From: Marcus Harazin
Sent: Monday, January 23, 2017 4:38 PM
To: DSRIP_Midpoint
Cc: Maria Alvarez; Lara Kassel;
Subject: Comments on Final DSRIP Mid Point Assessment

I am submitting comments for the New York StateWide Senior Action Council on the FINAL Mid Point Assessments. (These comments are in addition to our initial comments previously submitted on December 21)

The New York StateWide Senior Action Council, Inc. is a consumer run organization that promotes the independence and quality of life for older persons and their care givers. StateWide has member chapters across the state including Chapters in Albany (Capital District) and Saratoga Counties.

Our comments are related primarily the PPSs in the Capital District including:

Albany Medical Center, Alliance for Better Health Care, and Adirondack Health Institute.

However, many of these comments are applicable to most PPSs.

Thank you for the opportunity to comment on the FINALI Mid Point Assessments of the PPSs. The time available to comment on this massive amount of information was limited by we tried to capture some points base on our experiences to date.

Comments:

StateWide agrees with recommendations identified in the Final Mid-Point Assessment. The PPSs are moving heavily into the implementation phase and DoH is pushing to implement VBP strategies during this phase. DoH has also recognized the support and involvement of community based organizations as essential to the success of most PPS projects. I

Workforce Development Strategies-

PPSs should clearly identify plans to increase workforce capacity in the areas of patient navigator, care transitions, evidence based disease self management programs, home care and palliative care.

Engagement in Community Health and Long Term Care Planning-

All PPSs should contribute to development of other critical health planning efforts in the local and regional area. These include the plans developed by Public Health Agencies, Mental Health Agencies, Long Term Care Councils, and Area Agencies on Aging. Efforts should include sharing information and data on under served or unserved populations and on causes of frequent hospital readmissions as well as on the location and characteristics of hotspot areas identified by the PPS.

5% Funding Process Should be Opened to CBOs

Little information has been available from all of these PPSs regarding how CBOs might be able to partner with the PPSs to use 5% funding available for non-safety net providers. This is the only flexible funding that the PPSs have to address social determinants and other community based services. Each PPS should be required to identify how such funds are being used and how community based organizations my make proposals to utilize such funds to address problems that cannot be fully addressed through existing PPS projects.

PPS Consumer Listening Sessions

Input from Medicaid recipients about community health care needs is critical. Each PPS should be required to with with CBOs hold consumer listening sessions to gain insights regarding barriers and needs, especially in hotspot areas.

Value Based Payment Demonstrations-

PPS should engage local CBOs in developing and testing VPB approaches that include non-medical services. Little experience or guidance exists to help CBO negotiate this financing terrain. Once models is successfully developed they can be shared with other PPSs to encourage far deeper engagement of CBO in PPS projects. The flexibility afforded by VBP allows providers to work out of the clinical box.

An example cited by DoH would be when a hospital utilizes funding flexibility to have a home delivered meal dropped off by Federal Express to help support nutrition needs rather that readmitting a patient due to dehydration or other nutrition related problem. A better example would be to utilize the local home delivered meals program so that nutritional status is observed and the safety of the patient is monitored during the visit.

Utilize CBOs in Care Transitions and Care Navigation Strategies -

Increased availability of patient navigation is a critical component of DSRIP. Medicaid recipients most at risk of readmission can benefit from patient navigation. Most PPSs have focused placement of navigators and care management in the emergency rooms and hospitals. The PPSs need to find ways to contract with CBOs to provide such services out in the community. CBOs are often in the best position to meet address the problems of various special needs groups such as the elderly or limited English speaking populations. PPSs should also coordinate such services with local NYConnect long term care programs and 211 information and assistance programs.

Marcus Harazin
Coordinator Patient Advocates Program
New York StateWide Senior Action Council

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Patients Rights Helpline: 800-333-4374

Center for Disability Services

Where people get better at life

January 23, 2017

DSRIP Independent Assessor
Public Consulting Group
Boston, MS

To Whom It May Concern,

On behalf of the Center for Disability Services located in Albany, New York, I am writing in support of the implementation achievements of the Albany Medical Center Hospital Performing Provider System (AMCH PPS) related to projects 2.b.iii and 3.b.i.

The Center for Disability Services, a private not-for-profit health and human services agency in Albany, NY, founded in 1942, touches the lives of approximately 12,000 individuals/patients and their families in the Capital Region (and beyond) each year. CFDS provides a full array of services for individuals with disabilities and their families including residential, adult day/vocational, Medicaid Service Coordination, school-age and preschool programs, a pediatric skilled nursing facility, and transportation services.

The Center's healthcare practice, Center Health Care, provided nearly 66,000 outpatient adult/pediatric primary care, dental, medical specialties and outpatient therapy/counseling services for approximately 7000 patients in its Article 28 and Article 16 clinics in 2015. 56% of the services provided through the Article 28 Clinic were for individuals with intellectual and developmental disabilities (IDD) and the remaining 44% were for patients without IDD (many with TBI, MS, or other chronic disabling conditions). The greatest number of Article 28 Clinic appointments were for dental services (8778) and the second greatest were for primary care/women's health services (6323). These were followed by psychiatry (3818) and neurology (3518). 84% of the individuals receiving services at Center Health Care have Medicaid in their funding stream.

Through significant and successful Practitioner Engagement efforts by the PPS, I and several others from our agency have become actively involved in the clinical committees responsible for guiding the implementation of the aforementioned projects. Within our organization, some of the activities we have undertaken/are in process to support the implementation of project 2.b.iii include:

- Achieving NCQA Patient Centered Medical Home 2014 Level 3 recognition in February of 2016
- Addition of a full-time RN Care Manager in our Primary Care practice to support all aspects of the PCMH, a large piece of which includes managing care transitions

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- Strengthening data exchange through HIXNY connectivity
- Active participation in the Primary Care Advisory Group
- Active participation in the Clinical Integration Workgroup
- Assisting the PMO with the selection of a PCMH vendor by reviewing RFAs
- Looking for opportunities to expand primary care access
- Collaborating with EDs for transitions of care (in process)

As participants in project 3.b.i my organization has taken the following steps toward implementation:

- Adoption of strategies from Million Hearts Campaign
- Adoption and implementation of JNC 8 guidelines and Cholesterol Management guidelines
- Adoption and implementation of Walk in Blood Pressure checks without copayment or advanced appointment
- Documentation of self-management goals and providing patient support (in process)
- Using the EHR and registries to track patients with HTN or who are in need of follow up (in process)
- Implementation of medication regimen simplification (once daily regimens and/or fixed dose combination pills)
- Using the EHR to prompt the 5A's of tobacco control and referring patients to NYS Smokers Quitline as appropriate

To provide balance, there have been times when we have been disappointed in the PPS's response to proposals, suggestions and/or requests that we have put forward that we felt could be mutually beneficial (most often a lack of response). For example the Center has offered a potential solution to address some of the transportation issues with attributed patients on numerous occasions but has not received a response, even to say that they are not interested. Likewise, we have reached out on numerous occasions to see if there was a way for the Center to engage with the asthma project, without a meaningful response. This lack of follow through and responsiveness can create the perception that the majority of the PPS's DSRIP funds and efforts are being directed inwardly to the Medical Center and PMO itself.

Despite these concerns we hope to convey the significant accomplishments that have been made by the PPS to meet the required milestones and, more importantly, to transform care delivery in our region. AMC was the first, and has been the most consistent of the three PPS with which we are affiliated, to engage and encourage the Center's active participation in all aspects of PPS planning and implementation.

Thank you for your consideration of this perspective.

Sincerely,

Maria Kansas Devine, MD
Chief Medical Officer
Center for Disability Services

COMPA

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COALITION OF MEDICATION-ASSISTED TREATMENT PROVIDERS AND ADVOCATES

January 23, 2017

To: dsrip_midpoint@pcgus.com

Comments on the DSRIP Independent Assessor Mid-Point Report

COMPA, the Coalition of Medication-Assisted Treatment Providers and Advocates, is the non-profit membership organization dedicated to treating addiction through the use of pharmacotherapy as a part of a comprehensive bio-psycho-social approach to treatment. Our program members treat New Yorkers from every corner of our state and help them to overcome their dependence on illicit opiates and other drugs. COMPA represents the Opioid Treatment Programs of New York State, currently providing medically needed opioid addiction treatment services to approximately 41,000 New Yorkers and is the New York State member program of the American Association for the Treatment of Opioid Dependence (AATOD).

The New York State Delivery System Reform Incentive Payment Program (DSRIP) is the key to restructuring the Medicaid system with the goal of reducing avoidable hospital use by twenty-five percent over five years. COMPA supports the goals of DSRIP and the Medicaid Redesign Team's Waiver of improving the quality of healthcare and outcomes for Medicaid beneficiaries while containing costs. We are mindful that if New York fails to improve and meet the DSRIP milestones, there will be real consequences impacting the delivery of services to the vulnerable population that we serve.

Thank you for the opportunity to submit comments on the DSRIP Independent Assessor Mid-Point Report. We have focused our comments on the feedback and concerns received from our members, specifically: Partner Engagement, Project 3ai, and Reporting.

Partner Engagement

There is a range of experience of regarding partner engagement across our member programs in the Performing Providers Systems (PPSs). Examples of some non-hospital based member programs who report a high degree of involvement and participation in PPSs and hold Governance and Co-Lead positions include VIP Community Services in Bronx Health Access Bronx Lebanon and Bronx Partners for a Healthy Community/ St. Barnabas and Lower Eastside Service Center in Mount Sinai PPS.

Nevertheless, the Independent Assessor (IA) overall finding on partner engagement is troubling. *"A majority of the PPS are behind on their Partner Engagement goals at this point in DSRIP. Most PPS need to focus their attention and funding to engage key partners."*

The complex, high-utilization populations that significantly impact the cost of the health care system in New York through avoidable hospitalizations and use of the EDs are those with behavioral health disorders. The presence of drug and alcohol disorders or mental illness is associated with higher per capita costs and hospitalization rates (Boyd et al., 2010). Individuals with SUD are among the highest-risk populations for medical rehospitalizations and are often underdiagnosed at initial hospitalization. (Irmiter, Barry, Cohen, & Blow, 2009)

COMPA received many reports from member programs who were unable to or had difficulty joining PPS networks during implementation and this has continued during the periods of "open enrollment." The lack of partner engagement of SUD Providers is evident in the IA Assessment in most PPSs throughout the state. Not visible in the IA Assessment, but equally of concern, are reports from members *within* hospital-based systems. There is often a lack of engagement and inability to participate in DSRIP in a meaningful way for SUD providers and especially of for Opioid Treatment Program (OTP) providers that operate within the same hospital-based PPS system. The infrastructure required to operate the PPS networks have not necessarily enabled communication, nor participation within hospitals among those that provide care.

In response to an apparent lack of enthusiasm on the part of PPS organizations to welcome and engage, SUD providers have informally been advised to push their way in to get a seat at the table. This is an inefficient way to meet DSRIP goals. It increases demands on the smallest providers with the fewest resources. A requirement that puts this burden of engagement on the PPS where there is a control of funds and established infrastructure is recommended.

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

As the IA notes, *Project 3.a.i is one of the most important projects in DSRIP thus it is critical that the project is implemented successfully.*

New York's Opioid Treatment Programs (OTPs) provide a unique platform for fully integrated behavioral health and medical care that meet the goals of project 3.a.i./Model B. OTPs are regulated to provide medical examinations, treatment is comprehensive and multi-disciplinary, and includes counseling and medication, and OTP patients visit an average of 3.5 times per week. This collaborative medical model combined with frequent contact, allows for medical and clinical staff who get to know the patient particularly well; in many cases, the OTP serves as the most, or only, source of stability in the patient's life.

One barrier to implementation and to meeting DSRIP patient engagement targets has been an inability to integrate coverage between medical and behavioral health for facilities by Managed Care Organizations. The inability for programs to be reimbursed at a sustainable rate is a serious problem for one of the most important projects in DSRIP and its successful implementation. Although the Integrated Outpatient Services License is available to providers, it does not address the issue of reimbursement, as MCOs are not required to pay primary care claims under this arrangement.

While a Value-Based Payment arrangement for an integrated primary care and behavioral health bundle may be contemplated, it will take considerable time and care on the part of all stakeholders to achieve. In the meantime, the benchmarks for success in this important project and the successful implementation of the model for vulnerable populations, depend on a coordination of a reimbursement for New York's

Behavioral Health facilities. It is unclear how to meet the DSRIP timelines for this important project with no resolution to this issue for so many providers across the state.

Another challenge, discussed in Project 3.a.i but not in the IA Assessment, is the lack of access and extremely long waits to specialty care for Medicaid beneficiaries. Integrated care providers hoping to expedite this care through connection to the PPS network report that even same-hospital based primary care providers have similar challenges.

Reporting

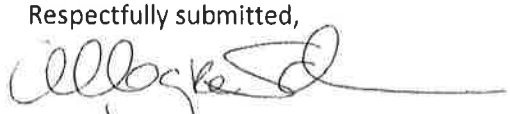
There is a significant need to streamline reporting requirements. PPS partners are burdened with surveys, meetings, and reporting that far exceeds the flow of funds and costs of participation. Many providers have determined that if training and/or educational, or referral opportunities are available then DSRIP will prove to be worthwhile for them as providers. It will become increasingly difficult to motivate partners to participate without serious reevaluation. The 360 survey itself is a low sample with some low responses, which ultimately calls into question the ability to measure and gain insight in the future unless partner engagement is addressed.

Conclusion

DSRIP has successfully promoted collaborations among providers that would others not have been brought together. This was a critical goal, with the intent to serve as a stepping stone to Value Based Payment arrangements. There is still work to do in terms of Value-Based Payments, but the collaborations have their own rewards. It is important for Medication-Assisted Treatment and OTP providers to meet and collaborate on a variety of projects. This is has been an opportunity for providers to familiarize themselves with our field which might otherwise not have occurred.

COMPA is concerned that the lack of attention to and participation of SUD providers, as noted in the IA Mid-Point Assessment is significant given the importance of this high-risk, high-use patient population. New York's Opioid Use epidemic and its impact on the healthcare system with the associated costs, makes this lack of engagement of SUD providers in the PPS networks by 25% more alarming in terms of achieving the goal of reducing avoidable hospital use over five years. COMPA recommends using the Midpoint Assessment as an opportunity to review DSRIP from a "bottom-up" perspective.

Respectfully submitted,



Allegra Schorr
President
COMPA

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STATE WIDE

New York StateWide Senior Action Council, Inc

Improving The Lives of Senior Citizens & Families in NY State

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January 19, 2017

To New York State Department of Health DSRIP Team,

The New York StateWide Senior Action Council, Inc. is writing to support the Albany Medical Center (AMC)Performing Provider System efforts to implement the Delivery System Reform Incentive Payment Program.

We are a community based organization that provides patient advocacy and counseling in the Albany area and we are a partner with AMC on the 2.A.I, 2.A.V, and 2.D.I. projects. We are participating on the project team for the Medical Village/Alternative Housing project (2.A.I) We also participate as members of the Community Affairs and Consumer Advisory Committee(CCAC), Project Advisory Committee and Cultural Competency and Health Literacy Committees for this PPS. We currently co-chair the CCAC. That committee is unique. The other PPSs in our area do not have such a committee and there are far less opportunities presented for dialogue and input. Through the CCAC, AMC has held meetings in each hub of the PPS area providing community based organizations, providers, and consumers with access to the AMC PPS activities. They have also actively engaged partners through their Cultural Competency and Health Literacy Committee to help identify gaps in the current system and provided training to strengthen the capacity of communities to better serve culturally diverse and limited English speaking populations.

We wanted to note that AMC has made efforts to be inclusive of our organization in the implementation in the projects that we are working with them on. While role has been a limited one to date, we expect to play a bigger role in reaching Medicaid enrollees through the 2.D. I Medical Village/Alternative Housing project which will be moving from a formative to an implementation stage. This project will help increase access to health and supportive services through innovative approaches to aging in place such as Neighborhood Naturally Occurring Retirement Communities (NORCs). It will consider possibly transforming are nursing home resources so that they can increase the level of community based care for high risk populations such as the elderly and disabled.

In addition to engaging community based organizations through the Community Affairs and Consumer Advisory Committee, the AMC PPS has made extra efforts to work with community based organizations

to engage Medicaid beneficiaries through innovative consumer listening sessions in order to find out more about their critical needs and barriers to good health. Our agency was one of the CBOs who worked with AMC on this project. We convened five listening sessions at inner city low income and family type housing in the City of Albany and in senior citizen housing in Saratoga County. Similar sessions were held by other CBOs. The results from these sessions have provided AMC with a better understanding about both medical needs and important barriers related to social determinants of health in the PPS area. This approach is one that should be used by all 25 PPSs so that input from Medicaid beneficiaries is considered in the implementation, design and delivery of care through the transformed systems.

We hope that this information will provide a fuller understanding to the efforts that the AMC PPS has made to implement their DSRIP plans for system transformation in their five-county service delivery area.

Sincerely,

Maria Alvarez

Maria Alvarez
Executive Director