THE STATE OF NEW YORK

Moderator: Jason Helgerson
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12:30 p.m. ET

Operator: This is Conference ID # 83070360.

Good afternoon. My name is (Shelly). And I will be your conference operator today.

At this time, I would like to welcome everyone to the DSRIP PPS call.

All lines have been placed on mute to prevent any background noise. After the speakers remarks, there will be a question and answer session. If you would like to ask a question during this time simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jason Helgerson, you may begin your conference.

Jason Helgerson: Thank you very much. Good afternoon, everyone. And I want thank everyone for taking time out of their Friday afternoons to participate in this operator assisted call.

Today's call is really with schedules in lieu of a face-to-face meeting at the request of the PPS is we decided that for this month, for the month of July we would forgo a face-to-face meeting explicitly to sort of give the PPSs more time to work on some of the key deliverables that are still outstanding. And sort of try to, you know, respect that and give all of you sufficient time to do what you need to do.

But at the same time, we know we put out a considerable amount of additional new material including things fairly recently. So what we want to do is schedule this call to give everyone opportunities to bring their questions to the table. We have here around us and participating not only staff from Department of Health including (Payee Chan and Greg Allen) but others also from the health department.

In addition to that, representatives from the public consulting group, our independent assessor are also here available to also answer questions considering much of the new material that's been put out – was developed by them. So hopefully, we have the people in the room that can answer the questions that arise. If, for whatever reason we can't we promise to get back to everyone on the call and throughout to all the PSSs any questions that we are unable to answer but hopefully we can. We hope that – hopefully quite a folks in the room and hopefully we will be able to provide you with the direction and clarifications that you need.

So we are set up here to be here from 12:30 to 3:30 if that is in fact necessary. We will see how it goes. My hope is to try to take every questions that comes to the floor. I hope everyone has the agenda of the particular items that have been identified. What we would to do it (inaudible) possible stick to the –a lot of time for each item. But if we exhaust questions, we will move on to the next items which should sort of give us potentially more time for those additional items.

If we finish early, great. Happy to give people time back in their busy days at the Friday in July. But that said, fully purged day here at 3:30 if there are questions that need to be answered.

So with that, what I would like to do is begin with the first item which is scheduled for a time slot of 12:45 to 1:30 so we have roughly 45 minutes for this topic. And the topic is implementation plans and first quarterly progress reporting. And I don't know, (PCG), do you have anything you want to open with or should we just go straight to question?

All right. Why don't we go straight to questions, we are on time at the moment. So operator, do you want to take the first in queue?

Operator: Certainly. Your first question comes from the line of (Michelle Mercery), your line is now open.

(Jamie Bono): Sorry, I was on mute. This is actually (Jamie Bono) from Millennium. We have a couple – I will just tart with one question but in terms of the implementation plan in the risk communication sections that have already been completed, we are trying to include the feedback from the independent assessor. And now, we are limited to 3,900 characters. Are we going to have to reduce the size of our overall risk communications for each work stream?

(Michael): The current accounts are limited to that. Yes, they would have to be reduced in that area.

(Jamie Bono): So then my (inaudible)…

(Michael): Sorry. This is (Michael) (inaudible) company group.

(Jamie Bono): Thanks. My follow is, will there be a way to actually edit those because right now in the map you can't edit the content and it's been arbitrarily truncated.

DSRIP TEAM: Sorry, this is Shilpa from PCG. You can edit your content up until 3,900 characters and anything else that your copy, pasting in will get truncated at that. And you can edit any of those point any of those boxes up until you submit your report.

(Jamie Bono): Thank you very much.

Jason Helgerson: Excellent.

Operator: Again, if you like to ask a telephone questions please press star then the number one. And your next question comes from the lien of (Courtney Casiraghi), your line is now open.

(Courtney Casiraghi): Hi. So we heard from (KPMG and PCG) that we do not need to fill out the provider ramp up tables and that zeros would be sufficient for the quarter one submission. Can you confirm that that's true?

DSRIP TEAM: So that is not accurate. This is Shilpa from (PCG) again.

The first quarterly report is meant to base on your activities and sort of project your activities for the five years. So all tables where fields are shown going out until DY 524 need to be filled in with an accurate projection of your numerical provider ramp-up.

Now, the ramp up itself in terms of meeting those numbers that are included is for informational purposes only but the table needs to be filled out in its entirety.

(Courtney Casiraghi): OK. And then what they also told us is that we can change the numbers with each quarterly submission. So like, you know, say we are submitting something our quarterly report in quarter three, we could change the numbers in quarter two to reflect something more accurate so long as we explain it in the open text box.

DSRIP TEAM: So in every quarter from DY one quarter two-point forward the modules will be – the report will sort of get restructured so that you – every (PPS) is providing an update on the actual activities from the previous quarter. So in next quarters report you can…you can provide sort of the real time activity in terms of providers that were engaged in quarter two. But there will not be an opportunity to re-project over the five years.

So if there is any big gap or distinction between your actual activity and what was baselined in this Q1 report then that explanation should be provided for the IA in the accompanying merit of text box.

(Courtney Casiraghi): OK. And then related to the provider ramp-ups, so if you are familiar, there are two modules that have provide a ramp-up per project except for the domain for project. So first module outlines all of the different provider types and then there is a set deadline that we committed to in scale and speed.

And so what our question is, is when you go to the other provider ramp-up table that's associated with the domain one metrics and milestones the timelines are often different. So, you know, what our question is, do the ramp-up have to match between those two modules or can they be different?

DSRIP TEAM: Right. So for the provider types that are specified in the project requirements the ramp-up do have to match. And obviously if it's associated with the projects requirement that for example, systems transformation base so that needs to be completed in DY 2. Then the earlier overarching time frame trunk the speed and skill commitment.

So the ramp-up that shown for example for a (PCP) level requirement needs to then be accurate to the total number of (PCPs) that are committed to in the original project implementation speed module. But the timeline should match the timeline for the requirement itself as it's described in the domain one project requirements document from June 18th.

DSRIP TEAM: And the only time that ramp-up won't match is if we are asking a ramp-up for the second module that's specific to a subset of the total provider classification. So specifically if we are asking for safety net providers obviously that would be a subset of your total primary care physician on the initial module.

DSRIP TEAM: Right. And then that safety net ramp-up needs to hit the commitment of safety net that were submitted also in January.

DSRIP TEAM: In the speed and scale tables.

(Courtney Casiraghi): OK. So let me repeat that to make sure that I understood. So, you know, say in the first module we committed to 500 (PCPs) by the end of demonstration year four. But then when you go back to the other module and, you know, if the project requirement then have to be completed by the end of demonstration year two, those 500 (PCPs) have to meet the requirement by demonstration in year two.

DSRIP TEAM: Yes.

(Courtney Casiraghi): OK. And then can you also confirm that there is no risk in mitigation for domain four projects?

DSRIP TEAM: Yes, those are the (PPS) engaging an existing prevention agenda activities, there is no risk mitigations module for domain four projects.

(Courtney Casiraghi): Is there ever going to be a risk and mitigations module?

DSRIP TEAM: It's not planned at this moment.

DSRIP TEAM: Would you like one?

(Courtney Casiraghi): So I mean that's the guidance we got back in like February so people have been working on it so we are expecting and see in map but if it's not going to be there it's not going to be there and that's good to know.

DSRIP TEAM: OK.

(Courtney Casiraghi): And then do you also…

[Crosstalk]

(Courtney Casiraghi): And then, can you also confirm that the workforce section is going to be – there is nothing required for the word force section with regards to quarter one?

DSRIP TEAM: Yes. As you can see in map, there is no work force section for quarter one. It will exist in quarter two but is only required for submission in quarter three.

(Courtney Casiraghi): OK. Thank you.

DSRIP TEAM: All right. thank you, (Courtney). Next up?

Operator: Your next question comes from (Tom Manion), your line is now open.

(Amie Vankapen):OK. I guess my name is misspelled, this is (Amie Vankapen) from the Mohwak Valley (PPS). Can you hear me?

DSRIP TEAM: We can hear you.

(Amie Vankapen): All right. So I guess trying to clarify what I think somebody else just previously asked which is previously we had submitted speed and scale at the project level by provider type. But what we now have to create within the next five days is the speed and scale at the requirement level for those same providers.

DSRIP TEAM: Not all providers, just those providers that are specified in that second module. And a lot of that clarification was provided over a month and a half two months ago where we, you know, to some degree alleviated some of the requirements on speed and scale that were only going to be measuring certain project requirement specific to certain provider classification.

(Amie Vankapen): Right. I guess – so have had the domain one desert project requirement milestones and metric document for some time but it wasn't clear to us until we saw the entry format of the map tool that you were actually looking for a quarterly number for each of those provider level requirements. And not only were you looking for quarterly – then today you are clarifying that you are not just looking for quarterly progress due date but you are looking for projected speed and scale for each one of those. That was not made clear in the domain one desert projects requirement metrics and milestones.

So I just wanted to clarify that in fact that that is analysis we ask to complete and turn within the next couple of days.

DSRIP TEAM: Correct.

(Amie Vankapen): Fantastic. Thanks.

DSRIP TEAM: All right.

Operator: And your next question comes from the line of (Janneth King). Your line is now open.

(Chris Bell): Hi. Good afternoon. This is (Chris Bell) with the (COAs) performance provider system.

I have a question around module two of the integrated delivery system to (AI) project. Previously we haven't been asked to submit expectation of provider commitments for this project. And so I wanted to: A - confirm that that was a purposeful inclusion for the 31st submission.

DSRIP TEAM: Yes. So, even at the point of the project plan applications, speed and scale submissions in January provider speed and scale commitments and safety net provider, speed and scale commitment were submitted. And those correlate to these project implementation speed module in map.

(Chris Bell): Great. Follow up question to that is around the numbers that are total committed in that column there. These numbers for us differ from our January table. And in January we were given the detail of each provider type. Will we get that level of detail again so we know exactly who is coming in these numbers?

DSRIP TEAM: Yes. That's on – there is a couple of efforts going on there but within the actual map and implementation tool there is the expectation for the next release, the quarterly report which will go it live in October. There will be that drill down capability to understand where providers fit in the various classification consistent with the table for speed and scale.

(Greg Allen): Yes. This is (Greg Allen). And those as we have been discussing in our previous meetings, those tables are being greatly cleaned up and updated, and addressing some of the feedback that we received from the providers in the (PPS).

And as we had previously mentioned, if we for instance collapse the number of providers in a given category, we will liberalized the target percentage that you have to hit commensurate with that at any changes that happened in those categories.

There are not large scale numbers of change in categories based on what we are looking at right now but there are changes in providers being added to categories and deleted from categories. So, we will have a very liberal interpretation of hitting the targets when those come out. But there will be drop-down capability to select providers within categories so you will be able

to see, you know, for your network which providers are hitting the various categories including the safety net, non-safety net, (PCP), non-(PCP), and all the other service category.

(Chris Bell): We have any opportunity to revise these projections then given that we won't know who the players are until October or is it – which we use our best estimates for the ramping up for the numbers based on our understanding of our timeline and our implementation plan?

DSRIP TEAM: Great. For the (latter), please use your best estimate and as sort of large-scale revisions need to be done will complete those on the back end like Q2.

And two, one of your first point, if the numbers that you are seeing in map in that module for your total commitments, don't mess your January speed and scale submission. Please, contact your performance facilitator and we will double check that.

DSRIP TEAM: Great. We will surely do that.

DSRIP TEAM: But just to clarify what I was saying before, so if you have committed to a certain number say 75 out of – and there were 100 providers in the category. And now we redo that category and there was fewer than 100 like down to 80. We would certainly not going to hold you to 75 out of 80 when you had committed to 75 out of 100. We would commit you to a percentage of the 75 that was even liberal so we would basically give you a pass on a certain percentage above the suppression in the volume, in the total universe.

And we will be working with (PCG) to figure out of, you know, methodology to do that. So we are not going to hold you accountable to the cleaning up with those categories any reduction in the universal providers.

DSRIP TEAM: All right. Next question.

Operator: Your next question comes from the line of (Lauren Winerhong). Your line is now open.

(Lauren Winerhong): Thank you very much. This actually piggy backs nicely of that previous question so we very much appreciate any flexibility that you guys are able to extend when we get cleaned up provider type categories that may reduce our numbers.

I guess my biggest concern is the fact that our partner organizations have until October to really fully commit to the project so that would really impact the provider ramp-up tables. And I think a lot of us are going to be doing a lot of what could end up being duplicative work to make those tables accurate between now and the end of the month when we are going to be getting a lot of new information, and partners will have time to technically pull out a project if they have decided to.

So, I guess I'm just asking beyond some kind of margin for changes based on categories, what level of flexibility will you give given the fact that partner still have some time to make decisions about what they are willing to commit to.

DSRIP TEAM: Right. So, I'm glad you raised that question but it's important to point out. We are prepared to again be flexible when it comes to the fact that if we re-character – re-categorize providers and as a result there is a change in the actual number providers in your network in a particular category. We aren't going to hold you accountable if you committed to a number and the total number available here in your (PPS) in that (sort) of category went down for whatever reason, we will make adjustments for that.

That said, assuming, let's say for instance for you as the (PPS) there is no adjustments, right? And the providers you have by category remained the same, I mean theoretical example you are still held accountable for what you committed to an application.

There is not in anticipation of us being quote flexible around your those kind of commitments because at the end of the day the amount of points you received in the application was a direct reflection on your commitments around scale and speed. So there is not going to be flexibility in that regard.

What we are saying is that for whatever reason because of this re-characterization of the file that we would do in order to basically clean that up, we are not going to – when that clean up occurs and if there are changes that affect you we are not going to have those changes negatively affect you.

DSRIP TEAM: But I also think it's important to say that the point at which you are selecting the actual providers because you are using an example of an individual provider, you (will) not selecting those individual providers until that next quarterly report when we put that drop down capability upright in October. And that would be based on the new categorization with a new master list that we would be, you know, maintaining through the life of the project.

So – and your new targets, we would be recalibrating in advance of that selection you would be cognizant of the target, you would be getting a new set of providers and you would be selecting at that point. So there is some time here to be thinking about which providers they partner with.

DSRIP TEAM: And I think that's the thing too is that, you know, and we said this before that at various points in time we could open networks to allow (PPSs) to add providers. And if necessary, we could explore the possibility and the run up to, you know, sort of October time frame. It looks like (PPSS) need to add providers specific types meaning they weren't in your initial network.

We could potentially explore that as a way to help you ensure that you can meet your speed and scale. This has only been anticipated that providers could joint (PPSS) at later point but the opposite was not the case which was providers could, in essence, leave with the exception of the structural changes which are going to be allowed at the midpoint set.

(Lauren Winerhong): OK. Thank you very much.

DSRIP TEAM: Thank you. Next question.

Operator: Your next question comes from the line of (Kuan Lilly). Your line is now open.

(Kuan Lilly): Hi. Thanks for taking my question. So, for the July 31st quarterly report in the budget and funds for our table, it appears that the waiver revenue line has been pre-populated, and it seems to reflect only net project evaluation.

So, in some cases this is different than (announced) that (PPSS) had filled in for the June 1st implementation plan. Could you give us all some guidance on how you prefer as modify our budget and funds for the table to reflect any differences in what waiver revenue?

So for example, what you suggest changing all the table lines proportionally?

DSRIP TEAM: So, there is a discrepancy obviously between sort of funding that's been displayed for waiver revenue, only (quarterly) potentially the federal fund. So, at this point that the known defects on our side, and we are working to resolve that.

But for right now, the information provided in budget and fund flow should reconcile with the waiver revenue displayed.

DSRIP TEAM: So that will have to be updated. We are aware of the issue. We will update the amounts but given the validations in the system it requires you to reconcile your budget and your fund flow to this numbers populated in the tool.

DSRIP TEAM: And just to be clear on that, that number is accurate for the purpose of performance money. It just doesn't address all the equity polls, the high performance, et cetera. So we are eventually going to update it to include those all-in dollar amounts on a performance bases. But at this point, it's the straight up project evaluation, net federal funds coming to the regular performance program.

[Crosstalk]

(Kuan Lilly): Why I mentioned that the – some (PPSS) have including safety net equity guarantee funding in the table. Could you give us an update on the timing of when those guaranteed funds and the performance funds are planned to be distributed?

DSRIP TEAM: Sure. So we are still in the process of working on the mechanics for how they are going to be distributed so I don't have a firm date but, you know, what we are hoping is really no later than October 1st.

You know, if (PPSS) has, which actually in our view ties pretty closely to what time the (KPMG) survey of the (PPSS) suggested was dates when (PPS) leads were going to begin to flow funds down to downstream providers understanding that you got a lot of contractual issues to resolve and there is still program integrity issues outstanding, and things like that so that what most (PPSS) are still holding on the distribution.

But that said, if individual (PPSS) have particular – if there like a cash flow issue, individual (PPSS) should contact us directly.

(Kuan Lilly): Great. Thank you so much for the insight.

Operator: And your next question is from the line of (George Clifford). Your line is now open. From the Albany Medical.

(Christy Mcintire): Hi. This is actually (Christy Mcintire) from the Albany Medical Center (PPSS). I have two questions, the first question, we received the independent assessors feedback and we have noticed that there are sections within some of the work streams that are augmented saying that they are just not listed and (inaudible) no feedback on them.

Can we assume that those are sufficient and we can move forward with those or is that something that we need to follow up on?

(Mike): This is (Mike) rom (PCG), yes.

(Christy Mcintire): OK. Thank you.

And then the second, I'm a little confused for a question – from questions that have been asked. Is there something that's supposed to be pre-populated for us in the map tool because we do see the milestones in there. But beyond that I have concerns that there is things that may be in there for others that I would like to have too?

So there is certain information that is sort of pre-populated for each PPS in map. In addition to obviously the organizational milestones and project requirements, by (PPS) you should be able to see your speed and scale commitment in the project implementation speed and patient engagement speed module. But outside of that, your report is mostly blank for data entry.

(Christy Mcintire): OK. I'm just verifying because I don't remember seeing that the first time went in but I have been in several modules. If it's not or if we have a conflict, is that something that we would contact (KPMG) on?

DSRIP TEAM: Yes, our performance facilitators will be able to verify that with you and contact – and sort of circle up with us if there is problem.

(Christy Mcintire): OK. Thank you.

DSRIP TEAM: Great, thanks. How about next question?

Operator: Your next question comes from the line of (Shelly Kelly). Your line is now open.

(Caroline Cross): Hi. This is (Caroline Cross). I'm sitting with (Shelly). We have a few questions for you.

The first is for pre-completion reporting, from June it sounded like we are only doing pre-completion reporting for organizational section. The first question is, are we required to submit pre-completion reporting for the July 31st reporting period or only subsequent periods?

DSRIP TEAM: So pre-completion reporting for the organizational prescribed milestones if that's what you are referring to then that is act for the July 31st report as well.

(Caroline Cross): OK.

DSRIP TEAM: The initial implementation plan that was excelled did focused on the organizational sections and not all the projects. But for this submission that the quarterly report that do at the end of the month, everything is expected to be completed both on the project and organizational components of the implementation plan/quarterly report.

(Caroline Cross): OK. So, as a follow up, are we required to submit pre-completion reporting for all requirements or only then end-progress requirements?

DSRIP TEAM: Yes. Are you referring to organization milestones or projects requirements?

(Caroline Cross): Both.

DSRIP TEAM: So, for organizational milestones adhering to the 421 domain one achievement values webinar, pre-completion reporting is required for all pertinent organizational prescribed milestone.

For project requirement pursuant to sor t of filling out your projection and filling out all of the fields that are available there is no expectations for sort of additional reporting at this point on that until you get to the point of completing your projects requirements.

(Caroline Cross): OK. Thank you.

The next question is, where should (PPSS) add the sub-desk for organizational and project sections, should we be adding those into the prescribed milestones modules or the (PPS) defines milestones module? So if the subsets aligned in our associated under existing prescribed milestones then they should be added in associated with the correct prescribed milestone into the prescribed milestones module.

If there is separate activity for, in terms of milestones tasks sub-step that you are conducting outside of the preview of the prescribed milestones then as a whole that should be reported within the (PPS) defined modules.

(Caroline Cross): OK, great. And then what type of information should we be adding into the description field as we add those sub-steps?

DSRIP TEAM: So the description field is asking for a description of the activity that's going to be performed. So there is a name field and then there is a description field. So the name filed ideally should be briefer than the description field.

(Caroline Cross): OK. And the last question is related to data security but also the July 31st report. And the question is, has the state considered delaying the transition to dual factor identification until after this quarterly support is complete?

DSRIP TEAM: Yes. So as included on the announcement that we have been able to move that date from June 29th to August 3rd.

(Caroline Cross): OK. All right. Thank you.

Operator: And your next question comes from the line of (Joel Lamantele). Your line is now open.

(Elisa Coreilli): Hi. This is (Elisa Coreilli) sitting here with (Joseph Lamentia) and our team. Just having a few questions, I will start just piggybacking off of the discussion about pre-completion reporting. Can you just validate that we should be populating those updates in the narrative boxes tied to each milestone?

DSRIP TEAM: Right. So for whatever pre-completion reporting that goes above and beyond the visible field that should be using either the narrative or the file upload functionality.

(Elisa Coreilli): OK. Thank you.

And is the description fields required for every task if we do a sufficient job describing the task within the task box?

DSRIP TEAM: Right. So the description field is required.

(Elisa Coreilli): OK.

DSRIP TEAM: If you want to work around it essentially you could copy-paste the same information from the name field into the description field.

(Elisa Coreilli): OK. Next question is in regard to the project engagement spread tables. We understand that the unit level requirements are tied to specific domain one milestones which is part of the other module. So is this high level table just a roll up which means that if there isn't a unit level requirement in the project it would be left as zero engaged so like pharmacy for (interact) for example?

DSRIP TEAM: No. So the project implementation speed is essentially thee big brother of the provider level requirements. So that adheres to the original provider classifications that were committed to for speed and scale in January 14th. So that table should for all of the provider categories displayed show the actual ramp up to hit the total commitment by the time frame that's displayed.

(Elisa Coreilli): OK. So how would the DOH be assessing and looking at the engagement requirements for some of the unit levels that are identified but we don't have to show like a data source or wouldn't be tied to project engagement numbers

(Mike): So, this is (Mike) from (PCG).

So, we would expect for those partners requirements that were identified as project level that the (PPS) would report as a project wide data source or project wide evidence whereas the provider requirements, provider unit level reporting would be through the individual providers as demonstrated or identified in the domain one milestones and metrics document.

(Elisa Coreilli): OK. All right. My next question is in regards to project to (DI), you have (PAM) provider as a unit level for us to identify a spread. Can you confirm that our training requirement is the (PAM) provider?

DSRIP TEAM: So I will start…this (Mike) from (PCG) and (inaudible) chime in.

So in the application submitted in January, (PPS) has identified how many individuals will be trained in (PAM) active – patient engagement technique to the life of the project or by the time they said they would. So we expect that ramp-up to be consistent with the totals that the (PPS) is committed in the January projects application.

(Elisa Coreilli): OK. So I will take that as our training commitments.

DSRIP TEAM: Correct.

DSRIP TEAM: Yes.

(Elisa Coreilli): OK.

The next question is, can some of our start dates that are populated be prior to April 1st?

DSRIP TEAM: No, so start dates really is this 4-1-2015.

(Elisa Coreilli): OK. So they should start beginning in April. OK. I think that's all. Thank you.

DSRIP TEAM: Thanks very much. Next up?

Operator: Your next question comes from the line of (inaudible). Your line is now open.

(Irene): Hi. This is (Irene) from the (frontline PPS). I just had a follow up question on the work force section that was mentioned a few minutes ago. So, it was mentioned that – we have noticed the work force section isn't in the map tool. However, we still receive feedback from the independent assessor. Should we assume that we are not going to include that, you know, we are not going to address our feedback until the next submission period to make those update?

DSRIP TEAM: That's accurate.

(Irene): OK. Thank you.

Operator: Again, if you would like to ask a telephone question, please press star then the number one on your telephone keypad.

Your next question comes from the line of (Kelly Owens). Your line is now open.

(Kayleen Florio): This is (Kalyeen Florio) actually at around (Adirondack) Health Institute. And my question is with regards to domain four projects, I understand that we will submit that milestones at our (PPS) pre-defined specifically in our own December project plan application.

My question is, does that have – can we make any changes? Can additional milestones be added and can any come out? And finally, in addition to the

milestone itself are you also looking for a fully developed set of tasks underneath those milestones?

DSRIP TEAM: So, yes to all three. We would like the most sort of accurate picture provided of the activities that you are planning and that you have already undergone. So if any of those activities have change from the December report definitely please reflect to that in the module itself.

If there is sort of significant change in terms of not reporting on any of those milestone it would be prudent to include a brief explanation in the narrative as to why those were removed or replaced. And then definitely, please include sort of further milestones as to activities you have planned and the pertinent task associated under each of those milestones.

(Kayleen Florio): Great. Just one follow-up question…

DSRIP TEAM: Actually, different question. I see the module of the section where we can add our (PPS) defined milestone. And we have (PPS) defined milestone for some work streams but not all is that acceptable.

So in addition to the required milestones, there is the module where the (PPS) can submit the milestone that they have specifically defined. We have those for some work streams but for other works streams we felt the required milestones really were the entirety of our milestone.

(Kayleen Florio): Right. So if the prescribed milestones encompass the entirety of your planned activities right now then that is – that module itself is sufficient. Thank you.

DSRIP TEAM: Very good. Next question.

And then also, a note for folks, I think some folks have been sending in questions to (Brook), have you been receiving them? So please use the process here for submitting your questions. Please raise your virtual hand here and get in the queue if you want to ask question on this topic, that's the process not sending e-mails to (Brook). So thanks.

Next up?

Operator: Your next question comes from the line of (Ariel Gulfinmat). Your line is now open.

(Pia): Hi. This is (inaudible) Medical Center. My question is also related to provider ramp-up. So for those projects where in the detailed milestones we have certain provider types listed. And then in the module two which is the higher level, this is for roll-up or the meeting all project milestone.

So, how would we be measured on meeting all project milestones by the time it didn't exist in the lower levels, in the milestone level? What kind of evidence would be have to provide?

(Mike): Sure. This is (Mike) from (PCG). So the project wide requirements often deal with training protocols or (EXR) certification that are (PPS) project wide, policy and procedures, governance, things like that so that's where we would want to see the independent assessor would request.

Evidence of the training were conducted across all relevant partners included in the project where the policies and procedures have been adapted, things like that at the, what we are calling the project wide level whereas the provider level would be a list of (PCPs) achieving patients and medical home level pre-certification or other types of more specific project requirements to provider unit.

(Pia): Great. (Mike), thank you.

And for the second question is, if we have let's say a (PCP) type provider and we have multiple milestones that relate to (PCPs) for instance. We have only one place for (PCP) in the higher level so we just provide that ramp-up that is the most aggressive in that level?

DSRIP TEAM: So the project implementation speed module were just sort of the higher level should reflect your ramp-up accurate to your original speed and scale commitment. And for anything that needs to be more aggressive that should be aligned within the project requirements module, that should be aligned with the appropriate requirement that have a more aggressive timeline.

(Pia): Got it. So the higher level should match the speed and scale, and then milestones should be based on whatever we believe is the ramp-up, appropriate ramp-up?

DSRIP TEAM: Yes.

(Pia): Thank you.

DSRIP TEAM: Excellent. Next question.

Operator: And your next question comes from the line of (Maureen Dorin). Your line is now open.

(Maureen Dorin): Yes. Hi. Thank you. This Westchester Medical Center, (PPS). So I have a couple of questions that may seem mundane but they get to know the actual entry of items within the portal.

First, they know that we had a question asking about the description text box. The description text box was not in the original template for the earlier sections that we submitted June 1st. We went through remediation process and we received our feedback from the (IA) which would indicate to me that the steps we have submitted at that time had been reviewed. And like in our case, most of them were accepted. We were not asked to add too many more steps.

Therefore, having the required description box seems to me a little bit after the point and the answer that you can just copy a step and put it in. If you are the person doing this work for July 31st, I timed myself on the actual minutes that will (crone) to hours, actually into a couple of full days that I would lose just with having to do that because we are talking hundreds of steps.

I have left that box blank and I have saved, and I've not got an error message so I guess choose and reporting, and what I want to share as my other (PPS) colleagues, I mean, why couldn't we leave that test box blank if we have already been through the remediation to those sections and we are not remediating most of our steps.

DSRIP TEAM: So the description, the description field is a required field. And the distinction between the description field and the original, the sort of first field that appears, is that the first column is the name column. So the idea was that they weren't necessarily containing the same information. At this point, they are required field.

And if you are in with…if you are within a module that allows you to save as a draft you will be able to save. But once you get to the point of submitting your report you will not be able to hit save and continue, and actually attach and submit your report if those description fields are blank.

(Maureen Dorin): OK. But I guess, let me make this clearer, I'm just (inaudible) to consider why now have a requirement for this description text boxes on sections that we submitted June 1st that the assessor already reviewed and commented on so he/she must have had enough understanding if I didn't get pushed on almost most of my milestones and the steps that I submitted which are now called task.

And the answer that (PCG) gave to one of the earlier question on this was, well if you don't have anything else to add just simply copy that first box, your task box into the description. Now, I have to tell you that that's not a really good use of your time and that's very time consuming on hundreds and hundreds of these tasks because we don't have the description boxes and we don't feel like we should be making them now after the fact after our entire sections have been already reviewed. And we are found in large part to be accessible other than what I have to do for remediation.

So, I'm just asking you think about it from a work process flow from a (PPS). You can take it away and think about it but I think making that a required field after the fact just doesn't seem to make a lot of sense.

And my next question is on the dates, if you are in the system for all of your tasks that have not yet begun, you know, you have three options as you know. So if you put the on-hold because I have reviewed the webinar you sent, and unless I misunderstood if I have task that begin, let's say (DY 1) Q3, they are on-hold, they are not in progress.

When I put the on-hold that wipes out my start and end dates in the system. So, how will I be able to communicate my dates to the assessor because they get wiped out. I mean I keep them in and then I go to save, you know, and I have the on-hold and the system wipes those dates out.

DSRIP TEAM: Right. If you are selecting the in-progress status that will allow you to choose future dates. So if you already know the planned date of the activity in the future for (DY) 1 Q3 then select the in-progress status and you can save with the dates that you are keying in.

DSRIP TEAM: The on-hold status.

DSRIP TEAM: Yes, does wipe out your – wipe out any (PPS) under dates and include just before 1 2015 as the start and 331 2020 as the end date because that's an overall – that's a more sort of rigid indication to the (IA) that the activity is planned maybe a couple years down the road or sort of there is a blocker to actually completing the activity right now.

[Crosstalk]

(Maureen Dorin): Yes. Can you be clearer because now you are redefining what in-progress means versus on-hold? So in-progress to me is I have already begun, I am in-progress working on the task. Understand that if it doesn't – I'm not using a salacious lead to indicate, you know, this isn't two years out so you can't redefine that.

So if I put on-hold which is what I have done now for anything beyond (DY) 1 Q3 that's not started which means when I submit July 31st you are not going to have my start and end dates in which originally we were asked for, for almost the entire implementation plan because obviously we are only in (DY) 1 Q2. I mean I have to promise that personally, you have saved me a lot of data entry time but I didn't know that at first. So, you know, I put in the entire section and went back and said, "These aren't in progress, put on-hold and save." And I was wiped out.

So I'm OK with that but understand that's what you are going to get.

DSRIP TEAM: Sure. That's the (PPS) (inaudible) on-hold status, we will review the report as is right now. And then when the activity does come to pass sort of it needs to be reported then in future reports (PPS) will need to change those dates and sort of provide an explanation for the…

(Maureen Dorin): That's fair. So, to my other fellow (PPS) who is listening to this that that's going to save you a big risk on playing with the start and end dates, and your projects because it's been a very demanding process.

And then finally, I have the request too on behalf of all of us, it's a real tedious entry to put the (roles) table and the stakeholder tables. And I have asked you to respectfully consider that since these aren't being evaluated moving forward. I'm not part of (scoring), is there any way that you can allow upload our roles and stakeholder tables as either an Excel spreadsheet like we currently have them for June 1st or word doc because it's a lot – and as I think unnecessary entry time for us the way the system is designed now.

I timed myself on, you know, some of these tables are really long. And I'm just wondering why we can't just upload those.

DSRIP TEAM: So we understand that this is a big lift, right now obviously in order for the (IA) to be able to judicate and keep mapping the one source of truth for information. We do need the module itself to be filled out.

(Maureen Dorin): So why can't we upload it in the map?

[Crosstalk]

DSRIP TEAM: We could take it back and discuss it with this date. Also, that was the decision that was made (inaudible).

DSRIP TEAM: OK. But I was saying is that if it doesn't impact…

[Crosstalk]

(Maureen Dorin): To those two sections and just remove the individual (literally) sell by sell entry of this. And every line you put you have to save this before you can add the next one, a time date. Again, you are to…

DSRIP TEAM: We appreciate the issue. I think we've got you, we have heard you. We will (pick) and look at it.

(Maureen Dorin): OK. Thank you.

DSRIP TEAM: Operator, next caller, please.

Operator: Your next question comes from the lien of (Courtney Casiraghi). Your line is now open.

(Courtney Casiraghi): Hi, again. Just a couple of questions. So what time does the map portal officially close on July 31st? Is it going to be 5:00 P.M. or 11:59 like it's been previously?

DSRIP TEAM: 11:59.

(Courtney Casiraghi): OK. My other question is, is there going to be like a real-time quality support or contact person that (PPSS) can contact for like almost immediate support in the map portal because as the previous call was mentioning, it's extremely tedious and time, you know, it takes a lot of time.

And what we have experienced so far is that the map portal can be extremely slow particularly in the days leading up to the official submission. And so, you know, we just want to know who we can contact. We were previously told that the (CMA) help desk is a good person to contact. But we contacted them like three days ago and we still haven't heard anything.

DSRIP TEAM: That's good feedback for us to get. If you can document that for us and send it up through your (PCG) folks will follow up with that with (CMA). (CMA) has been adding a bandwidth resources to map and separately provisioning out various portions to the system. We have previously been running this on the Medicaid (day) warehouse full back on. They have added servers and process, and capability.

So we are hoping that those sets of action including some very recent ones will include – improve the performance when we've got sort of key usage times. And we do track that and we have been looking at that. And we have

performance issues that are resulting in your – in a uniform submission problem, we will address that at that time.

But we would encourage everybody to get this done as really as possible recognizing that, you know, it's summer and you've got swing resources working on this. But waiting to the 11th hour is, you know, likely to cause the system to run slower so the fewer (PPSS) that do the better off it's going to be on the system side.

(Courtney Casiraghi): OK. Thank you.

And then last question, in our budget and fund flow module, we have realized that the budget categories don't match up with the budget categories that we have submitted in the implementation plan. And so, when we raised this with our (KPMG) representative earlier this week they mentioned that a crosswalk document is coming to kind of explain some of the discrepancies and the terminology used between the map and the implementation plan.

So when does that documents going to be released?

DSRIP TEAM: So, unfortunately I don't think any of us in the room are aware of a crosswalk document that is to be released. I will drop my head though, the budget categories do align. There are two additional categories that we sort of work with DOH to include with your cost of non-covered services and other.

So there is a total of five categories in this July report compared to the three from the June report. And that's the only discrepancy per say that you should be seeing.

(Courtney Casiraghi): OK. Well, we will just erase that again with our (KPMG) representative. Thank you.

DSRIP TEAM: All right. thanks very much. Next up?

Operator: Your next question comes from the line of (Janneth King). Your line is now open.

(Janneth King): Hi. Thanks for taking our call. This is (Janneth).

Where – as we are looking at the project plan implementation load, we have been over the last couple of months really focused on doing good implementation planning. And we just wanted to check and make sure we are doing it correctly so it's reflected in map.

The example of III (AI) that was given in the presentation during the webinar was listed as a good level of detail. So under III (AI) there was 10 steps, 10 sub-steps that were listed.

If we use that as a guideline of the level of details that the (AI) is looking for, for a clear action plan, would we then take something at that level of detail and make those sub-steps underneath the milestone (cap)?

DSRIP TEAM: Yes.

DSRIP TEAM: No. Those will be taxed themselves underneath the milestone.

(Janneth King): So each one – those 10 steps, so at your presentation, if you pull that out, those all would be 10. We would add, let's see, there is the task so a milestone is loaded in and then it looks like the metric deliverables are loaded in as two pre-populated tasks then all..

DSRIP TEAM: Then you would add 10 tasks underneath that.

(Janneth King): Where would you – do you (inaudible) I'm going to meet the milestone then or I mean it's not…

DSRIP TEAM: Correct.

DSRIP TEAM: OK. Now, we go to the bottom.

DSRIP TEAM: So, we wouldn't put those kind of things in narrative or an upload document.

DSRIP TEAM: No, those need to be – added as new tasks.

(Janneth King): And my understanding is that when I add those, so one of the examples is establish a (PCMH) certification working group. Once I type it in like that it is set, I can't change that over the five-year period.

DSRIP TEAM: No, you will be able to change task names and descriptions as necessary over the five years.

(Janneth King): So I could but I can't eliminate a task?

DSRIP TEAM: You cannot delete.

(Janneth King): So, what does mean that if I can't delete it then can I – what do you mean then? So, say we are never going to have a (PCMH) certification working group, how would you not delete it but change it?

DSRIP TEAM: Right. So in the future reports you would be able to – if you are never going to have a (PCMH) working group you would put the task itself, that line item would be on-hold status. And then provide an explanation in the narrative (task) box as to why that activity is now sort of deleted if you will in terms of not going to ever be completed and any sort of further understanding that the (IE needs).

(Janneth King): OK. And then you just said, additional ones as you want.

DSRIP TEAM: Exactly.

DSRIP TEAM: Yes, I think the idea here is to basically be able to track overtime task that were envisioned and then understanding some of those tasks may not occur but to have sort of an on-going record so how the work plan is in essence updated over time.

(Janneth King): OK. That is very helpful because this has been confusing and we are just trying to make sure that we are consistent throughout all our plans. OK. Thank you very much.

DSRIP TEAM: I appreciate the question.

DSRIP TEAM: Next up.

Operator: And your next question comes from the line of (Cara Patrity). Your line is now open.

(Cara Patrity): Hi. We are here with Community Partners, Western New York. We had two problems actually with the map tool we started to implement. We noticed that you guys did load the deliverables as sub-steps to the milestone so we didn't originally prepare this in our implementation plans. Are we now expected to have a timeline for the deliverables for the specific milestone?

DSRIP TEAM: The task?

DSRIP TEAM: The metrics/deliverables under each project requirements are loaded in and those do need timeline.

(Cara Patrity): Ok. And then when we are loading our provider ramp-up table and pretty much anything where you need to load in numbers we have noticed that the tool actually deletes the numbers a lot of the time so it takes a lot of time to actually input because you never know if it's going to actually take the number submission. Is there something you guys have been working on that you are aware of?

DSRIP TEAM: We are not aware of that issue. If it's occurring, we would ask you to please immediately submit a ticket to the (CMA) help desk and simultaneously inform your performance facilitators or account managers, and we will look to resolve it. If you can also like take a video like snippet of the problem as it occurs that will definitely help us resolve it.

(Cara Patrity): OK, yes. We did actually submit our initiative to our (KPMG) representative and to the DOH so we just haven't heard back yet.

DSRIP TEAM: Did you submit to the (CMA) support as well?

DSRIP TEAM: I don't know what a (CMA) support is?

(Cara Patrity): We are not sure what that is.

DSRIP TEAM: Yes. So don't worry, it has been – the issues has been forwarded. We know about the issue so we will make sure that somebody looks into it right away.

DSRIP TEAM: But just in general for all the folks listening, if you are experiencing any performance issues in map that it is a very good idea to submit a support ticket to (CMA) so the support staff get right on that.

(Cara Patrity): OK. Thank you.

DSRIP TEAM: The (CMA) help desk information, the phone number and the e-mail address is on the map home page when you log-in.

(Cara Patrity): OK. Thank you.

DSRIP TEAM: Thank you.

Operator: Your next question comes from one like of (David Rosales). Your line is now open.

(David Rosales): Hi. Thank you. This is (David Rosales) supporting One City Health, just a couple of follow ups from earlier questions. One is just on the pre-completion reporting so just to be clear, so for this 731 mission for any milestones – organizational requirements that are in progress which will be, you know, the vast majority we are required then to provide a narrative for each describing the progress is that correct?

DSRIP TEAM: Yes. The January – the submission due in July 31st is the baseline implementation plan for the projects so no pre-completion would be expected.

(David Rosales): OK. I'm sorry. So, my understanding based on how the question was -- responded to earlier is that for this submission we not only provide all of the milestones and steps so we also have to…we also required to report on progress for anything that is pre-completion. Are you saying that what do not need to do that in this initial baseline submission?

DSRIP TEAM: So I think we are – confusing two different terms, so if there are – if the (PPS) is further along in – and works steps for a particular milestone in terms of (EHR) meaningful use development then the independent assessor would like

to be – would like that information included in the July 31st implementation plan.

I know some of the comments came back between the original implementation plans whether a view has came out with more information was needed. And some of the (PPS) (inaudible) further along, you know, meet all these steps because we are – we have already embarked on the project in these project requirements.

So the independent assessor in the next implantation plan would like to see, you know, those that may have been completed already to understand why you are at the place where you are at which is a little different I think than the term pre-completion documentation that's been used in various other webinars.

(David Rosales): OK. So that part was clear. So to the extent that there is work that's been done and we want to reflect that then we used – we either upload documents or we use the narrative section to reflect that.

But our understanding was that any milestone that is pre-completion status which is the vast majority now that we have a reporting requirement every quarter. And the question is, do we need to provide narrative updates across, you know, across all of our milestones in the organizational section in this submission? Or does that start really in October when, you know, when we are using it as a baseline?

(Mike): So we would expect. This is (Mike) from (PCG) that the organizational as well as II (AI) implementation plan would be revised to reflect some of the guidance or comment that the review team has provided.

(David Rosales): Right.

(Mike): So that would be updated and revised but not necessarily providing more documentation around those milestones – those work steps from milestones.

(David Rosales): OK. So we – OK, so that's good. And so we don't have to necessarily report on progress at this stage unless we have work, you know, that's already been done that we feel like should be communicated.

DSRIP TEAM: Right (inaudible).

(David Rosales): OK, great. Just one other quick follow-up, on the domain for flexibility around changing domain for milestone, so thank you for the clarification there. Is that also true for the timing as well?

DSRIP TEAM: Yes.

(David Rosales): OK, great.

DSRIP TEAM: All right. Thanks. Move on to the next.

And so, we are over the allotted time for this topic but given the fact that we have deliverable due dates to the 31st, I think it make sense to continue on with questions. We have seven in the queue so, and many of (key) customers which we are always glad to have repeat customers.

That said, particularly for those of you who are repeat customers if you could try to keep your questions sort of, you know, short and distinct. We want to try to make sure we have time to get everybody as well as the rest of agenda.]

So next up?

Operator: Your next question comes from the line of (inaudible). Your line is now open.

DSRIP TEAM: Hi. Thank you. I guess my question is for the project specific reporting requirements where you have to make provide number commitment or roll-out commitments. There are number of requirements that you are committing that don't really have in the (phases) and they are more binary achievements.

So things like (Rio) or (Shiny) connectivity or (PCMH) recognitions, those are sort of binary and may happen all at once for a large group of providers

because they all, you know, participate in one group practice or something like that.

Earlier in, you know, maybe two months ago when the implementation plan first came out, we were given the guidance that weren't allowed to put, you know, continuous quarters of zeros for provider level commitments. Is that still the guidance even for the things that, you know, it is possible that 100 doctors or (PCPs) would come online at once for (Rio) connectivity or (PCMH) certification?

(Michael): Yes. This is (Michael) from (PCG).

Yes, you can – your understanding of the guidance is correct which is why we instituted the idea of work steps and sub-steps within each milestone. So a (PPS) can, and we understand can wait until a certain point of (for your) time to make all the medical villages turn their lights on all at the same time.

However, the work steps associated with those part of requirements must demonstrate a logical and appropriate fast forward in terms of meeting those requirements.

[Crosstalk]

DSRIP TEAM: If appropriate based on the approach to (PPS) is taking to meet a specific project requirement.

DSRIP TEAM: Can you repeat that last part? Sorry, you sort of faded in and out.

DSRIP TEAM: So you can put zeros in your ramp-up if you are implementing the type of approach that you described to meet a specific project requirement. But at the end of the day if that particular project requirement has a time frame required for a completion it is expected that the entire ramp-up will be completed in accordance with those time frame and consistent with your commitments in speed and scale.

DSRIP TEAM: OK. Thank you.

DSRIP TEAM: Thanks very much. Next up?

Operator: Your next question come s from the line of (Tom Manion). Your line is now open.

(Amie Vankapen): Hi. It's (Amie Vankapen) again from the Mohawk Valley (KPS). This is just sort of to re-clarify the question on in on-hold versus in-process versus completed. I had also post this question prior to (PCG) and I was told that actually not started will be added as of status.

So, first I want to ask is that in fact the plan? And second, if we want to make – if we want to get all our days from the system now unlike Westchester, can we go ahead and enter a future dates and put the process and is not yet or as in process even though we haven't started yet so we can at least get that timeline in there. Is that acceptable?

DSRIP TEAM: So not started, we are aware of this defect and we are working on it. There is not a planned release for the status at this current period in time. And yes, as you would like to use in progress to then delineate sort of future activities through the start and end dates, you can do so.

(Amie Vankapen): Great. Thank you.

DSRIP TEAM: Next up?

Operator: Your next question comes from the (Wilver Yen). Your line is now open.

(Wilver Yen): Hi. I just the same question about the status with not start. I also heard that not yet started was going to be an option but sounds like it's not, so thank you.

DSRIP TEAM: Thank you. Next question.

Operator: Your next question comes from the line of (Michelle Mercery). Your line is now open.

(Michelle Mercery): OK, hi. Hi. I have a question about the patient engagement module of the map tools. I noticed that there is an option two attached or uploaded document but I don't understand what document would need to be attached

there. And I also wasn't able to tell whether that was mandatory or just optional?

DSRIP TEAM: So the patient engagement speed module in map just like every other module has the ability for a (PPS) to upload or to (hyphen) the narrative or upload any document.

The expectation specific to patient engagement is that if necessary you would provide documentation to attest to or sort of as evidence by for hitting a certain patient engagement. And that will come into play much more in future quarter.

(Michelle Mercery): What are those requirements? I don't think we've ever had any description or explanation of what exactly we have to provide to prove that we have met those targets?

(Michael): So this is (Michael) from (PCG). So, indeed (inaudible) more technical guidance will be put forward around the types of reports, the template of how the patient engagement achievement will be demonstrated by the (PPS).

Actually each project has an (acumen) engaged definition into how you have selected which patients will be from your attribute population would be in impacted or served by the project you are selecting. And then…and also each project as part of requirement that the (PPS) have established the (EHR) or some type of IT platforms to track patient's engaged in the project so that's kind of the two pieces that will go into the template or the format that the independent assessor will develop in terms of you are inputting information, uploading information that is to demonstrate that you have hit a thousand of your 5,000 targeted patients by in a certain quarter.

(Michelle Mercery): So those attachments will be mandatory?

(Michael): It will be mandatory to provide evidence demonstrating the engaged patient based off from the definition that were provided previously in the project application.

DSRIP TEAM: So, on this call, there had been a number of things so far where you have told us that there will be guidance come – forthcoming like a decision on uploads and these file formats, and some other things. Do you have a timeline of when we can expect this between now and the next quarterly report so that we can be in a good position to modify our process?

DSRIP TEAM: In term s of patient engagement speed and a lot of I would say, in terms of, you know, for every single organizational milestone as well as project requirements, we did articulate data sources or the types of activities that we would want to see to demonstrate that (PPS) has have successfully completed those particular requirements.

So we have been working, the independent assessor team has been working to develop somewhat minimum standards in terms of what those requirements look like as well as we are – some of the requirements or milestones with, like, copies of meeting minutes and agendas where we have articulated before, we do not want PPS assess to upload every single minutes, documents, from the various meetings that they have.

So, the expectation is, you know, no later than mid-August to have that clarification out to all PPSs.

DSRIP TEAM: OK. So, that is a bit of a concern because it kind of puts us in the same position we are in now. And the other, again, it just, again, I just want to ask again, do you know – have a timeline for when these kinds of decisions might come out overall for things like technical functionality in the map and changes to the process?

DSRIP TEAM: Can you be more specific on the technical changes to map? I mean, I do not think we are – there were some folks that…

[crosstalk]

DSRIP TEAM: I will give you a simple example. If we had a template – it has been brought up already – if we had a template that we could fill out in Excel and then upload, it would make our whole process much different, including on boarding staff and allocating resources.

We are concern about waiting about sometime in mid-August for that. We really like a timeline for when this might be addressed more currently.

DSRIP TEAM: So, that is a recommendation for modification to the tool. So, we are taking that back and we are going to circle back with (CMA) and look into it.

DSRIP TEAM: But right now, we are not planning the functionality is going to be available anytime soon to complete the reports that are out, that are required for completion by 7/31.

DSRIP TEAM: No. We have got many, many, many quarters and (disrupts), so, you know, we can optimize this going forward and, you know, recognize that we will – map will continue to evolve based on your feedback, and we appreciate it. We appreciate your patients for the pieces of this that are not optimal right now.

DSRIP TEAM: All right. Next up?

Operator: Your next question comes from the line of (Joel Mantel). (Joel Mantel), your line is now open.

DSRIP TEAM: Hi. This is (Alyssa), again. I just had a point of, for future reference. It was mentioned earlier that for task that we would be able to put on hold on a project plan, the project side of things, not the (orc) side, that there would be an opportunity to write in a description that that particular task is on hold and why. But there is not an option for a narrative or a description on task on the project side.

So, maybe, in the future, you want to consider that anticipating that some of our task that we put in for July 31st may become on hold.

DSRIP TEAM: Right. So, throughout the application, organizational or project side, any information detailed that needs to be clarified in a narrative or with uploading documents regarding tasks, should be communicated at the milestone level.

The narratives and the upload functionality exist at the milestone level.

DSRIP TEAM: OK. And then the other piece around patient engagement, I also wanted to highlight, there has been a lot of planning on our part in regards to taking with this state has given us the DOH patient engagement definition and turning into something that we can operationalize it based on the many different partners that we are looking to engage in the project.

And providing technical guidance, mid-August, I think we will wind up probably kind of throwing it for a loop in term so of all the planning that has to go into this. So, if there is any way that (PCG) or (KPMG) can at least begin to consider answering our questions around patient engagement in a more timely fashion, it will be helpful for us so that we do not put ourselves in a position to get technical guidance mid-August, which kind of deters what we are organizing today.

DSRIP TEAM: I think that is a great suggestion. We will take it back and we will see what we can expedite. Thank you very much.

Operator: Your next questions comes from the line of (Joan Child). Your line is open.

(Joan Child): Hi. This is (Joan Child) from Montefiere Hudson Valley Collaborative. I have a question around the comments from our independent assessor in relation to the example for the workforce strategy section that was given out on the project informed patient (friend) reporting document.

There are nine steps that are listed there, and as I look at the comments from my independent assessor, I think he would actually like (advert) similar comments to these nine steps that were listed. And I am just trying to understand which I should give more weight to; the comments from our independent assessor or the nine-step example in the workforce section under the detailed gap analysis?

DSRIP TEAM: I would give more weight to the example in the presentation.

(Joan Child): So the example in the presentation? Thank you.

DSRIP TEAM: Yes.

(Joan Child): The other question I have around that has to do with the dates in the examples as well. They take us out on the detailed gap analysis to (DYQQ3), so that would be the end of December 2016. Does that appear in the line with – does that timing in alignment with your perspective?

DSRIP TEAM: If those dates were put there to be (illustrated) and not prescribed, but those dates were…

(Joan Child): It would be acceptable if we had those dates come out.

DSRIP TEAM: As long as they were consistent with your prior commitments, potentially, yes.

(Joan Child): OK. And then secondly – and then the other piece is something was said earlier about workforce not being in currently existing in the map tool. So, are our modification to our implementation plan for workforce, are they still due July 31st?

DSRIP TEAM: No. So, the workforce section will become available in map in quarter two and require with a quarter three submission. So, any (re-opts) that needs to be done based of a (VAC) feedback should be incorporated within quarter two or quarter three report submission.

(Joan Child): Great. Thank you very much. Oh, I think we have another question. No? OK. Thank you.

DSRIP TEAM: Thanks so much. Next question?

Operator: Your next question comes from the line of (Lauren Waterhorn). Your line is open.

(Lauren Waterhorn): Hi. Sorry to be a repeat-question-asker. I will try to keep this really brief. So, the quarterly report submission has an associated (AV). So, if we submit our quarterly report but accidentally skip a section and, for whatever reason, we are not alerted to that fact by the map's tools and internal edit checks, will we have the opportunity to fix that mistake before imperiling the associated achievement value?

DSRIP TEAM: Right. So, if you, in general, are leaving a section blank or any sort of task box blank, the report – the application itself should, will prevent you from submitting the report at the point of your PPS lead attesting and submitting.

However, if something still goes through that sort of has (junk state over) is blank, then we do have the – after the 30 days of IA review, the PPS does have 15 days for remediation of that report if further information does need to be included or something was accidentally admitted.

(Lauren Waterhorn): OK. Thank you for that. And this is – this may not be high priority, given the fact that you have all of these request on the map tool, but back on June 1st or prior to that, I think it might have been the IA, they gave us a check list for thinking about sections that needed to be completed.

Is there any chance that you guys are going to issue anything like that for us just to make sure in the next two weeks that we are hitting every element that needs to be reported?

DSRIP TEAM: The IA, I do not believe issued a check list, at least that we are aware of. It may have been done by the, you know, support team.

DSRIP TEAM: But it was really, it just issued to make sure that you address the things that needed to be completed. It was just, really, that kind of tool for yourself. But other than that, I think as of (Fed) earlier, basically, everything needs to be completed.

DSRIP TEAM: Yes. And the system will remind you of that. Of course, you try to make your report.

DSRIP TEAM: Right. Next question?

Operator: Your next question comes from the line of (Kerry Olman). Your line is open.

DSRIP TEAM: Again, this is (Karin for Lloreal). I will make this one quick. My question is with regards to speed commitments and how to handle it when the dates do not align with the required timeframe to meet the specific milestone that is part of that project?

So, if we had made a speed commitment, I understand that if we have made a speed commitment overall that is later in time, then the point where a specific milestone has been defined by DOH as being required, that we are still (held) the meeting that one milestone at that earlier date. But in this – but how do we handle it the other way around?

If we have made a speed commitment for a project that says, we will meet all requirements at a point in time that precedes a mandated timeline from one of those requirements, can we still, for that one milestone, build towards that later date?

DSRIP TEAM: Yes. Well, a whole lot. So, if – but you were locked in to your commitment in (speeding scale), that is what trumps everything; regardless if there are prescribed milestones that may be occurred at a later time.

DSRIP TEAM: So, if the speeding scale commitment that we made preceded that that applies to that, to every single milestone, including ones that may have been…

DSRIP TEAM: Yes.

DSRIP TEAM: OK. Got it. Thank you.

DSRIP TEAM: Thank you. Next up?

Operator: Your next question comes from…

DSRIP TEAM: Only a couple more left on this (stop).

Operator: Certainly. Your next question comes (Michael Gaddle). Your line is now open.

(Michael Gaddle): What should we have as relative to (2DI) patient activation? And just for clarification purposes here, that in terms of activating our patients, administering the PAM, scoring them, and of course, then engaging the patient into primary care community care services and the like, the follow up and the reassessment of these patients in terms of reporting and the like, do I understand it that it is not necessary to report on a (re-PAM)?

But in terms of overall activation, as part of the overall performance, we can just simply report where we believe that patient is within our system a year, two years, three years down the road?

DSRIP TEAM: Hi, Michael, this is (Betty). No, I think, you know, as we, as according to the CMS and to the (2DI) description, what we are really looking is that there is an ongoing engagement with these patients.

And you know, when the PAM, when the Patient Activation Measure assessment is done, it is actually (voted) into a database. You are doing it on the insignia tool; it is automatically scoring, it is (voted) into your database, as well as the large insignia database.

That is the information that we will be using for measurement, and we will be looking for that measurement over time, (one to two accordingly). We will be looking at these, you know, what we have to report to CMS, is again, that level of engagement and that change in activation score.

So, this is not sort of a one-time outreach by any means. It is – this is really about people, community health workers and such types of folks being out in the community and regularly working with the folks that they encounter and, yeah, helping them whether it is accessing services or talking about how you are doing on, you know, on the various sort of disease knowledge, other health behaviors and other connections to community health resources.

(Michael Gaddle): OK.

DSRIP TEAM: I will be working with you further. You know, we are in touch with the Greater New York Hospital Association. We realized, you know, we were all kind of parallel tracks when we were kind of align in our efforts to be all involved with all the PPSs working on (2DI), and we will discuss this further.

(Michael Gaddle): All right. Very good. Thank you.

DSRIP TEAM: Thank you. Next up?

Operator: And your last question comes from the line of (Rachel Mark). Your line is now open.

(Rachel Mark): Sorry about that. Unmute. So, just a functional question about adding tasks in the map. It appears that as you add multiple, it does a reverse, which means that if you start by entering your first sub task or task, it then adds above. Meaning, that when we went to add, it – our first task is now at the bottom of the list and our last is at the top.

Do you need to have that in the correct calendar order or would that be a feature or functionality that you would change in map?

DSRIP TEAM: As long as the start and end date of the activity reflect the correct chronological implementation of the activity, then you should be fine.

(Rachel Mark): So, some of them may – some task may start and end in overlapping manner. So, I am just trying to make sure that when the independent assessor looks at those, would it make sense for us to make sure they are represented down the list in chronological order, like with the one, two, three, four, five?

Base on – I am just trying to make sure that when the independent assessor looks at those, that they would not get confused if number nine is at the top of that list and one is at the bottom.

DSRIP TEAM: Right. So, I mean, that is definitely a great observation. If you would like to number your task within the name itself, that will sort of further clarify for the IA in which order you will be implementing the task.

The other suggestion is, potentially, if you do know how many tasks you will be adding in under the milestone, to just hit the plus button, you know, 10 times for 10 tasks, and then you will have all the 10 rows already there, and you will be able to sort of input all at once and save so they will – you can input as you would like to order them, you know.

But definitely, if you – if there, if they are already out of order and you just sort of enumerate them, that will assist the IA in review.

(Rachel Mark): OK.

DSRIP TEAM: But we will look at that as well for future functionality.

DSRIP TEAM: Very good. Well, thank you very much, everyone. That brings us to the end of the queue for that first topic.

So now, what we would like to do is encourage folks to raise their hands to ask questions about the next topic which is earning payments. I do not know if PCG or I figure anyone wants to – Greg wants to make any opening remarks while people are signing in.

DSRIP TEAM: Earning payments is good; not earnings payments is bad. And if you have any questions about either those two topics, we are happy to answer them.

DSRIP TEAM: That is our DSRIP humor for today. Thanks, Greg.

DSRIP TEAM: If there is no questions, we can come up with a top 10 list.

DSRIP TEAM: No question. No.

DSRIP TEAM: Well, it takes a while for them to – we will get folks a few minutes here to sort of jump in the queue.

All right, folks, we have two in the queue. So we have the queue, and let us get started with the first questionnaire.

Operator: Your first question comes from the line of (Rosanna Sasic). Your line is now open.

DSRIP TEAM: Yes, hi. This is Mark from the Care Compass Network. And we had a question in regards to the previous section where we talked about workforce being delayed until later this year.

We have multiple steps being completed earlier this year, and the question was: If it is not being reported till Q3, would workforce then not be considered as a (waited) factor for the payments based on Q1 and Q2 deliverables?

DSRIP TEAM: So you are basically indicating that there is a specific (AV) driving milestone for workforce and there is a specific requirement day for that completion but you guys have already completed that or will (stand) by the time the module will be open?

DSRIP TEAM: If the evaluation for that is not going to be until Q3, which is my understanding from the previous discussion, that the submission of workforce deliverables was not required until Q3.

If we had deliverables due in Q1 and Q2, would they be (waited) during the Q1, Q2 evaluation? I do not know if that could happen.

DSRIP TEAM: Well, their module will be open for the Q2 report. And I think what we have been trying to communicate, and probably not as clearly, is that the workforce impact analysis, they are looking at how many staff are going to be impacted in the various types of staff across the PPS would not going to be held in terms of the baseline numbers until the Q3 report.

The module itself, in its entirety, will be open. So, there is specific milestones in terms of analysis or documentation that the PPS has had to complete in Q2. We would expect those to be populated in the module.

DSRIP TEAM: In the module, it is due…

DSRIP TEAM: At the end of Q2.

DSRIP TEAM: October 31st.

DSRIP TEAM: Correct.

DSRIP TEAM: OK. So, it is Q2. OK.

DSRIP TEAM: Q2 for those things who are defined as Q2; the tables to really articulate the impact analysis, which is really, I think a lot of the angst from PPS is to be able to do that in a timely manner. Those tables and those modules are not going to be evaluated in a formal manner until the Q3 report.

DSRIP TEAM: And while we are on that topic, why do not we – I just say that, no, we know that you have been asking for standard definitions around, you know, what is, you know, rehiring, redeployment, et cetera, as well as some standardization around (jot) files, and that we are working on and hopefully you will get that in the next week or two.

DSRIP TEAM: Excellent. All right. Next question?

Operator: Your next question comes from the line of (Tom Minin). Your line is now open.

(Jeff Gruffle): Hi, this is (Von) of PPS, this is (Jeff Gruffle) speaking. Just a question regarding the determination of a dollar value for an achievement value of one. Is there (privacy) in that regard? Is there a number available as yet?

DSRIP TEAM: So one of the things that we committed to in the last PPS meeting was to develop a forestland example, and, yes, we have made progress in that; it is something that we have been working on extensively, and we are hoping to get that out soon.

But, again, that will be specific to forestland, not a particular PPS. Ultimately, at the end of the day, when official (AV) scorecards are provided to PPS, they will see both in terms of how they did in (AVs) and what the corresponding dollar amounts were for each (AV).

(Jeff Gruffle): Thank you.

DSRIP TEAM: All right. Next question?

Operator: And your next question comes from the line of (Quan Moo). Your line is now open.

(Quan Moo): Hi. Thanks for taking the question. Really, it is more towards evaluation, I guess, which also, of course, really, payments. Could you give a sense of the final (PMPM) that was used for valuation?

DSRIP TEAM: The benchmark (PMPM), you mean?

(Quan Moo): Yes. That is right.

[off mike]

DSRIP TEAM: Three dollars and twenty-six cents, somewhere in there. I will look it up while we are on the phone here. It is $3.20. And again, that is with the high performance taken out; the three percent reserve taken out.

DSRIP TEAM: But I think it is around ($3.25), correct?

DSRIP TEAM: Yes. I said (that I was out of penny off, Carlos). It is probably that penny you took out.

(Quan Moo): OK. Great. Thanks so much.

DSRIP TEAM: No problem.

Operator: There are no further questions at this time.

DSRIP TEAM: All right. So, maybe perhaps we can move on to the next agenda item which is data security. I know we have Carlos is on the line, Nice Tech is here. Are there any presentation or just open for questions once again?

DSRIP TEAM: I think open for questions.

DSRIP TEAM: OK. So, a couple of questions already: Two popped up on data security, three popped up. So, we have some interest on data security. So, let us bring on the first question.

Operator: And your first question comes from the line of (Michelle Murser). Your line is now open.

(Jaime Wono): Hi. This is actually (Jaime Wono) from Millennium Collaborative Care. My question is about consents and VAA – I am sorry, not consents. VAAs and relationships about flowing the map data. And I also have a question about kind of what is going to be available, but – so, if we have an existing VAA that shares health data with partners in the network, you know, for example, or

claims data, specifically through the network, I am still confused as to why we are not able to share data from the map with our partners.

It seems like it would be critical to some of our projects where we have to create registries for targeting patient intervention or to facilitate handoffs between providers as part of an integrated delivery system.

Can you speak to that a little bit?

DSRIP TEAM: Right.

DSRIP TEAM: Right. We agree with you that sharing the data, the information, (PHI) level information, downstream, downstream providers is vital to the success of the initiative. We are in 100 percent agreement.

That is why we have been working very hard to implement a state-wide (up sell) process so that we can give individual members information about (DSRIP), information about PPS assignment, what a PPS is, and then give them the opportunity to opts out of having their information shared.

If they do not opts out, then their information will be, or you will be allowed to share that information with the downstream partners. The issue is that just within the context of (HIPAA), and the requirements around, you know, that and secured – really, particularly about data sharing and particularly personal health information, we need to go through that process, and that is – I do not know if Greg, if there is anything more you want to add.

DSRIP TEAM: No. I think that is exactly it, and we are trying to, you know, fast track that opt out process as quickly as we can. I mean, if we did not do opts out, we would have to do opts in which would require individual member consents. So, we are speedily trying to get to those opts out.

In the meantime, you know, the lead PPS can utilize the data that we provide and can begin doing analysis on that data. On top of the requirements that we have about how to share that data, in the opt out, we do have the security requirements and we have, you know, a policy here that we do not want that data to be passed around without having to (factor) up allocation in a

completion of a security assessment, and that we have been, you know, pushing out a lot of information to you, folks, on security assessment in a two factor process.

We know that that presents some technological challenges, but it seems not a day goes by that we do not have, yet, another press story about personal information, health information or otherwise being compromised at some level.

And please recognize that for this, for us, this is, you know, now, you know, potentially the distribution of personal health information for millions of low income New Yorkers, and we take the protection of that very, very seriously.

And even though this is, you know, very burdensome, we will do everything in our power and your power to assure that that data is as secure as we can make it. So, and I know many of you have been concerned about that burden and we have been concern about it too.

But frankly, when you think about what we are going to have at the end of this, we are going to have the capability to administratively share without individual consent, information from a large network of providers down into all of the various partner agencies, simply to an opt out process, which is I think a fairly liberal way to pass a considerable amount of health information.

We are completely behind the (care) integration and the clinical improvement opportunities for that. But we have to be very cautious that we (inaudible) on both, following the confidentiality provisions that have been laid out by our counsel, and also making sure that we follow the security provisions as we have sent them to you.

We do not want to be in breach of either one of those things at any point in the enterprise, and we recognize that it is going to require some patients. And that until we get to the conclusion of the opt out process; you cannot optimally start implementing your projects. But we do think there is a lot of setup analysis that can be done by the lead and advance of that opt out concluding and in advance of you implementing two factor.

The other thing I will say is that we are building map capabilities that will be protected by two factor. So, for those of you that do not have the fast capability to share this (PSI) data among network partners, we are working really fast on building capabilities and map so that map can be the two-factor solution for you.

And again, it will not be optimal in terms of fully integrating claims and encounter data with health record data, et cetera, but it will offer, at least a, you know, crawl-walk-run solution here in terms of getting your network members access to that (PHI) behind the state implemented to factor firewall.

So, we are recognizing the difficulty that you might be, and some of you in implementing that, by trying to build that capability centrally at the state level.

(Jaime Wono): So, if I am already accessing this Medicaid claims data of the state, provided to factor up (indication) through (CMA) and (inaudible), I already have access to that. What I just need is the mapping between our attributed members and (CIN) so that I can enter those (CIN) of the key.

I guess I do not know. We still do not know how big the data extract is going to be, so it is difficult for us to prepare our infrastructure here to receive it on the 21st. There is just still a lot of unknowns in preparing to get that data and meet the achievement target that we are, you know, being held to.

DSRIP TEAM: Yes. So we can take back, if you request these on file size, I think you have got file structure information, your request is on file size, we can take that back, try to get it out through PPS.

(Jaime Wono): Because we got two different pieces of information about file structure as well: One states that there is no PA – there is no actual contact info; and the other is much more liberal, the former being a formal data dictionary.

So, we would appreciate some clarification on that as well.

DSRIP TEAM: Well, there are also just – remember, there is two files that we are sending: One is a roster file, which is a much more simplified patient, patient ID, and some demographics and contact; and then the other is a much more

detailed claims extract file which has, you know, service information, provider information, volume information, et cetera, in it.

So, there is two very different specifications out there for two very different files.

(Jaime Wono): OK. Thank you.

DSRIP TEAM: Yes.

DSRIP TEAM: Next up?

Operator: Your next question comes from the line of (Janet King). Your line is now open.

DSRIP TEAM: Hi. This is Joey from (Flex) in Rochester, New York. A question around – we had some; I guess it was not clear where unencrypted map data can reside. There were some language in the work, in the webinar around (new Co.) and leading the organizations. I just want to make sure we were clear on where it can reside.

DSRIP TEAM: This is an encrypted at rest question.

(Rob Zeglan): Yes. Hi. This is (Rob Zeglan), one of the security consultants on the project. When the data is received initially for the – and the (DA) addendum before the security assessment is done, and you have these other capabilities pull in to place, it is – there is tight restrictions on it to keep it secure, and those were, that it reside, you know, in one building on a truly local area network, basically no remote access, but it is within that single land, you know, tightly defined land within a building and it is on a secure server that is stored, encrypted at rest.

That is so…

[crosstalk]

DSRIP TEAM: So it needs to be on premise?

(Rob Zeglan): On premise, right. And folks can come in and work there and use it, but you cannot, you know, get copies of it, they cannot take it away; it needs to reside there in that initial release until you have done your secure, your identity assurance assessment that prescribes how you are going to share it out to your partners or what the application roles are like, et cetera.

After you do that assessment, it will come out to what assurance (level) you need to be at, and that will dictate, you know, do you need (multi factor) of indication or not.

So, you know, in some cases, if you are just giving, you know, analytical views and not actually seeing the actual (PHI), if that is how you are sharing, you are allowing access to it, you might not need two factor.

If in fact the end users see lots of personal health records, could copy them, that jumps up into assurance level three where the two factors are required.

DSRIP TEAM: OK. Thank you.

DSRIP TEAM: Thank you very much.

Operator: Your next question comes from the line of (Tutandra VarMicha). Your line is now open.

(Tutandra VarMicha): Hi. Good afternoon. I have one comment and two questions. So, my first comment is, it had been over three years (Bronx) receive the (CMA) grant to create (Bronx reason) of informatics center. And as a result, we have created a (Bronx reasonable) analytics data warehouse.

So, in our implementation plan into the planning phases, we were thinking that the (Bronx) view will be our master data management in analytics (vendor), and we have accordingly put them in, as a (vendor) in our (PPSDA) and complying with all the (DUS) specific security requirements.

Now, reading the FAQs, I understand the (Bronx) view can be our vendor, but during the call, we were informed that (Rio) at the moment cannot be a receiver of the Medicaid data as such until December.

So, I needed some clarification on my question number one.

DSRIP TEAM: I think where you are going is initially, that data can only be received by that PPS until we have completed the opt out period and then we have, you have done the security assessment. And we know that even the (RHIOs) are going to have some upgrading to do on access standards to meet the state access standards here.

So, but, yeah, we cannot share data outside of the lead PPS corporate structure until such time as the opt-out is completed.

(Tutandra VarMicha): Understood. My second question is, when does Medicaid data answers Medicaid data? For example, with all (malefactors authenticates) process and (active TV) protocol is completed, the derivative of Medicaid data becomes (answered) Medicaid data or they are PPS data?

So, in terms of, for instance, cleaning and documentation, where does Medicaid data answers Medicaid data?

DSRIP TEAM: We are having trouble understanding the question. Can you repeat it for us, please?

(Tutandra VarMicha): So, my question is, suppose, with all the security requirements and (SFTP) process, we receive Medicaid data on our encrypted address data servers, or service data base.

Suppose we do that, even the conclusion to our (sequel) query on those member roster or claims file, when does Medicaid data becomes as Medicaid data, or answers Medicaid data? Does that derivative also needs to go through the same (forensic) cleansing and documentation after…?

[crosstalk]

DSRIP TEAM: Yes. I mean, there is – (HIPAA) has, you know, I think there is 21 or so key fields to make it (PHI). If the, you know, analysis you have done in the extraction is basically been identified and is not (PHI), then it would not –

these requirements would not hold it. It remains (PHI) and it, you know, then it would need to be protected as we described.

DSRIP TEAM: And we use the (HIPAA) standard for re-identification to whether or not it is (PHI) or not (PHI).

DSRIP TEAM: Yes. The security rule has pretty specific guidance on how to re-identify those two methods. There is a safe harbor method and then there is a status (position) can determine that.

We can share those requirements with you. If you go to (CMS) slide on the privacy or on the security rule, they are right in there.

(Tutandra VarMicha): OK. Thank you.

Operator: And your next question comes from the line of (Kelly Oland). Your line is now open.

DSRIP TEAM: Hi. This is Bob calling in (AHI). A couple of questions: The data that is going to be scheduled fully from the 21st, if we opt not to receive that data on the 21st, can I assume that it will be available up until when the opting process is completed?

And then the second question would be, I understand the restrictions about distribution of this set of data after the opt – I am sorry, opt out. So I think I might have said opt in before – opt out. After the opt out process has been completed and you start to stream additional data to us, will that data, will be have liberty, assuming we have gone through the idea assurance assessment, the appropriate (DAAs), (VAAs), and so forth, will we be able to share that data with a vendor who can combine it with other data sources?

DSRIP TEAM: So, on the first question, which is the easier one, we will provide you with those files when you are ready to receive them.

DSRIP TEAM: Upon request.

DSRIP TEAM: Upon request, and right up to, and including after the opt out period. You know, we have to work out the technical aspects of, you know, putting them

in your secure location, et cetera. But, yeah, from a policy perspective, we are wide open to giving it to you when you are ready.

And that second question about, there is always – I just want to unpack it a little bit because I think there are a couple of questions in there. I think one piece was, OK, we have now completed our security assessment, we have said that we have the right kinds of security on top of the database and how we are going to transmit that data.

And now we have got new data coming in, which let us just call it an update to the data that existed before. So the first question I heard was, is that security assessment that we just did durable for the updates that may happen? That was question number one.

And our security guys are nodding yes, and saying it is durable. Is there reassessment that is required?

DSRIP TEAM: The assessment is on your application and how it is sharing the data, and what kind of roles usually would have and what types of data they would see. So, the assessment would stand until you have changed the application on how you are sharing it.

DSRIP TEAM: OK. OK. So, until you change, for instance, a downstream news pattern or a capability, or you go to (PHI) and – OK. So, it is durable; unless something significant changes, was the answer to the first question.

The second part of the question, I heard you say is, if I am now going to bring this data in and integrate it with some additional data, right? And the one that everyone has been talking about, is taking our claims and then counter extract, and marrying it to medical record data, (EHR) data, et cetera, and maybe having a vendor in flow to do that.

I want to make a couple of statements and just check it: And number one, I think that each data has to be tagged with the consents that were generated for the originating data, right? So we have got…

[Crosstalk]

DSRIP TEAM: These are opted out. Yes.

DSRIP TEAM: Right. So, for the (DSRIP) data, we have got a whole set of patients that were opted in for a network that was approve for (DSRIP), right? And we can retain that as the permissions on your medical record data.

Let us say it came in from (Rio) and you had a set of tags on it for which providers could see that clinical data, you have maintain those tags, I guess, in that integrated data set. So you knew not to push out data for which you did not have the proper permissions to the whole network.

And so far these guys are nodding yes to everything I am saying. Is there anything else to say on that in that regard?

DSRIP TEAM: I think just the other piece was, and this is probably obvious, but just to be sure, that if you get new updates, you got to keep removing the patients' records to opt it out. So, like, every time you get a refresh, you got to kind of keep it separate.

If you start to mangle everything in databases, that becomes very difficult. So, you want to put some thought ahead of time knowing you have to clean out those records for the ones that opt it out so they do not incidentally share it out.

DSRIP TEAM: And I will just say this, many of the – in the (CIO) work that we have been doing, the (CIO) has been coming to us and saying that cataloging a permissions is very complicated, and it is something that the PPSs feel, some of them anyway, would be better as a state-wide service.

And so, we are looking at developing a map capability as part of our master data management strategy that we are pursuing already, to create an integrated flow of data. And we are going to work with a couple of (RHIOs) to pilot test an idea of how to integrate the (EHR) data that is going in through the (Rio) with the claims in (carrier) data and create that permissions lagging as a business product that we could share with the PPSs.

DSRIP TEAM: Thank you.

DSRIP TEAM: OK. Next up?

Operator: Next question comes from the line of (John Deondisol). Your line is now open.

(John Deondisol): Hi. Good afternoon, everyone. (John Deondisol) with (ACP). There is a lot of guidance out there regarding sharing data with providers and limiting that (inaudible) to complete. So, is there any guidance on the (staff) members directly so we have them engage with the primary care physician just to start the process?

DSRIP TEAM: Right. I mean, I do not think there is anything to prevent you from doing the full regular (HIPAA) consent process here, and engaging members, and getting them to consent the services, et cetera, if that is what you were basically…

[crosstalk]

(John Deondisol): Are you suggesting that the PPS lead would use the data that we make available to them to do patient outreach? Is that what you are suggesting?

DSRIP TEAM: Correct.

DSRIP TEAM: Yes. I think the one issue there is that I think we would caution doing that in advance of the opt-out period. And again, we have had a dialogue internally about this, and then it landed in a position. But just to share with you the concern that has been raised in the policy side is.

If the member has (assertively) not gotten the ability yet to opt out of information sharing, and we give you a file and you use that to outreach to them and offer (DSRIP) services in advance of an assertive effort to have them opt out, we could get (bull) back from them on what is this and why are you using my data in this fashion.

So, while we have not locked on a position yet, our developing opinion here, and Jason can make a ruling right now, is that we are discouraging that

specific level of outreach, but we are encouraging the development of an outreach strategy looking at the data that is available so that you could begin to do some hot spotting; figure out where your highest risk members are, develop indexes of those that you want to outreach to first so that when we conclude the opt out period, you are ready go live with that kind of outreach.

DSRIP TEAM: Right. And what I would also say from patient outreach standpoint, for instance, let us say you have primary care providers, new primary care network who have patients that are assigned to them for PCP purposes. I mean, the (southern stop) those PCP offices from, as they do with normal part of their work, to do outreach to those patients, especially in their (EHRs) or whatever, they have got, you know they are detecting that there are issues around, you know, they have not been in for regular appointments or they do not seemed to be engaged.

I mean, I think there is nothing that stops your network from beginning to work with the provider, or work with the patients that are already serving. And I think particularly around the PCP relationship where you have an assigned, you are the assigned PCP for individual, obviously, then in that environment, there is an existing clinical relationship which I think can be leveraged to actually begin the outreach process.

I think the concern Greg raises is that if you use specifically the data that is given to you through this process, our concern sort of gets into something of a gray area in law, is whether or not you, as a centralized entity, can use that exact data to go out and do outreach.

And our fear is, is that you could end up, or you could end up in some (castigation) because you may have used information prior to somebody actually having – somebody back – somebody on the (ACP), we could hear you.

So, that is I think where – that is where we are coming down, is I think at the end of the day, you know, use your network; use existing clinical relationships, and we discourage you from using the actual data to say, you know, do mailings or to do outreach until we completed the (up sell).

(John Deondisol): OK. That is helpful. Thank you.

Operator: And your next question comes from the line of (Irene Cohort). Your line is now open.

(Irene Cohort): Hi. This is (Irene Cohort) on PPS again. So I have two questions on what has already been discussed, and I think I need more clarification. So, the first question is around patient consent.

You know, I think you touched upon recently with one of your answers that there are two sort of separate stage in the patient consent. Right now, you are doing the opt out, which is the part of the PPS situation, and then the other one seems to be on the PPS responsibility side when, you know, we are sort of using care management under or such, or the (Rio) to sort of send information from one provider to the next.

Can you just clarify that because it was not that clear? I know that one of our concerns is, you know, patient can send on that end, can she? Because it is not like they know what providers are part of a PPS. So, they might go to hospital A and say, no, and then the next day, they may go to, like, a clinic in the community and say, yes.

And so, and reason this is critical for is, is that the independent assessor ask for more detail on data security milestone under the (IT) processes and workflow. So, I just, I guess, if you could provide a clarity on that, that would be great, and I can ask my next question after that.

DSRIP TEAM: So, on the – so there are two forms of consent: One is the (up sell) process that the state will run specifically around the sharing of Medicaid data or Medicaid information by the PPS (link) with their downstream partners. That is a process that we will run; we will mail out six million plus letters over a period of several months. The idea being that we will have completed (that process) by the end of the year.

At that point, you will know from which members you could share information from downstream partners.

The second piece of information sharing, which is also essential, but it is something that is governed by existing state law and regulation, is this process of, in which individuals agree to have their patient records shared amongst providers that see them and have that information available for sharing on an as needed basis amongst providers, you know, that serve them in common.

So, that is a separate process. That is an opt-in process.

(Irene Cohort): And that is the real process, just to be really clear.

DSRIP TEAM: Right. Right. And it is the real process that continues to be the case. And we know there are challenges associated with that process, and it is (inaudible) an opt in process that does put a burden on the PPSs to work with the (RHIOs), to work with their network or providers to raise awareness among patients above the value of information sharing and to use any and all opportunities to get patients to agree to opt in for that data sharing.

We continue to be interested in doing whatever we can on our end to assist in that regard, but I think that PPSs should be having conversations with the (RHIOs) as well as their networks, and speaking creatively around strategies to raise awareness.

You know, there is that approach in Western New York, I think in Buffalo, where there is like a single consent…

DSRIP TEAM: A multiparty consent.

DSRIP TEAM: It is a multiparty consent form, that I think it is an interesting model that could be essentially be replicated in other areas. But I think it is one of those things where, I know it is a challenge, but I think we collectively, state-wide, have a strong interest in trying to raise awareness to the benefits of health information sharing amongst providers.

DSRIP TEAM: And that we have, you know, now we have got two outlets where we are already at this state have authorized a, basically, a multiparty consent vehicle. One is the opt out process and (DSRIP) which triggers the administrative

transaction: A.) Between the state and the PPS; and B.) Between the PPS and the network partners.

So, that is big, right? And then the second one is health home where a single assertive patient opt in signature triggers information sharing among the care management network.

And as David mentioned, we wanted to get the (RHIOs) to the place where they have all implemented multiparty consent so that this aligns on the administrative transactions at the top of the (trees), and also all the underlying clinical transactions as much as we can.

But until we get to that multiparty consent, a lot of the (RHIOs) are one click at a time; add one provider. But some of them do have list capabilities where you can go down and click an entire list. But we are working with them to try and develop, you know, more multiparty consent.

(Irene Cohort): OK. Thank you. The second question is a little separate from patient consent. It has to do, and I think you have kind of touched on it already, but I will just reiterate – reask the question with more detail.

So, you guys mentioned that, you know, the new (poll) were not – (RPS) is a new (call) and one of the concerns that we had after the data security webinar was about where that information should reside after, you know, it is received, and we have not had that security (as of today) created.

So, there was, in FAQ, there was sort of, it mentioned that there would be more updates on amendments to the (DEAA) for situation with (new Co.). I mean, what is the status with that and it provides, you know, it is a little difficult right now because we are trying to plan, OK, were is this data going to reside, and we want to make sure that we plan accordingly.

It is an investment to make sure that we have the right servers, or if it is not in our location, which is not necessarily at any other (colleague) location, that is OK for us to have it there.

DSRIP TEAM: So, maybe I can take a shot at this one. Irene, the guidance that will be sent out was sent out is particularly for NewCo receiving DOH Medicaid data. Since most NewCo are not physical entities with a physical location, the NewCo leads have to decide between the NewCo partners where they will store the data basically. The NewCo guidance/document that will be sent out will allow the PPS to formally designate one of the Co-Lead NewCo partners as the recipient of DOH Medicaid Data.

When the Co-Lead chooses the partner that will be the recipient of DOH Medicaid data, the gatekeeper and the two (IT status) users should come from that one designated NewCo lead partner.

Those are the basics for the information now. Should you need more than that?

(Irene Cohort): Right. But, yeah, OK. That is a little bit more – you are cutting off a little. Sorry. In terms of the – there was mention of amendments coming down for (new Co.) and I was just wondering what the status of that is.

It was mentioned in the FAQs for the data security webinar.

[off mike]

DSRIP TEAM: You are right. So the amendments are in draft. I mean, hope to have something out next week. And just to be clear Carlos' point, which is a great clarification for (new Co.).

The thing is, is that a new (new Co.), if the (new Co.) itself is not in a position, you know, since they are new corporations, they are not often in certain situations where they have the existing infrastructure to host the data, that the option for them is to pick amongst their, you know, sort of owners or the lead organizations within the (new Co.) to pick one of those to be the host for this information, and then that host has to meet the other requirements in order to be (useful).

[crosstalk]

(Irene Cohort): Right. OK. But if we have servers available in our location and a (new Co.) location, and that is not (inaudible) yet. So the (new Co.) location, and that should be the sufficient, provided that we, you know, fulfill those requirements of security (inaudible).

DSRIP TEAM: Yes. I mean, as long as the, as long as the location meets the security standards, then there is no problem with the (new Co.) being the host.

(Irene Cohort): OK. I think that is a clearer point. Thank you.

DSRIP TEAM: You are correct.

(Irene Cohort): Yes.

DSRIP TEAM: Next up?

Operator: Your next question comes from the line of (Janet King). Your line is now open.

DSRIP TEAM: OK. We have a short list of questions that are related. The first is, is patient demographic data that is collected via (PAM), so insignia's database, considered (PHI)?

DSRIP TEAM: Yes. You have got patient name, (RND), right?

DSRIP TEAM: Yes. So the answer is yes it is.

DSRIP TEAM: And so, if we need consent, is there a universal consent measure in place for providers, for PPS providers that we can use in administering the (PAM)?

DSRIP TEAM: A little consent? Just give us why you are collecting the consent? If one, or assuming one of the PPS partners administers the (PAM) and they have received the list of (PAM) members post opt out, as the administrative transaction governed by the (DEA) and the (VA), are you – why would you need patient consent?

Are you talking about sharing (PAM) results or to administer the (PAM)?

DSRIP TEAM: Yes. This is (inaudible) talking. If we have to share this information, we have to – with across multiple providers. Because it identifies them, it is when you feel that unethical that we inform the patients that we are sharing this data. So, we have to collect that consent. And remember, this is for both Medicaid and uninsured individuals which will not be covered in that out process.

So, can you comment some stuff…?

DSRIP TEAM: Yes. Sure. So, your question is, are you – not the administering, because he asked about administering the (PAM), but you are talking about you have administered the (PAM), you did not need a consent to do that, but while you are…

DSRIP TEAM: No, no, we do.

DSRIP TEAM: You do.

DSRIP TEAM: We are saying that before we could even interrupt with this person to collect their demographic data, we need to inform them through the process of consent that their information could potentially be viewed by providers, even outside of those that they are currently being seen as.

[crosstalk]

DSRIP TEAM: Right. But…

DSRIP TEAM: Go ahead.

DSRIP TEAM: Yes. I mean, but the reason for the consent, I just want to be clear here, is the reason for the consent is so that you could share the data after you administered the (PAM), right?

DSRIP TEAM: Yes.

DSRIP TEAM: That is what the consent – OK.

DSRIP TEAM: And it is also, it (inherits) consent around we want to be engaged with you, you are now willing to be engaged with us.

DSRIP TEAM: Yes.

DSRIP TEAM: Yes.

DSRIP TEAM: And the language that we have done in the (DSRIP) opt out, I think, could be leveraged in the consent. But is your question, do we agree with you, you would need a consent to share that data, especially for the uninsured, if that is the question, then I would say, yes, we agree.

DSRIP TEAM: Actually, the question is more whether the state would provide any guidance as to the specificity of that language. So, if you guys already have some level of universal consent language that we can use for this.

DSRIP TEAM: Fair enough. Why do not we – we could take our opt-out language, which references the benefits of (DSRIP) and turn it into something that could be utilized for the (PAM) consent.

DSRIP TEAM: Well, especially since the – it is optimizing with the health homes as well. I know there is a lot of work done on those consent.

DSRIP TEAM: Yes.

DSRIP TEAM: Yes. Yes. We will try to pull those two things together.

DSRIP TEAM: OK. Thank you very much.

DSRIP TEAM: On a related note, how is – what is the recommendation in handling (PAM) data for patients who are receiving chemical dependent services or adolescent services like (PAM) parenthood?

DSRIP TEAM: So, your suggestion, your excellent suggestion for us to utilize the heath home consent would help us address the 42 CFR requirements around substance abuse information.

You know, the separate issue that you might be asking on minor consent, we have to take back, but state law pretty much requires parental notification and

consent before services could be delivered. So, we will put that one on this list too.

DSRIP TEAM: OK.

DSRIP TEAM: And where that one is (teed) up right now in the kids' health home. So, sort of good time for us to think about it. But basically, it would require parental consent if services are to be provided.

[off mike]

DSRIP TEAM: What was the question?

DSRIP TEAM: We just wanted to – thank you very much for providing us with that language. We just wanted to get an idea of timeline when we might be able to anticipate some of that language just as ourselves and probably many other PPSs are currently or about to rule out (PAM) implementation.

Is there – do you think you would be able to give us some indication of when we can expect this language from you?

DSRIP TEAM: Yes, I would look at – so, Cindy, I would think that we would want to address this as with some – with other stakeholders to. So, why do not we give ourselves a month and then also perhaps a little bit, you know, working through the (2DI) workgroup.

DSRIP TEAM: OK. Thank you so very much, Peggy.

DSRIP TEAM: Last question, not related to (PAM), but it is back with, I guess, the housing of map data. So, if we were to have a kind of a posted solution that maps, you know, identity assures that we set, we use in getting assessed by identity assurance, would that be an acceptable location?

DSRIP TEAM: Yes, absolutely. Many of the Cloud providers are quite sophisticated with these capabilities. And often, it is economically feasible to have them do it for you; they can do it at lower cost sometimes. But, yeah, as long as they can meet the same requirements and the reference, state policies, and standards

around identity assurance; how they do the identity proofing, how they provision the (tokens) and the data being encrypted, yes.

The encryption at rest, you want to look. That is kind of a high bar, but there are Cloud providers that do it. There is a federal standard called FedRAMP, you want to look for a lot adherence to that, the Cloud providers who are at that level can typically provide that level of security.

DSRIP TEAM: Did you say FedRAMP?

DSRIP TEAM: FedRAMP, F-E-D-R-A-M-P. Yes.

DSRIP TEAM: OK.

DSRIP TEAM: We will note on that for – just to make sure the Cloud providers…

DSRIP TEAM: Thank you.

DSRIP TEAM: Thanks. Thank you.

DSRIP TEAM: They cannot hear you. You have to be closer.

[off mike]

DSRIP TEAM: Just to – we would like to add just one additional note to ensure that the Cloud provider can ensure the (distraction) of the data, the pre opt data that is required.

DSRIP TEAM: Right. So, that is the key point, is that you will receive this data file that includes all of the members who are attributed to you. So, once we have completed the (up sell) process, you will be sent an essence updated files, and that will reflect who you can and cannot have access the data for.

You have to, in essence, destroy the file that you had previously received and hence is now being replaced by the file that represents the intent of the patients, in terms of those who wanted to opt out of having their information (show).

DSRIP TEAM: You probably just want to have a business associated agreement with that vendor, you know, they are handling the (benefit) on your behalf and all, you know, that is something that they do (and should) understand what that is and, you know, be open to that, because they have to agree to all the same things you will be agreeing to with the department.

DSRIP TEAM: Right. Again, just to (inaudible) about the timeline and order, once the opt out process is (completed); we will notify the PPS that we have (projected) DOH Medicaid data. And before we send that updated data, we needed documentation that the (contact) that the (patient) has have has been (disposed) properly.

DSRIP TEAM: OK. All right. Next up?

Operator: Your next question comes from the line of (Crystal Rado). Your line is now open.

DSRIP TEAM: Hi. Good afternoon. I was hoping to get some clarification on and what is meant by remotely sharing (PHI) data. It is referencing a physical location, does that mean the facility as a whole or are you expecting the user to be in the data center with the server to access that information?

DSRIP TEAM: The way it was defined was within the facility, within the true local area network that is contained within a single structure. So, if you have got a VPN connection to a remote location or whatnot, that is considered a remote access. It would be within the same physical building and the same local network that the server resides.

DSRIP TEAM: And that would be until the security assessment is complete, and then those activities would be authorized, but we expect the security assessment first.

DSRIP TEAM: So, security assessment, implementation of the required controls depending on the level that comes out of that, and then you can relax that requirement.

DSRIP TEAM: One additional note is WiFi is not considered part of the solution. So, in that case, it would be considered on a remote side because it is not a physical Ethernet plan.

DSRIP TEAM: So, as long as they are on the same LAN – OK. I guess my second question would be the information we have received from you; is that encrypted right off the bat? Because I know we are going to have it encrypted at rest as well.

DSRIP TEAM: When you receive it from the secured file transfer process, the file will be encrypted – the files.

DSRIP TEAM: OK. OK. Thank you.

DSRIP TEAM: All right.

DSRIP TEAM: Thank you. Next up?

Operator: And your next question comes from the line of (Kara Petrudy). Your line is now open.

(Kara Petrudy): Our question has already answered. Thank you.

DSRIP TEAM: Great.

DSRIP TEAM: That was the best question we ever made. Surprise.

DSRIP TEAM: All right.

[off mike]

DSRIP TEAM: Just to say, next week, we will be having a webinar that (CMA) will be hosting on the secured trust file transfer process in getting ready to receive this data that some PPS are not fully ready and they have been calling a lot of question. So, we will be preparing this information next week for you.

DSRIP TEAM: When is that again?

DSRIP TEAM: That is next week.

DSRIP TEAM: When?

DSRIP TEAM: I do not know, I do not have the exact date.

DSRIP TEAM: OK. We will work on…

DSRIP TEAM: They are offering that. Yes.

DSRIP TEAM: OK.

DSRIP TEAM: So date should be announced early next week. All right. So with that, take us to the (inaudible) security – oh, we have one more question here from – let us bring the one more question up.

Operator: All right. Your next question comes from (Michael Carlburry). Your line is now open.

(Michael Carlburry): Hi. I want to clarify about the Cloud provider. (One of you said) we cannot use a Cloud provider until the opt out process is complete.

DSRIP TEAM: No.

(Michael Carlburry): Is that correct or is it now possible to do that?

[off mike]

DSRIP TEAM: After the security assessment, you have to complete your security assessment hopefully in that Cloud provider.

DSRIP TEAM: It will include the Cloud provider and their capabilities in that they can provide those required controls.

(Michael Carlburry): So, pre-completion of the opt out process, we can use a file provider?

DSRIP TEAM: Correct. As long as they – as long as you fully pass the security assessment and meet the state's requirement, you can use the Cloud provider.

DSRIP TEAM: Yes. If everything has come back and you are head of the curve and you have met all these things and have their capabilities, I think the answer is yes. I think if you are asking before you did that, you know, in the initial, with the (VA), then it says you get the data, have to be within the building for encrypted.

I do not think…

DSRIP TEAM: You cannot go give it to Cloud provider and access it.

DSRIP TEAM: Right.

DSRIP TEAM: We just want to be careful here, though, that if you complete the security assessment pre opt out, you can utilize all the capabilities that your security assessment authorize, but you still cannot share that data downstream with your…

[crosstalk]

DSRIP TEAM: If you are putting it in the Cloud but only accessing it by the (lead), that is fine, but you cannot put it in the Cloud and open up to access to your network prior to the opt out competing.

So, you got two things, right? You got the – you got to do the confidentially requirements through opt out and you got to complete security assessment.

(Michael Carlburry): Right. I think I understand. I mean, I guess the transition I missed was when the original concept essentially, it lay inside of a close building all through, (inaudible) operated by the PPS (lead) to the second that we are, you know, we have remote access during this opt out period.

Again, by (inaudible) employees, after we do this security affidavit. But the assumption was it still refer to a data center owned and operated by us, as opposed to a…

[crosstalk]

DSRIP TEAM: Yes. So the data center owned and operated by you with wired only access is what we are requiring prior to the completion of the security assessment. Be respective of the opt out; you got to do the security assessment and you cannot move the data beyond your data center and your four physical walls and, you know, wires into it kind of thing until you complete the security assessment.

But you cannot share that data, even after you have completed the security assessment with your partners until you complete the opt-out.

(Michael Carlburry): All right. That is helpful. The way I asked it earlier was treating our Cloud provider as a (inaudible) partner. There are some language that talks about technical partners being essentially (inaudible) partners and treated the same as a (inaudible) and clinical provider.

Where it is obviously a Cloud provider is the same thing, right? So I think I understand now. Thank you.

DSRIP TEAM: OK. All right. That is the end of the questions no data security. So, we are on to the initial discussion items. So, I think, Peggy, you wanted to make some remarks before you open it up for some final questions?

DSRIP TEAM: Right. I mean, again, just – we know that people who have questions regarding what course, you know, as previously said, we have been working with (11/99), with our health workforce folks, as well as talking to the Department of Labor to get a standard definition and standard, or standard job titles that we can then share with you.

I think, you know, we are all – we appreciate that everyone is looking for that kind of job definition consistency that will enable us to really look at these, you know, within a go from each PPS launch (intuitively), as well as across PPS.

You know, there is a larger effort; we do have a DSRIP and shift larger workforce workgroup. These are initiatives from our DSRIP panel, as well as the shift innovation council, and the interest, again, is looking at the workforce transformation over time.

The shift side has been looking at advance primary care with that particular focus as well as you all know, the (DSRIP) side as far as the larger healthcare workforce and the impact of the reductions in avoidable (ED) admissions, and all that we have been striving for.

So, those definitions, again, will be coming out in the next week or two. Additionally, we are working internally to see what else we can standardize and, you know, in collaborating with others to kind of reflect more of a industry approach and to get that out to you.

And as, you know, we said earlier on the (PCG) side, you know, the third, (we have probe with) the first submission, again, is your initial projection is informational; it is really the January 31st, which is the final piece, and we are all cautious and we want to work with you on that.

And so, we will – and on compliance, I know that the (inaudible) updated, there were update (cues) based on their guidance document that was released earlier this week, just to (punch) you to that website.

And at this point, we can take any other questions.

DSRIP TEAM: Yes. Open the floor. Two popped up quickly.

Operator: Your first question comes from the line of (John K.L.). Your line is now open.

[off mike]

John: … collaborative. I have a question about the project (inaudible). Can the behavior of health consultation, can it be telephonic to satisfy the requirement of having a behavior health and resources during all hours in collocation? And the same thing with primary care, can it be like a consultant that is available to end the question whenever (inaudible)?

DSRIP TEAM: Yes. Those are good questions. So, the challenge is sort of open-mic. We do not necessarily have all the right people in, but I would ask you to submit that formally to us through the general DSRIP e-mail so that we can particularly, I think we want to consult on the (three AI) with our own (inaudible) colleagues on that.

But why do not you send us – those are great questions and we will try to get clarification out to all parties.

DSRIP TEAM: I just give you this initial reaction, which is that, you know, we are trying to build out, for instance, health psychiatry to underserved populations in rural areas, et cetera. So, part of this make (inaudible) context as well. So, if you could give us a little context, that would be helpful.

DSRIP TEAM: Sure. Sure. Does it…

[crosstalk]

DSRIP TEAM: And you do not have to give it to us now. You can give it to us in the written thing and we will take it up at that point.

DSRIP TEAM: And you know, one of the – this is one of our topics, actually, that we want to spend a little more time on and are looking to our two-day conference in September, to have a session where we can talk further about the behavior health integration and such things as tell a psychiatry. So, we will be able to do that then.

The other thing, I want to just take this opportunity, as you know, as we are looking at (III AI), you know, the whole integration on model and the regulatory waivers associated with that.

I would like to clarify one thing; we have not received any applications to date for that regulatory waiver. Yes, we granted the waiver as pending to (five) specific application, which is available on the website. You can submit those application sites specific one by one. You do not need to do a batch application from the PPS.

Once you have a site and you are clear about what, if you want to file it, you can submit that; you do not have to wait for all the others.

PPS: Can I ask one more question? In terms of the waivers, the waiver for having two business on the same day, one psychiatric and one medical within the same site, I know that is a federal issue, so I am wondering, is there a way to do that because – to support these projects?

DSRIP TEAM: Right. The ultimate way to do that is to get out of (inaudible) and move to valley base payment. Because when you do that, that gives you the maximum flexibility. I think that is something we would be happy to work with you on. I think that is a good example. I mean, we are going to bump in to some of these things on the federal side, I am not afraid to ask for things on the federal side.

That said, the ultimate way out is value-base payment. And as I was suggesting yesterday when I spoke at the United Hospital Funds, we are encouraging PPSs and providers more generally not to wait on value-base payment to move fairly quickly into value-base payment.

And one way to do that is – one of the best way to do that is you get out of some of these restrictions such as the one you described.

PPS: OK.

DSRIP TEAM: Next up?

Operator: Your next question comes from the line of (Kara Petrudy). Your line is now open.

(Kara Petrudy): Hi. We had a question about the pack. We know there were suppose to have Medicaid representation. Is it possible to compensate these people for sitting on the pack and maybe for transportation, something like that?

DSRIP TEAM: Certainly. Good question. What you can do is, and we do this right now with our oversight and review panel that we have a member who we are – and we do, and you can cover travel expenses.

So, if the person has to for gas or bus or some form of transportation, addition if you have hotel stay or other type of expenses, we certainly do that for members of our oversight review panel. There would be nothing that would stop you from doing similar.

If you want to ask question about, like, compensation be on that, I would suggest that you submit it formally. I would want us to run that task to our

lawyers, just to make sure that I – because I do not know if the answer is, I hate to give you an answer without consulting with the lawyers first.

(Kara Petrudy): OK. So, who should we contact about that?

DSRIP TEAM: I think send it through the general (DSRIP) e-mail.

(Kara Petrudy): Yes. We are asking because I know with the house plans, they do compensate people to be on their appeals committees and they will provide a meal and they will provide monetary reward to attend.

DSRIP TEAM: Yes. It is a great question. I am not saying that there is anything that would – I mean, there is maybe completely permissible. I think it just makes sense for us to check to see if there would be any – I mean, you know, I cannot decide, you know, if it is being done in Medicaid manage care, that is a good chance that it would be allowed on this circumstance.

But I just think it is worthwhile for all of us just to check on that.

DSRIP TEAM: Yes. And what is being done with Medicare manage care, that has above Medicaid managed care.

DSRIP TEAM: OK. Yes.

DSRIP TEAM: (PMS) anyway, but…

DSRIP TEAM: Yes.

(Kara Petrudy): OK. That is it. Thank you.

DSRIP TEAM: Thank you. Next up?

Operator: And your next question comes from the line of (George Clifford). Your line is now open.

(George Clifford): Good afternoon. Thank you.

Our local (zip) funded entity advised us that they received notice from the DOH that their award, their anticipated award has been reduced by 50 percent.

And that is relevant to us in (DSRIP) because both the Albany med PPS and the Alliance for Better Health, our neighboring PPS, were collaborating with (zip) on workforce issues and some training issues, some prevention agenda issues among other things.

And so, the loss of funding is going to impact our ability to collaborate with them, it is also going to require us to rethink some of our action steps in terms of the deliverables that we have already provided in the organizational section.

So, I am wondering, first of all, if you can confirm that in fact the fifth funding has been cut, and whether you have any suggestions in terms of alternatives.

DSRIP TEAM: Sure. So, well, I cannot confirm as that the exact amount of reduction. I cannot confirm on top of my head what that reduction was, but there was a reduction off of what was initially anticipated.

The reason for that reduction was that after further consultation with (CMS), we are able to determine that the amount of federal funding available through the initial – through the initiatives that (federal financial) participation was much more limited than hoped.

As a result, we had fixed appropriation available the budget for this purpose, and we are just not going to be able to draw down as much federal money to all support the initiative, and that is what has led to that reduction in the future years, future budgets.

We will be looking to see to potentially supplement those awards, but, yes, the answer is that – now, in terms of it, there is nothing that would stop a PPS or the multiple PPS in the region contracting with the (fifth) to provide those set of services.

And obviously, you would use funds out of your existing award; that would be an appropriate use of (DSRIP) funds to partner and other PPSs, in fact, are using their funds to contract with the (pre-courser) to (fifth), the regional health planning organizations of which, I think is only one remaining, or

maybe there is a couple that are remaining, for example, I think also in addition to the (figure length).

And so, those are – and so, I think there is definitely (precedents) out there for how those entities have been brought in as active partners, and it is good to hear that you are partnering, but there would be nothing that would prohibit you from establishing an additional constructional arrangement to help fund activities that are done by the (fifth) on behalf of the PPS in the region.

Any other question? All right. Well, we have come to the end of the question; no one is in the queue. And we have come to closing remarks. So, we are going to end here a little early.

Do you have anything big to say other than – oh, we have one more question already jumped in at the last minute. So, take that last question.

Operator: Your final question comes from (Michelle Mersery). Your line is now open.

DSRIP TEAM: Just started the wire.

PPS: Just started the wire. Can you tell us what we might exact a transcript or a recording of this call?

DSRIP TEAM: It should be – it usually takes about 48 hours to turn that around. So, since we are near getting approach to closing it this Friday, I would say probably close the business Tuesday, maybe Wednesday, but that would give you the timeframe.

PPS: Great.

DSRIP TEAM: For those of you who want to do it all over again.

DSRIP TEAM: Sure. Thank you.

DSRIP TEAM: So you will not have the opportunity to listen to it over the weekend, unless you yourselves recorded this. So, but, yes, so we will try to make it no later than Wednesday of next week.

So, with that said, I want to thank everyone for participating. As always, we greatly appreciate all the hard work that is going in to this initiative; so much creativity and effort going on.

We know there is a lot of work to be done up to the 31st with the implementation plans. And obviously, we know that there is continuous to be more information coming out from us and you all have to absorb all that, and it is no easy task. But, you know, as I – I have chances to travel on state and meet with many of you, I am very impressed, we are all very impressed by how much hard work is going into it.

So, thank you everyone. I look forward to your feedback on this as an alternative to in person. I still think (inaudible) has great value, but I also think we were able to answer a lot of questions today, and so I think we definitely would love to use this format in the future for discussions and feedback.

So thank you very much and have a good weekend.

Operator: This concludes today's conference call. You may now disconnect.

END