole.

The budget section would require commitment of financial resources in isolation of other potential PPS costs. No other section of the application requires detailed line item budget information and while every PPS will as matter of operations be developing detailed budgets, PPSs are still in the process of finalizing their initial PPS networks and inventorying assets and capabilities. Some PPSs as of October 2014 do not yet have finalized CNAs, which are required to inform project selection, and are in the process of identifying needed capabilities and training to implement projects. It can be undoubtedly assumed that every PPS has a commitment to train and develop their workforce for the tomorrow DSRIP will bring and to ensure the success of the initiatives but it is significantly premature to assess the full impact of DSRIP on job reductions, job creation and employee benefits.

The workforce strategy budget requirement is further problematic as a method of comparison amongst PPSs as it does not provide detailed definitions or DOH's expectations for the cost categories associated with the funding types. Lacking definitions, PPSs will interpret costs differently and offer estimates that cannot be comparatively rated.

Moreover, the requirement for a detailed budget and five year funding commitment stands in direct contrast to the purpose of DSRIP, a program that focuses on performance results rather than process. Over the five year program period, PPSs will continually monitor progress and make adjustments to resource allocations, staffing, skill portfolios, and programmatic elements in order to achieve the agreed-upon objectives. A sound strategy, credible capabilities, and verifiable relationships with workforce partners are a more appropriate indicator of programmatic success than rigid commitments to financial allocations that will, and should, be adapted to meet the unanticipated circumstances and marketplace changes the PPSs will encounter.

The challenge of the entire health care industry is to develop a workforce that can adapt to the changing healthcare marketplace including increasing demand (driven by both demographic changes and increased insurance coverage), delivery system reform including a system-wide focus on reducing inefficiencies, innovations and increased attention to primary care, chronic care, prevention, behavioral health and population health.

Workforce planning is about "getting the right staff with the right skills in the right place at the right time." (U.S. Department of the Interior; Workforce Planning Instruction Manual (2001)). It is a complex undertaking to say the least. To be successful and to have the greatest impact, workforce planning must be grounded in its contribution to organizational performance and long term sustainability of both a high performance workforce and a high quality care delivery system. Workforce planning must thoughtfully link workforce strategies to organization performance goals.

Factors that must be considered in a comprehensive workforce strategy include: Staffing (recruitment, assessment, retention, deployment and re-deployment, training and development, succession, reduction in workforce, performance metrics); System Transformation (work process redesign, reorganizations, site of service revisions); Culture (vision, values, diversity, engagement, change management); and Infrastructure (performance incentive programs, statutes and rules, policies and procedures, contracting).

Allowing PPSs to develop a workforce strategic plan by the end of DY1 will provide enough time to map out and vet with stakeholders the project level common job titles, functions/responsibility levels, compensation requirements, education and training expectations, and staff/patient ratios as well as a comprehensive, provider-level assessment of current workforce assets (professional and paraprofessional), including identification of excess capacity and shortages.

Secondary Recommendations

Absent amending the current PPS Workforce Strategy section as described above we recommend DOH request a high-level estimate of new job creation as a result of DSRIP with the understanding that it will be very high level and will need to be refined across DY1 and revisited annually. Additionally, the PPS could conceivably describe, narratively, the types of positions that will be created and their role in the system transformation, the order of magnitude by which their project selection is anticipated to impact the workforce (for example, implementation of a Medical Village project would likely have a larger transformative effect on workforce than implementation of an asthma protocol), and a process by which labor will be involved in the ongoing development and training of the workforce.

F. Data-Sharing, Confidentiality & Rapid Cycle Evaluation (p. 22)

No comments.

G. PPS Cultural Competency / Health Literacy (p. 24)

No comments.

H. DSRIP Budget & Flow of Funds

- **Description / PPS Plan to Distribute DSRIP Funds (p. 27)**

Recommendation 1.H.1:
PPSs should have the flexibility to develop funding distribution methodologies through their described governance processes that advance the overarching goals of the DSRIP projects and demonstrate fairness but are not tied to arbitrary, siloed funding categories. DOH should require PPSs to outline their approach to fund distribution and accountability in a text field and should eliminate the requirement that PPSs distribute funding based on provider category.

The development of the funding methodology should be openly discussed and debated with adequate stakeholder representation across the PPS provider network to ensure buy-in and support for the methodology. The funding methodology should also be revisited regularly (at least annually) to determine whether the current approach is incenting and ultimately resulting in positive behavior change and outcomes within the PPS. The funding methodology may be revised and adjusted to account for shifts in PPS goals, projects, and changes in earned DSRIP funds in later years. PPSs may create Finance Committees or Workgroups within their governance structure to support the ongoing development and review of the funding methodology.

Comment:
A transparent and consensus-based governance process should serve as the foundation when developing the methodology to allocate earned DSRIP funding. As part of the governance process, a PPS will address how funds will be distributed among PPS providers, but the preliminary projection of funding to individual provider types is both premature and contrary to overarching DSRIP goals. The Application currently requires each PPS to develop a methodology to allocate earned DSRIP funding among the participating providers in a PPS. In the Application, DOH asks PPSs to "describe on a high level how the PPS plans to distribute funds among the clinical specialties, such as

primary care vs. specialties, and, among organizations along the care continuum such as SNFs, LTACs, and Home care." The section also asks applicants to "outline how the distribution of funds is consistent and/or ties to the governance structure" and "how the proposed approach will best allow the PPS to achieve its DSRIP goals." Given that PPSs are still finalizing the clinical interventions and metrics, as well as the financial investments and incentives to support their successful implementation, DOH would be better served at this stage by requiring PPSs to outline their approach to fund distribution and accountability in a text field and eliminating the requirement that PPSs distribute funding based on provider category.

- **Percentage of Payments Amongst Defined Funding Distribution Categories (Entered Into Table) (p. 27-28)**

  Recommendation I.H.2:
  DOH should replace the proposed table of prescribed categories of DSRIP performance payment allocation with a narrative description, thereby requiring an account of how the PPS will use its governance process to determine, on a regular basis, appropriate funding allocations across the four budget categories, as well as other categories it determines critical to its operations and ability to achieve DSRIP goals. This governance process should be transparent and include adequate representation of PPS stakeholders to engender trust and buy-in to the ultimate allocation methodology. Engaging stakeholders in developing and refining the methodology will ensure that they both have an understanding of the process and will hold each other accountable for performance against agreed upon goals.

  Comment:
  The draft Application requires a PPS to complete a chart with the PPS's proposed approach for allocating performance payments against four budget categories. While DOH's intent seems to include understanding how a PPS plans to utilize and distribute performance payments, there is insufficient definition of the four budget categories and a lack of clarity as to whether a PPS will be able to adequately describe their approach without accounting for changes in DSRIP funding over the five-year program.

  Recommendation I.H.3:
  If DOH elects to require the budget category table without amendment, DOH should clarify that the percentages represent aggregated estimated percentages over the five-year DSRIP period; are subject to change under PPS governance procedures; and are based on the maximum funding amount. The categories and percentages should be held at the funding category level and not the multiple sub-categories within the three specific categories defined by the State.

Comment:

The Application requires applicants to identify the percentage of payments the PPS intends to distribute amongst defined funding distribution categories. Funding distribution categories must include (but are not limited to):

1. Cost of Project Implementation: the PPS should consider all costs to be incurred by the PPS, such as salary and benefits, contractor costs, materials and supplies, and its participating providers in implementing the DSRIP Project Plan.
2. Revenue Loss: the PPS should consider the revenue lost by participating providers in implementing the DSRIP Project Plan through changes such as a reduction in bed capacity, closure of a clinic site, or other significant changes in existing business models. In addition, funding can be distributed based upon providing the necessary funding to sustain the safety net.
3. Internal PPS Provider Bonus Payments: the PPS should consider the impact of individual providers in the PPS meeting and exceeding the goal of the PPS' DSRIP Project Plan.

Within the four identified budget categories, there are likely multiple sub-categories that cannot be adequately represented or explained by a summation percentage. For example, the category of revenue loss may represent funding the PPS will allocate to providers who are closing facilities or beds to account for lost revenue during such a critical transition. The PPS may also plan to support safety net providers that are financially fragile and represent critical access points for target patients or that are otherwise important to the success of a DSRIP project of the overall initiative.

The intent of funding distribution can be determined by basing the percentages included in the table on the full receipt of DSRIP funds. However, PPSs cannot be required to pay specific percentages to individual funding categories for the actual funds received without regard to whether specific milestones, pay-for-reporting metrics, and pay-for-performance metrics that that were or were not achieved or not. As an example, if a number of pay-for-performance metrics are missed, it logically follows that the PPS providers will also not have made their related performance goals required for bonus payments. This would result in a lower percentage of bonus payments for that given period.

Different funding categories will also require different levels of funding in different years. Project implementation may be higher in earlier years while revenue loss and performance bonuses may be higher in later years when project implementation is complete and DSRIP performance targets are being achieved. Adopting this approach would allow individual PPSs to better align their funding with DSRIP award payments.

- ***Additional Financing Related Comments for DOH Clarification:***

  "Other" Category:
  DOH should explain whether there are restrictions on what and how many additional funding categories can be identified in the "Other" category. Specifically, DOH should specify if there are categories into which a PPS would not be allowed to distribute funding.

  Funding Distribution Timing:
  DOH should clarify that funds not distributed in the year they are received can be reserved for use in other DSRIP years (in line with permissible uses of DSRIP funding).

  ***Non-Medicaid Population*:**
  DOH should clarify whether DSRIP will support the entire cost of resources that apply to all patient populations. Several DSRIP programs will require incremental resources that will serve a broad patient population beyond Medicaid . For example, an effective ED Triage program will likely require new protocols and processes that are applicable to all patients served by the ED.

I. Financial Sustainability Plan

- **Assessment of PPS Financial Landscape (p. 29)**

  Recommendation I.I.1:
  Rather than requiring an assessment of the financial status of every single participant in the DSRIP network, DOH should specify that it expects PPSs to undertake financial assessments of the financial health of the most critical project participants (for example, the providers with the most attributed beneficiaries or greatest project engagement). Additionally, DOH should indicate that PPSs will not be expected to collect financial information from privately-owned entities. Finally, DOH should adopt a policy that any financial information shared with the State to analyze this issue will NOT be made public or be disclosed under the Freedom of Information Law.

  To simplify a PPS's data collection process, the DOH should recommend that the PPS align its financial frailty assessment with other MRT Waiver requirements, including the use of the IAAF funding eligibility as the threshold for a financial means test requirement. For example, in order for non-large public hospitals to qualify to receive IAAF funds, they needed to demonstrate:
  - Less than 15 days' cash and equivalents
  - No assets to monetize

- No resources available from affiliates, foundations, etc.

PPSs should be encouraged to survey each hospital partner in the PPS with the following questions:

- Did you apply for and receive IAAF Funds?
- Do you meet the State's requirements to receive funds)?
- Will successfully achieving the required metrics for our DSRIP projects (provide a list of relevant metrics) have a negative financial impact on our organization? If yes, please describe.

Comment:

Designing and supporting a PPS network to ensure that Medicaid beneficiaries attributed to the PPS have access to the full range of services necessary is an important component to the success of DSRIP. However, it is unrealistic to impose a detailed financial assessment on every participant in the network on the lead applicant, particularly by the application deadline of December 16, 2014 and raises the question to what end. Instead, we believe it is reasonable to expect the lead applicant to work with its hospital partners and largest provider partners to assess financial viability using the IAAF framework.

The requirement is further complicated by implementation challenges owing to the potential public disclosure of confidential or sensitive financial information. While public organizations are obliged to make financial information publically available, PPSs have been told that our privately-owned partners, including many private provider practices, are unwilling to share publically the details of their financial condition. At this critical juncture of DSRIP implementation where network participant relationships are just beginning to form and DSRIP is bringing historically competitive organizations into partnership, PPS leads seek to balance the need to collect financial information with concerns about public disclosure that could result in some partners decisions not to participate in the project.

- **Path to PPS Financial Sustainability (p. 30)**

Recommendation I.I.2:

We recommend that DOH remove the requirement to "describe how the PPS will ensure fragile safety net providers will achieve a path of financial sustainability." If the requirement is not removed, we recommend modifying the subsection to read: "To the extent permissible under DSRIP, describe the PPS's approach to assist financially fragile safety net providers achieve a path of financial sustainability." DOH's reviewers can assess the PPS based on the likelihood that the proposed strategies will result in a

strengthened delivery system that provides a continuum of care for Medicaid beneficiaries.

Comment:

The application requires PPS leads to "describe how the PPS will ensure fragile safety net providers will achieve a path of financial sustainability." Achieving financial sustainability for some providers may involve other considerations outside the scope of the DSRIP program, and outside the influence of the PPS. For example, a provider's financial challenges may stem from difficulties with its non-Medicaid book of business. While a PPS may be able to create strategies that support the financial viability of safety net providers, ensuring that they achieve financial sustainability would require a level of contractual and financial obligations to which a PPS could not commit. Further, the intent of DSRIP is not to shore up the bottom line of individual providers but to catalyze delivery system reform and provide the infrastructure to prepare the system for value-based contracting, an environment under which the business models and service delivery platforms of some organizations may need to significantly transform for long term sustainability.

Recommendation I.I.3:

We recommend that the DOH provide standard definitions for the following terms:

- Financially Fragile. DOH should define "financially fragile", confirm that the financial fragile test applies to Article 28 providers (i.e. hospitals), and provide metrics and a timeframe to determine whether a provider is "financially fragile."
- At Risk for Financial Failure. DOH should define "at risk for financial failure" with specific metrics and examples.
- Financial Restructuring. DOH should define "financial restructuring", clarify whether the definition includes the restructuring of financial assets and obligations, and explain how DOH or PPSs will identify whether a partner requires financial restructuring.

Comment:

The Financial Sustainability Section of the application includes terms that lack commonly-recognized definitions. For example, there are no standard definitions for "financially fragile," "at risk for financial failure," and "financial restructuring." In the absence of a DOH-recommended definition, PPSs may create definitions that are inconsistent and/or do not meet DOH's intended purposes.

J. Bonus Points

No comments.

II. DSRIP Project Plan Applications (Domain 2, 3, & 4)

A. Overarching Comments on Structure

- **Request for Partners Participating by Each Individual Project**

Recommendation II.A.1:
For the Project Plan Applications, we recommend DOH remove the Provider Table for each project in favor of alternative approaches to assessing network participation. Since the complete listing of a PPS's participant network has been provided to the DOH, we recommend that the DOH assess the overall robustness of the proposed provider network as part of the Organizational Application within Section 2 - Governance.

For the Project Plan Application, we recommend that Project Description and Justification Section include a request for a description of the key participants and their roles in support of the proposed project. In addition, we recommend that the DOH include the provision of a detailed list of project participants as reflected by contractual arrangements as a DY 1 process metric.

Additionally, if DOH ultimately elects to require providers use the table to list individual partners by project, we note the table currently requires that providers name their NPIs. However, many projects require community organization involvement and social service agency partnership. The NPI is a federal identifier for covered health care providers and may not encompass the range of DSRIP partners who will participate in a given project.

Comment:
The Application requires PPS's to list the individual participating providers in each individual project plan by separately by project.

This approach is counter to the overarching objective of breaking down siloes and creating an integrated system of care in which all providers in a PPS are actively engaged in the care transformation effort. Since a key tenant of DSRIP is to expand coordination across the care continuum, the lists of participating providers for each project will consist of nearly all participating providers in the PPS's network. In previous DSRIP application processes, including the Project Design Grant Application, the provision of large lists of organizations into the DOH's online tools was a labor-intensive, manual process that was a repetitive and time consuming requirement for the Project Plan submission.

Further, while we appreciate that some individual providers will be more active in individual projects based on their scope of practice or patient populations served, the requirement for that level of granular detail is ahead of where PPSs are in the planning process for most projects and requires a detailed implementation and operations plan. Throughout the CNA process, PPSs have been identifying "hot spots" which are zip code level clusters of prevalence of certain conditions or medical needs. By doing this, PPSs will implemented projects across a PPS but with varying levels of intensity depending on population need. The CNA process has been extensive and is still ongoing. As the final project selection was dependent on CNA results it is premature to assume PPSs can have provider-level detailed implementation plans at this stage.

- **Project Description and Justification**

Recommendation II.A.2:
For thoroughness of response, DOH should uniformly allow 1,500 words for responses to each of the Project Description and Justification sections.

Comment:
Although the questions are extremely similar in structure and scope, the application allows 1,500 words for the Project Description and Justification sections for projects in Domains 2 and 4, but only 1,000 words for the Project Description and Justification sections for projects in Domain 3.

Recommendation II.A.3:
As the project plan applications will be comparatively scored if more than one PPS selects a given project, we recommend DOH provide additional description on the scope and breadth of resources it considers relevant for this question. **DOH should specify that the term "resources" refers to the health care resources and community based service resources identified in the CNA guidance and Section 3 of the DSRIP PPS Organizational Application.**

Additionally, as many PPSs are finalizing their PPS network lists and inventorying capabilities while simultaneously developing their clinical project plans, we recommend DOH allow providers to update their lists as part of the detailed implementation plan submitted prior to April 1, 2015 and the DY1 process measures.

Comment:
In Section 1.a., the application requires that the PPS "identify the approach to develop new or expand current resources, or alternatively to repurpose existing resources to

meet the needs of the community." Resources could refer to a wide range of facilities, staff, and/or technology tools.

- **Scale of Implementation**

Recommendation II.A.4:
In order to reduce the potential variability in PPS interpretations of objective measures, DOH must provide more detailed and specific definitions, guidance, and examples of the expected "targeted population" for the program.

Comment:
The DSRIP PPS Application Scoring Guide indicates that the scoring methodology includes a combination of objective and subjective measures depending on the Domain and project:

- Project 2.a.i has 40% as subjective and 60% as objective
- Projects 2.a.ii – 2.c.ii and Projects 3.a.i – 3.g.ii have 20% as subjective and 80% as objective
- All Domain 4 projects will be 100% as subjective

In Section 1.b., the application calls for the PPS to define the target population. As noted in specific instances in our comments that follow, there are multiple, legitimate interpretations of what may constitute "the "targeted population." From a scoring perspective, the DOH's reviewers will face substantial challenges when comparing and ranking the PPSs' differing definitions and calculations of the target population. The varying interpretations and subsequent values will create circumstances in which some PPSs will be unfairly penalized (or rewarded) for its particular interpretation of what is intended to be an objective criterion. Further complicating the scoring is the complexity of the projects, many of which have multiple components and interventions (projects 3.a.i, 3.a.ii, 3.f.i, for example) that each target different patient sub-populations.

In some instances, while the definition of a "target population" may seem to be inherent in a project's focus, each PPS has, by design, discretion when defining sub-populations (for instance, a behavioral health intervention may incorporate youth beginning at age 12 in one PPS and age 14 in another; or a supportive housing effort may be limited by the location and availability of licensed units; or a PPS may have strong DD provider partners who can extend the reach of a project to a population with special needs).

Absent a standard methodology for identifying or defining the population in response to this question, applicants are left making judgment calls as to whether the question

refers to a quantitative or a qualitative expectation. If quantitative, what data source should applicants use to develop a baseline?

Finally, absent a defined patient attribution panel and detailed claims data, it is not possible to determine, especially in geographies with more than one PPS, how many patients in a given PPS might have a particular condition or be eligible for certain services. Regional prevalence of an underlying condition or health care need may, in some cases, be available as a result of the CNA process but incorporates all residents of the area not prevalence among Medicaid beneficiaries. Finally, it is during the implementation planning process that the PPS work groups will consider in detail the pace at which patients can be 'actively engaged' in a particular project and /or intervention within the project.

Recommendation II.A.5:
DOH should replace the term "Targeted Population to Benefit from Project" with "Targeted Population to be Served through Interventions Associated with Project".

Comment:
The term "benefit" is problematic as the overarching goal of DSRIP is for all Medicaid-eligible beneficiaries (and ultimately all New York residents) to benefit from the DSRIP efforts. As PPSs work to develop their integrated delivery system approaches (project 2.a.i), they will be seeking to identify high need, high utilizing patients regardless of DSRIP "project" eligibility and developing a "no wrong door" system of access to the most appropriate resources and care coordination support.

The methodology to define the number should align with the recommendation above.

Recommendation II.A.6:
DOH should provide the denominator for the percentage calculation and a final listing of all designated safety net providers in the State by early November 2014.

Comment:
For Section 2.a. in several projects, the application requires a PPS to identify the "Percent of Safety Net Providers by County" and the "Number of Safety Net Providers" (based on DOH Safety Net Provider designation). The ability for PPSs to calculate the percentage depends on the DOH's provision of the number of safety net providers by county.

- **Speed of Implementation**

- **Actively Engaged Patients**

Recommendation II.A.7:
In order to reduce the potential variability in the PPSs' interpretations of objective measures, DOH must provide more detailed and specific definitions, guidance, and examples for "*Actively Engaged* Patients."

Please see Attachment A for comments and suggested edits by metric.

Comment:
The metrics outlined for patient engagement by project were not referenced in earlier guidance documents and have not been vetted by stakeholders. Most are not commonly used or known measures. While some are rather straightforward to calculate, others present notable challenges in collecting and reporting data from multiple health information technology systems (both EHR and care management systems). Targeted population definitions and inclusion criteria are not included in the Application guidance and may be ambiguous for some projects. In some cases, the proposed engagement metrics seem disconnected from project requirements. Several patient engagement metrics clearly require an assignment process at the individual beneficiary level and enrollment in a formal program but it is as yet unclear that DOH will be able to make person-level attribution and tracking to the PPS, especially in regions with overlapping PPS geographies.

As currently structured, "patient engagement" and speed of implementation account for 40 points of an individual project plan score. Therefore, the ability for PPSs to attest to their ability to implement a plan that meets patient engagement measures is critical to a successful effort. PPSs are at risk of not qualifying for DSRIP funds if they do not meet a measure; clarity proves essential.

Recommendation II.A.8:
The Application requires PPSs "indicate the Demonstration Year and Quarter by which…. all project requirements" will be achieved for each project. We recommend the targeted quarter for "completion" in the case of recurring requirements be the first quarter in which the activity is undertaken or initiated.

Comment:
In Section 3 of the Project Plan Applications, item 3a. asks PPS to "indicate the Demonstration Year and Quarter by which…. all project requirements" will be achieved. The guidance is unclear related to how to address project requirements that are reoccurring throughout the project period. As currently structured, the inclusion of reoccurring requirements would compel every PPS to indicate completion of all project

requirements in DY 4, Quarter 4 because they would not be able to complete a recurring item.

For example, in Project 2.a.i Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management, requirement 9 states: "Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform." The corresponding Metric/Deliverable is "PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted." In order to be responsive to question 3a., our interpretation is that this requirement will not be fully achieved until the last monthly meeting occurs.

- **Current Medicaid Initiatives in Which the Provider is Participating Entered Into Table**

Recommendation II.A.9:
In order to understand the relationship of the proposed DSRIP project to other initiatives, the PPSs recommend that the DOH require PPSs to describe how the proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s). This should stop short of requiring a full listing of all projects currently being implemented by all PPS participants.

We further recommend this list be provided one time, in one location, via upload, and not recreated in table form across several different individual project plan applications. Maintaining as a separate document will also allow the PPS to monitor it and make regular updates to help facilitate mid-term project status updates.

If DOH does not adopt the proposed approach, we recommend clarifying that projects listed in the table identify Medicaid projects sponsored or supported by the U.S. Department of Health and Human Services as alluded to in section 4.c. We further recommend PPSs be able to upload an Excel or PDF table of initiatives rather than hand-keying every entry into an online template field by field which is time-consuming and cumbersome.

Comment:
The Application calls for the PPS to identify, by entity, the initiatives in which the provider is participating which are funded by the U.S. Department of Health and Human Services and describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s). Given the wide scope of funding and programmatic initiatives sponsored by the U.S. Department of Health and Human Services and the depth and breadth of PPS networks, a comprehensive

catalogue of each entity's involvement requires significant research across the PPS's participants.

- ***Additional Related Questions for DOH Clarification***

  Detailed Implementation Plan:
  When will the form and content of the "Detailed Implementation Plan due April 1, 2015" be made available?

B. Overarching Comments on Cross-Project Concepts

- **Definition of PCP**

  Recommendation II.B.1:
  We recommend that a consistent definition of PCP be employed throughout the Application. We recommend PCP be defined as the primary care provider/practitioner (with "practitioner" indicating any licensed primary care practitioner).

  Comment:
  The acronym "PCP" is used several times throughout the Application. At various locations, the term PCP refers to either a "primary care practice" or "primary care provider/practitioner." It is further unclear if a primary care provider/practitioner would include only physicians and osteopaths or other licensed primary care practitioners such as a physician assistant or nurse practitioner.

  The use and intended definition appears to vary across projects and, in some instances, within a project. We are unclear where the Application intends to measure: 1) the number of organizations/practices, 2) the number of practice sites/locations where services are provided, or 3) the number of individual primary care practitioners.

  As an example, in the Application, Project 3.c.i. notes that the threshold for the implementation of "disease management evidence-based best practices requires 80% PCP engagement," and refers to the "Number of participating primary care providers" in the Scale of Implementation table in 2.a. However, in the Project Requirements section, Project Requirement #2 calls for engaging "at least 80% of primary care practices within the PPS…," which suggests that PCP be defined at the practice level. Project 3.b.i, meanwhile, refers to PCPs in a way that suggests but does not state that the count should be of individual practitioners providing services, but Project Requirement #20 states that PPSs "engage a majority (at least 80%) of primary care practices in this project."

- **Safety Net Provider Definition**

  Recommendation II.B.2:
  DOH should provide a final definition of "safety net provider" that is common across all DSRIP project requirements (or confirm where on the DSRIP website to find the current definition for use in the application) and should add the word "eligible" before the term in both Project Requirements and Milestones and Metrics (see Artifact 3) when appropriate.

  Comment:
  The term "safety net provider" is used several times in the Project Requirements section of several individual project plans. Usually the term is used as both the numerator and denominator to identify a population that must comply with a requirement. "Safety net provider" might apply to a hospital, a physician, a physician group practice, a clinical professional, an FQHC, a home and community based services provider, a behavioral health services provider, etc. – among others. Safety net provider has a specific DSRIP definition with regard to eligibility for incentive funding; however it is unclear if the same definition holds when the term is used for individual project requirements as non-DSRIP defined safety net providers are also eligible to participate in individual DSRIP projects. In some instances the term is also used in association with national programs, such as the NCQA PCMH accreditation program or the "Meaningful Use" of certified electronic health record technology incentive program. These programs define specific parameters around eligibility of participation which may not align with the NYS DSRIP definition of "safety net provider."

- **Health Information Technology**

  Health information technology (IT) infrastructure and data analytics are a critical foundation to population health management and creating interconnectivity amongst PPS partners. While no section of the Draft DSRIP Project Plan Application requires a health IT plan or IT solutions specifics, several Project Requirements and Domain 1 metrics include IT-related requirements. We anticipate the strategic plan for implementing an IT infrastructure will be a more prominent component of the forthcoming detailed implementation plans.

  Recommendation II.B.3:
  Throughout the entire draft Application, DOH should utilize consistent health IT, health information exchange, and population health terminology to avoid confusion and ensure clarity related to project requirements.

Specifically, DOH should clarify the following health IT, HIE, and population health terms:

- *Clinically interoperable system*: Does this refer to an IT system or a system of care? If the former, what is its functional scope? Is it a single system or multiple systems that interoperate?

- *Population health management*. The application references, "Perform population health management by actively using EHRs and other IT platforms" What is the definition of population health management in this context? Is a PPS expected to define the scope of its population health management system as it relates to IT use?

- *Participants in HIE*. In various locations, the Application uses differing terminology to describe HIE participants: "safety net providers", "all providers," and "clinical partners". Given the potential implications for the different participant groups, DOH should use consistent terminology unless the intent is to target different participant groups.

- *Actively sharing EHR data*. Does this refer to providers actively sharing EHR data, or does it mean that all providers must be using a shared EHR platform (from a single vendor or set of vendors)? Does this requirement seek to impose that the EHR data has to be sent directly between providers or does it allow a third party system where the data can be viewed, such as through a RHIO or another portal?

- *Public health registry*. Sample of transactions to public health registries – What is the definition of a public health registry? Is this related to public health agency reporting, or is it simply a registry for population health management regardless of its use or governance? *(See further discussion in the detailed comments on Artifact III, Domain 1 Project Requirements Milestones and Metrics)*

- *Encounter Notification System (ENS).* Project 2.b.iii, ED Care Triage for At-Risk Populations, requires that the "Encounter Notification Service (ENS) is installed in all PCP and EDs." What does this system refer to? Is this hospital ADT alerting or a different kind of notification?

Comment:
The draft Application contains imprecise terminology and requirements. Different terms are used for what could represent common or the same requirement. The

current level of ambiguity makes it challenging for PPSs to assess the implications for implementation and develop their Application responses.

Recommendation II.B.4:
With respect to health information exchange capabilities, DOH should explicitly include the option for local health information exchange to fulfill project requirements and should not prescribe the method or approach to exchange. Project requirements should focus on the project objectives and allow flexibility to PPS to determine the most appropriate health IT tools to accomplish those objectives.

Attachment C provides a table of recommended changes to the draft documents *New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program DSRIP Project Plan Applications: Domain 2 DSRIP Project Plan Applications; Domain 3 DSRIP Project Plan Applications; Domain 4 DSRIP Project Plan Applications and New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program Domain 1 DSRIP Project Requirements Milestones and Metrics: Project Requirements Milestones and Metrics: Domain 2; Project Requirements Milestones and Metrics: Domain 3.*

Comment:
The DOH envisions a broad range of entities participating in health information exchange in New York. On September 3, 2014, DOH released a proposed rule that defines the process whereby qualified entities (QEs) will be certified to participate in the SHIN-NY. The proposed regulation allows for RHIOs and other non-RHIO, health information exchange organizations to apply to become QEs. In order to be consistent with DOH regulations, the DSRIP Application documents should include the term "local health information exchange" as part of the project requirements.

As currently drafted, the DSRIP requirements may unintentionally undermine a PPS's ability to use the appropriate health information sharing technology to achieve the DSRIP objectives. Recognizing the need for flexibility in a rapidly evolving marketplace, the proposed SHIN-NY regulation call does not identify specific technologies or HIE functionality, but instead relies on the creation of a certification process that "ensures standard criteria are met for providing services to its members and that the number of QEs is sufficient to provide access to health information exchange services statewide." Likewise, the DSRIP Application should also avoid prescribing specific technologies (e.g., secure notifications/messaging, sample transactions to public health registries) and instead rely on the PPS applicant's determination of its best approach to achieving the State's DSRIP objectives which would then undergo federal and/or state certification processes.

- **Patient Centered Medical Home Level 3**

Recommendation II.B.5
DOH should verify that the PCMH 2014 Level 3 requirement is applicable only to those sites/providers deemed eligible by NCQA, rather than to all providers as currently stated.

Recommendation II.B.6:
DOH should revise the requirement that 100% of (eligible) providers achieve NCQA PCMH 2014 Level 3 to a percentage target (such as 75%). As national provider programs such as Meaningful Use and the Physician Quality Reporting System (PQRS) have demonstrated, 100% compliance to a complicated set of requirements and practice transformations is not likely, in reality, and in light of other major national coding and reporting transitions occurring over the next two years, including ICD-10 implementation and Meaningful Use Stage 2 (which includes SNOMED CT adoption), some practices may require more time than the draft Application currently allows to complete compliance.

Comment:
Several individual projects contain NCQA PCMH 2014 Level 3 requirements.

The NCQA PCMH 2014 Level 3 standard is the most advanced form of PCMH accreditation NCQA currently offers. National averages indicate it can take a practice 18 or more months to prepare for and achieve NCQA PCMH recognition. While several practices in New York have already achieved NCQA recognition and will be focused on the (significant) evolution to the new 2014 standards, many providers, particularly those in smaller practices with a high percentage of Medicaid patients and which concomitantly have limited resources, will be starting the journey from a less advantaged position. It is unrealistic to expect that PPSs will have the full breadth and scope of resources needed to provide transformation support to all practices in their PPS out of the gate and on the same timeline. According to the Agency for Healthcare Research and Quality (AHRQ), only 10% of practices nationally have achieved any level of NCQA PCMH recognition. The DSRIP requirements should to allow for an achievable a glide path or ramp up plan.

Further, PCMH metrics are directly linked to PPS incentive payments. DOH should clarify what the consequences are if a PPS fails to meet the metric that 100% of their eligible providers achieve the standard. Is each metric an all-or-nothing measure that, if not achieved, could result in the entire PPS being financially penalized, potentially

missing its entire annual incentive payment despite achieving all other metrics? Is the PPS allowed, through a sound governance structure, to have discretion to both remove providers who do not achieve PCMH recognition or meet quality standards as well as retain – without penalty – any provider that does not achieve recognition in the timeframe defined by DOH, but are otherwise determined to act as good partners and adhere to all other protocols? (Similarly, the same set of considerations applies to the implications for the PPS if 100% of eligible providers do not reach the Meaningful Use requirement.)

- **Meaningful Use**

Recommendation II.B.7:
Requirements across several individual projects contain provisions related to "Meaningful Use standards" for EHRs. DOH should amend these entries to specify that providers eligible for participation in the Meaningful Use EHR Incentive Program will be required to have implemented Certified Electronic Health Record Technology (CEHRT) in the edition specified by the Office of the National Coordinator (ONC) for Health Information Technology as of DY 3.

DOH should also strike the term "or other IT systems" from the requirement on page 145 as the CEHRT requirements for Meaningful Use are specific to EHRs.

Comment:
The term "Meaningful Use" appears in the Project Requirements of several different projects, presented in slightly different terminology, such as (among others):

- "Achieve 2014 Level 3 PCMH primary care certification, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3." (p.2)
- "Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3." (p. 111)
- "Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 for EHR systems used by participating safety net providers." (p. 120)
- "Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3." (p. 145)

It is important to note that the provider eligibility requirements for the EHR Incentive Program are defined by statute under the American Recovery and Reinvestment Act

(ARRA) of 2009. All eligible professionals, eligible hospitals and eligible critical access hospitals are required to utilize certified electronic health record technology capabilities defined by the ONC, and which ONC modifies from time to time. The specific capabilities of the technology vary to some extent by type of provider specialty and year.

C. Domain 2 - Comments on Individual Project Plan Applications

- **2.a.i Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management (p. 1)**
    - **Project Requirements (p. 1)**

Recommendation II.C.1:
The first project requirement states that all PPS providers must be included in the Integrated Delivery System (IDS). We strongly urge DOH to amend this requirement.

This project should focus on developing the population health-management services and capabilities that are necessary to effectuate the evolution to value-based contracting. Whether the system is a single hospital or a diversified network, or the payment mechanism is an ACO contract, bundled payments or full-risk capitation, the same core capabilities are required.

We recommend the DOH to remove Project Requirement #1 as currently written and replace it with Project Requirement #3 ("PPS must ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services").

The PPS may pursue several pathways to supporting the development of IDSs. If the PPS covers a small geography, it may seek to develop one large IDS. If the PPS covers a large geography, it may seek to develop a centralized services resource that may be leveraged by multiple ACOs and IDSs in a region - or over multiple regions - such that a common data analytics, practice support and quality / clinical protocol development infrastructure is used to support several different provider groups in value-based contracting to support an aligned, regional system of care.

Key to any IDS's success is the bringing together of local medical neighborhoods of providers who voluntarily support the full continuum of care, effectively collaborate around agreed upon standards of care and, most importantly, improve the quality of

care delivered. Forcing disparate groups of providers into risk contracts should not be a DSRIP requirement.

Comment:
Requirement #1 states: "All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary, to support its strategy."

Deciding whether to join an ACO or an IDS is a strategic decision that must be carefully considered by every individual participating provider relative to its circumstances. Likewise, inclusion of a provider in an ACO or IDS by the entity ultimately at risk must be carefully vetted through a set of well-defined criteria and the provider must contractually agree to a set of participation requirements. Value-based contracting is contingent on the ability of the IDS to provide a higher quality set of services due to the highly financially and/or clinically integrated relationships and operations of the providers in the network.

Requiring an IDS to include every single provider in the PPS runs counter to the goals of a viable IDS and may, in fact, violate antitrust laws and requirements. DOH's plan to include a full continuum of care perspective in developing the IDS is well heeded but there are multiple ways a system of care may approach collaborating with various provider types. While there are possible benefits for providers in an ACO or IDS, there are considerable challenges in establishing an effective integrated network. Provider readiness and capacity for culture transformation must be a key consideration for the IDS, including but not limited to:

- Information Systems and Infrastructure: Is the potential IDS participating provider using an EHR? What level of EHR integration is currently in place? Does the provider currently use or will they commit to using an IDS-wide care management system?
- Practice Operations: How does the provider currently manage chronic care populations? Is the provider open to employing or collaborating with care managers or other non-physician extenders to support the monitoring of patient adherence to clinical treatment recommendations?
- Clinical Care Protocols and Care Transitions? Is the provider willing to contractually adhere to common IDS practice guidelines and protocols?
- Data Analytics: Is the provider willing to adopt data analytics tools to help measure and meet quality and cost targets? Is the provider willing to utilize the IDS's dashboard tools and respond to performance support tools and resources?

Additionally, there are significant infrastructure requirements to being able to administer the finances of being a risk-bearing entity.

Rather than requiring every participant in a PPS to be in a contractual, risk-bearing IDS, the PPS should focus on ensuring patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services (Project Requirement #3) through the combination of a clinically integrated system and a tightly aligned network of ancillary service providers and community based organizations, the structures and participants of which should be at the discretion of the program's provider-led governance.

Recommendation II.C.2:
DOH should clearly state that the PPS has discretion to define Population Health Management activities and patient registries for the purposes of meeting requirement #6.

Comment:
Recommendation #6 states: "Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers."

- **Scale of Implementation (p. 3)**

In addition to overarching comments detailed above please see the following recommendations related to scale of implementation:

Recommendation II.C.3:
As noted above, we recommend a consistent, Application-wide definition of PCP to mean individual primary care practitioners.

Comment:
The table requires "Expected # of PCPs." PCP is an undefined term.

Recommendation II.C.4:
As noted above, we recommend restructuring this approach and not binding the PPS to a total number of providers included in the IDS. Rather, DOH should require, by the end of DY1, a detailed plan to develop an IDS, an outline of provider requirements to join the IDS, and a pathway for the IDS to develop a risk-based contracting approach. Further, it is unclear to what end the number of providers per county is of value, absent some useful comparative data or adequacy standards.

Comment:
The table requires the applicant to indicate the total number of providers by county that the PPS intends to include in the IDS by end of Demonstration Year 4 or sooner.

- **2.a.iii Health Home At-Risk Intervention Program (p. 11)**

  - **Project Requirements (p.11)**

Recommendation II.C.5:
We recommend DOH strike the sentence: "PPS uses EHRs and HIE system to facilitate and document partnerships with needed service."

Comment:
Requirement #7 reads: "Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. PPS uses EHRs and HIE system to facilitate and document partnerships with needed services."

The meaning behind the requirement is unclear. Should the requirement be interpreted to mean the PPS must be able to show features within the EHR or HIE that demonstrate that network resources are being engaged and that health IT is being used to do so, or is it to show that all network providers are present in the EHR, or to require summary of care documents or care alerts to be transmitted electronically, or that referrals to other service providers be documented in an electronic care management system, etc? Further, in order to report on the metrics associated with this and other projects, each PPS will need extensive health IT infrastructure, including care management resources that align with and/or support health home programs.

- **2.a.iv Create a Medical Village Using Existing Hospital Infrastructure (p. 16)**

  - **Project Requirements (p. 16)**

Recommendation II.C.6:
DOH should drop or amend the requirement that all project participants achieve PCMH accreditation.

Comment:
Project Requirement #3 states: "Ensure that all project participants meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3." The purpose of the Medical Village is

to repurpose existing hospital infrastructure into integrated outpatient centers to provide emergency and or urgent care. Standalone ERs and Urgent Care Centers to do not qualify for NCQA Level 3 PCMH accreditation. Further, the medical neighborhood of providers considered in a Medical Village project may include several social and behavioral health service providers and community based organizations that also do not qualify for (nor would it be appropriate to impose) PCMH standards.

- **2.b.i Ambulatory ICUs (p. 26)**
    - **Project Requirements (p.26)**

Recommendation II.C.7:
DOH should drop the sentence "Eligible patients have been identified." It is unclear how this term relates to the already stated requirement that all patients "engaged" in the project are being tracked. Further, patient consent will likely be required to be tracked via electronic health records so **we recommend the state define all "engaged patients" as those who have provided consent.**

Comment:
Project Requirement #10 states: "Use EHRs and other technical platforms to track all patients engaged in the project, including collecting community data and Health Home referrals. Eligible patients have been identified."

- **2.b.ii Development of Co-Located Primary Care Services in the Emergency Department (ED) (p. 31)**
    - **Project Requirements (p. 31)**

Recommendation II.C.8:
We recommend the phrase "have EHR capability that is interoperable with the ED" be removed. Interoperability with the ED is undefined and is not an industry standard concept. Rather, if it feels necessary, DOH should outline that it expects that participating primary care practices are able to receive notifications that a patient has a been admitted to the ED and are able to access discharge reports within a specified amount of time by DSRIP year 3. It should be up to the PPS to determine how that notification and access to information happens and not be prescribed to be an EHR function.

Comment:
Project Requirement #2 states: "Ensure that new practices will meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. At start up, the practice must have open access scheduling extended hours, and have EHR capability that is interoperable with the ED."

Recommendation II.C.9:
DOH should clarify the requirement related to "health plan PCP."

Comment:
Project Requirement #7 states: "Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager as applicable. EMR System with Real Time Notification System is in use."

- **2.b.iii ED Care Triage for At-Risk Populations (p. 36)**
    - **Project Requirements (p. 36)**

Recommendation II.C.10:
We believe the ED Care Triage initiative is too narrow and prescriptive in its Project Requirements (and particularly in the associated project metrics – see Section III) and may inadvertently serve as disincentives to the most appropriate course of treatment for the individual patient.

***Comment*:**
We recommend the project be expanded to embrace tactics that address appropriate hospital admission diversion as well as ED triage. The ED team should be permitted the flexibility to spend more time with patients as they are discharged from the ED to ensure they will not inappropriately use the ED for future minor healthcare needs. Their immediate medical problem should be addressed and the care managers in the ED can both refer with as warm a hand-off as possible to a PCP and work to support social issues that can be addressed prior to a PCP visit.

Recommendation II.C.11:
We recommend the Project Requirement for "immediate" appointment with a PCP be amended (and that associated metrics be amended – see Section III) in favor of immediate availability by the end of the five year DSRIP project, if not sooner.

Comment:

According to a January 2014 Center for Medicaid Services (CMS) Informational Bulletin, "Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings," Medicaid beneficiaries use the ED at an almost two-fold higher rate than the privately insured. However, "this is not due to widespread inappropriate use of the ED amongst Medicaid beneficiaries, who tend to be in poorer health than the privately insured population; at least two studies found that the majority of ED visits by nonelderly Medicaid patients were for symptoms suggesting urgent or more serious medical problems. These studies estimate that non-urgent visits comprise only about 10 percent of all ED visits by Medicaid beneficiaries, and suggest that higher utilization may be in part due to unmet health needs and lack of access to appropriate settings."

This project, as currently proposed, intends to use care managers/navigator embedded in ED to direct patients in the target population into either (or both) immediate care management services via Health Homes or NCQA 2014 Level 3 PCMHs.
However, the emergency room physicians should not (and will not) be held to doing only minimum medical screening without treatment of the patient's immediate needs in the ED – particularly for high medical need patients and those with chronic conditions. Rather than diverting the patient from ED care in every case, this project should also focus on those who are at high risk of repeat unnecessary ED use. Once the patient is identified, a relationship can be formed and a treatment approach can be developed but that process may best occur in some cases after the provision of treatment in the ED setting to avoid unneeded hospitalization and ED use in the future.

Further, and a particularly acute challenge in some regions of the state, there may not be "immediate" availability of appointments at a PCMH NCQA Level 3 provider, or even a non-Level 3 provider due to shortages in primary care services. These are issues that DSRIP funding intends to help mitigate but will take time. In the meantime, PPSs participating in this project need to be afforded flexibility to implement solutions that advance the goals of the program but are accomplishable in the region and appropriate to the patient population. (For example, as indicated by the research cited in the CMS bulletin, the patient's immediate health needs may not be primary care in nature.)

Given the critical impact this project can have on access to care for Medicaid beneficiaries and the overarching goals of the DSRIP project to reduce potentially avoidable hospitalizations and ED use, PPSs should not be in a position to consider not selecting this project simply because the ability to successfully operationalize an immediate appointment with an NCQA 2014 Level 3 PCMH is not achievable or realistic in the near term (nor is it always the right answer).

- **2.b.iv Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions (p. 41)**

    - **Project Requirements (p. 41)**

Recommendation II.C.12:
DOH should clarify to which "member" Project Requirement #5 refers. Clarity is needed on whether member refers to a managed care plan member, an individual beneficiary assigned to a PPS, or participant who gives consent to be enrolled in a specific care transitions program.

Comment:
Project Requirement #5 states: Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.

- **2.b.v Care Transitions Intervention for Skilled Nursing Facility (SNF) Residents (p. 46)**

    - **Project Requirement (p.46)**

Recommendation II.C.13:
DOH should drop this requirement or revise to define the types of data that should be shared between SNFs and other care providers at transitions in care rather than prescribing a technical requirement that may not be feasible or the most effective or cost efficient means to achieve an end.

Comment:
Project Requirement #5 states: "Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3."

The phrase "shared EHR system capability" is an undefined concept that could be interpreted to mean providers sharing data contained in an EHR or could be interpreted to mean that SNFs must share a common EHR platform with other providers, such a hospitals. Rather, the aspirational requirement should be that the most actionable data follows the patient, accessible at the site of care.

- **2.b.vi Transitional Supportive Housing Services (p. 51)**

    - **Project Requirement (p.51)**

Recommendation II.C.14:
We suggest DOH remove or amend the requirement related to Medicaid Managed Care Organizations and covered transitional services. This requirement is outside the PPSs control and there are strict regulatory requirements that relate to transitional housing outside the control of both PPSs and Managed Care plans. **DOH should clarify what obligations the PPS is under in ensuring services are covered and/or amend this to requirement to read "…to ensure needed services at discharge are covered and in place, to the extent possible under current law and provision of benefit restrictions."**

Comment:
Project Requirement #5 states: "Establish coordination of care strategies with Medicaid Managed Care Organizations to ensure needed services at discharge are covered and in place at the transitional supportive housing site."

    - **Scale of Implementation (p. 52)**

Recommendation III.C.15:
We strongly urge DOH removes the metric related to "Number of Transitional Beds Established for High Risk Patients" as a required scale of implementation metric for this project. If DOH feels a scale metric beyond volume of patients served (which may be defined as an estimated cumulative unduplicated count of high-need Medicaid recipients who will be referred to a housing-related service identified by the PPS) is important and appropriate, we recommend DOH develop an alternative metric that is based on establish Memorandums of Understanding (MOUs) and other service agreements between participating hospitals and community housing providers to allow the transitional supportive housing.

Comment:
The Scale of Implementation section requires a "Number of Transitional Beds Established for High-Risk Patients." The eight project requirements do not include a provision to increase transitional beds. Moreover, our understanding is that DSRIP funding cannot be used to pay for transitional beds housing and there are significant regulatory and licensing issues related to transitional housing that are beyond the PPS's control. Nonetheless there is considerable opportunity to help high need patients achieve housing stability by adding transition services and by training and supporting

care mangers and care navigators regarding proven approaches to maintaining complex clients in stable housing.

C. Domain 3 - Comments on Individual Project Plan Applications

- **3.a.i Integration of Primary Care and Behavioral Health Services (p. 86)**
    - **Project Requirements (p.86)**

Recommendation II.C.16:
PPS should be afforded flexibility to select age appropriate screening tools and interventions to address age appropriate conditions (e.g., trauma rather than substance abuse). Language in the project requirements referencing "all patients" should be amended to include "as appropriate to the age of the patient."

Comment:
Several project requirements refer to "all patients" and seem to imply tools and requirements must uniformly be applied to all patients, regardless of age. It is unclear as currently drafted what flexibility a PPS has if it desires to provide integrated care to children under 12. For example, will the PPS have flexibility to select age appropriate screening tools and interventions to address age appropriate conditions (e.g., trauma rather than substance abuse)?

Recommendation II.C.17:
In the model where Behavioral Health services are integrated at PCMH sites, the Application appears to require having behavioral health services available onsite at all practice hours. PPSs should be afforded flexibility to determine resource allocation and staffing schema based on patient panel needs. DOH should define behavioral health services available during all practice hours to mean screenings with a timely access point for follow up when required either through onsite behavioral health services, on call services for acute needs, or a follow up appointment within a reasonable amount of time with a behavioral health specialist.

Comment:
Staffing every hour the practice is open with a behavioral health clinician may be cost prohibitive for many practices and may not even be possible due to provider shortages. Further, many Article 28 providers are opening for longer hours and more days to address primary care access issues and it may not be practical to have behavioral health clinical staff onsite at all times. Under DSRIP, we anticipate incentives to increase access

to primary care and expect heightened efforts to expand hours and practice sites, such as through extension clinics.

Recommendation II.C.18:

In Model B, Behavioral Health Service Site, we recommend DOH clarify that the behavioral health clinic site does not have achieve NCQA 2014 Level 3 PCMH or APCM standards by DY3.

Comment:

In the draft Project Toolkit it is unclear whether the PCMH accreditation requirement applies only to Model A, PCMH Service Site, or to all three models. Integrating primary care into an existing behavioral health site provides an important opportunity to advance the goals of project 3.a.i but it is impractical for behavioral health sites themselves to achieve the PCMH standards and is a deterrent to PPSs pursuing this critical model. Behavioral Health sites can conceivably partner with PCMH recognized primary care providers who offer on-site primary care services in a behavioral health clinic, which is notably different than the behavioral health site achieving PCMH accreditation itself.

Recommendation II.C.19:

Co-location does not automatically promote communication between providers. Furthermore, physical co-location will not always be possible due to provider shortages, patient volume, and space constraints. **We recommend virtual co-location through a shared electronic care plan supplemented by telephonic interdisciplinary care team meetings should be deemed as meeting the DSRIP requirements for Project 3.a.i.**

Comment:

The DSRIP application and planning process should build upon the 'lessons learned' by organizations who have invested in and played a key role in the development and implementation of population health strategies to effect improvements in access to and quality of health care services. One key lesson learned is that virtual co-location can be both an effective and feasible means to achieving the goals of project 3.a.i. For example, Maimonides Medical Center (lead applicant for the Community Care of Brooklyn PPS) has worked to develop and disseminate its electronic care plan (Dashboard) to many contracting agencies in the Brooklyn Health Home with excellent success and significant outcome improvements in reducing ED use and acute care admissions for patients. The planned leveraging of Maimonides' grant-funded work on the development of the Dashboard and related care coordination efforts is a key element of the DSRIP effort in Brooklyn. Specifically, the Dashboard is web-based and interoperable with Healthix so it can achieve significantly enhanced coordination and communication. The platform houses care coordination tools that can be accessed by medical and social service

providers across different electronic health information systems throughout the borough. Providers at multiple partner organizations are "virtually co-located" through this dashboard. They communicate in real time with each other using a suite of tools including secure messaging, assessment and care management tools, alerts from hospital/ER admissions and discharges, and longitudinal patient clinical summaries. A similar approach may be employed by other PPSs to advance the transformation objectives of this DSRIP project.

- **3.a.ii Behavioral Health Community Crisis Stabilization Services (p. 92)**
    - **Scale of Implementation (p. 92)**

Recommendation II.C.20:
As crisis stabilization services are not site-based in the same way as project 3.a.i, for example, we recommend DOH strike the currently proposed metric of "number of sites" and replace it with a metric related to "service area coverage."

Comment:
While there are some site-based resources employed in a Behavioral Health Crisis Stabilization services strategy (e.g. hospital, observation beds), crisis services are generally described in terms of geographic coverage (e.g. county or zip codes within county). It would be a more accurate description of scale to ask for service area coverage rather than sites.

- **3.b.i Evidence-Based Strategies for Disease Management in High Risk / Affected Populations (Adults Only / Cardiovascular Conditions) (p. 111)**
    - **Project Requirements (p. 111)**

Recommendation II.C.21:
Revise entry to read "Million Hearts" campaign.

Comment:
Project requirement #13 refers to the "Million Lives" campaign.

- **3.c.i Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease – Primary and Secondary Prevention Projects (Adults Only / Diabetes) (p. 120)**
    - **Project Title (p. 120)**

Recommendation II.C.22:
Please revise the project title. It is our understanding that project 3.c.i is a practice-based intervention rather than a community supports based intervention. (Project 3.c.ii is focused on evidence-based strategies in the community).

Comment:
In the Draft Project Tool Kit, this project is titled, "Implementation of Evidence-Based Strategies for Disease Management;" rather than, "Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease."

- **Project Requirements (p. 120)**

Recommendation II.C. 23:
We request DOH clarify if the threshold or definition for "engagement" is intended to differ from participating in the project.

Comment:
Project Requirement #2 states that the PPS must: "Engage at least 80% of primary care practices within the PPS in the implementation of disease management evidence-based best practices."

- **3.d.ii Expansion of Asthma Home-Based Self-Management Program (p. 135)**

  - **Scale of Implementation (p. 136)**

Recommendation II.C.24:
DOH should include non-Medicaid billing organizations in the definition of "community based providers."

Comment:
The Application requests information on the "total number of home care or other community-based providers the PPS intends to include in the project by the end of Demonstration Year 4, or sooner as applicable" but does not provide a definition of "community-based providers."

- **4.b.i Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those With Poor Mental Health (p. 177)**

  - **Project Requirements (p. 177)**

Recommendation II.C.25:

DOH should eliminate Project Requirements #5 and #7 as they are not within the power of the PPS to change. These policy changes are dependent on State and Medicaid Managed Care action and should be removed.

Comment:

Project Requirement #5 requires a PPS to "[i]ncrease Medicaid and other health plan coverage of tobacco dependent treatment counseling and medications." Project Requirement #7 requires a PPS to "[c]reate universal, consistent health insurance benefits for prescription and over-the-counter cessation medications." Both of these requirements require policy changes directed by the State and Medicaid Managed Care Plans and are not achievable by a PPS.

III. Domain 1 DSRIP Project Requirements Milestones and Metrics

A. Comments That Apply to Multiple Projects

- **"Clinical Interoperability System is in Place"**

  Recommendation III.A.1:
  The term "Clinical Interoperability System" is not widely recognized in the industry. **DOH should provide examples of the types of systems (or components of systems) that meet DOH's "Clinical Interoperability System" definition or clarify that PPSs will be afforded flexibility in designing infrastructures that advance the project requirements.**

- **"HIE Systems Report"**

  Recommendation III.A.2:
  Several projects call for an "HIE Systems report" as back up documentation to support achievement of a required metric. **DOH should clarify what that means and what type of information will need to be included in it or strike that language from the back up documentation list as it is a term that is not recognized in the industry. Preferably, DOH should list the types of functionality or capabilities required to support the objective and grant the PPS flexibility to document how those capabilities are accomplished.**

- **"Sample of Transactions to Public Health Registries"**

  Recommendation III.A.3:
  DOH should at minimum strike the word "public" from the requirement if the project requirement does not explicitly require submission of data to a public health agency. In most cases, we believe, based on review of project plan descriptions, this requirement is intended to encompass use of a registry for population health management, regardless of its use or governance. However, **we also recommend DOH consider removing this as a Domain 1 metric altogether, keeping metrics focused on goals and objectives and allowing the PPS the flexibility to determine the best health IT tools and resources to accomplish them.**

  Comment:
  Requirements related to registry reporting must be explicitly detailed at a far more granular level than what is currently included in the Application metrics guidance. We strongly urge DOH not to narrow reporting to "Public Health Registries." However, any

requirements related to public health registries must detail which public health entities in New York State are capable of accepting an electronic transmission. What are the pathways for electronic submission (direct from provider only? via RHIO? Other?) ? What are the file specifications and how do they vary across entities? This is of critical concern as PPSs will need to be able to attest to exactly when they will be able to accomplish this (by an exact quarter) and will be financially penalized if not compliant. While a well-intentioned metric, there are a vast number of complexities and contingencies that must be considered in detail in order to be able to comply with such a requirement, most of which are outside the control of a PPS.

- **Requirements to Use Secure Messaging**

  Recommendation III.A.4:
  We recommend DOH strike all required Metrics/Deliverables that call out "secure messaging" as DOH should not prescribe the method or approach to exchange, rather they should focus on the goals and objectives of the projects and allow the PPS flexibility to determine the most appropriate health IT tools to accomplish those objectives.

  However, DOH elects to retain the explicit requirement of using secure messaging, DOH should revise the companion required documentation because it suggests the functionality must be limited to the HER to meet this metric. Several providers utilize DIRECT or secure messaging through platforms that are not EMR-based. Meaningful Use allows DIRECT messaging through HISP when appropriate as well and most projects already require use of Meaningful Use Certified Electronic Health Record Technology

- **"All Practices Meet NCQA Level 3 PCMH and/or APCM Standards"**

  Recommendation III.A.5:
  DOH should insert the word "eligible" before "practices" as NCQA has a strict set of requirements to determine which types and specialties of practice are eligible to participate in the accreditation program. A PPS will likely have many different types of specialty practices in their network.

- **PCP Definition**

  Recommendation III.A.6:
  In alignment with our recommendations in Section II above, DOH should employ a consistent definition of PCP throughout the Application. **We recommend PCP be**

defined as the primary care provider/practitioner (with practitioner indicating any licensed primary care practitioner).

- **Timeline**

Recommendation III.A.7:
Detailed implementation plans are currently scheduled to be due in April 2015. **PPSs should be allowed to revise and update their estimates for being able to comply with individual project metrics that are not expressly time-bound in the Application (such as "PPS adheres to AHA Dietary Guidelines for all foods served" or "PPS implemented a comprehensive Medication Adherence Program,".) PPSs should be given flexibility to develop more granular operating and implementation plans that establish realistic and measurable project targets and allow DOH to accurately track progress and milestones.**

Comment:
The Metrics/Deliverables section includes the following footnote: "Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application."

B. Detailed Comments on Metrics and Deliverables for Specific Projects

- **2.b.ii ED Care Triage for At-Risk Populations (p. 24)**

Recommendation III.B.1:
While the Project Requirements seem to offer some flexibility in primary care partnerships, recognizing that creating linkages to primary care and helping patients utilize more appropriate services is the overarching goal and some providers may face primary care availability shortages, the associated metrics clearly require that all practices be NCQA 2014 Level 3. **We strongly urge DOH to revise this metric. While working with Level 3 PCMH practices will be a goal, it is not practical and may not be feasible in all situations.**

Comment:
While the Project Requirements for this project state that "Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling," the associated metric requires "All practices meet NCQA Level 3 PCMH and/or APCM standards." (See expanded discussion in Section II.)

- **3.a.i Integration of Primary Care and Behavioral Health Services (p. 62)**

Recommendation III.B.2:
PPSs should be afforded flexibility to determine resource allocation and staffing schema based on patient panel needs and should not be required to staff behavioral health professionals during all practice hours. DOH should define behavioral health services available during all practice hours to mean screenings with a timely access point for follow up when required (either through onsite behavioral health services, on call services for acute needs, or a follow up appointment within a reasonable amount of time with a behavioral health specialist).

Comment:
A Metric/Deliverable for Project Requirement 1 states: "Behavioral health services are co-located within PCMH practices during all practice hours."

Recommendation III.B.3:
DOH should remove requirements related to using a specific technology, in this case the EHR, from the project metrics. PPSs should have discretion over employing the appropriate health information technology tool to accomplish the goals of the program. An EHR may not be the right technology to accomplish a specific goal and should not be prescribed as a required solution.

Comment:
A Metric/Deliverable for Project Requirement 3 states: "Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record." A Metric/Deliverable for Project Requirement 4 states: "EHR demonstrates integration of medical and behavioral health record within individual patient records."

Integration of medical and behavioral health patient information in an EHR is problematic for several reasons including both legal/regulatory and technical. Further, an EHR is not designed to be an integrated care management and care planning tool. It is a technology with a functional requirement to store specific elements of patient data as structured data and the EHR in and of itself is limited in its ability to analyze data and create usable data for patient care. The market has developed several innovative,

provider-focused tools on integrated care planning for medical and behavioral health and PPSs who implement this project should have the ability to select the technology solution that is most appropriate and most effective for their networks.

IV. DSRIP PPS Application Scoring Guide

Recommendation:

Cross-PPS active collaboration is essential to the overall success of the DSRIP program. The comparative scoring formula may inadvertently penalize providers in the same region who are collaborating around common project implementation. **DOH should establish a category for bonus points for PPSs who enter into meaningful, contractual MOUs to collaborate around implementation of common DSRIP projects in a substantial way.**

* * *

manatt
manatt | phelps | phillips

ATTACHMENT A: Actively Engaged Patient Definitions for Domains 2 and 3

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
2.a.i	Create Integrated Delivery System	Patients residing in counties served by the PPS having completed a RHIO Consent Form.	The RHIOs are in varying states of development and provide, in effect, a public utility. Many IDSs across the country have private HIEs. An IDS may use the RHIO to transmit certain information but use their own IT systems for patient care and inter-provider data-sharing. DSRIP should not prescribe how the IDS functions from an IT management perspective and a consent form with the RHIO does not measure patient engagement with a system of care. The requirement that the actively engaged population should always be a subset of the target population does not account for the definition of Actively Engaged in the project - "patients residing in counties served by the PPS."
2.a.ii	PCMH / Advanced Primary Care Certification	Participating patients who receive appropriate preventive care screenings to identify unmet medical or behavioral health needs from participating PCPs.	
2.a.iii	Health Home At-Risk Intervention Program	Participating patients who complete HH Patient Information Sharing Consent Form (DOH 5055).	This measure does not account for the goal of the project, which is to divert patients at-risk of needing health home services before they reach the health home and would have completed the form. Recommendation: Patients in PPS identified as Health Home at-Risk based on DOH definition (single moderate or severe chronic condition) with an established “comprehensive care management plan.”
2.a.iv	Hospital-Based Medical Village	Participating patients who had two or more distinct services at a Medical Village in a year.	While utilization can, in some instances, be viewed as a proxy for engagement, the goal of this project is to repurpose hospital inpatient infrastructure to provide outpatient and community based services. A relatively healthy patient may only need one primary care visit per year and can still benefit from and be engaged in the Medical Village.

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
			Growth in visits to "Medical Village" site(s) by unique Medicaid beneficiaries may be a more appropriate metric. In addition, does the definition of "services" include any ED/OP visit/utilization? Recommendation: Number of participating patient visits to "Medical Village" site(s).
2.a.v	Nursing Home-Based Medical Village / Alternative Housing	Participating patients who had two or more distinct services at Medical Village within a year.	While utilization can, in some instances, be viewed as a proxy for engagement, the goal of this project is to repurpose hospital inpatient infrastructure to provide outpatient and community based services. A relatively healthy patient may only need one primary care visit per year and can still benefit from and be engaged in the Medical Village. Growth in visits "Medical Village"-wide by unique Medicaid beneficiaries may be a more appropriate metric. Recommendation: Number of participating patient visits to "Medical Village" site(s).
2.b.i	Ambulatory ICUs	Patients who had two or more distinct services at an Ambulatory ICU in a year.	A patient may not require ambulatory ICU services more than one time a year. Patient engagement related to such near emergent care services may be better managed by awareness of / knowledge of the service being available rather than multiple uses of the service. A more helpful measure may be number of patients identified as ED "frequent fliers" who utilize ambulatory ICU services but that data would likely be difficult to collect and track in the early years of DSRIP implementation.
2.b.ii	ED-Based Primary Care	Participating patients who presented at the ED for triage but were successfully and appropriately redirected to PCMH.	What does "successfully" mean? Also, it would be difficult to determine whether a given patient is appropriate to redirect to PCMH until screening is completed.

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
			DOH should also consider expanding the list of redirected organizations beyond PCMH practices.
2.b.iii	ED Care Triage for At-Risk Populations	Participating patients presented at the ED and appropriately referred for medical screening examination and successfully redirected to PCP.	What does "successfully" mean? Also, it would be difficult to determine whether a given patient is appropriate to redirect to PCP until screening is completed. DOH should also consider expanding the list of redirected organizations beyond PCPs.
2.b.iv	Care Transitions Intervention for Chronic Health Conditions	Patients who complete care transition plans within 30-days of discharge.	How does a patient "complete" a care transition plan? Who/what determines the plan has been completed by the patient? Recommendation: Patients discharged with a PPS-created care transition plan
2.b.v	Care Transitions Intervention for SNF Residents	Patients who complete care transition plans within 30-days of discharge.	How does a patient "complete" a care transition plan? Who/what determines the plan has been completed by the patient?
2.b.vi	Supportive Housing Services	Participating patients who utilized transitional supportive housing and were appropriately monitored throughout transition period.	What is the transition period? The universe of patients eligible for services is limited by housing availability, licensure and regulations. Is this measure intended to be a total number of patients served or a percentage of patients who received outreach services? Also, given the various definitions transitional housing (e.g., NYC Department of Homeless Services calls their shelters transitional housing), the State should provide a

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
			more specific definition. Should/can actively engaged populations include patients receiving transitional supportive services provided through housing organizations, but who are not necessarily receiving housing services per se? How are outliers considered? DOH should also consider allowance for creative housing solutions within the PPS that are outside regulation or funding, e.g. respite beds within other housing options. Recommendation: Number of patients referred to housing organizations for transitional supportive services by PPS
2.b.vii	INTERACT Inpatient Transfer Avoidance for SNF Residents	Participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles.	What specific factors or metrics should be used to determine that a hospital transfer was avoided and that it can be attributed to the INTERACT principles?
2.b.viii	Hospital/ Home-Care Collaboration	Participating patients who avoided home care to hospital transfer, attributable to INTERACT-like principles.	What specific factors or metrics should be used to determine that a hospital transfer was avoided and that it can be attributed to the INTERACT-like principles?
2.b.ix	Hospital Observational Programs	Participating patients who are utilizing the OBS services that meet project requirements.	
2.c.i	Community-Based Health Navigation Services	Participating patients assisted by community navigators (in-person, telephonic, or web-based).	

October 29, 2014

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
2.c.ii	Telemedicine Expansion	Participating patients who receive telemedicine consultations.	
2.d.i	Uninsured and non/low-utilizers	Number of individuals who completed PAM® and have an established patient activation score.	There are other patient activation techniques (other than PAM) mentioned elsewhere in the Application.
3.a.i	Behavioral Health / Primary Care Integration	Patients engaged per each of the three models in this project, including: A. PCMH Service Site: Number of patients screened (PHQ-9 / SBIRT) B. Behavioral Health Site: Number of patients receiving primary care services C. IMPACT: Number of patients screened (PHQ-9 / SBIRT)	How does this measure consider pediatric beneficiaries (applicable to all models)? For behavioral health model, what is the definition of "primary care services?"
3.a.ii	Behavioral Health Community Crisis Stabilization	Participating patients receiving crisis stabilization services from participating sites.	DOH should provide a detailed definition of crisis stabilization services.
3.a.iii	Behavioral Health Medication Adherence (Community-Based)	Participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).	The definition of "documented self-management goals in the medical record" is unclear and exceeds the scope of the typical medication adherence programs. Please clarify if PPSs have discretion to determine what defines a "self-management goal." In addition, is one documented goal sufficient?
3.a.iv	Behavioral Health Withdrawal	Patients who have received outpatient withdrawal	

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
	Management/ Detox (Community-Based)	management services at participating sites.	
3.a.v	Behavioral Health Interventions Paradigm in Nursing Homes (BIPNH)	Participating patients impacted by program initiatives (bed census).	
3.b.i	Cardiovascular Disease Management (High Risk Adult Populations)	Participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).	The definition of "documented self-management goals in the medical record" is unclear. Please clarify if PPSs have discretion to determine what defines a "self-management goal." In addition, is one documented goal sufficient?
3.b.ii	Cardiovascular Disease Prevention Program (Community-Based, Adults)	Patients participating in programs at project sites.	
3.c.i	Diabetes Disease Management (High Risk Adult Populations)	Participating patients with at least one hemoglobin A1c test within the previous DSRIP year.	
3.c.ii	Diabetes Prevention Program (Community-	Patients participating in programs at project sites.	

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
	Based, Adults)		
3.d.i	Asthma Medication Adherence (Community-Based)	Patients receiving these services from providers at participating sites.	Additional clarity should be provided regarding what is intended by the term "receiving."
3.d.ii	Asthma Home-Based Self-Management	Participating patients on home assessment log, patient registry or other IT platform.	Are all patients with asthma diagnosis considered actively engaged if evaluated and included in a patient registry? Or do they need to have received a service related to their diagnoses in order to meet the threshold of active engagement?
3.d.iii	Asthma Management Guidelines	Participating patients with asthma action plan.	
3.e.i	HIV/AIDS Center of Excellence	Participating patients who received at least four anti-viral prescription within the previous DSRIP year.	
3.f.i	Perinatal Maternal/ Fetal Health Program	Number of expecting mothers and mothers participating in this program.	There are three sub-program options in this project. How is "participating in this program" defined?
3.g.i	Palliative Care/Medical Home Integration	Participating patients receiving palliative care procedures at participating sites.	What is the definition of a "palliative care procedure"?
3.g.ii	Palliative Care/Nursing Home Integration	Participating patients receiving palliative care procedures at participating sites.	What is the definition of a "palliative care procedure"?

#	Description	DOH Definition of Actively Engaged Patient	Comment(s)
3.h.i	Renal Care Medical Home	Participating patients actively receiving services at Specialized Medical Home(s) for Chronic Renal Failure.	

October 29, 2014

ATTACHMENT B: Project Scale Definitions for Domains 2 and 3

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
2.a.i	Create Integrated Delivery System	• Expected # of Hospitals • Expected # of PCPs • Expected # of Nursing Facilities • Expected # of Behavioral Health Providers • Expected # of All Other Providers	For this project, DOH should consider a consistent interpretation of "providers" to mean reports at the organization level for all provider types.	• Expected # of Hospitals • Expected # of Primary Care Providers (organizational level) • Expected # of Nursing Facilities • Expected # of Behavioral Health Provider Organizations • Expected # of All Other Provider Organizations
2.a.ii	PCMH / Advanced Primary Care Certification	PCPs participating in project	What is the expected approach to defining PCPs? - What specialties/program types should be included in the definition of PCP? - What level is appropriate for reporting/counting participating "PCPs" for this project (individual practitioner, practice site, or organization)?	DOH should define PCPs as Primary Care Providers and counted at the individual (practitioner) level.
2.a.iii	Health Home At-Risk Intervention Program	PCPs participating in project	What is the expected approach to defining PCPs? - What specialties/program types should be included in the definition of PCP? - What level is appropriate for reporting/counting participating "PCPs" for this project (individual practitioner, practice site, or organization)?	DOH should define PCPs as Primary Care Providers and counted at the individual (practitioner) level.

October 29, 2014

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
2.a.iv	Hospital-Based Medical Village	Expected Number of Medical Villages Established		
2.a.v	Nursing Home-Based Medical Village / Alternative Housing	Expected Number of Medical Villages Established		
2.b.i	Ambulatory ICUs	Expected Number of Ambulatory ICUs Established		
2.b.ii	ED-Based Primary Care	Emergency Departments which contain co-located primary care services		
2.b.iii	ED Care Triage for At-Risk Populations	Emergency Departments with Care Triage		
2.b.iv	Care Transitions Intervention for Chronic Health Conditions	Hospitals		
2.b.v	Care Transitions Intervention for SNF Residents	Skilled Nursing Facilities		
2.b.vi	Supportive Housing Services	Number of Transitional Beds Established for High-Risk Patients	The eight requirements listed for this project do not include a provision to increase transitional beds. Moreover, our understanding is that DSRIP funding cannot be used to pay for transitional beds.	Develop an alternative metric based on establishing MOUs and other service agreements between participating hospitals and community housing providers to facilitate the efficient use of existing or development of new transitional supportive housing.

October 29, 2014

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
2.b.vii	INTERACT Inpatient Transfer Avoidance for SNF Residents	Project Scale Number Committed SNFs participating in the INTERACT program		
2.b.viii	Hospital/ Home-Care Collaboration	Home care facilities participating in INTERACT program		
2.b.ix	Hospital Observational Programs	Hospitals participating in project		
2.c.i	Community-Based Health Navigation Services	Community-based navigators participating in project		
2.c.ii	Telemedicine Expansion	• Providers ("hub" sites) participating in project • Providers ("spoke" sites) participating in project		
2.d.i	Uninsured and non/low-utilizers	Expected # of individuals trained in PAM® or other patient activation techniques		

October 29, 2014

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
3.a.i	Behavioral Health / Primary Care Integration	• Expected # of PCPs • Expected # of Behavioral Health Sites • Expected # of Substance Abuse Sites • Expected # of All Other Provider Sites	What program/organization types should be included in the definition of PCP? What is the definition of “all other sites" that applies to this project and other projects where that category is requested? Can partners that do not directly provide medical services (e.g., CBOs) be listed as safety net providers if they serve largely safety net populations, given that they are not considered providers and thus cannot be certified pursuant to the DOH’s existing process? If so how?	
3.a.ii	Behavioral Health Community Crisis Stabilization	Sites participating in project	Crisis Stabilization services are not typically measured by sites, rather by geographic coverage (e.g. county or zip codes within county). In this definition, how are outreach and mobile crisis "sites" to be determined?	Replace “sites participating” with “service area coverage.”
3.a.iii	Behavioral Health Medication Adherence (Community-Based)	• Expected # of PCPs • Expected # of Behavioral Health Sites • Expected # of Substance Abuse Sites • Expected # of All Other Provider Sites	What program/organization types should be included in the definition of PCP? What is the definition of “all other sites" that applies to this project and other projects where that category is requested? Can partners that do not directly provide medical services (e.g., CBOs) be listed as safety net providers if they serve largely safety net populations, given that they are not considered providers and thus cannot be certified pursuant to the DOH’s existing process? If so how?	

October 29, 2014

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
3.a.iv	Behavioral Health Withdrawal Management/ Detox (Community-Based)	• Expected # of PCPs • Expected # of Behavioral Health Sites • Expected # of Substance Abuse Sites • Expected # of All Other Provider Sites	What program/organization types should be included in the definition of PCP? What is the definition of “all other sites" that applies to this project and other projects where that category is requested? Can partners that do not directly provide medical services (e.g., CBOs) be listed as safety net providers if they serve largely safety net populations, given that they are not considered providers and thus cannot be certified pursuant to the DOH’s existing process? If so how?	
3.a.v	Behavioral Health Interventions Paradigm in Nursing Homes (BIPNH)	Number of total licensed beds in participating facilities		
3.b.i	Cardiovascular Disease Management (High Risk Adult Populations)	PCPs participating in project	What is the expected approach to defining PCPs? - What specialties/program types should be included in the definition of PCP? - What level is appropriate for reporting/counting participating “PCPs” for this project (individual practitioner, practice site, or organization)?	DOH should define PCPs as Primary Care Providers and counted at the individual (practitioner) level.

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
3.b.ii	Cardiovascular Disease Prevention Program (Community-Based, Adults)	Number of sites with evidence based self-management program		
3.c.i	Diabetes Disease Management (High Risk Adult Populations)	Number of participating primary care providers	What is the expected approach to defining PCPs? - What specialties/program types should be included in the definition of PCP? - What level is appropriate for reporting/counting participating "PCPs" for this project (individual practitioner, practice site, or organization)?	DOH should define PCPs as Primary Care Providers and counted at the individual (practitioner) level.
3.c.ii	Diabetes Prevention Program (Community-Based, Adults)	Number of sites with evidence based self-management program		
3.d.i	Asthma Medication Adherence (Community-Based)	Number of PCP sites and all other community provider sites	What is the expected approach to defining PCPs? - What specialties/program types should be included in the definition of PCP? - What level is appropriate for reporting/counting participating "PCPs" for this project (individual practitioner, practice site, or organization)?	DOH should define PCPs as Primary Care Providers and counted at the individual (practitioner) level.

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
3.d.ii	Asthma Home-Based Self-Management	Number of home care or other community-based providers	What is the definition of "community-based providers?" Should it include Primary Care Providers/Practitioners who would be engaged in the medical management aspects of the intervention? Per the discussion of PCPs above, at what level should these be reported for providers (Organization? Practice site? Individual practitioner?) Also how would the state recommend reporting providers that are not defined as Medicaid Providers and/or are not part of the PPS network participants but are contracted to provide services that directly support the interventions?	
3.d.iii	Asthma Management Guidelines	Number of participating prescribing providers		
3.e.i	HIV/AIDS Center of Excellence	Number of PCPs/COE(s)		
3.f.i	Perinatal Maternal/ Fetal Health Program	Number of programs	Should the count for number of programs include network partners for Model 2, or just the number of centers of excellence?	
3.g.i	Palliative Care/Medical Home Integration	Number of participating PCMHs		
3.g.ii	Palliative Care/Nursing Home Integration	Number of participating nursing homes		

October 29, 2014

#	Description	DOH Definition of Project Scale	Comment(s)	Proposed Definition
3.h.i	Renal Care Medical Home	Number of Specialized Medical Home for Chronic Renal Failure site(s)		

manatt
manatt | phelps | phillips

ATTACHMENT C

Requirements Related to RHIOs and SHIN-NY in Draft Application as They are Currently Proposed

Artifact #2: New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program DSRIP Project Plan Applications: Domain 2 DSRIP Project Plan Applications; Domain 3 DSRIP Project Plan Applications; Domain 4 DSRIP Project Plan Applications. Artifact #3: New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program Domain 1 DSRIP Project Requirements Milestones and Metrics: Project Requirements Milestones and Metrics: Domain 2; Project Requirements Milestones and Metrics: Domain 3.

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Page #**	**Metric/Deliverable**	**Data Source(s)**
2.a.i	Integrated Delivery System	1	4	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	2	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
					3	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
2.a.ii	Increase PCMH	6	4	Ensure that all PPS safety net	7	EHR meets connectivity	DURSA (Data Use and

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
	Certification			providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.		to RHIO's HIE and SHIN-NY requirements.	Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
					7	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
2.a.iii	Health Home At Risk Intervention	11	3	Ensure that all participating providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	10	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
					11	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
							materials; list of training dates along with number of staff trained in use of alerts and secure messaging
2.a.iv	Medical Village Using Existing Hospital Infrastructure	16	4	Ensure that all Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	15	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
2.a.v	Medical Village Using Existing Nursing Home Infrastructure	21	8	Ensure that all Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	19	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
2.b.i	Ambulatory Intensive Care Units	26	5	Ensure that all project participants are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners,	21	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
				including secure notifications/messaging	22	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
2.b.v	Care transitions intervention for skilled nursing facility (SNF) residents	46	5	Ensure that all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Y3.	36	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions.
2.b.vii	Implement INTERACT (SNF)	56	8	Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	41	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions.
2.b.ix	Implementation of observational programs in hospitals	66	4	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information	48	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
				exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.			health registries; use of DIRECT secure email transactions
3.a.ii	Behavioral health community crisis stabilization services	91	8	Share EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	70	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions
					70	Alerts and secure messaging functionality are used to facilitate crisis intervention services.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; Written training materials; List of training dates along with number of staff trained in use of alerts and secure messaging
3.b.i	Cardiovascular - Evidence-based strategies for disease management in	111	2	Actively share EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including	84	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
	high risk/affected populations (adult only)			secure notifications/messaging, by the end of Demonstration Year 3.			DIRECT secure email transactions
					84	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
3.c.i	Diabetes - Evidence-based strategies for disease management in high risk/affected populations (adults only)	120	7	Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	96	EHR meets connectivity to RHIO/SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management	140	2	Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	105	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Page #**	**Metric/Deliverable**	**Data Source(s)**
3.e.i	Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for Management of HIV/AIDS	145	6	Model 2: Ensure coordination of care between all available services preferably through a single electronic health/medical/care management record.	113	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
			7	Model 2: Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	114	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
					114	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
3.f.i	Perinatal Care -	150	5	Model 2:	119	EHR meets connectivity	DURSA (Data Use and

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)			Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.		to RHIO's HIE and SHIN-NY requirements.	Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
					120	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
3.h.i	Specialized Medical Home for Chronic Renal Failure	163	6	Ensure all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	129	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
						PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training

October 29, 2014

Artifact #2: Project Plan Applications					Artifact #3: Metrics & Milestones		
Project #	Project Description	Page #	Project Req. #	Project Requirement	Page #	Metric/Deliverable	Data Source(s)
							materials; list of training dates along with number of staff trained in use of alerts and secure messaging

manatt
manatt | phelps | phillips

October 29, 2014

ATTACHMENT D

Requirements Related to RHIOs and SHIN-NY in Draft Application with Recommended Revisions

The table below includes proposed changes to Project Requirements and associated Metric/Deliverables and Data Source(s). The table references two documents:

- *New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program DSRIP Project Plan Applications: Domain 2 DSRIP Project Plan Applications; Domain 3 DSRIP Project Plan Applications; Domain 4 DSRIP Project Plan Applications*

- *New York Department of Health Delivery System Reform Incentive Payment (DSRIP) Program Domain 1 DSRIP Project Requirements Milestones and Metrics: Project Requirements Milestones and Metrics: Domain 2; Project Requirements Milestones and Metrics: Domain 3*

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
2.a.i	Integrated Delivery System	1	4	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
2.a.ii	Increase PCMH Certification	6	4	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
2.a.iii	Health Home At Risk Intervention	11	3	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
2.a.iv	Medical Village Using Existing Hospital Infrastructure	16	4	Ensure that all PPS providers that are participating in the Medical Villages share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

October 29, 2014

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
2.a.v	Medical Village Using Existing Nursing Home Infrastructure	21	8	Ensure that all PPS providers that are participating in the Medical Villages share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
2.b.i	Ambulatory Intensive Care Units	26	5	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
2.b.v	Care transitions intervention for skilled nursing facility (SNF) residents	46	5	Ensure that all participating hospitals and SNFs share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

October 29, 2014

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
2.b.vii	Implement INTERACT (SNF)	56	8	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
2.b.ix	Implementation of observational programs in hospitals	66	4	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
3.a.ii	Behavioral health community crisis stabilization services	91	8	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

October 29, 2014

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
3.b.i	Cardiovascular - Evidence-based strategies for disease management in high risk/affected populations (adult only)	111	2	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
3.c.i	Diabetes - Evidence-based strategies for disease management in high risk/affected populations (adults only)	120	7	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
3.d.iii	Implementation of evidence-based medicine guidelines for asthma management	140	2	Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists and ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

October 29, 2014

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
3.e.i	Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for Management of HIV/AIDS	145	6	Model 2: Ensure coordination of care between all available services	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
		145	7	Model 2: Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.
3.f.i	Perinatal Care - Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)	150	5	Model 2: Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

October 29, 2014

Project Plan Applications					RECOMMENDED REVISIONS TO Metrics & Milestones	
Project #	**Project Description**	**Page #**	**Project Req. #**	**Project Requirement**	**Metric/Deliverable**	**Data Source(s)**
3.h.i	Specialized Medical Home for Chronic Renal Failure	163	6	Ensure that all PPS safety net providers share data through local health information exchange, RHIO, or SHIN-NY enabled exchange by the end of Demonstration Year 3.	Connectivity to a Qualified Entity or other method of health information exchange specified by the DOH.	Participation agreement with a Qualified Entity or other method of health information exchange specified by the DOH.

Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237

To Ms. Ceroalo:

Montefiore Health System is pleased to submit comments on the Statewide Health Information Network for New York (SHIN-NY) proposed rule. As an institution that was one of the earliest adopters of electronic medical records nearly 20 years ago and one that has played an integral role in supporting the Bronx Regional Health Information Organization, we appreciate New York state's move to an information exchange architecture that will support robust data sharing across care settings and geographies. We submit the following areas for further consideration:

- **Advance a Simplified Patient Consent Process**

We urge simplified, comprehensive, and consumer-friendly consent protocols. Specifically, we seek regulatory support to enable patients to sign a single consent form to support information exchange and care coordination among providers connected to a qualified entity/regional health information organization, with minimal administrative burden. We appreciate that the entities connected to a given QE/RHIO may change over time, so recommend notifying patients at regular periods of network changes and allowing patients to opt-out, if they so choose, of new network entities or individual providers accessing their information to support their care.

Effective care coordination, as envisioned under the Delivery System Reform Incentive Payment program and beyond, will necessitate access to patient information among providers in as close to real time as possible. It is important therefore to have a regulatory framework, such as the one described above, that allows providers working together in a region to access and exchange patient information for the purpose of seamlessly integrating and orchestrating that patient's care.

- **Access to Aggregate De-identified data and Integration with Social Data Sets**

We believe it is important for researchers and analytics teams to have access to aggregate de-identified data collected by the qualified entities/RHIOs in order to best understand utilization patterns over time and construct system-level analyses that advance our collective understanding about delivery system reform.

Likewise, we believe that QEs/RHIOs offer a unique opportunity to understand not simply patient healthcare utilization, but, with the proper connectivity, also social determinants of health. To that end, we recommend that data collected through these means also be linked with other state or local data sets such as social service use, corrections information, educational data sets. This type of data coordination will offer meaningful insights into how social factors impact healthcare.

- **Transparency in State Designated Entity performance**

The regulation indicates that the Department of Health will contract with a state designated entity to manage the development and operations of the SHIN-NY. Because of the crucial program integrity and operational role that this SDE will play, we request transparency in the overall performance of the SDE against the stated goals of the State.

- **Compulsory participation**

We fully support that the regulation will require healthcare facilities and private practitioners with an EMR to connect to the SHIN-NY. Concurrent with this requirement, we believe it is important for the state to ensure not simply compulsory healthcare provider participation, but also vendor interoperability and technology to facilitate these connections.

- **QE Recertification**

Qualified entities will be required to recertify on a regular basis. We would request that the state advance a process for an off-cycle review process in the event of an alleged incident or misuse of information.

- **Supplemental Rationale for new QEs**

As the regulation itself notes, a number of regional health information organizations are already operational in New York State. To ensure that there are a manageable number of QEs throughout the state, we suggest that the state require new QEs not yet operational to submit a rationale for their application if there is an alternative RHIO or other QE in their geographic area.

- **Alignment with DSRIP Timeline**

We urge a rapid implementation timeframe for the SHIN-NY regulations in accordance with the DSRIP program timeframe, but understand that full implementation will not be feasible prior to the start of DSRIP. At a minimum, however, we urge the early delivery of Patient Record Lookup (PRL) to enable providers to use patient-consented RHIO access to get a more comprehensive view on the patient's total care.

October 29, 2014

To: New York DSRIP Team / Public Consulting Group (Independent Assessor)
Fr: Mount Sinai PPS Team
Re: Questions, Comments, and Feedback on the DSRIP Project Plan Application and Domain 1 Metrics

I. Organizational Application

Workforce Strategy – Section 5

1. On p. 18 under "Retraining Existing Staff" the application states, "Describe the process and potential impact of this retraining approach, particularly in regards to any identified impact to current wages and benefits to existing employees."

   Please describe in greater detail what information the state is looking for in the description of the retraining "process" and "potential impact," particularly in regards to the requirement to identify impacts to "current wages and benefits to existing employees." Does this requirement apply to unions only?

II. Project Plan Applications

Overarching Scale, Scope, and Speed Recommendations:
A. The state should reconsider its requirement of having PPSs set these benchmarks permanently during the planning period. We highly recommend moving this requirement to the implementation phase. Here's why:

- Clarification on this requirement was just provided on October 27th, giving very little time for PPSs to methodically and carefully determine these benchmarks.
- Too many other DSRIP elements are in flux right now and many items have been delayed by the state, which hinders PPSs ability to make these decisions, for example outcomes from the financial stress test, attribution results, and the ACO/COPA requirements (which impact governance decisions and the ability to effectively achieve benchmarks). With so many unknown factors that will impact the size and capacity of PPSs, it doesn't make sense to make these decisions during this phase.
- To determine these benchmarks, PPSs must collaborate not only with providers, but also with other PPSs, to understand how provider target populations must be split up between different PPSs and their respective projects, a task that both PPSs and providers cannot do effectively in the given timeframe.

B. If the state does not reconsider moving this requirement to the implementation phase, we ask that the state provide the PPS numbers for the attributed population by episodic-based populations required for Domain 3 performance measurement to better understand what the targeted population is so that Domain 1 metrics are aligned with Domain 2 and 3 metrics.

1. **In the "Partners Participating in this Project" sections (global throughout all project plans)**: We anticipate that some providers may agree to participate in projects and then later drop out, due to the tight timeframe of the DSRIP planning process. To address this issue, we recommend

allowing PPSs to "swap" providers if necessary, to address this issue and ensure that goals can be met by the PPS.

2. **In the "Scale of Implementation" sections (global throughout all project plans)**: Using project 3.a.i as an example, the instructions in this section state the following and include a table that needs to be filled out:

   "Please indicate the total number of PCP sites, BH provider sites, SA provider sites, and all other sites that PPS intends to include in the project by the end of Demonstration Year 4, or sooner as applicable"

Project Scale	Number Committed	Number of Safety Net Providers*	Percent of Safety Net Providers By County
Expected # of PCPs			
Expected # of Behavioral Health Sites			
Expected # of Substance Abuse Sites			
Expected # of All Other Provider Sites			

**Based on Department of Health Safety Net Provider designation*

   Please clarify all denominators.

   In the first row and second column, does the state want to know the expected number of PCPs that are safety net eligible? Same question applies to all the different provider types listed in the table.

   For the first row and third column, is this the number of safety net PCPs by all PCPs participating in the project by county? Or is it safety net PCPs by all safety net providers in the PPS by county? Or is it safety net PCPs by all providers by county?

   Are the provider types currently listed in the chart the ONLY provider types that can be added/included in the table? Or are we going to have the freedom to add a larger variety or providers?

3. **In the "Scale of Implementation" sections (global to all project plans):** In the table below, we need clarity on the following terms:

Patient Scale	Commitment
Targeted Population to Benefit from Project	
Total Attributed Population	
% of Total Attributed to Benefit from Project	

   Please define "Targeted Population to Benefit from Project" – We understand that is refers to the target population the PPS defines and is not link to the attributed population. Please clarify the parameters for this targeted population. Is all Medicaid lives that may benefit?

   Please define "Total Attributed Population" – Does this refer to the total population that was attributed to our PPS? Or does it refer to the subset of our attributed population who may potentially be eligible for this project?

Our understanding is that these requirements will be translated into Domain 1 metrics. Please detail the reporting requirements to determine whether these benchmarks have been met.

4. **In the "Speed of Implementation/Patient Engagement" sections (global to all project plans):** Regarding the following table….

Patient Engagement Speed	DY0 (Baseline)		DY1		DY2		DY3		DY 4	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Expected # of *Actively Engaged* Patients										
Targeted Population										
% of Patients that are *Actively Engaged*										

Again, please define "targeted population" and provide data to inform the metrics for these requirements. In addition, please define "actively engaged" in writing.

Our understanding is that these requirements will be translated into Domain 1 metrics. Please detail the reporting requirements to determine whether these benchmarks have been met.

5. **In the "Project Resource Needs and Other Initiatives" section**: Should Medicaid initiatives that will be implemented in 2015 be included since they are not yet off the ground, yet planning is actively happening? (i.e. HARPs, FIDA, etc.)

6. Do the tables included in the Project Plan Applications count towards the word counts?

7. When will the prototype application be completed and scored? Will the prototype application be shared with the public?

8. Please provide share when the details of the "Implementation Plan" going to be finalized and shared with PPSs.

9. Please confirm the due date for the "Implementation Plan". The Project Plan Application states that they are due *by* April 1, 2015. Is the due date April 1, 2015?

10. Please clarify when it will be determined which PPSs will be eligible to submit an "Implementation Plan." Will all PPSs who submit something on 12/16/14 be required to submit an "Implementation Plan" regardless of the score of the DSRIP Plan Application?

11. Please confirm the date by which the online DSRIP Project Plan application will be available to review and what the format/template will look like. We highly recommend using a format other than Excel (which was used for the Design Grant and safety net/VAP forms). Excel is an extremely difficult for formatting and review. It is critical that we know the format in advance so that we can adequately prepare for the upload.

12. Please clarify whether PPSs be able to upload and edit information in the online application before submission.

13. Please confirm that the application narratives will be subject to word counts as opposed to character counts. If character counts will be used, please provide the numbers and specify whether spaces will be included in those counts.

Project 3.a.i:

14. For project 3.a.i, PPSs have the opportunity to select 1-3 initiatives. Please clarify that the 1,000 word limit applies regardless of the number of initiatives that are selected? Or does the 1,000 word limit apply for each initiative that is selected, for example if both the PCMH Service Site and BH Service Site models are selected, would we be allowed to have a 2,000 word limit?

Project 3.a.i and 3.a.iii:

15. Please clarify in the project scale implementation table, whether you are referring to physical sites or providers.

III. Domain 1 Metrics & Milestones:

1. When looking at the Domain 1 metrics for 3.a.i, the 100% screening rate as outlined in Project Requirement 3 and/or 5 (depending on the Model), is not realistic, particularly when considering this project is targeted at Medicaid beneficiaries with a BH condition. We suggest looking to ACO goals of 40-50% vs. hospital medical home goals of 85%. Those are more realistic.

2. [QUESTION FROM 2.A.I] In the Domain 1 DSRIP Project Requirements Milestones and Metrics document, under project requirement 7, the first metric states, "Primary care capacity increases improved access for patient seeking services – particularly in high-need areas". This is a pretty heavy metric. What are the thresholds? Everyone knows that there is a massive PCP shortage, not just in NYC, but nationwide. It is not realistic to expect DSRIP to be the cure for the shortage, nor are greater numbers of PCPs going to start appearing to ensure that this metric can be met. We suggest that this metric is deleted as it is unrealistic, especially considering that DSRIP only lasts 5 years.

3. [QUESTION FROM 2.A.I] The first metric associated with project requirement 5 and the third requirement associated with project requirement 7 are the same. Just to clarify, this metric will be used to assess both project requirements?

   Is the requirement for the "PPS" to achieve NCQA Level 3 PCMH standards and/or APCM in project requirement 5 the same as the metric in project requirement 7, which is worded slightly different and states "all practices" must achieve this metric?

4. When will the details of Domain 4 metrics be released?

5. On p. 64 under the Model 2 3.a.i metrics, Project Requirement 1, one of the Metrics states, "Primary care services are co-located within BH practices during all practice hours". This is not

very realistic, especially for smaller community based organizations that we will likely collaborate with. Also, please clarify what constitutes a primary care provider being present? Can there be an on-call physician? Or a nurse trained in primary care for triage?

6.

137-139 West 25th Street
12th Floor
New York, NY 10001
(212) 627-2227
www.thenyic.org

NYIC Comments on NYS Project Plan Application for DSRIP

October 29, 2014

The New York Immigration Coalition respectfully submits the following comments in response to New York State's Delivery System Reform Incentive Program (DSRIP) Project Plan Application. The New York Immigration Coalition is an umbrella organization representing over 150 groups statewide that work with immigrants. The comments below will focus on community/consumer-related provisions of the Plan, as NYIC's advocacy work and stakeholder engagement make this an area of strong expertise.

Overall Recommendations

1. **The structure of the *Performing Provider System* (*PPS)* must clearly spell out the governance structure among lead institutions and participating organizations.**
2. **The State should add evaluators from across New York to the evaluation team beyond the consulting firm designated to assess the applications. The process of choosing health care consumers and community-based organizations who are free from conflicts of interest should begin now so that they will be available for the process of evaluating the PPS applications early next year.**
3. **The application should require PPSs to demonstrate their ability to conduct community outreach in culturally competent manner and the ability make institutional changes that make health services more accessible. It also should require formal involvement of community-based organizations that serve consumer health care consumers and hard-to-reach populations.**
4. **The focus on population health should include an explicit focus on health disparities and on closing the gaps in health care services and outcomes between different groups.**
5. **PPS institutions should formally contract with community-based organizations, and CBOs should receive compensation for their collaboration. CBOs need appropriate financing to ensure that they are able to participate meaningfully and are able to meet deliverables.**

Critical Issues of Concern for Communities and Consumers

Leadership

Much of the success of each PPS will rely on the lead organization. The lead will need to be open to initiating change in how care is provided and to be able to function as part of a collaborative effort. Large institutions are not typically comfortable sharing power and decision-making with smaller institutions. Without organizational changes within the lead

organization, carrying out the mandates of this project for the five years of the waiver will be very difficult. Additionally, the governance structure of the PPS must clearly delineate bi-directional relationships with community-based partners.

Assessor/Evaluator

The Assessor is an international corporation chosen by the State Health Department, the Public Consulting Group (PCG). Based on the description provider on their website, their expertise in community engagement and addressing health disparities is not evident. There is a strong need to add evaluators from across New York who represent a variety of health care consumer and stakeholders populations. The process of choosing impartial health care consumers and community-based organizations should begin now so that they will be available for the process of evaluating the PPS applications early next year.

Health Care vs. Medical Care

The New York State approved 1115 Medicaid waiver is complicated, sweeping, and potentially transformative. Business as usual in the medical care system will not accomplish the major goal of this waiver – reducing unneeded hospitalizations by 25% over the five years of the waiver. Superficial changes may make a small difference by reaching people amenable to being reached. But for those who are not engaged in the system and/or are not easily reached by health outreach, more dramatic changes need to happen. A broader health care planning effort is needed to truly transform the system, involving more than just health care providers and medical personnel**.** Comprehensive change requires multi-disciplinary providers, outreach in culturally competent manner, and adjustments to the system that make services more accessible. It will also require meaningful and sustainable relationships with trusted community-based organizations so that harder-to-reach residents feel comfortable in seeking health care services.

Health Care Disparities vs. Population Health

The focus on population health should include an explicit articulation of the need to address health disparities and close the gaps in both health care services and outcomes disparities between different groups. It is not enough to improve outcomes for everyone if disparities remain.

Partnering vs. Contracting

We are pleased to see that partnerships with community-based organizations are mentioned within many of the domains and projects. As noted above, working with community organizations will be an important determinant of success in achieving the goals set in the projects selected for implementation. Reaching populations that might otherwise be left out is a critical part of the overall success of the waiver. Except in rare instances, however, there is no mention of contracting with community organizations. Community-based organizations will

need to be remunerated appropriately for the time they invest in making the PPS a success. A requirement that PPSs contract with community-based organizations will be important. For example, the Organizational Application document, Section 8, details the budget and flow of funds, and contains the following language: "Describe on a high level on how the PPS plans to distribute funds among the clinical specialties, such as primary care vs. specialties, and, among organizations along the care continuum, such as SNFs, LTACs, and Home Care." It would be ideal to see parallel languages that communicates expectations regarding partnerships with community-based organizations.

Prepared by Claudia Calhoon and Jackie Vimo, in consultation with Judy Wessler, the Commission on the Public's Health System and Health People.

137-139 West 25th Street
12th Floor
New York, NY 10001
(212) 627-2227
www.thenyic.org

New York State NURSES ASSOCIATION Advocating for patients. Advancing the profession.

October 29, 2014

dsripapp@health.ny.gov

New York State Department of Health
Delivery System Reform Incentive Payment Program (DSRIP)
Proposed DSRIP Project Plan Applications

Comments of the New York State Nurses Association

The New York State Nurses Association is the largest union representing registered nurses in New York State, with over 37,000 members engaged in direct patient care. We are firmly committed to promoting quality health care, attaining universal access to care and increasing the role and voice of nurses and other healthcare workers, patients and impacted communities in healthcare decisions that directly affect us.

We have reviewed the proposed DSRIP Project Plan Applications in the context of the broader DSRIP program and have the following comments and concerns:

1. Democratization of Healthcare and the Restructuring Process

NYSNA is heartened by the relative degree to which the DSRIP program, in comparison to past 1115 Waiver projects, has attempted to include health care workers, patients, local communities, and healthcare advocates in the creation and implementation of the program as a whole and in the ongoing development of Performing Provider Systems and their concrete projects.

Though the level of transparency and efforts at broader inclusion are a step forward, we feel that the process as it has unfolded thus far does not go nearly far enough in providing a meaningful voice and degree of democratic input into the process.

We have already noted that the Project Advisory Committee (PAC) structure includes nurses and other affected parties in a somewhat haphazard and uneven way. Though some PPS PACs have been open to including workers in the process, we have found very little involvement of patients and healthcare advocates in the PAC structures.

More troubling, these PAC structures are generally providing only a shallow level of inclusion. The PACs are generally treated as bodies that are given updates and reports, but are not included in the core decision making process with respect to the specific program proposals and we are not confident that they will be incorporated in a meaningful way in the implementation process.

Most PACs, in our experience, have relegated worker representatives to participating in PAC sub-committees addressing the effects of workforce displacement. The fundamental decisions regarding the

design of the programs and projects to be implemented, which will directly impact nurses and other workers, as well as patients and local communities, however remain the exclusive province of the lead provider and partner provider executives and managers. Neither workers, nor patients and the communities are integrated into the real power of shaping the projects and their implementation.

The tendency in the DSRIP program as it has developed to this point has been to seek the "transformation" of our healthcare delivery system without addressing or "transforming" the concentration of power and control in the hands of managers and executives who are often overly driven by financial and business interests rather than the needs of healthcare workers, patients and the communities that we serve.

This flaw in the DSRIP structure continues to assert itself in the proposed DSRIP Project Plan Applications. The proposed draft creates a series of "requirements" and scoring systems to determine the allocation of funding for proposal which are seemingly predicated on an underlying Community Needs Assessment (CNA).

The CNAs are supposed to be based upon and to incorporate a high level of community engagement and input. The CNAs are thus assumed to serve as a main nexus to allow the affected communities to assert their preferences and interests in the proposed projects that will be developed to address identified needs.

It has been our observation, however, that the CNAs key function in providing input from the communities have largely been carried out with little or no effective contribution by the communities. Much of the ostensible involvement of the community in developing the CNAs has consisted of little more than the scheduling of a few public forums at which briefings or summaries of the CNAs were provided after the fact.

The lack of effective community input in the CNA process calls into question the degree to which the community will have any effective role in the projects that will be approved at the end of the application process.

It is accordingly, our position, that the applications should include specific scoring criteria related to a demonstration of the actual degree of community involvement in the preparation of the CNAs and the project proposals that will flow from the findings of the CNAs. We also believe that the applications should include a specific requirement of direct participation in the design and implementation of projects by healthcare workers, patients and community groups. Finally, the scoring of each proposal should include this principle as a key element. Ultimately, the success of the entire program and the specific projects will depend on the direct care workers, the patients and the local communities. Without their active participation in the process, the likelihood of success will be unnecessarily limited.

2. The proposed scoring system is skewed toward the financial aspects of restructuring

The underlying premise of recent state policy in reforming the healthcare delivery system is encapsulated in the "Triple Aim" – to improve health outcomes of the community, to improve the quality of healthcare and to reduce per capita costs of providing care (basic premises of the ACA, MRT reforms and the DSRIP program).

We are concerned that the three prongs are increasingly being collapsed into a singular drive to cut costs. Indeed, the current 1115 Waiver program was predicated upon the State receiving a share of the $15 billion of prior cost cuts to Medicaid spending in the form of an $8 billion grant to fund even more cost cutting.

The overemphasis on reducing expenditures for healthcare in and of itself might be defensible if it was outweighed by the drive to increase access to high quality care and improve health outcomes. After all, the primary function of a healthcare delivery system is to deliver healthcare, not to generate revenues for providers and reduced costs for payers.

The proposed DSRIP application and scoring system fails to maintain the necessary emphasis on healthcare and overly promotes a focus on the financial aspects of restructuring and the reduction in costs.

This misplaced emphasis is evident in the relative weight given to the different components of the proposed scoring system.

The scoring system for each project on the application is weighted in a manner that gives low priority to the underlying health care impact of the proposed projects and unduly high priority to the aspects of the projects that will generate cost reductions.

The scoring system generally provides 20% of the score to "project description and justification." This is the scoring category that includes an assessment of the needs identified in the CNAs, as well as such factors as potential challenges to implementation, the relation of the proposed project to addressing assessed needs and other aspects of the core proposal. The only criterion in this scoring category that incorporates the community served is the CNA, but it is only one aspect of the smallest scoring category and is thus minimized in its impact of the final score of the project.

The remaining 80% of the total potential score of each project is in the category of "scale of implementation" (40%) and "speed of implementation" (40%). In both of these scoring categories, which account for the bulk of the final score and dwarf the scoring impact of the CNAs, the conceptual emphasis is essentially on the amount of cost cuts/savings that will be generated. The bigger and more widely applied a project is the higher the score. The faster that is fully implemented the higher the score. In each case, those projects that will deliver bigger cost savings and do so faster (essentially a measure of the business concepts of expanded volume and increased velocity of turnover of capital) will receive a higher score.

In reviewing the individual criteria for determining the scale and speed of implementation, the information that is provided is often directly related to concrete cost reductions – beds closed, buildings converted, number of providers brought into the project, number of patients enrolled/incorporated, etc.

In addition to inappropriately reducing the scoring value of actual community health needs, access to care and quality, this skewing of the scoring system also presents a danger to the longer term viability of our overall healthcare system by encouraging the already existing trend of consolidation and concentration of providers into large horizontally and vertically integrated enterprises. Though such integration is not necessarily a negative or dangerous factor, it does raise concerns that providers will be encouraged to form very large networks, to expand into new markets and product lines (i.e., combining

direct care, indirect support operations, real estate and insurance functions over wide geographic and population areas).

By encouraging such concentration and expansion through the use of the DSRIP grants (which will only last for four years), there is a real threat that when the DSRIP funding streams expire some of these suddenly expanded systems might find themselves overextended and subject to financial stresses that could cause their collapse. The recent excesses of deregulation and overexpansion of the banking/ financial services industry should give some pause and highlight the dangers of encouraging the development of "too big to fail" healthcare institutions driven by government subsidies and the desire to expand their revenues to engage in destructive and potentially catastrophic market behaviors.

Accordingly, we recommend that the scoring system be revised (a) to provide the greatest weight to the correlation of a project to the actual, concrete healthcare needs of the communities served by the PPS, (b) to provide greater weight to CNAs that actively and extensively incorporated healthcare workers, patients and communities in determining such healthcare needs, and (c) to lessen the scoring weight of project size and speed of implementation.

3. Reducing beds and infrastructure is not that same as reducing unnecessary admissions

The core operating principle of the 1115 Waiver that gave rise to the DSRIP program was the goal of reducing "unnecessary" hospital admissions by 25%. This is on its face a laudable goal with which it is impossible to disagree. No rational commentator could plausibly argue that we should encourage "unnecessary" admissions (except perhaps for operators of for-profit healthcare operations and non-profit operators who sometimes act increasingly like for-profit entities). Indeed, it would be easy to argue that the 1115 Waiver does not go far enough on this score – we could support a goal of reducing "unnecessary" hospital admissions by 100%. This programmatic goal is essentially a tautological statement that lacks any real meaning.

The problem that we are increasingly concerned about is that the goal of reducing "unnecessary" admissions by 25% has de facto been transformed into programmatic goal of reducing hospital capacity by 25%. This shift in meaning has animated much of the discussion about the DSRIP program and is prevalent aspect of the PPS planning that came to light in the initial phases of the program.

If "unnecessary" admissions are to be reduced, one must first determine what is necessary and what is not. We have already noted that one of the key determinants of "necessary" healthcare needs is to be found in the CNAs, which under the proposed scoring system are one of the smallest components (a fraction of 20%) of the total project scores.

We have further noted that an accurate gauge of a community's healthcare needs requires the active input and participation of that community and the completion of a thorough and detailed study of what the community says that it needs and of the basic data and trends at play. We and others have raised concerns that this level of analysis was not apparently the case in many if not most of the CNAs that have appeared so far.

If an intensive and deep assessment of community needs has not been carried out, then it follows that we do not have a complete picture of what is necessary and what is not. The failure to conduct proper CNAs is further compounded by the fact that these CNAs have also tended to focus on what is lacking in particular communities (i.e., access to primary care, coordination of services across providers, continuity

of care, compatibility of IHT systems, etc.). The fact, however, that a particular service or type of care is not available in a given community does not lead to the corresponding conclusion that what *is* there is "unnecessary" or excess capacity. The lack of primary care does not necessarily mean that a community is over-bedded. To determine that, one needs to study not the outpatient needs of the community, but its actual and projected needs for inpatient beds.

In order to arrive at the conclusion that beds should be closed and converted to ambulatory or primary care, one must not only conduct a full study of the availability of and need for ambulatory care, but also of the need for inpatient beds.

We note that the expansion of healthcare coverage can simultaneously improve health outcomes *and* lead to increased demand for inpatient care. As more people gain access to basic health coverage they may have fewer incidents of presenting to EDs or hospitals for acute care episodes, but may also have need for increased admissions to treat previously undiagnosed conditions or long-standing conditions of a less serious nature (e.g., joint replacement). As the baby boom generation ages, for example, it is expected that there will be increasing demand for inpatient services that will offset the decrease in demand from the expansion of availability of primary care (studies show that inpatient bed needs will increase by 19% over the next decade due to the demographic shift to an older population).

The proposed application section dealing with the creation of medical villages (Domain 2.a.IV) encourages projects that will close hospital beds and convert them permanently to outpatient services.

Thus, for a project under Domain 2.a.IV any conversion to medical village use can only be applied to staffed beds (and not to licensed but inactive beds). This presents a bit of a contradiction, in that it would seem that the fact that a bed is occupied and staffed might be an indicator of possibly some level of need (as opposed to a bed that is not staffed, but which is precluded from being closed and converted to a medical village use by Domain 2.a.IV by definition).

In addition, Domain 2.a.IV also expressly excludes any reference to a CNA showing of excess capacity. When it comes to hospital bed closures and conversions, the application assumes and takes for granted that excess hospital capacity does not need to be established by reference to demonstrable data. Excess bed capacity is assumed to be true by the terms of the application. To convert bed to medical village use, you only need to show a need for the primary or other outpatient services, but you don't have to show that the existing bed capacity is not needed – that is assumed.

The inherent assumption that bed closures do not require a CNA or showing of lack of need should be discarded. Any application that seeks to close hospital beds should be required to establish that there is no community needs for the beds and no future need is projected. This is even more necessary where the proposal is not to merely stop staffing a bed or to give up the license, but to actually destroy the infrastructure and permanently convert it to housing or ambulatory use.

NEW YORK eHEALTH COLLABORATIVE

October 24, 2014

Submitted to: dsripapp@health.ny.gov

To whom it may concern:

Thank you for this opportunity to submit comments on New York's draft DSRIP PPS Plan Application materials. As the state designated entity for health information technology in New York State, the New York eHealth Collaborative (NYeC) is charged with fostering adoption and use of health IT in an effort to support and improve the State's health care system. NYeC believes that DSRIP offers a not-to-be-missed opportunity to achieve the Triple Aim and, simultaneously, foster adoption of health IT to support that goal.

NYeC has conducted a review of the draft DSRIP PPS Plan Application materials and offers the following comments about health IT in the Application:

- **Change references in Application from "local health information exchange/RHIO/SHIN-NY" to "SHIN-NY qualified health IT entity (QE)"**.
  As you may be aware the New York State Department of Health (DOH) has proposed a regulation on the subject of the SHIN-NY and, in that proposed regulation, DOH defines a '"qualified health IT entity" or "QE" as "a not-for-profit entity that has been certified as a QE under section 300.4 of this Part and has executed a contract with the state designated entity under section 300.7 of this Part, pursuant to which it has agreed to be bound by SHIN-NY policy standards." (See http://w3.health.state.ny.us/dbspace/propregs.nsf/4ac955878100677485 2569bd00512fda/e00f1f2cd3b9582285257d43006a8427?OpenDocument)

- **More clearly define the data sharing standard intended in the statement "ensure all PPS safety net providers are actively sharing EHR systems" with the SHIN-NY.**
  NYeC recommends a minimum data sharing standard of least the following (if available in the certified EHR): patient demographics, encounters, laboratory results, medication, allergies, procedures, and diagnoses. Further, PPS safety net providers should be encouraged to share all the data elements in CMS's Meaningful Use Stage 2 Summary of Care Record whenever possible. The data elements in the Meaningful Use Stage 2 Summary of Care Record are:
  1. Patient name.
  2. Referring or transitioning provider's name and office contact information (EP only).
  3. Procedures.
  4. Encounter diagnosis
  5. Immunizations.
  6. Laboratory test results.
  7. Vital signs (height, weight, blood pressure, BMI).

8. Smoking status.
9. Functional status, including activities of daily living, cognitive and disability status
10. Demographic information (preferred language, sex, race, ethnicity, date of birth).
11. Care plan field, including goals and instructions.
12. Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider.
13. Reason for referral
14. Current problem list (EPs may also include historical problems at their discretion).
15. Current medication list, and
16. Current medication allergy list.

(see http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_15_SummaryCare.pdf)

- **Modify the existing reference to a DURSA as evidence of participation in the SHIN-NY and instead refer to a "QE participant agreement."**
  DOH's proposed SHIN-NY regulation defines a QE Participant as any health care provider, health plan, State or local health department, or other type of person or entity authorized to be a QE Participant under the SHIN-NY policy standards that has executed a participation agreement with a QE, pursuant to which it has agreed to participate in the SHIN-NY and be bound by SHIN-NY policy standards.

- **Modify the metric for use of the SHIN-NY from "PPS uses alerts and secure messaging functionality" to "PPS uses Directed exchange (secure messaging), alerts and patient record look up."**
  Usage of these three functions, all of which all QEs must provide as part of the DOH's proposed regulation and would therefore be available to all PPSs and their partners, would have an immediate effect on the care coordination improvements necessary to achieve DSRIP goals.

- **Either clarify or remove the reference to data source of "sample transactions to public health registries" for the project requirement to connect to the SHIN-NY**.
  Most transactions to public health registries go directly from the EHR to DOH as per the requirements for Meaningful Use Stage 2 (examples include ECLRS, immunization registry and public health surveillance). As such, these transactions may not be evidence of connection to the SHIN-NY but rather evidence of Meaningful Use certification.

- **Delete "DURSA certification" as a data source for the project requirement of "[e]nsure that EHR systems used by participating providers meet Meaningful Use and PCMH Level 3 standards."**
  Meaningful use certification from CMS or NYS Medicaid should be the definitive information source for this standard.

Again, thank you for this opportunity to submit comments. Please do not hesitate to be in touch if you have questions or would like to discuss these comments in more detail. I can be reached at dwhitlinger@nyehealth.org or (646) 619-6403.

Sincerely,

David Whitlinger
CEO, New York eHealth Collaborative

NEW YORK eHEALTH COLLABORATIVE

40 Worth Street, 5th Floor, New York, NY 10013-2988 nyehealth.org 646.619.6664

North Country Behavioral Healthcare Network

PO Box 891
Saranac Lake NY 12983
www.behaviorhealthnet.org

(518) 891-9460 Phone
(518) 891-9461 Fax
info@behaviorhealthnet.org

Serving the North Country since 1997

Attention: DSRIP Application Team
Subject: DSRIP Application Public Comment

October 28, 2014

The North Country Behavioral Healthcare Network is a coalition of 23 non-profit behavioral health provider agencies serving seven of the state's northern most counties. Our region spans both the AHI and North Country Initiative PPS territories. Thank you for the opportunity to comment on the DSRIP draft application and to provide recommendations for the final document.

Health care reform will touch the lives of every New Yorker in one way of another. Though DSRIP is now specifically targeting the Medicaid population, the SHIP envisions that the emerging PPS and advanced primary care practices will become the system of the future for all payers. It is vitally important that the lead agencies engage in a project selection and planning process that is both inclusive and transparent. Clearly this was the State's intention, but as the DSRIP team has heard as it has traveled through the state for various presentation, most recently at the ASAP conference in Saratoga Springs, lead agencies are not uniformly embracing the notion of stakeholder inclusion.

There is a concern that more than a few DSRIP lead agencies have been slow in engaging in the planning process particularly when it comes to the integration of behavioral health with primary care related projects. Additionally, at last week's DOH Rural Health Council meeting DOH representatives heard from council members that important input from some of the state's 35 Rural Health Networks has, in many cases, been unwelcome by lead agencies. As a lead off recommendation for the final DSRIP application we would like to see a requirement that the lead agencies demonstrate that they have sought meaningful input from each of the NYS Department of Health Rural Health Networks that operate in their catchment areas.

Other General Comments
There are a number of features within the current application which appear to put rural communities at a disadvantage.

Scoring: Scoring applications based on the raw number of providers participating not in relation to the number of providers in the PPS service region disproportionately disadvantages rural PPSs. A PPS serving a large geographic rural region with every provider participating, with strong governance and well-formed clear measurable objectives based on population need will score lower across every project simply based on rurality. DSRIP project funding is per-member-per-month (PMPM) thus larger urban PPSs will, and should, receive more funding because they have more concentrated populations and more attribution, they do not need a secondary advantage by scoring rural PPS's lower automatically reducing the PMPM potential of the rural project initiatives.

The concept that large urban providers will need a greater PMPM to serve their attributed patient population does not conform to the logic used to reduce PMPM as the greater number of projects are undertaken due to economy of scale. It will take all of the PMPM to consistently and measurably achieve the outcomes of the projects for both the largest and the smallest PPSs. Significant reductions in this based on scoring will put projects at risk.

Application scoring should be based on the ability of the PPS to effectively carry out the proposed activities to transform the health system and improve the health outcomes of the total attributed population served.

Funding Distribution – Application Scoring Impact: Section 8 budgeting and funding distribution percentages will be based on PMPM project expectations. Project implementation costs and revenue losses are fixed costs to achieve DSRIP outcomes. If application scoring causes a significant reduction in PMPM, the percentage of payment required to cover fixed costs will increase which will decrease the remaining percentage available for incentive payments to internal PPS providers. It is clearly understood by the NYSDOH DSRIP team that realigning provider incentives is the key to Delivery System Reform success. This unintended consequence of the scoring mechanism and its impact on valuation must be thought through if the DSRIP is to be successful.

Specific Comments

3.a.i. Integration of Primary Care and Behavioral Health Services
Domain 1 DSRIP Project Requirements Milestones and Metrics:

Pages 62 (Model 1) and 64 (Model 2) Project Requirement 1 – The Metric/deliverable is defined as "**co-located services during all practice hours**". **When asked during Q&A, both Jason Helgerson and the NYSDOH OPCHSM, indicated this is not intended to be the requirement, thus it is our understanding this is an error on the application that requires a simple modification.** If not, a requirement for co-location of primary care and behavioral health during all practice hours will preclude the integration of primary care and behavioral health in all but the most urban settings. It would be an inefficient use of resources to place a primary care provider at a BH clinic during all hours of operation as there would not be sustainable volume to utilize the capacity or vice versa.

Pages 62 (Model 1) and 65 (Model 2) Project Requirement 3, and Page 67 (Model 3) Project Requirement 5 – The metric/deliverable of **"100% of individuals receive screenings (SBIRT, PHQ(etc) at project sites" is unattainable**. There is no certifying or quality agency that requires 100% screening as a metric – this requirement would preclude any PPS from meeting the deliverable. The NCQA 2014 requirement for documentation of PHQ-9 (or other depression screening) is a practice generated report (or medical record review if EMR cannot generate the report) with a numerator and denominator based on unique patients in a 3 month period, that indicates that more than 50% were screened. Since each of these screenings are meant to be periodic preventive screening tools it would be unnecessarily burdensome on both patients and providers to expect screening at every visit without evidence of improved outcomes over periodic screening. We **recommend that the NCQA 2014 requirement of more than 50% of**

unique patients seen in a 3 month period be adopted as the appropriate metric/deliverable for this project.

3.a.i. Integration of Primary Care and Behavioral Health Services

Program application page 87 section C. IMPACT Model 4. Designate a "Psychiatrist" and

Domain 1 DSRIP Project Requirements Milestones and Metrics:
Page 67 (Model 3) Project Requirement 4

Based on the new scope of practice under the Nurse Practitioner Modernization Act which takes effect January 1. 2015 which allows Nurse Practitioners with > 3600 hours of practice to operate without a Written Practice Agreement and the shortages of Psychiatrist across NYS, we would request that this section be modified to read a "Psychiatrist or Psychiatric Nurse Practitioner".

Again, thank you to all on the NYS DSRIP team who are leading the way along a very difficult process. Thank you for your consideration of our comments.

Respectfully submitted,

Barry Brogan, RN, MAPP
Executive Director
North Country Behavioral Healthcare Network

North Country Family Health Center, Inc.
238 Arsenal Street Watertown, NY 13601
phone: 315.782.9450 FAX: 315.782.2643
formerly North Country Children's Clinic
www.NoCoFamilyHealth.org

October 28, 2014

Attention: DSRIP Application Team

Subject: DSRIP Application Public Comment

Thank you for the opportunity to provide comment on the DSRIP application on behalf of the many PPS partners across the North Country Initiative's Tug Hill Seaway region. The DSRIP will build the base for comprehensive change to healthcare delivery in our region; moving from a healthcare system to a system for health. This is the right thing to do and we appreciate the effort that has been put in by all.

In light of this, it is critical that the scoring and technical areas of the application support sustainable system transformation across all of NYS, both rural and urban. Thank you for the opportunity to speak to the application on behalf of the rural providers and rural residents we serve.

General Comments

Scoring: Scoring applications based on the raw number of providers participating not in relation to the number of providers in the PPS service region disproportionately disadvantages rural PPSs. A PPS serving a large geographic rural region with every provider participating, with strong governance and well-formed clear measurable objectives based on population need will score lower across every project simply based on rurality. DSRIP project funding is per-member-per-month (PMPM) thus larger urban PPSs will, and should, receive more funding because they have more concentrated populations and more attribution, they do not need a secondary advantage by scoring rural PPS's lower automatically reducing the PMPM potential of the rural project initiatives.

The concept that large urban providers will need a greater PMPM to serve their attributed patient population does not conform to the logic used to reduce PMPM as the greater number of projects are undertaken due to economy of scale. It will take all of the PMPM to consistently and measurably achieve the outcomes of the projects for both the largest and the smallest PPSs. Significant reductions in this based on scoring will put projects at risk.

Application scoring should be based on the ability of the PPS to effectively carry out the proposed activities to transform the health system and improve the health outcomes of the total attributed population served.

Funding Distribution – Application Scoring Impact: Section 8 budgeting and funding distribution percentages will be based on PMPM project expectations. Project implementation costs and revenue losses are fixed costs to achieve DSRIP outcomes. If application scoring causes a significant reduction in PMPM, the percentage of payment required to cover fixed costs will increase which will decrease the

North Country Family Health Center, Inc.
238 Arsenal Street Watertown, NY 13601
phone: 315.782.9450 FAX: 315.782.2643
formerly North Country Children's Clinic
www.NoCoFamilyHealth.org

remaining percentage available for incentive payments to internal PPS providers. It is clearly understood by the NYSDOH DSRIP team that realigning provider incentives is the key to Delivery System Reform success. This unintended consequence of the scoring mechanism and its impact on valuation must be thought through if the DSRIP is to be successful.

Specific Comments

2.b.iv. Care transitions intervention to reduce 30 day readmissions for chronic health conditions.
Domain 1 DSRIP Project Requirements Milestones and Metrics:

Page 31 – Project Requirement 1 – Develop standardized protocols for Care Transitions Intervention Model with all participating hospitals, partnering with home care service or other appropriate community agency. **The data source does not match the project this appears to be a copy and paste error from PCMH requirement areas (i.e. page 6 project 1, page 15 project 3 etc).** If PCMH achievement at Primary Care practices is a requirement to develop Care Transition Intervention Models at Hospitals this will significantly impact the speed of implementation for Care Transitions Models which can be rapidly developed and deployed. PCMH Level 3 certification may take practices 1-3 years depending on current status.

3.a.i. Integration of Primary Care and Behavioral Health Services
Domain 1 DSRIP Project Requirements Milestones and Metrics:

Pages 62 (Model 1) and 64 (Model 2) Project Requirement 1 – The Metric/deliverable is defined as "**co-located services during all practice hours**". **When asked during Q&A, both Jason Helgerson and the NYSDOH OPCHSM, indicated this is not intended to be the requirement, thus it is our understanding this is an error on the application that requires a simple modification.** If not, a requirement for co-location of primary care and behavioral health during all practice hours will preclude the integration of primary care and behavioral health in all but the most urban settings. It would be an inefficient use of resources to place a primary care provider at a BH clinic during all hours of operation as there would not be sustainable volume to utilize the capacity or vice versa.

Pages 62 (Model 1) and 65 (Model 2) Project Requirement 3, and Page 67 (Model 3) Project Requirement 5 – The metric/deliverable of **"100% of individuals receive screenings (SBIRT, PHQ(etc) at project sites" is unattainable**. There is no certifying or quality agency that requires 100% screening as a metric – this requirement would preclude any PPS from meeting the deliverable. The NCQA 2014 requirement for documentation of PHQ-9 (or other depression screening) is a practice generated report (or medical record review if EMR cannot generate the report) with a numerator and denominator based on unique patients in a 3 month period, that indicates that more than 50% were screened. Since each of these screenings are meant to be

North Country Family Health Center, Inc.
238 Arsenal Street Watertown, NY 13601
phone: 315.782.9450 FAX: 315.782.2643
formerly North Country Children's Clinic
www.NoCoFamilyHealth.org

periodic preventive screening tools it would be unnecessarily burdensome on both patients and providers to expect screening at every visit without evidence of improved outcomes over periodic screening. The **NCI medical director and medical management committee recommend that the NCQA 2014 requirement of more than 50% of unique patients seen in a 3 month period be adopted as the appropriate metric/deliverable for this project**.

3.a.i. Integration of Primary Care and Behavioral Health Services

Program application page 87 section C. IMPACT Model 4. Designate a "Psychiatrist" and Domain 1 DSRIP Project Requirements Milestones and Metrics:
Page 67 (Model 3) Project Requirement 4

Based on the new scope of practice under the Nurse Practitioner Modernization Act which takes effect January 1. 2015 which allows Nurse Practitioners with > 3600 hours of practice to operate without a Written Practice Agreement and the shortages of Psychiatrist across NYS, we would request that this section be modified to read a "Psychiatrist or Psychiatric Nurse Practitioner".

3.b.i. & 3.c.i. Evidenced-Based Strategies for Disease Management in High-Risk/Affected Populations

This is a more generalized concern expressed by the physician leadership and the medical management committee that the NYSDOH DSRIP team be cognizant of the fact that the strategies of the Millions Heart Campaign are good today but that medicine is a growing and changing field and the PPS's physician medical management/quality committees must be able to adopt the best clinical guidelines and disease management protocols as they evolve and should not be tied to implementing what may become outdated and no longer best-practice guidelines for 5 years.

Again, thank you to all on the NYS DSRIP team who are leading the way along a very difficult process. We look forward to assisting the people of our region to engage with a transformed system for health and to assisting our providers and community organizations to successfully achieve that transformation. Please contact me at (315) 782-9450 if further clarification on any of the above is required. Thank you for your time and consideration.

Respectfully submitted,

Joey Marie Horton

PRIMARY CARE DEVELOPMENT CORPORATION

www.pcdc.org

Primary Care Development Corporation Comments on Draft DSRIP PPS Plan Application
October 29, 2014

PCDC is pleased to provide the following comments on the DSRIP Draft Project Plan Application. The application itself is an important vehicle for advancing DSRIP goals and objectives. These comments on the application are part of our broader effort to ensure that access to quality primary care – a stated goal of New York State's healthcare leadership – remains front and center as DSRIP evolves. Additionally, these comments focus specifically on primary care transformation and access, and should not be considered a comprehensive review and commentary on the application. We look forward to working with the State, PPSs, and provider organizations to realize the goal of access to high quality primary care for every New York State resident.

1. PCMH 2014 Level 3/Advanced Primary Care requirements

The application appropriately sets a high bar by requiring that all participating primary care providers achieve PCMH 2014 Level 3 (or Advance Primary Care status) by Year 3. The rigor of this standard will play a significant role in transforming primary care practices into a true medical home model that can help PPSs achieve overall DSRIP goals.

However, we note a wide variance in transformation readiness among New York State's primary care providers, who may be ill-prepared to undertake transformation at this level without a significant infusion of upfront resources. These costs may include purchase of an electronic health record system that enables patient registries, connection to a RHIO, and care coordination resources.

The SIM/SHIP may provide funding for practice transformation, but that will in implementation phase until Year 2 of DSRIP. The application should ask PPS leads how they intend to provide resources for primary care practices for PCMH/APC readiness. New York State may also want to consider allowing an extended timeline for those practices that are not PCMH-ready, and making available upfront funds to practices through the PPS for this purpose.

In terms of ongoing documentation of "medical homeness," We note that all of these that you want documented have to be

Some of the Metric/Deliverable Data Sources overlap with NCQA PCMH requirements (for example MU, policies and procedures for team based care, documented process for transitions of care). We recognize the need to ensure ongoing "medical homeness," but believe there are other means other than documentation of processes which have been attested to through the PCMH recognition process. Instead, we suggest focusing on true measure of access, coordination and quality that PCMHs is expected to produce.

2. Healthcare Provider and Community Resources Identified Gaps (P. 13)
Currently states: "We suggest specifying primary care gaps Identify the health and behavioral health service gaps and/or excess capacity that exists in the community, *specifically outlining*

excess hospital and nursing home beds." We suggest specifically adding primary gaps to this, including current capacity and capability to achieve NCQA PCMH 3 (has an EHR, panel management, care coordination infrastructure, etc.). A PCMH readiness assessment can be conducted using any number of tools (including PCDC's) and would be an important component of defining a primary care baseline.

3. **Behavioral Health Integration**
   Behavioral Health integration is key to DSRIP success yet project 3.a.1 focuses on a "light touch" integration. As currently configured, project 3.a.1. encourages co-location of services, screening for depression, IMPACT model, etc. Project valuation does not appear strongly connected to the DSRIP goal of reducing avoidable admissions. Can there be flexibility in designing projects that may not touch many lives but have an impact on the lives of those with serious mental Illness? Additionally, many of the smaller mental health providers are already financially fragile. While adding primary care capacity to their scope of service is important, additional upfront resources may be required to help mental health providers build capacity to undertake integration of primary care.

4. **Workforce (P. 19)**
   In discussing new jobs, we recommend listing other categories that align with New York's vision of a transformed health care workforce, such as care managers, practice coaches and community health workers. PPSs workforce plans should be evaluated primarily on how effective they will be in recruiting and training/retraining a workforce that has the skills and capabilities to support and advance new care models.

5. **Project Valuation**
   Projects that touch numerous lives quickly appear to be valued higher than those that go deep and target those with significant health issues that are generally higher utilizers. We would suggest a higher weighting for projects designed to meet the needs of frequent and high utilizers of hospital and specialty care. Likewise, our understanding is that the attribution model values each Medicaid patient equally. We would suggest weighting attribution more heavily for Medicaid enrollees with a higher total cost of care.

Prepared by Julie Peskoe, Senior Project Manager, Performance Improvement (jpeskoe@pcdc.org, 212-437-3954) and Dan Lowenstein, Senior Director of Public Affairs (dlowenstein@pcdc.org, 212-437-3942)

About the Primary Care Development Corporation (PCDC)

Founded in 1993, PCDC is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities.

Capital Investment: PCDC provides the capital and know-how to build, renovate and expand community based health facilities, so that providers can deliver the best care to their patients.
Performance Improvement: PCDC provides consulting, training and coaching services to help practices deliver a patient-centered model of care that maximizes patient access, meaningful use of health IT, care coordination and patient experience.
Policy & Advocacy: PCDC leads and supports successful policy initiatives that increase access to quality primary care, improve the health of communities, and lower health system costs.

QUA INC

Peg Graham, MBA, MPH
Founder
Tel: 917-837-8689
Email: pgraham@quainc.com

October 28, 2014

NYS Department of Health
VIA email: dsripapp@health.ny.gov

Re: Public Comment
NY Draft DSRIP PPS Plan Application materials
Submitted from the perspective of a consumer dependent on community service organizations for supportive services

To Whom It May Concern:

Thank you for this opportunity to influence the transformation of the NYC healthcare delivery system via the rollout of the Delivery System Reform Incentive Program. I have over 3 decades of experience in healthcare, having worked at various times for a labor union, a local community advocacy group, a major academic medical center and a local city health agency. I am now a small business owner, obtaining health insurance through the NY State of Health Exchange, and appreciative of the contributions made by community-based organizations to the overall health and well-being of NYC residents at the neighborhood level through the City. I am also someone living with a chronic condition who has come to appreciate the limitations of the existing healthcare delivery model. My relief comes from yoga and xigong classes, not medical interventions.

My comments are not technical in nature; rather, they come in the form of bemoaning a "missed opportunity." I find the following description of the current state of healthcare delivery persuasive:

> "The healthcare sector is bearing the brunt of a missing or under-resourced social services sector; front-line personnel with limited resources are stretched to respond to patient concerns; the need for a holistic approach to caring for people's health and social needs is widely acknowledged but requires professional collaboration between health and social services; and many barriers and difficulties exist in establishing relationships between health and social services."
> *Bradley E Taylor L The American Healthcare Paradox: Why Spending More is Getting Us Less, 2013, p. 78.*

Yet, the DSRIP process fails to treat social service organizations as true partners in the transformation effort. Rather, the application reflects an overarching concern with the needs of the existing hospital system, attempting to hold it harmless for transformation. There appears to be an underlying assumption that the social service organization sector can hold its own. I suspect that this assumption is ill-founded.

Specifically, New York City residents would be better served if the application <u>REQUIRES</u>:

1. Sharing of the DSRIP funding with social services organizations;
2. displacing them.

2. Calculation of the impact of volume growth as more patients come on line with evidence that financial resources are directed towards strengthening social services organizations, not displacing them.
3. Leveraging of existing social service organizations supportive services in new protocols, accompanied by penalties for displacing such entities.
4. Technology support to social services organizations to enable bi-directional communication of changes in patient status post-discharge. Right now, the underlying assumption appears to be that hospitals will create new ways of following the patient into the community, rather than engaging with already existing, and culturally appropriate, entities already "in" patients' homes to optimize people's health/functional status.
5. Interoperability of community-based patient/client IT systems so that community-based organizations that provide services in multiple neighborhoods across the city do NOT need to learn disparate Electronic Medical/Health Record systems.
6. Return on Investment projections that include the financial impact on community-based social service organizations.
7. Workforce planning includes the impact on community-based social service organizations.

We fear that, without such requirements being included in the application, PPS solutions will reflect the needs of our medical system, overwhelming the existing social service sector. The likely result will be over-medicalization of care, and continuing ratcheting of costs.

Instead, let's make sure that the contributions of social services is recognized and respected in these transformations. Otherwise, NYS and NYC will have missed an real opportunity for meaningful improvement in the spectrum of care. There is too much at stake to simply support the transformation of the medical model from one iteration to a different version of basically the same thing. Let's make this change real.

Respectfully,

REFUAH COMMUNITY HEALTH COLLABORATIVE (RCHC)

COMMENTS ON DRAFT DSRIP APPLICATIONS

Lead Applicant: Refuah Health Center

WORKFORCE STRATEGY

Having a well-defined workforce strategy is an essential part of a transformed delivery system; however, the draft DSRIP organizational application does not enable an emerging PPS to provide an adequate description of the workforce strategy and instead focuses on only a few elements of what a comprehensive strategy should include (i.e., retraining, redeployment, and hiring staff). The questions do not ask or allow potential PPSs to provide important details, including what the overarching workforce strategy is; the evidence for how it will support a coordinated and integrated system of care and DSRIP projects; and how it will achieve the DSRIP objectives and result in the Triple Aim of better care, care outcomes, and lower costs. Absent that critical context, the numbers that are required are not meaningful and could easily be misinterpreted.

Recommendation: Instead of the current questions, the organizational application due December 16 should instead require PPSs to submit a description of what their evidence-based workforce strategy is overall and for each project (e.g., care coordination and management workforce, interdisciplinary patient care teams, etc.), their training/retraining approach that will enable providers and staff to succeed in the new care delivery models, and how the new workforce strategy will contribute to achieving DSRIP objectives.

Recommendation: Rather than requiring specific numbers and percentages of staff who will be retrained, redeployed, and hired for the application due December 16, the State should require funded PPSs to provide those specifics in a written workforce plan and budget by the end of DY1. That will enable PPSs to conduct a comprehensive assessment for each project, which should include assessing the impact to the existing workforce as well as workforce gaps and should be vetted through thorough, iterative community engagement process. It also will allow PPSs to develop the project implementation/operational plans and initiate the implementation phase. That will help ensure that the workforce strategy truly supports transformed care delivery and project strategies.

Additionally, funded PPSs should conduct an annual reassessment of the workforce strategy and make revisions, as needed, to enable PPSs to adapt to any delivery system and workforce changes that may arise during the implementation of the project. This will help ensure that the workforce strategy continues to reflect what is needed to support delivery system transformation and achieve DSRIP objectives.

RHIO OPT IN/OPT OUT

Requiring patient consent for data exchange through the RHIO via an opt-in method will reduce percentages of patients that will participate and diminish the benefit of sharing data via the RHIO exchanges. It will also lengthen the timeframe to full implementation as it will take time for all patient records to be updated with patient consent one the proper forms are signed.

Recommendation: The State should allow an opt-out method for patient consent requirements for all state RHIOs. Changing to patient opt out would allow all patient data from a RHIO-participating provider to be exchanged with the local RHIO at go live. Patients that do not want to exchange data would be required to mark a separate form/box field at time of care if they do not want to participate in the exchange or allow access their shared data. This change should be made at a state-wide level to increase the rate of participation and increase the amount of data being shared.

Southern Tier Independence Center

Access your world.

October 29, 2014

Southern Tier Independence Center (STIC) comments on NY Draft Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS) Plan Application:

Southern Tier Independence Center, Inc. (STIC) is a Center for Independent Living. We are a non-residential not-for-profit community based agency serving people with all types of disabilities of all ages as well as their family members and service professionals. We are dedicated to empowering people with disabilities to live independent, fully integrated lives in their communities. Established in 1983 and located in Binghamton, NY, our programs and services cover most of the counties of south-central NY.

STIC comments on NY Draft DSRIP PPS Plan Application released 9/29/14

1.) PPS Organizational Application:

Section 2 Governance:

- *The Project Advisory Committee (PAC)* (pg. 6): Detailed guidance should be given to the PPS regarding members to include in PAC.
- *Oversight and Member Removal* (pg. 7, 8): What formula will be used to determine when a PPS member should be removed from a PPS network? Please define with the distinction between "lower performing" and "poor performing" members. This document should provide the PPS with standard protocols and requirements to assist a low or poor performing member in improving performance rather than removal. How is DOH guarding against provider competition or dislike and ensuring that a PPS member is not unjustly sanctioned or removed?

Section 3 Community Needs Assessment:

- *Community Resources Supporting PPS Approach* (pages 11, 12): There is no mention of a requirement to contract with and provide DSRIP funding to the agencies listed on the community based resources list. Please define the expected level of involvement with these organizations.
- *Community Population Health & Identified Health Challenges* (pg. 13) should include health disparities.
- *Healthcare Provider and Community Resources Identified Gaps* (pg. 13) should address language barriers, long waits for appointments, and need to increase care coordinators/case managers/clinical staff that follow through to make sure health risks are addressed and health care needs are met. This might involve increasing number of physicians and psychiatric providers and having 24 hour availability or at least evening office hours.
- *Stakeholder and Community Engagement* (pg. 14). Why is this section worth only 5% of the total points available for *Section 3 Community Needs Assessment*? There should be greater focus on consumers and community based organizations involvement in the planning process.

Section 5 PPS Workforce Strategy:

- If a PPS underestimates the percentage of workers who will be redeployed/recruited/retrained and wages affected as a result of DSRIP how will this affect DSRIP payments to the PPS?
- *Stakeholder & Worker engagement* (pg.20, 21): Will the frontline workers in the planning and implementation of system change be paid via DSRIP funds?

Section 6 Data Sharing, Confidentiality, and Rapid Cycle Evaluation (pg. 22): Why is this section worth only 5% of overall PPS structure?

Section 7 PPS Cultural Competency/Health Literacy:

- *Approach to Achieving Cultural Competence* (pg. 24): "Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients." Please add guidelines to address health disparities.
- *Approach to Improving Health Literacy* (pg. 25): How can PPS improve health literacy without first solving language barriers, education (e.g., consumers who cannot read), cognitive, hearing (e.g., consumers using sign language), and other impairments? This section should include the building blocks to health literacy instead of merely providing a definition.

Section 8 DSRIP Budget and Flow of Funds:

- *Description* (pg. 27): "Describe on a high level on how the PPS plans to distribute funds among the clinical specialties, such as primary care vs. specialties, and, among organizations along the care continuum, such as SNFs, LTACs, and Home Care." The funding is directed toward clinical services and does not mention funding to non-clinical services offered by community based organizations. Funding must be distributed to CBOs involved in project planning and meeting DSRIP project outcomes. This should also include peer support services, since they've been found to reduce visits to emergency rooms, help people to remember appointments, etc.

Section 9 Financial Sustainability Plan (pg. 29, 30):

- Will there be funding for PPSs to continue the success of their projects after DSRIP five year term is over? What measures will be taken when a PPS needs more funding to successfully complete DSRIP projects within the five year term? One goal of DSRIP is long term sustainability of the health care system, so it would make sense to have alternative funding.

2.) DSRIP Project Plan Applications (Domain 2, 3, & 4) and Domain 1 DSRIP Project Requirements Milestones and Metrics:

Accessible, affordable, quality health coverage should be the foundation for all the projects in order to meet the goals of DSRIP program. Delivery of health care services should be performed in a culturally competent way, in the patient's primary language, with health care hours that accommodate the patient's lifestyle to a higher degree than seen with the current delivery system.

Greater attention should be placed on Social Determinants of Health (e.g., employment, housing, environment, food, security to name a few) to increase population health and eliminate disparities. Domain 4 involves NY's Prevention Agenda (improving the health of NYers to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups experiencing them), so Project Requirements and Milestones and Metrics should focus on addressing health disparities to drive project success.

Public Consulting Group (PCG), Independent Assessor, is focusing on the link between the Community Needs Assessment (CNA) and the PPS choice of projects, so why did PPS submit proposed projects prior to completion of CNA? CNA should drive the project selection of the PPS.

Project 2.a.i Create an Integrated Delivery System focused on Evidenced-Based Medicine and Population Health Management:

"Actively engaged is defined as patients residing in counties served by the PPS having completed a RHIO content form." If the goal is to get 100% RHIO consent forms throughout the network (as stated by a PCG representative on the NY DSRIP Draft Project Plan Application Review 10/2/14 webinar) all providers in a PPS must be equipped to do so and must have patient consent. PPS scores should not be impacted if patients decide to opt out of the RHIO. A better measure would be documentation of the number of attempts to get patient consent to join the RHIO. Additionally not all providers have the funding to set up an interface to contribute to a RHIO and they may not be eligible for incentive payments to do so. Therefore their contribution in the RHIO is limited beyond the free "public good" baseline services (e.g., patient look up).

Project 2.b.iv Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions:

Mobile Crisis and Support Teams should be incorporated into this project to drive project success.

If the expectation is to use EHR and other technical platforms to track all patients engaged in the project then patient consent must be given, and every patient may not be willing to give consent. This pertains to other projects (e.g., Project 2.c.i) as well. There is no regulatory waiver for Information Sharing in the *Regulatory Flexibility Guidance for Performing Provider Systems* dated September 18, 2014. This document states, "Because patient consent issues are governed by HIPAA and state confidentiality statutes, there is no ability to waive regulations under PHL § 2807(20)(e) and (21)(e). However, DOH, OMH and OASAS will coordinate on the development of a model consent form for use by PPS providers that would cover all forms of patient information exchanged by providers." Patients will still have to give consent for information sharing. If patients do not give that consent DSRIP project success will be impacted as communication within the PPS is key to DSRIP project success. That success will be limited without patient consent for information sharing. Project Requirements and Metrics and Milestones should be amended as a result of this. Another concern is that regulatory waivers may not exceed the life of the DSRIP project.

Project 2.c.i Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently:

How many navigators will be included in the project and is there a formula to determine this? The Project Requirements mention establishing caseloads, but do not give any guidance on the patient to navigator ratio. DOH should give guidelines. Non-clinical resources involve so much more than transportation and housing, so please include others. Will navigators be paid via DSRIP funds? What happens to those employees when the five year term has ended?

Project 3.a.ii Behavioral health community crisis stabilization services Domain 1 DSRIP Project Requirements Milestones and Metrics project requirements:

"Share EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3." Why is this a project requirement if NY SHIN-NY draft rules published 9/3/14 state that "adoption of certified EHR technology for health care facilities outside of hospitals and Federally Qualified Health Centers (FQHCs) is low because they are not eligible to receive meaningful use incentive payments." Will DSRIP funds be used to set up interfaces for providers to share information in RHIOs (beyond the no charge patient look up)?

Project 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care:

A potential problem exists because this outreach is limited to an evidence-based methodology, the Patient Activation Measures (PAM). This is a tested method, but it may not be the best way of reaching this population.

3.) DSRIP PPS Application Scoring Guide:

We're pleased to know the "Independent Assessor will go through a comprehensive training program prior to the evaluation period. The training will include meetings with NY state agencies such as OMH, OASAS, OPH, and other stakeholders to develop program specific scoring methods." Please articulate "comprehensive training program" and "program specific scoring methods."

Please consider the Independent Assessor, PCG, Inc., collaborating with additional assessors such as community residents, clinicians, health plan representatives, community organization members, or health care specialists with no conflicts of interest. Please consider a separate entity to do the subjective scoring.

"Each prospective PPS must achieve a minimum passing score to participate in the DSRIP program. The Independent Assessor will score each project and average the scores across the projects submitted. If the PPS scores less than an average score of 60% across all their projects, the application will be failed and sent back to the PPS for remediation." As stated by a PCG representative on the NY DSRIP Draft Project Plan Application Review 10/2/14 webinar there will be more to come on this process. When will we know more? The scoring process is complex. DSRIP Program, being a health care initiative, involves stakeholders, consumers, and community members that may need further guidance on the scoring process in order to fully understand it.

Thank you for the opportunity to provide input.

Transitional Living Services
of Northern New York

482 Black River Parkway · Watertown, New York 13601 · Tel: (315) 782-1777 · Fax: (315) 785-8628

October 29, 2014

Attention: DSRIP Application Team

Subject: DSRIP Application Public Comment

Thank you for the opportunity to provide comment on the DSRIP application.

Transitional Living Services (TLS) believe it is critical that the scoring and technical areas of the application support sustainable system transformation across all of NYS, both rural and urban. We therefore wish to speak on behalf of the rural providers and rural community our agency serves.

Scoring: Scoring applications based on the raw number of providers participating not in relation to the number of providers in the PPS service region disproportionately disadvantages rural PPSs. A PPS serving a large geographic rural region with every provider participating, with strong governance and well-formed clear measurable objectives based on population need will score lower across every project simply based on their rural location; DSRIP project funding is per-member-per-month (PMPM) thus larger urban PPSs will, and should, receive more funding because they have more concentrated populations and more attribution, we believe that larger urban areas do not need a secondary advantage by scoring rural PPS's lower thus automatically reducing the PMPM potential of rural projects.

Application scoring should be based on the ability of the PPS to effectively carry out the proposed activities to transform the health system and improve the health outcomes of the total attributed population served.

Specific Comments

3.a.i. Integration of Primary Care and Behavioral Health Services

Domain 1 DSRIP Project Requirements Milestones and Metrics:

Pages 62 (Model 1) and 64 (Model 2) Project Requirement 1 – The Metric/deliverable is defined as "**co-located services during all practice hours**". **When asked during Q&A, both Jason Helgerson and the NYSDOH OPCHSM, indicated this is not intended to be the requirement, thus it is our understanding this is an error on the application that requires a simple modification.** If not, a requirement for co-location of primary care and behavioral health during all practice hours will preclude the integration of primary care and behavioral health in all but the most urban settings. It would be an inefficient use of resources to place a primary care provider at a BH clinic during all hours of operation as there would not be sustainable volume to utilize the capacity or vice versa.

Pages 62 (Model 1) and 65 (Model 2) Project Requirement 3, and Page 67 (Model 3) Project Requirement 5 – The metric/deliverable of **"100% of individuals receive screenings (SBIRT, PHQ(etc.) at project sites" is unattainable**. There is no certifying or quality agency that requires 100% screening as a metric – this requirement would preclude any PPS from meeting the deliverable. The NCQA 2014 requirement for documentation of PHQ-9 (or other depression screening) is a practice generated report (or medical record review if EMR cannot generate the report) with a numerator and denominator based on unique patients in a 3 month period, that indicates that more than 50% were screened. Since each of these screenings are meant to be periodic preventive screening tools it would be unnecessarily burdensome on both patients and providers to expect screening at every visit without evidence of improved outcomes over periodic screening. The **NCI medical director and medical management committee recommend that the NCQA 2014 requirement of more than 50% of unique patients seen in a 3 month period be adopted as the appropriate metric/deliverable for this project.**

3.a.i. Integration of Primary Care and Behavioral Health Services

Program application page 87 section C. IMPACT Model 4. Designate a "Psychiatrist" and Domain 1 DSRIP Project Requirements Milestones and Metrics:

Page 67 (Model 3) Project Requirement 4

Based on the new scope of practice under the Nurse Practitioner Modernization Act which takes effect January 1. 2015 which allows Nurse Practitioners with > 3600 hours of practice to operate without a Written Practice Agreement and the shortages of Psychiatrist across NYS, we would request that this section be modified to read a "Psychiatrist or Psychiatric Nurse Practitioner".

We look forward to working with our community to engage with a transformed system of care and assist providers to successfully achieve that transformation.

Thank you for your time and consideration.

Sincerely

Ms. Stevie Smith
Executive Director

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Westchester Medical Center and its Center for Regional Healthcare Innovation (CRHI) recommend that **NYSDOH conceptualize "Transitional Supportive Housing Services" in a way that aligns with current national best practices for addressing homelessness.**

Addressing the housing needs of chronically ill Medicaid super-utilizers is daunting. Our PPS is one of the few, if not the only, DSRIP applicants in the state that is ready to tackle the issue.

Our plan has been developed in consultation with regional leaders trained by national experts in how to meet housing needs of people with complex care needs using existing housing resources. These leaders are already implementing innovative housing strategies successfully.

The reason this issue is daunting is because our nation has a huge housing crisis. Millions of private housing units are aging and dilapidated. Public housing authorities need tens of millions of dollars to address deferred capital needs. Millions of people have to choose each month between paying rent and having enough money to buy food. Housing subsidies have diminished and waiting lists for public housing and Section 8 are often closed for years.

The housing crisis is especially severe in our region, which includes some of our nation's most expensive housing markets. For example, in our region's largest city, the Yonkers Housing Authority's Section 8 program waiting list was closed for over 6 years. In 2012 the Housing Authority opened its Section 8 waiting list for just 10 days. During those 10 days it received **11,000** applications – enough to fill all their Section 8 openings for the next **35** years.

Clearly our regional housing needs are much too large to be solved by our healthcare system. Fortunately we do not have to solve our region's entire housing crisis in order to help ensure that our chronically ill Medicaid super-utilizers are able to get – and keep – housing.

Most of the homeless and unstably housed Medicaid super-utilizers in our region have managed in the recent past to *get* housing. However they haven't been able to *keep* it. They have lost it, sometimes for financial reasons, sometimes for behavioral reasons, often for both. We can help stabilize their housing by providing time-limited transitional housing support services while they are living in any kind of potentially permanent housing arrangement.

This comment consists of three main sections:

1) An explanation of how current national best practices for addressing homelessness have moved away from traditional transitional housing models toward Housing First and Rapid Rehousing strategies, including "transition in place" models that provide time-limited transitional housing support services in permanent housing settings,
2) A detailed description of our recommended model of Transitional Supportive Housing Services that aligns with these national housing best practices, and
3) A detailed recommendation of how our recommended model can and should be presented in the framework of NYSDOH's Transitional Supportive Housing Services application.
4) Comments on Domain One Requirements Milestones and Metrics for Project 2.b.vi.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

1) The New Best Practice: Rapid Rehousing instead of Traditional Transitional Housing

The traditional model of Transitional Housing is specialized time-limited housing that people go to in order to "get fixed" so that they can become ready for permanent housing. It consists of housing specifically dedicated to this purpose, sometimes using a scattered-site approach but often using a facility-based approach. It is often limited to a fixed number of housing units.

HUD and other national housing advocates have decisively rejected this approach in favor of Housing First models. Housing First means that you move people rapidly into permanent housing and there provide them the services they need to retain the housing.

The fact that HUD has rejected the traditional model of transitional housing can be seen most clearly in the funding priorities it has established for its Continuum of Care (CoC) program. This is HUD's largest program for the homeless and annually provides **$1.83 billion** for **7,100** local homeless housing and service programs across the U.S.[1] HUD offers tens of millions of dollars each year in competitive CoC funding for new housing. **None** of this competitive new funding can be used for traditional transitional housing. HUD allows CoCs to reallocate funding from existing programs to create new programs that better meet current needs. These reallocated funds can only be used for expanding Homeless Management Information Systems or creating new permanent housing. Again, not a penny of this reallocated CoC funding can be used for traditionally defined transitional housing.

HUD's CoC funding was dramatically transformed in 2009 by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. HEARTH established "a national goal of ensuring that individuals and families who become homeless return to permanent housing within 30 days."[2] It established criteria for "High Performing Communities" that included that their average length of stay in homelessness must have declined by at least 10% from the year before to be below 20 days.[3] These goals mean that communities are expected to move away

[1] Since 1994 HUD has required communities that want to access this funding to create regional or local planning bodies called CoCs that coordinate all housing and services funding for all types of homeless families and individuals. Over 460 CoCs have been formed representing large cities, large counties, and multi-county regions. Each CoC submits a single comprehensive application each year. No applications for CoC funding are accepted unless they are part of these local or regional consolidated applications. (Excerpted from "HUD's Homeless Assistance Programs: Continuum of Care 101", U.S. Department of Housing and Urban Development, June 2009.)

[2] HEARTH Act Purposes – Sec. 1002(b), cited in "Understanding the HEARTH Act" presentation by Norman Suchar for the National Alliance to End Homelessness' Center for Capacity Building.

[3] "Homeless Assistance Reauthorization – National Policy Update: Summary of the HEARTH Act", National Alliance to End Homelessness, June 2009. See also "Performance Measurement of Homeless Systems", Tom Albanese, Abt Associates, prepared for HUD's Office of Community Planning and Development.

from long stays in transitional housing and instead focus on moving people into permanent housing within days of initial contact with them.[4]

The U.S. Interagency Council on the Homeless published the first comprehensive national strategy on addressing homelessness in 2010. This plan makes explicit the Federal push to move away from traditional transitional housing. One of its specific recommendations is to "Encourage communities to transform transitional housing programs to permanent supportive housing or transition-in-place models where appropriate." It defined transition-in-place models as:

> "models that allow people to transition in place, that is, to move into permanent housing and have transitional supports that end when someone has connected to mainstream community supports."[5]

We recommend that NYSDOH **conceptualize "Transitional Supportive Housing Services" in a way that aligns with current national best practices for addressing homelessness by allowing use of transition-in-place models as defined above.**

Other Advantages of Transitional Housing Services in Permanent Housing Settings

We will help Health Homes, hospitals and other healthcare providers develop toolkits of transitional services in each county that can be tailored to an individual patient's needs, rather than trying to create multiple transitional housing facilities in each county. Focusing on services that can be added to housing rather than transitional housing facilities has several advantages.

1. Services cost less than facilities. Most transitional housing facilities, whether in nursing homes or homeless shelters, have 24/7 supervision, an expensive service not needed by most unstably housed, chronically ill Medicaid super-utilizers.
2. Services can be created faster than facilities. Mobile services can be rapidly created for scattered-site housing, while creating facilities for people with behavioral health issues usually takes years and is often delayed or blocked by community opposition.
3. Service volume can be adjusted to meet fluctuating need more readily than facility size. The volume of transitional housing services needed for super-utilizers will vary widely over time. It is easier to adjust a service caseload than it is to add or remove facility beds.
4. Scattered-site services can be more readily tailored to individual needs than facility-based service mixes. Facilities' service mixes are designed to serve a particular population. It would not be possible to have available facility-based capacity for every type of patient without maintaining excess capacity in multiple facilities.
5. Mobile services can overcome geographic barriers to housing utilization. Our 8-county service area spans **4,878** square miles. Even if we could create exactly the right mix of transitional facilities, their geographic distribution would be a barrier to effective utilization. Counties like Putnam, Sullivan and Delaware have little public transportation.

[4] A detailed discussion of how transitional housing programs can transform themselves can be found in "Retooling Transitional Housing", Kay Moshier McDivitt, National Alliance to End Homelessness.

[5] "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness – 2010", page 50, United States Interagency Council on Homelessness.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Moving a patient who doesn't own a car to another community cuts them off from their support systems. In more urban counties like Westchester and Orange, people often resist moving even temporarily into neighboring communities perceived as unfamiliar or unsafe. The most effective way to overcome geographic barriers is to bring services to the housing where the patient feels most comfortable and has the most available support.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

2) Our Recommended Transitional Supportive Housing Services Strategy

The following section lays out specific recommendations on how a Transitional Supportive Housing Services model should work.

The Challenge: NYSDOH wants DSRIP projects in this category to provide long-term housing stability but the DSRIP funding is time-limited and cannot be used to pay for housing.

Our Strategy: Our strategy focuses on building the capacity of existing Care Coordinators to provide transitional services that effectively stabilize housing for high-cost Medicaid users with acute or chronic housing instability. We will partner with Care Coordinators from 5 systems:

1. Our target area's 3 Medicaid Health Homes,
2. Patient-centered medical homes,
3. Hospital-based programs including discharge planners,
4. Managed Care Organizations, and
5. Other Medicaid funded care coordination not yet rolled into Health Homes or Managed Care.

We are building on the strengths of these five systems in order to build a system that is both cost-effective and sustainable.

Target Area: We have divided our 8-county target area into four quadrants.

Quadrant 1	Westchester and Putnam
Quadrant 2	Rockland and Orange
Quadrant 3	Sullivan, western Ulster, and Delaware
Quadrant 4	Dutchess and eastern Ulster

Target Population: Our project will target 3 groups of Medicaid recipients with major housing needs:

1) People who are homeless, *i.e.* living in shelters, on the streets, in cars, or places not meant for human habitation,
2) People who are living in housing that is unsafe due to physical characteristics of the housing, threatening behaviors of other tenants, or unsafe neighborhood conditions, and
3) People who are unstably housed, *i.e.* have moved at least twice in the prior 12 months.

Proposed Tool for Assessing and Prioritizing Housing Needs: We propose using a brief housing needs assessment tool that is becoming a national standard. It is called the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT).[6] It prioritizes housing needs on a 15-point scale and divides homeless people into 3 categories.

[6] The "SPDAT and VI-SPDAT Evidence Brief provides "brief outline of the extensive evidence and testing base for the Service Prioritization Decision Assistance Tool (SPDAT) and its short, street-based evolution, the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) (a pre-

- At one extreme there are people who will be able to find housing on their own with limited assistance, e.g. directories, housing lists, brief referrals.
- At the opposite extreme, there are a group of people (estimated at roughly 10% of the total homeless population) who are likely to need permanent supportive housing, quite possibly forever.
- Most homeless people fall in the middle category. They need more than a simple referral but they can be housed with a Rapid Rehousing approach. HUD defines Rapid Rehousing as time-limited services (usually up to 2 years), sometimes but not always accompanied with time-limited housing subsidies, that are individually tailored to help a person rapidly get and keep permanent housing.

Strategies for Finding Permanent Housing

Given that none of our 8 counties have enough high-quality housing that is easily affordable, it seems at first that it must be nearly impossible to help people find permanent housing. Despite that shortage, most low-income people in every one of our counties have permanent housing tonight. Opportunities to get permanent housing are always constantly available in every county for the simple sad reason that in every county there are always people being evicted. This "churning" means that, no matter how tight the vacancy rate, apartments are always available.

A few low-income people are lucky enough to secure subsidized housing through Section 8, public housing, CoC and other housing programs. Most however survive without subsidies.

Many do so by paying much more than 30% of their total income for housing.[7] It is not uncommon for low-income households to pay 40%, 50%, 60% or more of their total income for housing, often leaving them without enough money for food and other necessities. Thousands get by using emergency food programs like food pantries or soup kitchens to help them make it through the month. Our PPS partners can help DSRIP participants make their household budgets more sustainable by making sure that participants are aware of and use all local food programs. There are over **310** emergency food programs in our target area. Most have limited hours and limits on the number of food pantry bags a household can have in one month, but use of multiple existing food programs can make it possible for participants to pay rent without going hungry.

Many others throughout our region share housing. Older and younger family members often live with family members because they can't afford housing on their own. Thousands of individuals and families live in less stable shared housing arrangements. Some move frequently between family members, friends and even acquaintances as they wear out their welcome, in a process colorfully known as "couch-surfing". These shared housing arrangements can wind up lasting long-term, especially if service providers help teach the couch-surfers to resolve or avoid interpersonal conflicts with their hosts and to contribute in some way to the host household,

---

screen assessment)." The Evidence Brief can be downloaded at http://100khomes.org/resources/spdat-and-vi-spdat-evidence-brief.

[7] HUD has long recommended that households ideally should pay no more than 30% of their total income for housing. HUD considers anyone who pays more than 30% as 'housing cost-burdened." HUD now recognizes that millions of American households spend more than 30% of their income on housing, and nonetheless manage to retain their housing.

either financially (which can often be much less than full rent would be) or by helping with household maintenance, childcare or other needed tasks.

The tremendous need for safe affordable housing is a pressing problem whose solution lies beyond the health care delivery system. These approaches will make the most of the housing that is available and help people with chronic health needs become and *stay* housed.

Housing Needs To Be Addressed

There are many combinations of circumstances and needs that can make it difficult for high-risk patients with medical and/or behavioral health conditions to manage their health condition in the community and when hospitalized to safely transition back. We will identify Medicaid beneficiaries whose health is compromised by unstable housing through relationships with PPS partners throughout the continuum of care. We will triage patients' needs into 3 tiers.

Tier 1: Patients in Tier 1 need to access one or more available community supports that they are willing to accept. They need someone to find these resources, help ensure that the patient can access them, and coordinate initial service delivery. Many Health Home and other Care Coordinators are not aware of the full range of housing-related support services available because housing has not been a primary focus of their prior professional work and because the housing services are often scarce, fragmented, and operating in uncoordinated silos.

One example of a Tier 1 patient would be someone who will for the first time be wheelchair-bound when they leave the hospital, but their current housing is not wheelchair-accessible. The patient's problem might be solved with housing accessibility modifications, such as widened doorways and installation of bathroom railings and an entrance ramp. Another option of course is to find the patient alternative affordable wheelchair-accessible housing, but many patients would prefer to remain in their homes if they can be made accessible.

Another example of a Tier 1 patient could be an individual who needs to be linked to a home health aide or personal care aide to assist with activities of daily living, two local food pantries (each with limited give-outs each month) to help ease the constant necessity low-income people face to choose between paying rent and having enough money to buy food, and a senior center that offers support groups and, when the patient is ready, individual counseling for depression.

Tier 2: Patients in Tier 2 need to access one or more available community supports that they are not yet willing to accept consistently.

One example of a Tier 2 patient would be someone who consumes dangerously large amounts of alcohol or recreational drugs. These individuals are often very familiar with local networks of treatment agencies. They may have dropped out or been thrown out of many local treatment programs. Most substance abuse treatment programs don't do street or community outreach. They wait for individuals to arrive ready to acknowledge that they have a substance abuse problem and willing to accept some form of structured treatment.

Another example of a Tier 2 patient would be someone with schizophrenia who functions fairly well when they consistently take their prescribed psychotropic medications but rapidly decompensates when they stop taking their medications. Mental health clinics and individual mental health clinicians know when patients are no longer getting prescriptions for their

medications but they usually have no mobile staff who can track down the patient and try to re-engage them in treatment.

Care Coordinators from Health Homes, hospitals and the other types of health systems listed above could be the people who work fairly intensively with Tier 2 patients to encourage them to engage or re-engage in treatment. There are two major barriers to the Care Coordinators being able to successfully fill this role. The first is large caseloads that make it difficult or impossible to provide sustained mobile outreach to build a relationship of trust with these patients and help motivate them to accept treatment. The second is often a lack of training in evidence-based interventions such as Motivational Interviewing that can help them be more successful in producing behavioral change.

Tier 3: Patients in Tier 3 have the most extreme and complex needs. They are often severely mentally ill, heavy substance abusers with multiple poorly managed major chronic and/or acute medical conditions. These are often (but not always) the highest-cost Medicaid users. They are often the people who have the most emergency room visits and the least stable housing. Many of them bounce between jail, detox, hospitals, shelters, brief periods of "couch-surfing" when they are lucky, and living in cars, abandoned building, sheds, garages and parks.

Most Health Home, hospital and other Care Coordinators don't know how to find and engage these people. These patients have no stable address and no consistent phone number. The Care Coordinators don't have the street-level connections to find them using soup kitchens, police captains, and informal social networks on the street. Many Care Coordinators would not feel comfortable trying to find and engage someone in jail, on a park bench, or under an overpass. Many don't have the street credibility and "street smarts" to engage and win the trust of these patients and over time persuade them to make dramatic lifestyle changes.

Housing Stabilization Services To Be Provided

We will provide 3 major services to address these 3 tiers of need.

***1. System Builders (for Tiers 1, 2 and 3)*:** We will assign a System Builder to each of our four service area quadrants. Briefly, System Builders will :

- Help Care Coordinators understand and access the full range of locally available services,
- Give Care Coordinators opportunities to begin establishing personal relationships with key service providers,
- Encourage providers to give priority access to DSRIP participants, and
- Work with local providers to expand services and fill service gaps.

The System Builders will enable us to impact housing outcomes for the largest number of DSRIP participants. The System Builders will help Health Home Care Coordinators more effectively serve DSRIP participants from Tiers 1, 2 and 3.

2. Care Coordinator Team Training (for Tiers 2 and 3): A second form of housing support that we will provide will be training Care Coordinators and their community partners in evidence-based interventions that have been proven effective in helping service providers overcome clients' resistance to accepting recommended treatment and making recommended lifestyle changes.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

3. Housing Stabilization Counselors (for Tier 3): We will help Health Homes address Tier 3 needs by developing Housing Stabilization Counselors who will work as part of Health Home care coordination teams. We will help fund Housing Stabilization Counselors to be based in four of our target area's major urban centers.

The role of the Housing Stabilization Counselors will be based on that of Managed Addiction Treatment Services (MATS) care managers as the MATS model shifted to Health Home care management. MATS Care Managers proved effective at saving Medicaid millions of dollars by stabilizing housing and services for high-cost Medicaid substance users and reducing utilization of high-cost inpatient detoxification. They were able to identify and engage high-cost Medicaid recipients who were homeless or unstably housed substance users found in shelters, jails, emergency rooms, and on the streets. The MATS workers helped these high-risk patients stabilize their housing and access substance use treatment, entitlements and primary care.

Advantages of the Proposed Model for Key Stakeholders: Our model will produce major benefits for all of the major relevant stakeholders.

Consumers: Consumers will benefit dramatically from this project. Their Care Coordinators will be able to link them to a wider variety of support services. Their Care Coordinators will be better trained and better able to engage with them in more sensitive and effective patient-centered ways using evidence-based interventions such as Motivational Interviewing. Those with the most severe needs will receive intensive, sustained, flexible and mobile support from our Housing Stabilization Counselors who will understand housing and entitlement issues as well as mental health, substance use and medical issues. Most significantly, more high-need consumers will have stable housing with all of the practical, emotional, physical and social benefits that brings.

NYSDOH: NYSDOH will benefit from having us pilot and test sustainable engagement and service strategies to provide stable housing for chronically ill Medicaid super-utilizers who are homeless or unstably housed. NYSDOH will be able to use the lessons learned from our project to formulate and disseminate best practices for integrating housing supports with healthcare.

Medicaid Health Homes: Our project will help the new Medicaid Health Homes better achieve their triple aims of improving patients' experience of health care, improving population health, and reducing per capita health care costs. Our project offers the Health Homes 3 main benefits:

- More information in user-friendly formats their Care Coordinators can use to link their members to more types of housing-related support services,
- Free or reduced cost training for their Care Coordinators in evidence-based interventions that have been shown to enhance housing stability, and
- Additional staff that will work as an integrated part of their care coordination teams to handle members with the most severe and complex housing needs.

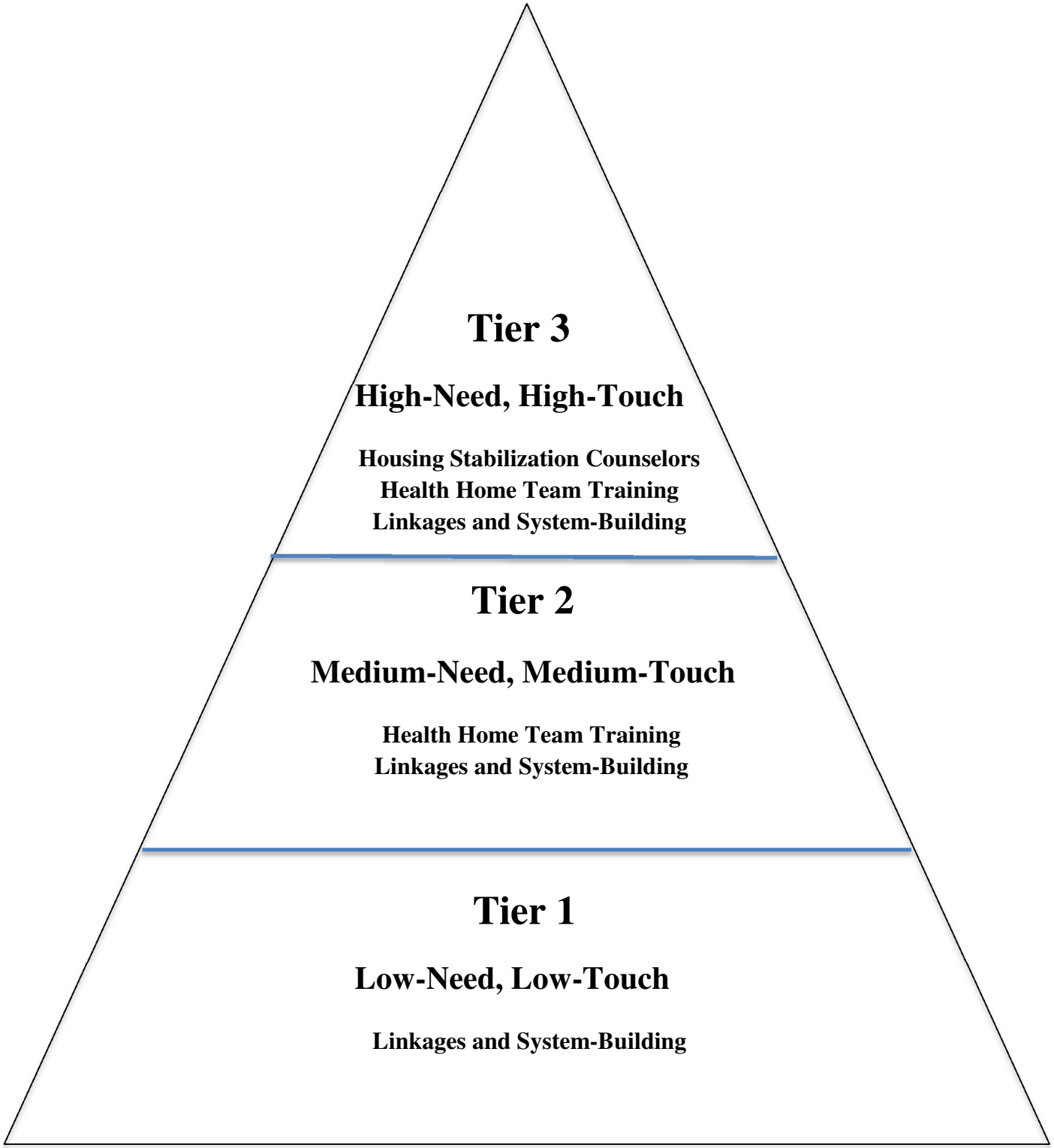
Hospitals: Hospitals will benefit from having increased access to housing-related support to help them reduce their rates of preventable readmissions and the associated financial penalties.

Our Healthcare System: Our project will benefit the healthcare system by improving outcomes and reducing overall costs. We will also pilot and evaluate strategies that could potentially be replicated nationwide.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

verview of Housing Stabilization Services by Tier: The following diagram gives an overview of how our three main DSRIP housing stabilization services will be targeted to the three Tiers of patient needs.

Comment re Domain 2 DSRIP Project Plan Applications:
2.b.vi Transitional Housing Supportive Services



Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Community Consultation: Our model has been developed after extensive consultation with the Westchester County Continuum of Care. We are now consulting with housing providers throughout the 8 Counties served by our PPS to learn how the model will be modified to meet local needs in each sector of our region. Westchester is the largest county in our target area. Its CoC is the second largest in New York, trailing only New York City. It has New York's second largest homeless population, second only to New York City.

The Westchester County CoC has been trained in community mobilization and rapid rehousing techniques by Community Solutions' 100,000 Homes Campaign and the Rapid Results Institute (RRI). HUD and the VA have funded the 100,000 Homes Campaign and the Rapid Results Institute since 2010 to provide training and technical assistance to communities to help them achieve rapid progress toward rehousing veterans and the chronically homeless.

Our model also incorporates extensive community input from throughout our 8 county target area. We have solicited input from Medicaid Health Homes, hospitals, behavioral health and mental health providers, County Commissioners of Mental Health, housing providers, and community advocates.

3) How The Recommended Model Can and Should Be Presented in NYSDOH's Transitional Supportive Housing Services Application

We urge NYSDOH to conceptualize "Transitional Supportive Housing Services" in a way that aligns with current national best practices for addressing homelessness by allowing use of transition-in-place models that provide time-limited transitional housing support services in permanent housing settings. We seek confirmation that the approach outlined below is an acceptable interpretation of what is required to complete the application.

2a. Project Scale: Number of Transitional Beds Established for High-Risk Patients: We propose to calculate this number as the maximum estimated point-in-time active caseload for the number of high-risk patients who will be actively receiving Tier 2 or Tier 3 services. We will define high-risk patients as Medicaid recipients identified by our PPS as having major housing needs because they are:

1) Homeless, *i.e.* living in shelters, on the streets, in cars, or places not meant for human habitation,
2) Living in housing that is unsafe due to physical characteristics of the housing, threatening behaviors of other tenants, or unsafe neighborhood conditions, OR
3) Unstably housed, *i.e.* have moved at least twice in the prior 12 months.

The count of beds will be the number of housing beds occupied by high-risk patients who are:

a) Being actively served by Care Coordinators who we have trained in evidence-based interventions such as Motivational Interviewing (Tier 2) who are using those skills to help persuade the participant to accept previously-refused services or to make previously-refused behavioral changes
b) PLUS those being actively served by our Housing Stabilization Counselors (Tier 3).

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services

Being actively engaged will be defined as having had a face-to-face or telephonic contact within the last 90 days that was structured to achieve initial engagement, assessment or reassessment, or to address a specific housing-related need.

2b. Patient Scale: Targeted Population To Benefit From Project: This number will be calculated as:

a) The cumulative unduplicated count of high-need Medicaid recipients who have received housing-related services from either DSRIP-trained Care Coordinators (Tier 2) or DSRIP-funded Housing Stabilization Counselors (Tier 3)
b) PLUS an estimated cumulative unduplicated count of high-need Medicaid recipients who have been referred to a housing-related service identified by DSRIP.

3b. Patient Engagement Speed:

Expected # of Actively Engaged Patients: This will be defined as the anticipated point-in-time caseload of high-risk patients actively receiving Tier 2 or Tier 3 services.

% of Patients that are Actively Engaged: This will be defined as the actual point-in-time caseload of high-risk patients actively receiving Tier 2 or Tier 3 services divided by the total number of participants who have been identified as high-risk and who still fall into one of the three risk categories, *i.e.* excluding those who have been successfully rehoused.

4) Comment on Domain One Project requirements and Metrics for this project.

Item 2: Develop protocols to identify chronically ill super-utilizers.

Agree with Metric/Deliverable, however the listed data source inclusion of documentation of NCQA certification for physicians/practitioners is misplaced. We agree whole heartedly with the importance of pursuing PCMH for ALL affiliated PCPs. However, while primary care practitioners will be ONE source of identifying those with unstable housing they will not be the only and probably not the best source for such documentation. Moreover, we expect to the extent the primary care physicians do identify patients with unstable housing we would not want to wait until year three of this project for them to begin to notify us. This requirement could needlessly delay implementation of a comprehensive program that could otherwise be put in place much more quickly.

Item 4: Establish coordination of care strategies with MCOS,

Agree with Metric/Deliverable, however the listed data source inclusion of documentation of a CONTRACT with an MCO is not the right form of agreement. An MOU would be more appropriate. And MCO is not likely to CONTRACT with a PPS that is not an incorporated entity and it is not necessary to have a contract to effect coordination. Again this requirement

could needlessly delay implementation of a comprehensive program that could otherwise be put in place much more quickly.

Item 6: Ensure Medical Records and post-discharge plans are communicated

Agree with requirement, however the listed Metric/Deliverable and data source inclusion EHR meets meaningful use could needlessly delay implementation of a comprehensive program that could otherwise be put in place much more quickly. Agree that when MU use requirement kicks in in year three it should be used to transmit records. Also the Data source of MU certification does NOT ensure that it is being used to transmit discharge summaries. An audit will be required to support that this is being done.

Thank you for the opportunity to comment.

Comment re Domain 2 DSRIP Project Plan Applications: 2.b.vi Transitional Housing Supportive Services